Through Assessment to Consultation

Edited by
Ann Horne
and Monica Lanyado

Independent Psychoanalytic Approaches with Children and Adolescents
Winnicott’s description of ‘doing something else’ or ‘working as a psychoanalyst’ when not engaged in the actual analysis of his patients resonates with the child psychotherapist today. Individual psychotherapy is certainly a valuable part of the work but much of the time the child psychotherapist is ‘doing something appropriate to the occasion’. Some of this time is spent in assessment work – for therapy, for the multiprofessional team and for other agencies – and some in consultation to colleagues and other professional staff or in a combination of the two.

Drawing from the Independent tradition in psychoanalysis, *Through Assessment to Consultation* explores the application of psychoanalytic thinking to this daily work, reflecting on what is actually done and why. Contributors to the three parts – ‘Assessment’, ‘Overlaps’, ‘Consultation and Beyond’ – provide a variety of clinical illustrations as they describe a array of approaches and settings in the tasks of both assessment and consultation, ranging from the light impact of the analyst’s presence in the grief of post 9/11 New York to the call to political potency of ‘Beyond Consultation’.

This book will help both new and experienced child and adolescent psychotherapists re-examine their role and function in the team and in the outside world, and will also be of interest to specialist health workers, educational psychologists and those wanting to explore more Winnicottian approaches to therapeutic work.

**Ann Horne** trained in the Independent tradition at the British Association of Psychotherapists. She has discovered that retirement (after ten years latterly at the Portman Clinic, London) can become very crowded and makes occasional sorties from behind the keyboard to speak and teach in the UK and abroad.

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Independent Psychoanalytic Approaches with Children and Adolescents series
Series Editors: Ann Horne and Monica Lanyado

Titles in the series

A Question of Technique
*Edited by Monica Lanyado and Ann Horne*

Through Assessment to Consultation
*Edited by Ann Horne and Monica Lanyado*

“This book is a welcome addition to the clinical accounts of Analytic work with children, young people and their families. The understanding provided here is a timely reminder that working indirectly to help frontline staff reflect is essential if good, objective decision making is to underpin the complex situations confronting workers in a whole range of settings in Children’s services.”

Judith Trowell, Professor of Child Mental Health, CSIP, University of Worcester & Honorary Consultant Psychiatrist, Tavistock Clinic.

“The application of a psychoanalytic approach to areas other than individual treatment forms an essential part of child psychotherapy practice. The wide-ranging and insightful contributions to this book address some of the most difficult and complex areas of work, including inpatient treatment, court reports, consultation to staff caring for victims of sexual abuse, and many more. Clinicians seeking to help new client groups while retaining a psychoanalytic perspective will find this an invaluable resource.”

Maria Rhode, Professor of Child Psychotherapy, Tavistock Clinic/University of East London.

“I highly recommend this book to anyone who is interested in the future of child and adolescent mental health. In the future child psychotherapists will rely increasingly upon the development and adaptation of their psychoanalytic knowledge and skills in the practice of assessment and consultation. This book addresses complex issues that the practitioner will face, such as the impact of a traumatised child’s disturbance, race and culture, and the use of the transference and counter-transference. The informative and accessible chapters cover work in CAMHS and specialist settings, including assessments for court, as well as special problems presented by under fives, the dangerous child, adolescents and risk assessments. I also recommend this book to policy makers, members of multi-disciplinary teams, and those in management and commissioning who would like to know how child psychotherapists could help to deepen and broaden the provision of mental health care for children and adolescents.”

Donald Campbell, Child, Adolescent and Adult Psychoanalyst & Past President of the British Psychoanalytical Society.
Through Assessment to Consultation
Independent Psychoanalytic Approaches with Children and Adolescents

Edited by Ann Horne and Monica Lanyado
In memoriam

Wallace Hamilton
Catriona Hood
Isabel Menzies Lyth

with affection and gratitude
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Sophie Robson trained as child and adolescent psychotherapist at the British Association of Psychotherapists, having previously worked with families, young people and children in education and community settings. She currently works for Bromley Child and Adolescent Mental Health Service with the Looked After Children’s team and Bexley CAMHS where she is a part of the Bexley Under Fives Service.

Gethsimani Vastardis trained as a child and adolescent psychotherapist at the British Association of Psychotherapists, where she has served as Head of Training. As a senior member of the BAP she continues to be involved in its professional life as a teacher, training supervisor and member of the child psychotherapy training committee. She was also part of the BAP team that developed and delivered the BAP/Birkbeck College MSc course on the Psychodynamics of Human Development. She has worked in various NHS settings and is the Head of Child Psychotherapy in a north London CAMHS. She has a particular interest in work with under fives and with children on the autistic spectrum and their parents. She retains a lively interest in classics.

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Peter Wilson has trained in social work, youth work and in child psychotherapy at the Hampstead Clinic (now the Anna Freud Centre) where he was a staff member before heading south to bring child psychotherapy to Brixton, Camberwell, Peckham and the Institute of Psychiatry. A former
Director of the Brandon Centre and staff member at the Brent Consultation Centre, he later became consultant psychotherapist at Peper Harow therapeutic community. From 1992 until his retirement in 2004, he was director of YoungMinds (of which he was co-founder), the children’s mental health charity, leading its development into an established authority in the field. He served on numerous committees and inquiries in relation to national developments in child and adolescent mental health service provision and lectured widely throughout the country on child development, organisational and service developments. Currently Clinical Adviser to The Place 2 Be, he is also a consultant in child and adolescent mental health services and child psychotherapy.
Acknowledgements

We are grateful to the editors and publishers of *Infanzia e Adolescenza* for permission to publish Vickie Hamilton’s chapter, originally one of six clinical reports in *Thoughts on Crisis Intervention with New York City Children after the World Trade Center Bombing* by C. Anzieu-Premmereur, S.W. Coates, E. First, V. Hamilton, D.S. Schechter and Z. Steinberg (2002).
1 Introduction
‘Appropriate to the occasion’

Ann Horne and Monica Lanyado

If our aim continues to be to verbalise the nascent conscious in terms of the transference, then we are practising analysis; if not, then we are analysts practising something else that we deem to be appropriate to the occasion. And why not?

(Winnicott 1962: 170)

I am not like what I was twenty or thirty years ago.

(Winnicott 1962: 169)

‘Practising something else’ and ‘doing something else’ will be familiar phrases to the reader versed in Winnicott. In ‘The Aims of Psychoanalytical Treatment’ he explores ideas about the appropriateness or otherwise of analysis in certain circumstances and at times will ‘find myself working as a psychoanalyst rather than doing standard analysis’ (Winnicott 1962: 168). Yet one might question whether this should, indeed, be called ‘doing something else’. This volume explores some of the work undertaken by child psychotherapists that is not standard individual psychotherapy or psychoanalysis. In its chapters, there is a recurrent theme: that appreciation and use of transference and countertransference phenomena is always part of what we do. The unconscious or ‘nascent conscious’ process intrigues us and we look assiduously to discern its workings. At times, however, we do not articulate this – or we find ways in which to express our understanding that do not involve offering interpretation. It may not be the one to one of the consulting room, the hurly burly of the chaise longue indeed, but it is just as passionate and just as psychoanalytic.

This book grew from discussions between the editors as to the nature of assessment. Paradoxically, it is not a handbook on assessment – was neither envisaged as such nor bears any pretence of being so. We concluded that assessment both continues throughout any work (it is always therefore ‘an assessment in progress’ even when we call it therapeutic or analytic treatment) and that it is also important to reach a formulation, a working diagnosis that one holds in mind and that has a dynamic life. As Winnicott
wrote: ‘The essential thing is I do base my work on diagnosis’ (Winnicott 1962: 169). We also noted that a request for an assessment invariably involves something additional – often a follow-up consultation. Yet we frequently speak of these two – assessment and consultation – as totally separate tasks. To consider a continuum, therefore, where much of what we undertake as child psychotherapists is located not at either end, in hypothesized ‘pure’ forms of assessing or consulting, but is more central, leaning in either or both polar directions and usually overlapping, seemed useful. And the title, of course, resonates with our Independent and Winnicottian identity.

This book is also about diversity. It demonstrates many of the ways in which child psychotherapists are currently helpful to children and their families by being involved in their internal and external realities other than in individual psychoanalytic work. In this, we hope to give pause to those who, in management, commissioning or other agencies, have a simplistic ‘take’ on what child psychotherapists do.

We have chosen to start the volume with an overview of assessment in the multiprofessional Child and Adolescent Mental Health Service (CAMHS) team. In Chapter 2, Mary Walker provides a measured and thoughtful ‘setting of the scene’: even here the role of the child psychotherapist is enormously varied in demands and practice.

In Chapter 3, Deirdre Dowling describes inpatient work with families who are being assessed for the court to see if the children are safe in parental care. In this anxiety-provoking situation the child psychotherapist’s skill enables the child and parent/s realistically to face and work on the problems in their relationships, whilst keeping the primary task of assessing the risk to the child in the centre of the frame. The necessarily protracted assessment is reported back to the court and is crucial to the life-changing decisions that need to be made.

Issues of risk also inform Chapter 4 by Parsons and Horne. They follow the course of the request for an assessment of risk, commenting on the stimuli that lead to the need for this being experienced in the referring agency, and offering considered thought and advice on the process at all levels.

In Chapter 5, Joelle Alfillé-Cook gives a specific focus on the problems of assessing adolescent patients, locating it in both a developmental and a clinical context, and exploring the clinician’s experience when engaging in adolescent work in a school setting.

Two of the chapters propound an overtly political agenda and urge us to look more widely than our clinical roles – indeed, wider than the family or team or Trust environment that normally preoccupies us. In Chapter 6, Caryn Onions interviews Dilys Daws about her pioneering work in parent–infant psychotherapy as well as her vigorous campaigning for child psychotherapy and infant mental health, through the founding of the Child Psychotherapy Trust and the Association of Infant Mental Health (UK).
This delightful interview gives a vivid account of Dilys Daws ‘doing something else’ in her unique, modest but always powerful way. By becoming active in setting up organizations that further the well-being of vulnerable children and being prepared to fight for their needs, politically and in the media, she has convincingly drawn attention to their plight, as well as how they can be helped. The core understanding of the infant and child’s inner world is always evident and is what gives her message its power.

Being prepared to get involved in the fray of organizations, government committees and the media is also Peter Wilson’s passion (Chapter 13). The conviction with which he has argued for a better understanding of child and adolescent mental health and mental health needs, culminating in co-founding YoungMinds, is also given authenticity by being steeped in his clinical practice as a child psychotherapist. His progress is very straightforwardly described, but the impact of a committed and experienced clinician being prepared to challenge the often inward gaze of the profession and seek remedy and progress outside has been dramatic. Daws and Wilson illustrate how vital it is to be able to move creatively between the intimacy of what is observed, felt and understood in the consulting room, to the external environment, so that necessary change can be brought about in the external as well as the internal world.

It is not surprising that Part II – Overlaps – involves at times more personal description. Indeed, the whole process of moving to ‘do something else’ necessitates a personal shift in clinical approach – as we noted in Winnicott’s words at the start of this Introduction: ‘I am not like what I was twenty or thirty years ago’ (Winnicott 1962: 169).

A different personal account, equally of finding an intervention ‘appropriate to the occasion’, is contained in a short memoir by Victoria Hamilton (Chapter 8) of a practical and humane response to the human tragedy of 9/11. Living and working in New York at the time of the bombings, she and Susan Coates offered their help at Pier 94 through their capacity to be ‘real objects’ who simply listened to the family experience of multiple trauma. This is a delicate and almost imperceptible approach to brief consultation and crisis intervention where, without any analytic explanation, a therapeutic encounter of the most profound kind can take place.

Iris Gibbs (Chapter 7) has long been called on to offer knowledge and support to colleagues in a wide range of organizations and her reflections on race and culture in both assessment and consultation are timely in a society that once again has resorted to the expression of anxiety through racial polarizations. This should be a known current in all our work and should inform all practice.

Although the risk presented by an apparently unpredictably violent and dangerous teenage boy who had admitted to several serious counts of arson is the frame of Ann Horne’s ‘From Intimacy to Acting Out’ (Chapter 9), the author reflects on the countertransference experience in such encounters and gently urges that omnipotence is not a helpful attribute in the child
psychotherapist. The case involves the unintended psychoanalytic assessment of the boy, thoughts on its usefulness, and the necessity of follow-up feedback and consultation to the staff of his secure unit.

The theme of ‘listening’ is the cornerstone of Monica Lanyado’s chapter about consultation to staff in specialized therapeutic units working with severely sexually abused and traumatized children (Chapter 11) The ‘impact on the listener’ of truly listening to and hearing about what these children have suffered – verbally, through play and particularly through nonverbal projections which must be processed in the countertransference – can become cumulatively traumatizing for the staff. The child psychotherapist’s experience of struggling to process her countertransference when working individually with these children is extremely valuable in helping her to recognize and work with these anxieties and defences – personal and organizational – when consulting to therapeutic unit staff groups. This kind of psychoanalytically informed consultation is seen as essential for the well-being and ‘health and safety’ of the staff.

‘Listening’ is also part of Sophie Robson’s chapter where the reader encounters the child psychotherapist as a part of a multidisciplinary team working with the under fives – seeing the families as well as facilitating a valued reflective meeting in which painful and difficult countertransference issues can be talked and thought about (Chapter 10). Again, the capacity to move from ‘sleeves rolled up’ participation in the team to reflective consultant is an important feature.

One could view Gethsimani Vastardis’s chapter (Chapter 12) as just as political as those describing the passions of Dilys Daws and Peter Wilson. It is. It is also a profoundly thought-provoking reflection on roles, groups and context – and one which all child psychotherapists (especially those in managerial posts) should find enlightening. Child psychotherapists have grown almost happenstance into management: organizations eventually require someone to take on the function. The author’s capacity to retain thought and to seek integration and joint ownership of issues is an exhortation to the profession.

The organization of the book into three parts, Assessment, Consultation and Beyond and, in true Winnicottian fashion, what we have called Overlaps – a kind of transitional section which bridges what is often taken to be the gap between the two – may strike some as contrived. Forgive us if it does. The continuum is neither static nor rigid and we move about it as we hope we have shown.

I aim at being myself and behaving myself (Winnicott 1962: 166)

Winnicott’s influence is more subtly present in the current volume than in A Question of Technique, the first book in the series. It is taken as a basic axiom of this Independent approach that the environment has an impact on the internalizations and psychological structure of the child. We therefore
consider and work with and in the environment that a child is trying to grow and recover within. This is intrinsic to the total therapeutic approach, be it with the legal system, secure unit, inpatient hospital setting, CAMHS team, education – and with the greater political world outside. More than that, there is a pragmatism and practicality about the chapters which illustrate a ‘have a go’ attitude – but in a thoughtful, responsible and disciplined way. We behave ourselves. This is an attitude which Kohon captures succinctly when he writes: ‘The Independent position is characterised by a reluctance to be restricted by theoretical or hierarchical constraints’ (Kohon 1986: 50).

Like Winnicott, as Independents we aim at being ourselves – and as true psychoanalytic practitioners we also include behaving ourselves, keeping a compassionate ethical sense that does not abuse the analytic method even while we explore extensions of our technique and understanding to a wide range of settings. The framework of the psychoanalytic approach is not rigid: it gives us a sure foundation and encourages us as individuals to find creative pathways in the variety of encounters that form our working days. We hope that this sample, this selection of ‘what else we do’, engages the reader.

References


Part I

Assessment
2 Every assessment matters

The child psychotherapist’s role in assessment in child and adolescent mental health settings

Mary Walker

Introduction

It is a common experience for all of us that entry into a treatment setting of any kind requires initial screening and assessment for complexity, severity and appropriateness. This is certainly true for child and adolescent services where there are a number of gateways to pass through before specialist treatment can be offered. Consequently, assessment procedures have become more formalised and provide an important first intervention for children and families.

It is helpful to look at the root of a word to understand better how it has been used. Assessment is derived from the Latin *assidere* and means ‘to sit beside’. This was originally used in the context of weighing up a person’s assets for the purposes of tax. In the framework of a Child and Adolescent Mental Health Service (CAMHS), clinicians try to understand the nature of a child’s difficulties and to weigh up those assets that will facilitate the development of individual potential and those which may hinder good mental health, resulting in regression and symptomatic behaviour. This will include an evaluation of the internal resources of the child and the external environment around him. Such an assessment leads to a formulation about the child’s difficulties and a recommendation of appropriate therapeutic intervention – child psychotherapy, systemic family psychotherapy, cognitive behavioural therapy, group work, referral for a psychiatric assessment and so on. It is a complex process, made all the more challenging as it has to be undertaken against a backdrop of government and trust frameworks and targets, limited resources, growing demand and in the context of a multidisciplinary (multiprofessional) team.

The need for mental health services for children and young people has long been established by research. Surveys completed by the Office of National Statistics (ONS) for the Department of Health (1999, 2004) show that 10 per cent of children in the UK suffer from mental health problems. The finding of the 2004 survey – that one in ten children aged 5 to 16 had a clinically recognisable mental disorder – confirmed the results of the earlier survey. In this most recent survey, 4 per cent of children were found to have
an emotional disorder (anxiety or depression), 6 per cent a conduct disorder, 2 per cent a hyperkinetic disorder and 1 per cent a less common disorder (including autism, tics, eating disorders and elective mutism). Two per cent had more than one disorder.

There is tremendous pressure on child and adolescent services to treat more children and to comply with government targets to reduce waiting times for assessment and treatment. Consequently, assessment procedures have needed to be clarified for both professionals and users of the service. This mounting pressure for increased capacity in CAMHS has also challenged the child psychotherapist’s traditional role as provider of longer term therapy. Increasingly we have adapted our practice to apply our specialist training and skills to other areas of multidisciplinary work. We regularly undertake initial assessments of young people as they enter the service as well as use our assessment skills in other ways, of which the specialist assessment of children for psychotherapy is now but one.

**The developing role of the child psychotherapist in child and adolescent services**

Child psychotherapy has been recognised by the National Health Service (NHS) as one of the core professions in child and adolescent services since 1949. Professional numbers were very small at first and mainly based in London where the training schools were located. The profession grew, however, to become an important contributor to the work of the multidisciplinary team. Initially the role was seen as principally providing psychotherapy to more disturbed children for an extended period. It was considered to be specialist rather than generic work, and additional input to the team was provided through team discussions, consultation, supervision and training. This approach was protective of professional boundaries and in keeping with the way other professions viewed their contributions to the team.

Major shifts in government policy in the 1990s placed much greater emphasis on services working together (NHS Health Advisory Service 1995; Department of Education and Skills 2004). There has in tandem been a focus on challenging the traditional roles held by the various health professions in the NHS and the government documents on ‘New Ways of Working’ (NWW, the most recent is April 2007) outline how this programme aims to change workforce practice and extend roles beyond current professional practice. As the NWW website states: ‘There is no single model for NWW; it is simply about making the best use of the skills in the workforce to meet need in a cost effective way.’

Child and adolescent professionals are beginning to feel the impact of this programme. There is real worry that, as services and treatments are targeted at specific client groups, there will be a reduction in the number of highly skilled practitioners able to oversee the broader developmental needs
of children and think about them in a more holistic manner. As a child psychotherapist I constantly consider how I can best utilise my training and core skills and make an effective therapeutic contribution both to the burgeoning clinical work of my team and to our clients. But as I look at my own practice and that of my child psychotherapy colleagues I do believe that as a profession we have been extending our role in our teams for quite a few years now.

Our training as psychoanalytic psychotherapists focuses on unconscious processes, the role of anxiety and defences, as well as on how emotional states affect our relationship to external reality. We are grounded in a thorough knowledge of child development and give a central focus to the emotional life or inner world of the child. Theoretical understanding and observational skills are seen as essential tools in our insight into children’s emotional states, their impact on family members and how the child’s experiences are communicated through play or the use of symbols. Our training provides us with an understanding of ordinary developmental processes as well as of risk factors such as trauma, neurological impairment and family dysfunction that may impede development. This prepares us to work effectively with a full range of disturbed and damaged children and practitioners have been applying these skills across a wide range of clinical work, groups and symptomatology: individual psychotherapy, family work, parent–infant work, work with parents, group work, work with special clinical groups such as adopted and looked after children, bereavement, child abuse, autistic spectrum disorders, court work, eating disorders, refugees and victims of torture, self-harm, gender dysphoria, learning disabilities and neonatal psychotherapy. To this can be added the provision of consultation, supervision and training for a wide range of health care professionals. Clearly there is a huge variety of work available. Not least is the challenge of undertaking initial assessments at the point of entry into the service for children and families as well as more specialised assessment for child psychotherapy.

**Initial assessments**

In the last few years one has often heard it said that CAMHS can provide an excellent clinical service to families – once you manage to get a first appointment with the clinic. Waiting times had become unrealistically long, impelling staff to make the service more readily accessible. Targets were set to reduce waiting times across the country and many clinics piloted schemes to speed up initial entry into the service. These have tended to involve setting a limit on the number of sessions available for assessing a young person’s mental health needs – sometimes one session and sometimes up to three. (An initial assessment has to precede any recommended specialist assessment.) A variety of instruments such as the Strength and Difficulties Questionnaire have been developed to give clinical staff information prior to
interview and a range of approaches to triage (prioritising on the grounds of risk) are pursued, including the Choice and Partnership Approach (CAPA). This approach has been piloted in SE England and aims to address patient choice and waiting times by allocating a patient to a staff member for treatment after a short interview.

This can pose quite a conflict of interest for the child psychotherapist who is trained to approach an assessment in a more measured manner, using skills of observation, knowledge of child development and understanding of transference/countertransference phenomena to build up a picture of a child’s inner world and the possibility of his being able to make use of therapeutic work. Instead, the child psychotherapist must now be involved at the earlier stage, taking a full personal, family and medical history and understanding the concerns of child and parents. Risk factors, be they self-harm or harm from and to others, are considered and a formulation is reached about the nature, severity and context of the mental health problems for the young person.

This is a considerable amount of information to obtain and all of us in CAMHS settings face the challenge to bring to a first appointment an attitude of warmth, curiosity and hopeful possibility. This first meeting, after all, is the start of a therapeutic process for the family. I do not think that this is so different from what we as psychotherapists try to offer children during an assessment for psychotherapy, although clearly it requires a broader and more focused approach. The aim is not to develop a relationship to the clinician but, in engaging family and child, to facilitate an emotional connection to the clinic as a place where worries can start to be safely explored.

**Clinical vignette**

**First meeting**

Anna, 15 years old, was referred to the clinic by her GP with the briefest of referral letters. It described how Anna would find herself engaging in checking behaviour and in certain rituals. She was worried that this would interfere with her school work and wanted help. As is our usual practice, the whole family was invited to a first assessment meeting, and I tentatively prepared myself to look into a possible presentation of obsessional-compulsive disorder.

Anna, her mother and younger brother arrived for the meeting. I started by asking about the checking behaviours and soon found that the details seemed to be vague. There was some lining up of shoes and washing of hands, but Anna denied that this was excessive and said that it had started the previous year, stopped, then restarted on Christmas Day. Her mother was less clear when it had started or stopped. At this
point I became curious about what else might be going on in the family and began to ask about the family history. I learnt that both parents had settled here from South America and raised their three children, of whom Anna was the middle child. It became clear that the extended family remained in South America and Anna’s mother had always felt isolated. This was compounded by the fact that her husband was trying to run a family business which was currently in financial difficulty. He was rarely at home and on his return he was tired, irritable and argumentative. As a father, he believed his family did not need outside contacts and had initially rejected his older son for over a year when he chose to leave the family business to pursue his own life. It became clear that Anna and her mother (and the younger boy) were struggling to make a life in the face of considerable fears about their father’s angry outbursts. The mother assured me there was no domestic violence. What I did learn was that the father did not know about this referral to the clinic or the fact that his wife had for nearly six months been taking antidepressant medication prescribed by her general practitioner (GP).

This history was delivered amidst tears and gratitude at the opportunity to talk more openly. The mother explained how hard it is to explain all this to the GP when ‘you only have ten minutes’. She admitted that she had become very reliant upon her two younger children and I could sense that there were anxieties about separation on both sides, something which might be fuelling Anna’s need to practise her rituals and checking behaviour. Anna herself seemed torn between supporting her mother and pursuing her adolescent drive to mix with her peers and challenge parental rules. Clearly this was a fraught situation and I was aware that cultural differences for this family were a powerful influence upon the style of the marriage and parenting. In the first instance I wondered if Anna’s mother could talk to her older son about these issues and how he might be able to help her talk to her husband about the difficulties for both mother and daughter. She agreed to pursue this and when I contacted the family after a short period they agreed to return with the father to think about family issues and how to support Anna in her worries about growing up. I felt that this first session achieved the objective of exploring the family problems and helping them to feel that the clinic staff could listen in a non-judgemental way.

Comment

This type of work places us firmly within a key area of the work of our multidisciplinary teams and allows us to apply our therapeutic skills and understanding creatively. Indeed, we can offer more than just initial
assessments as a way of helping colleagues to understand where a child’s particular difficulties lie. Some of us have taken additional training in the use of the narrative story stems (Hodges and Steele 2000) and can use this to help find out more about the internal working models of younger children who have been fostered and/or adopted. This can provide extremely useful information for the carers of such children and professionals in the network about the response of their charges to new parenting and enables us to make recommendations for treatment. We can also offer a view of the child or ‘state of mind’ assessments, whereby we offer to see a child individually for a number of sessions in order to explore his emotional difficulties and arrive at a formulation of the internal dynamics. This can be particularly helpful to colleagues who wish to understand more about a child and his or her contribution to family difficulties when they assess the family dynamics.

‘State of mind’ assessment

Katy, age 11, had a complicated early history, having been adopted at age five, and her adoptive parents remained puzzled about why she continued to behave in such a difficult manner towards them. I offered to meet Katy over three sessions and explore how she was approaching growing up.

My initial impression was of a young girl struggling to manage her life, both cognitively and emotionally. In our first meeting, Katy immediately tackled the putting together of a jigsaw and pursued this task for a long time before giving up, finding that some pieces were missing. This was understandably frustrating for her but her response was to launch into another activity rather than allow herself to have any feelings about it or even to be cross with me. She told me that she has been told she is a lovely girl but that she didn’t believe any of it. Instead she told me how she had had a hard life, how she was afraid she would be abandoned because of her bad behaviour and that she would become a tramp.

At our second encounter Katy could not remember anything about the previous one and showed no interest in trying to remember, even with my help. She set about drawing up a chart with two columns – the good things she liked and the bad things she disliked about herself. She adopted a teacher’s pose and I was placed in the role of a young child. She resisted my attempt to think about these varied aspects of herself and preferred to retreat into a physical pose of falling asleep.

In the final session Katy presented herself as a young adolescent, dressed in a flirtatiously short skirt, and informed me about the time she was bullied at school. When I tried to think with her about her
experiences, she again became very defensive, telling me she was bored, wondering when it was time to go and treating me in a dismissive manner.

In thinking about Katy, I could see that she was on the brink of early adolescence and that in some ways she was desperate to progress forward to this stage. But unfortunately it was clear that emotionally she was operating at a much younger level, and I was struck by how impossible it was for her to present a coherent narrative of her life, or her views about herself. As an adopted child she showed signs of an insecure attachment (despite many years of supportive parenting by her adoptive parents) and did not have an internal working model of parents or adults as helpful or benign. Rather, she expected adults to be critical of her and so felt that she had to present only the good side of herself as a way of securing affection. I was able to use my observations and experience with Katy to talk to her adoptive parents and describe a girl they knew all too well.

We thought about how further careful management of her at home and at school would be most helpful at present. She needed help to establish real and concrete skills and goals that she could work towards. Her emotional needs were certainly complex but at the time the invitation to think about herself in a more intimate therapeutic relationship posed too much of a threat to her fragile defences. Any pressure on her could be distressing and might be manifested in more difficult behaviour at home and at school. We agreed though that she would continue to need help and might be more available for individual work when older. These discussions seemed helpful to the parents and were fed into the network of school and other professionals.

A specialist assessment for child psychotherapy

The process of undertaking an assessment for psychotherapy does feel a more familiar realm to me as a practitioner and is certainly one in which I and my child psychotherapy colleagues feel we have a greater sense of control. There are differences between this and a core assessment: the main one is that the child psychotherapist is seeking to facilitate the opening up of a more dynamic interplay between therapist and child in the individual sessions. It is not about gathering specific information but more about creating a transitional space (to use Winnicott’s concept) in which established patterns of interaction can be observed and there is the possibility that new ways of relating can be initiated and explored. I like to think of a child psychotherapy assessment as an important therapeutic intervention in its own right.
Of course, there remains the pressure of how a scarce resource (child psychotherapy time) is allocated and to whom. For all members of the clinical team, specialist work now has to be balanced against other demands for clinical intervention and this does not make for an easy professional life. This dilemma means that we must evaluate carefully the best allocation of our available therapeutic time to young people and their families who can make good use of this treatment. The offer of individual psychotherapy results from a complex assessment requiring the consideration of a number of factors: the availability of resources, an indication that the external environment can support long-term treatment and of course the capacity of the child to make use of psychotherapy as the treatment of choice.

We are trained to approach our work with a particular emphasis on understanding the inner world of the child and how childhood experiences influence everyday life. The aim of child psychotherapy is to help children develop emotionally and to learn more about themselves and their relationships. It also seeks to help children with their symptoms. The hope is that such therapeutic work will assist the child in achieving appropriate developmental milestones and progress into adulthood with a more secure sense of self, leading to a creative and productive adult life.

Therapy takes time and aims to bring about internal change as well as change in the child’s behaviour. It is not a quick fix and this is something that the parents (and the young person) need to understand. A child’s psychotherapy may have an impact upon family relationships and parents need to be prepared for this. They will need to provide support and encouragement to their child to face difficult thoughts and feelings. This requires a commitment from them to bring their child to sessions and meet with a colleague to think about parenting issues. It is my experience that parents approach the possibility of therapy for their child with a variety of feelings. Some are concerned that therapy may stir things up and cause disruption at home, while others worry that the offer of treatment implies that they are ‘bad’ parents. Also, the issue of the confidentiality of the therapeutic work can leave some parents feeling envious and left out of the therapist–child relationship. These concerns are often realistic and need to be fully explored with the parents as part of the assessment process.

The assessment process aims to examine the possibility of change in the young person within the constraints of a therapeutic setting and a relationship with the therapist. The therapist uses her skills to build a picture of the child’s inner world – that is, a picture of the world that the child has in his or her mind. This internal world will be the result of an interaction between the child and external factors, such as the early mother–child relationship, and between the child and his own thoughts, feelings, impulses and fantasies. Factors such as age, gender, culture and family history have an impact on all of this as well as any past traumatic events, illnesses or physical disabilities.
The framework of the assessment

The framework and setting of the assessment is extremely important. It should be set up in a way that helps the child to feel safe and able to communicate about inner experiences. We want to create an atmosphere in which unconscious material can emerge and where we can observe the child’s relationship to the self and others, as well as the attitude towards us as a new and potentially helpful object. The therapeutic approach is key and aims to provide for the child an emotional experience that is containing and hopefully enlightening.

A child psychotherapy assessment takes time. I find it useful to gather certain information before meeting the child. This can be achieved by meeting with the referrer and parents to understand the concerns and the ‘Why now?’ aspect to the request. It is helpful to hear about the child’s behaviour at home and at school (via school reports), to hear about family relationships and about any societal pressures due to race, gender and culture. It is then important to meet the child with the parents or carers. This provides a chance to observe the interaction between child and parents and is an opportunity to ask about shared concerns. This can then become useful shared information between you and the child to discuss together. Finally, it is vital to obtain the child’s agreement to come along and join in the assessment process. When appropriate, a number of individual sessions are offered and in my experience I find that three is helpful. The shape of the weekly sessions in the same room with the same materials helps to provide containment for the child, and helps the therapist to gauge the child’s capacity to manage the gaps between sessions – an important indicator of how the child will manage the frustration of waiting between sessions and during the holiday breaks. After these individual sessions I arrange to meet with the parents and child to discuss their experience of the assessment process and to share my thoughts about whether psychotherapy would be helpful.

During the individual assessment sessions, the therapeutic approach does use many of the elements of the way a child psychotherapist would work in ongoing treatment but there are differences too. As in therapy, children are offered an unstructured session in which they are invited to talk or play, using the materials provided so that the nature of their worries and difficulties can emerge. In this way it is possible to become aware of a child’s preoccupations and notice the transference relationship between child and therapist. This will be helpful in understanding the child’s way of relating to current and internal parental figures. A child psychotherapist will also pay attention to any countertransference feelings and monitor her response to the child, whether it is one of distraction, or feelings of uselessness, or wanting to be teacherly or parental. Such observations of our countertransference tell us much about children’s internal worlds and are often a communication about frightening or intolerable aspects of themselves. As
Wittenberg says, it is of great benefit to the child if the therapist can ‘think, and digest and verbalise it rather than be frightened or overwhelmed’ (Wittenberg 1982: 133).

In an assessment, the therapist aims to provide few direct questions but rather to offer comments that promote clarification and the linking together of different aspects of the child’s experiences. The interaction needs to be conducted with an empathic attitude and to convey to the child that this is a safe and private setting in the presence of an adult who wants to understand what is going on inside them. I think most child psychotherapists will have a number of questions they would like to be able to answer at the end of the assessment, but these need to come out of the encounter with the child and may only be answered when thinking over the assessment as we try to describe and formulate the nature of a child’s strengths and difficulties. It is important to be curious about why the child is displaying these symptoms now and to clarify what falls within normal developmental limits for the child’s age and background, and what does not.

Anna Freud’s work on developmental lines for children through latency and into adolescence is particularly helpful here, as is her Diagnostic Profile (1965). This outlines the range of information needed to build a comprehensive metapsychological profile of the child and provides a helpful prompt in completing an assessment overview. It is important to understand something about the nature of a child’s anxieties and defences, his view about whether there is anything wrong with him, his use of fantasy, his attitude towards his mind and body, his object relationships and attachment patterns and finally, is he curious about this experience and perhaps open to receiving help?

It is clear that the task in the completion of an initial assessment is very different from that of an assessment for child psychotherapy, although many of the same skills are used. The unstructured session and close focus upon the conscious and unconscious communications of the child require a particular state of mind in the therapist, exploratory and reflective, in order to conduct the session and process the experience. Also, the child psychotherapist is generally cautious about producing a diagnostic category for a child – something that is now usually required in assessments in child and adolescent settings. There are occasions when a diagnosis can be made and may be helpful to the family – for example, in cases of children falling within the autistic spectrum disorder. On the whole though I think child psychotherapists prefer to view children and adolescents as operating within a shifting picture of developmental progression or ‘stuckness’ and environmental provision. It is important to address the interplay between these issues and how the child might be helped to overcome his difficulties. There is, however, a challenge here to us as professionals who may feel reluctant to label developmental difficulties in children and young people. We prefer to think of the needs of children and adolescents as being in a state of flux, requiring flexible interventions as they grow up. Yet at the
same time our managers are increasingly being asked to provide referral and outcome statistics, while services are being targeted for specific client groups. I think that this is going to be an area for debate in the coming years at local and national level.

Over all, I think that throughout an assessment for psychotherapy the therapist is looking for an exchange, however small, which shows that there might be a possibility of the child forming a therapeutic alliance so that the emotional work can be started. The process is a live encounter in the here and now and a key essential for both child and therapist is that there is openness to the experience. Assessment work can be quite challenging as the following example illustrates.

The challenge of Jack

Jack was a seven-year-old boy who was referred to the CAMHS clinic due to his longstanding difficult behaviour both at home and at school. Following an initial assessment, he was referred for a child psychotherapy assessment as it was felt that preliminary work on parenting skills had been completed and that Jack’s difficulties were entrenched and suggested disturbed internal relationships.

Prior to my seeing Jack, I was able to look over information from his school reports where it was clear that they were desperate for him to receive some help. He had attended several primary schools prior to his current school and disruptive behaviour had been an ongoing problem. An earlier educational psychology assessment showed that he was above average in general ability but that his reading and spelling were poor. He was distracted and distracting at school, engaging in risky behaviour, calling out names and trying to draw attention to himself. His self-esteem seemed very fragile and when things went wrong he would lock himself in the school toilets. It all amounted to a picture of a very unhappy boy.

The next step was to meet his mother with a colleague who would support her through the assessment and through treatment if this was indicated. I was able to learn more about his developmental history and general family circumstances. In brief, it seemed that Jack’s mother had married young but she and her husband had split up when Jack was small, with very little contact since then. As a single parent she had had to work long hours and Jack had experienced much early care in a day nursery. He had developed a terrible temper and threw tantrums when he could not get his own way. He was curious about his father and wanted to know how he could get a new one. His mother was keen for
him to have help and we arranged a meeting with Jack so that I could introduce myself and find out if he would come to see me.

When I went to greet Jack in the waiting room, he made it clear that he did not want to meet me and sat with his back to me. As his mother encouraged him, he lashed out, kicking her and punching the chair. His mother spoke to him again and I was impressed by her firmness. When he again refused, she managed to more or less carry him to my room. On the way, he lashed out and once in the room wrenched the chair around and sat facing the wall. It was quite a dramatic entry and I sensed how very frightened he was.

It required some quiet talking to his mother, and indirectly to him, to help Jack feel calmer and safer. After a while he did play with some toys and I noticed how he treated the small dolls roughly – they were dropped from great heights as he muttered how he hated people. He also did some drawings: one was of a fierce looking muscle-bound man while the other was of a small baby crying. He did not want to tell me about the pictures but I did think to myself about what a powerful communication they provided vis-à-vis his situation. Internally his infantile needs were crying out for attention and to be recognised, but the seven-year-old boy felt he had to present an image of physical aggression and invulnerability. By the end of the session he agreed to come and see me three times but stressed he would not enjoy it.

At the first individual session Jack was able to come to the room and showed considerable interest in the toys I had laid out for his use. I adopted a quiet and low profile approach, showing interest and commenting on his activities. I noticed that he again handled the small dolls in a very rough manner, tearing off their clothes and twisting their limbs into contorted shapes. The girl dolls were particularly targeted and he was able to tell me he didn’t like girls, except for his mum.

In the second session Jack was initially reluctant to come to the room but did manage to do so. He was immediately displeased to find that the toys had not been kept as he left them, despite my preparing him for this the previous week. He quickly rearranged things and positioned the small dolls in various fraught positions around the doll’s house, hanging them from the roof or under piles of furniture. I was beginning to notice how he seemed driven to provoke me into reprimanding him and there seemed a sadistic pleasure in the cruel treatment of the toys. As the play continued in a noisy and destructive way, I talked to him about how I thought he was working hard to make it difficult for him and me to talk together about his worries and that he seemed to be inviting me to give up and not invite him back next week. Jack ignored my words but I
noticed that the play changed. The furniture was replaced in the doll’s 
house and the dolls were placed upside down. He told me that they had 
to walk on their hands, or fly through the air as there was no gravity. At 
that moment, I sensed playfulness in his response and felt a little more 
hopeful that he and I might find some common ground to meet on. After 
a pause I spoke to him of how I knew there were many people who 
were worried about him, including his mum. There was no verbal 
response, but something painful happened to one of the dolls. I 
commented on how bad things were happening to the dolls in his game. 
Jack agreed with me and said that he didn’t like dolls. I remembered 
how he also did not like people or girls.

Jack enlarged on this, telling me that girls do stupid things, unlike 
boys such as him and his friends. He went on to tell me that he didn’t 
like teachers at school and he was always in trouble because he was 
bad. He triumphantly told me that ‘being bad makes me happy’. When I 
asked why, he told me that it upset people and he didn’t care. In fact, he 
explained that he liked watching when teachers became cross with him 
as their faces went red and then he would act even more badly. He 
ended by telling me that being bad was fun. It was quite a statement.

As Jack left the therapy room he seemed disoriented and set off in a 
direction away from the waiting room. He was humiliated when I 
indicated the right route and walked out without saying goodbye. I was 
left feeling acutely aware of his emotional fragility and how easily 
overwhelmed he could feel by a world that he perceived as belittling and 
incomprehensible. This view of Jack may not have been seen by the 
external world.

The final session began inauspiciously when he arrived with his 
mother 20 minutes late. I explained that I could see him for 30 minutes. 
Jack looked disappointed but quickly masked this by telling me he 
hadn’t wanted to come anyway. He stormed down the corridor and 
entered the room in an explosive and threatening manner. Toys were 
set flying around the room as he climbed and stamped on the furniture. 
Eventually I was able to say that I could see he wanted me to know as 
loudly as possible that he didn’t want to be here today but I also thought 
he was upset that he had lost half of his session time. I followed this by 
asking if he had any thoughts or feelings about our meeting last week. I 
was told, ‘None of your beeswax!’

As I watched more toys being trampled, I commented on how he was 
behaving in a way which was inviting me to send him out and not ask to 
see him again. I said I felt puzzled and wanted to think about this, 
particularly why he didn’t seem to think it was possible that I would
invite him to come here many more times. At this point, Jack's beha-
viour became more provocative as he found a pair of play scissors
(blunt) and threatened to cut the doll's hair. As I tried to talk to him about
this, he became agitated and held the scissors to his throat saying he
was going to cut himself. Not wishing to be provocative myself, I did not
talk but did give a kind of 'umm' sound. After a couple of minutes he
removed the scissors, threatened to cut his own hair, but instead gave
the doll's hair a trim.

I then spoke to him very firmly about how hard he was trying to make
me tell him off and think of him only as a bad boy like they do at school.
He walked over some toys on the floor, breaking them. I said that the
toys were getting broken and he replied that he didn't care. I said that
it was hard for him to believe that anyone would care about him,
especially me at this moment. He just thought I would be cross and not
care about the worries inside him. Jack seemed dismissive but I felt that
after this tense exchange the atmosphere of the session changed.

Jack filled the sink with water and this action seemed to release much
of the tension inside him. He played with various animals and invited
me over to see how they were floating on the raft he had made. I leaned
over the sink and watched him play. He dropped some of the animals
into the water and joked that they would have to hold their breath now.
Suddenly he had an idea – he would put his face in the water and hold
his breath. Before I could stop him he did just this, then came up and
said he had counted to 30. Before I could stop him he dived in again. I
noticed that his head was now close to the tap and bent over to try and
protect him, mindful of the fact that he had found accepting any help
from me humiliating before. Too late – he brought his head up quickly
and banged it. It obviously hurt but he did allow me to comfort him and
attempt to dry his face and clothes.

It was nearly time to end and I was able to talk to him about the
session and how I would be arranging with his mum for them to come
back and see me again soon. As we left the room, he remembered the
way and I was struck by the difference in the manner of his leaving:
the imperious and threatening boy who had arrived was replaced by a
more vulnerable child who had been able to accept help when hurt.

In thinking about Jack, there was clearly a wealth of material but it is only
possible to outline the main themes here. Developmentally, Jack was a
latency child but he did not seem to be in a position to be able to embrace
the tasks of latency. This should be a time when children move into the
world of school and begin to form identifications with other children and
significant adults, like teachers. It should be a time of membership of clubs, rules, fairness, the acquisition of self-control, an interest in learning and identification with heroes or idols. The earlier sexual interest in the parental couple lessens and there is general curiosity about sexual matters as boys and girls rehearse for adult roles in their play. This was not so easy for Jack. Internally he was still entrenched in a conflictual relationship with his mother and lost father. I became aware during the assessment that Jack harboured fantasies about his missing father and I suspected that he felt responsible for his leaving them. This preoccupation interfered with his ability to focus upon learning and he was unable to work or play productively alongside his peers. He seemed isolated at school and this fuelled the negative attention-seeking behaviour.

The circumstances of the family history suggested that the early relationship with his mother may have been compromised and in my experience with him over the sessions he did not feel like a securely attached child who had developed a coherent strategy to deal with separation and frustration. Rather his history of disruptive behaviour suggested an insecure disorganised-disorientated attachment pattern whereby he dealt with feelings of helplessness by becoming controlling towards parents and others, either in a care-giving or punitive way. Jack met me with little or no expectations that I might be a helpful adult for him.

Jack’s use, or abuse, of the toys was a challenging response to a new situation. The harsh treatment meted out to the dolls conveyed the picture of an inner world that experienced life as unsafe, uncaring and punitive. He had clearly identified with the aggressor as a major defence strategy. A helpful adult figure never appeared in the play to care for the mistreated dolls, but all of the play was a powerful communication about Jack and his ways of defending himself against the anxieties of rejection and abandonment. This ability to symbolise his inner world was a hopeful sign. I felt he needed help to feel less overwhelmed and fragmented so that he could play and think about his worries rather than having to project or act out all the time. As it was, he enviously attacked the good things that were offered to him: the dolls were hated and my words of attempted understanding were rejected and belittled. By the third session, however, there was a noticeable shift in his attitude. He was upset by the loss of our time and he was eventually contained by my attempts to understand and help him with his destructive feelings. The play in the sink with the animals and water signalled a move that he felt safe enough to let me stand alongside him and witness his curiosity and vulnerability. The raft did feel more like a bridge between us. The play also revealed the risks of exposing himself as he unfortunately bumped his head and needed my help. I think it was this incident which helped me to think that psychotherapy would be a helpful intervention for Jack as he seemed to have internalised some aspects of a reciprocal and caring relationship. I had also learnt that he was a bright boy with a fondness for sports and art at school.
I was, however, aware of what a challenging patient he might be and that the treatment would need to be intensive in order to provide the emotional containment necessary for Jack to work through his difficulties. Any treatment offer would need to be laid out with a clear timetable and boundaries requiring considerable family support. It would also require the allocation of clinical resources: clinical time from me and from a colleague to work with the family.

In my subsequent meeting with Jack and his mother I talked to them about how I thought that he had had some difficult and unhappy times in the past and that at present he had decided to be a bad boy, rather than a boy who felt sad or unhappy or angry. This had helped him to feel more in charge but actually it was getting him into a lot of trouble at home and at school. Initially Jack was not keen on the idea of therapy and his mother was concerned at the level of commitment required. We discussed this at some length and in a later meeting she was able to agree to twice weekly sessions, managing with the help of her family. Jack agreed to come until his next birthday which was about nine months away – symbolically this seemed a good starting point.

The specialist assessment sessions provide rich clinical material: this enables us to understand more fully a child’s difficulties and how the observed symptoms are an outward manifestation of a complex and often chaotic internal world.

Concluding remarks

Child and adolescent services are trying to respond to an increasing demand for therapeutic help for children and young people. As one of the core professions in CAMHS, child psychotherapists play a key role in providing not just psychotherapy but also a wide range of other interventions and applied work. They can offer initial assessments to children and families as they enter the service as well as other forms of assessment such as the ‘state of mind’ and ‘narrative story stem’ assessments. The assessment for suitability for psychoanalytic psychotherapy is a complex process. It requires an objective evaluation of the child’s assets and environment, and a live encounter with the child in the therapeutic setting.

Throughout this chapter I have shown that, as child psychotherapists in child and adolescent teams, we are being asked to change and adapt our roles. We now work in an environment that has to reflect a fluid and changing national picture of how children and families must be helped in order to promote good mental health. Consequently we are being asked to extend our roles – something which I think our training and skills do equip us to undertake. But, as in everything, there needs to be a balance between the provision of our core work, the assessment and treatment of children for psychotherapy, and the many ways in which our skills can be utilised in
applied work. These are amongst the challenges that face us as child psychotherapists in the years ahead.

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3 Thinking aloud

A child psychotherapist assessing families for court

Deirdre Dowling

In this chapter I look at the challenge facing child psychotherapists who take on the role of expert witness in family law cases, assessing parenting capacity when there is concern about serious harm to the child. Health expert witness teams are to be set up in NHS Trusts throughout England over the next few years to provide evidence to family courts and child psychotherapists could have a central role in this work (Chief Medical Officer 2006). I will argue that although the court is an unfamiliar setting, it can provide a thinking space and the containment necessary to protect the best interests of the child. As child psychotherapists, our psychoanalytic thinking and observations of children and families are valued by the judiciary, helping to elucidate the complex dynamics of family life. We can offer a view of the children’s experience of the world and how it is communicated through their behaviour and play. I will show how some families can use this enforced space for reflection to explore their parenting difficulties, and renew their bond with their child. Others desperately hold on to denial, and project blame on to others, even at the cost of permanent separation from their child. This will be evident as I describe my involvement as a child psychotherapist in a specialist psychotherapeutic assessment service, the Cassel: from outpatient interviews, through a residential assessment to a recommendation for court. The assessment is a dynamic process in which the parents’ capacity to change to meet their children’s needs is tried and tested in a therapeutic setting.

The court process

Court work creates great anxiety in child psychotherapists, from writing court reports to exposing our very private work to public scrutiny and then facing cross-examination in the witness box from potentially hostile barristers. Yet, paradoxically, these limitations can support the process of getting the best for the child in a highly emotive situation. My experience is that the legal process provides a structure in which thinking can happen. The rigorous process of observation, reflection, exploration, recommendation and reporting can provide a framework for our thinking through the highly
complex and conflicting issues of family breakdown. Like the analytic boundaries of a session, the formal legal structure can allow spontaneity and exploration of ideas within a clear set of rules.

But there is a more problematic side to the English legal system: that is, the adversarial court structure with its separate representation for the parents, the child and the local authority. In my view, this emphasises the opposing interests of parents and children, rather than addressing the central importance of the parenting relationship to the child, and the need for help for both sides of the equation. A similar split can be reflected in the professional agencies where adult mental health and child care services are often very separate. They can reflect the conflicting needs of the parents and the children, rather than support the family as a whole. An additional factor that can add to the isolation of parents in care proceedings is that many are not known to mental health services, as they have no formal mental health diagnosis. Instead they suffer from an array of personality difficulties from a lifetime of abuse, trauma and deprivation, culminating in a crisis in parenthood. Often it is their solicitors who are their only advocates and who become their support figures through the legal process. This is further complicated when parents have separated and each is fighting his or her corner, arguing why they would have the best to offer the child. Faced with these competing interests, the judge has the unenviable task of keeping an overview of the total picture. The independent expert is used to advise on those aspects of the proceedings that need more clarity.

There are powerful dynamics in these complex cases of family breakdown; and the guilt, blame and anger can be re-enacted in conflict between professionals or between children’s services and the parents. Kennedy (2005) in *Psychotherapists as Expert Witnesses* describes how deprived parents may turn to the local services for help, then quickly become disillusioned that their feelings of unmet need are unresolved:

>The authorities may then come to represent the families’ own unsatisfactory parents, which may then make the family themselves feel constantly humiliated, punished or misunderstood by those around them. They may then in turn attack back and punish those whom they see as responsible for this unnecessary persecution.

(Kennedy 2005: 225)

The independent expert is often called in to these fraught situations. Judith Freedman in her article ‘The Court, The Couple and The Consultant’ argues that the value of the role of the independent expert witness is that it introduces ‘a third position between the two contesting partners [social services and the parents] from which it is possible to help parents begin to explore the underlying dynamics of the abuse or their failure to protect the child’ (Freedman 2005: 116). She assesses parents at the Portman Clinic, a specialist service in London for those with difficulties concerning violence
or sexual behaviour. She points out that many couples seen there are in denial about the painful reality of harm to their child. The value of the assessment is that it gives the parents an opportunity to look at their relationship and see how their violence or mutual dependency have been detrimental to their children.

As child psychotherapists, we can contribute to this exploration of the parenting breakdown. Our knowledge of the impact of trauma and multiple separations on children’s development helps us interpret the complex life stories that the families bring. Our analysis is then linked to current observations of the child, the parent–child relationship and the family dynamics. Parsons (2000) talks about our dual role as psychotherapists, ‘the maternal containing function,’ and the ‘paternal adversarial function’, which challenge the patients’ reality, their negation of truth and powerful private logic. Both these containing and adversarial aspects of therapeutic work are vital in the assessment of parental pathology. Parents, under pressure of the assessment, may begin to face their part in child abuse or neglect when their powerful and conflicting feelings towards children are accepted and understood. For example, it can be a huge relief to parents to talk about their feelings of hatred towards their child whose behaviour has made them feel useless and humiliated, and to discover that this need not wipe out the loving feelings in their relationship.

In a legal assessment, the authority of the court backs the authority of the psychotherapist in her attempt to help parents face the truth of family breakdown. The time pressure of the court process can also act as a catalyst, a crunch point forcing parents to face the finality of their position if they wish to be with their children. These same time constraints also propel clinicians towards a recommendation about the children’s future, although often this feels painfully difficult given the complexities and uncertainties of the families involved.

The legal context

Becoming familiar with legal language is one of the first obstacles to overcome in order to feel confident and comfortable in the court setting. As a child psychotherapist with specialist expertise you may be asked to be an independent expert witness, to give advice to the court on the issues facing the child. This differs from cases where you will be called as a witness to give evidence on your work with a child, but not to give an overall view. As an independent expert, you may be acting alone or as part of a team who together will give an assessment of parenting capacity. The value of multi-disciplinary parenting assessments is that they bring adult and child mental health experts together to formulate ideas about the family functioning as a whole, and explore the underlying causes.

You are likely to be jointly instructed by all the parties, to avoid duplicate experts. In parenting assessments, the parties involved usually include
the children’s services who will have initiated care proceedings because of concern for the child, the Children’s Guardian appointed by the court to represent the interests of the child, and the parents, who may be separately represented in court. The Children’s Guardian, usually an experienced social worker, is a crucial figure, observing the whole process before making recommendations to the judge on behalf of the child. More straightforward care cases will be heard in magistrates or crown courts around the country, but the most complex cases will be sent to the high court, to the most experienced and senior judges.

The Children Act 1989 is the legal context for decisions about a child’s future. It lays out the twin and often conflicting concepts of partnership with parents and the paramount importance of the best interests of the child. The criteria used to assess the child are whether he is suffering significant harm or likely harm from emotional, physical or sexual abuse, or all three. The hardest to prove in court is always emotional harm. The question to consider is the level of risk to the child; and whether the child’s development is being seriously impaired by a failure in parenting. The court has a welfare checklist which it needs to address in making decisions about children. It must take into account the ascertainable wishes and feelings of the child in the light of age and understanding. As child psychotherapists we can show the court through detailed observations of the child’s play or responses in the sessions, what his or her feelings and anxieties are about the future. These may not have been clearly spelt out before in the proceedings. Similarly, our observations of the interaction between an infant and its parents, or a toddler playing with his mother in parent–infant sessions, can offer a vivid picture of the child’s attachment to the parent and the potential loss of that relationship.

Other factors in the court’s checklist are:

- the child’s physical, emotional and educational needs
- the likely effect of any change in circumstances
- the child’s age, sex and cultural background
- any harm the child has suffered or is at risk of suffering
- the capacity of the parent, or any other relevant person, to meet the child’s needs
- the range of powers available to the court in the proceedings.

One last question, which you will be asked repeatedly in court is, ‘Is this in the child’s timescales?’ Has the parent the capacity to change within the child’s timescale or does the child’s need for a clear decision now and permanency have overriding importance.

**Beginning the process: the outpatient assessment**

Seeing the court assessment as a psychotherapeutic process, a space for reflection during which the process of ‘observation, reflection, exploration,
recommendation, and reporting’ occurs, immediately makes it a more familiar task to us as psychotherapists. At the Cassel, we assess the more complex and high risk situations, where parents and children can only be reunited in a safe therapeutic setting. However, the issues we are asked to consider are the same as in other family assessment settings: the level of risk to children, and the parents’ potential to meet the children’s needs. After reading the court papers and the letter of instruction, an adult and child psychotherapist ‘pair’ offer two meetings. First, we meet with the parents alone, and then we see the whole family, concluding this second interview with a brief feedback meeting with the parents. Our initial psychotherapeutic assessment meeting is deliberately unstructured, to see if the parents are able to explore ideas and reflect on their experience. Fonagy et al’s (1996) research shows that the development of the ‘reflective self’ is a key indicator of parents’ capacity to change. For parents, this assessment meeting can offer an opportunity to stop and think, after a rollercoaster of assessments, court appearances and meetings with solicitors.

Prior to the assessment meeting, we would have received a large bundle of documents. These will include the chronology, social work reports, observations of contacts, other experts’ views, the parents’ statements and sometimes court material from the cases of previous children removed from the family. There will also be a letter of instruction from the leading solicitor, agreed by all parties. This outlines the specific issues we need to consider in the assessment (see Kennedy 2005: 39 for a more detailed discussion than I can give here of dealing with the letter of instruction and other court procedures).

Some assessors (Asen 2007) argue that it is not helpful to read these reports until after the first meeting with the parents, to preserve one’s independence of thinking. However, I find it essential to read them first. I like to know the family history, the risks and details of harm to the children, in order to inform our meetings with the family. It can be daunting reading these papers, the often terrible early histories, the story of the family breakdown and the impact on the children. I often wonder, at this stage, if there is any hope for change. Yet I am often surprised when I meet the actual mother and father in the interview and discover how differently they present than I expected. The impact of this first meeting, like the first contact with a child in psychotherapy, can be so revealing when looking back over one’s assessment and it is worth recording it in detail while it is still fresh in your mind.

The first interview

The parents (often a single mother) would have been through many formal assessments before reaching the Cassel as a tertiary resource, so ours is a psychotherapeutic assessment, beginning with the simple question: ‘What help do you think you need?’ This allows space for themes to emerge when
we explore with the parents how to understand the breakdown in their care. The aim is to achieve an understanding of their individual pathology, and the couple relationship; also to gain a view of their parenting capacity, their willingness to take some responsibility for their child’s suffering and potential for change. The danger is that all the blame will be projected outside as it is too threatening to consider their own contribution to the dynamic. It can be difficult to find a way safely to open up thinking and encourage some exploration when parents are feeling very persecuted.

The case of Sandra

We saw a young woman, Sandra, who had been severely sexually and emotionally abused as a child. She had recently separated from a longstanding violent relationship. (All examples are disguised to preserve confidentiality.) She told us she was determined to do what she could to have her children back and ‘put the past behind her’. Her two children had been severely neglected and exposed to the trauma of her violent arguments with her partner. She had an idealised picture of returning home with her children. She told us, ‘From now on it will all be different.’ When we tried to think with her about her exposure to abuse as a child, and how this might have led to her difficulties in protecting her children as a mother, she became angry and upset, repeating she ‘wanted to put the past behind her’. We could see that exploring the links between her despair and anger and her inability to protect her own children was frightening. We felt she was very worried about how explosive her feelings would be if she was stirred up in this way. It was hard for her to trust anyone to help her. It was not until the end of the second interview, when she knew we had seen her warmth with her children, that she could begin to think with us. Then she could allow us to talk about the tensions in her relationship with her daughter, and her fears of breaking down in psychotherapy.

This first interview is typical of many: the mother was highly defensive, fearful of exploring the pattern of violence and abuse in her past and present relationships or looking too closely at the impact on her children. Yet she was able to use the intervening week between our two interviews to mull over our conversation with her, and allow further exploration in the second interview. Other parents find the exploratory psychotherapeutic interview too threatening. They show us by their paranoid or persecutory fears that we should not proceed further or their fragile equilibrium would be shattered. As one father put it so eloquently, ‘I need my space. This place does not have enough windows or doors.’
Second interview with parents and child

In the second interview, we invite parents to play with their children while we observe, sometimes intervening to make a suggestion or a comment on the child’s play or behaviour, and see how they respond. We saw Sandra with her two children who were brought from foster care for the hour’s meeting.

Sandra met up with her two-year-old Mandy and Stephen, aged eight months, who remained asleep in the buggy. After exploring the toys in our room, Mandy looked with interest at our female puppet. She then looked at her mother’s face, as if wondering about the similarity. I remarked that it was like a mummy and then Mandy deliberately threw it away, watching her mother’s reaction, I suggested to Mandy that she might be angry because it felt like she had lost her mummy and that she (little girl) had been thrown away. Sandra was upset by her daughter’s play, and said how angry Mandy had been since she went into foster care. She did not know what to say to her. She knew her daughter felt rejected when she was taken into care, but she did not know how to help her. Sandra could then acknowledge that she could not really think about her daughter’s feelings without understanding her own, and that she needed help for herself.

In this interview, we observed the quality of the attachment between Sandra and her children, her sensitivity to the child’s communications and her ability to respond empathically. She was able to listen to our observations without feeling they were too much of an intrusion or criticism. She was clearly touched and concerned by Mandy’s play and this enabled her to tell us, in the child’s hearing, that she knew Mandy was distraught about their separation, although she could not talk to her daughter directly.

It is not easy for the parents in these interviews when they are brought together with their children from foster care for an hour’s assessment. Yet the picture we see is often an accurate reflection of the relationship that emerges later, if they come for a residential assessment. For example, I recall another mother who sat her baby son on her lap facing away from her, so there was no possibility of real interaction between them. When my colleague, an adult psychotherapist commented on this, the mother sadly acknowledged that she could not cuddle this baby who was the child of a rape. Then she told us the baby kept headbutting her in the chest. My colleague suggested this might not be anger, but the infant’s way of trying to get close to her mother, to her heart. The mother looked at her baby with renewed interest. Perhaps in her own ambivalence, she had not realised that her infant might actually want to get close to her. Whether this mother
could work through her fury about the rape, and allow herself to really bond with her baby, became a central issue in the therapy during the residential assessment.

The value of working jointly as psychotherapists is that parents feel held by ‘a parental couple’. This is very containing in the high anxiety of these assessment meetings. It may be the adult psychotherapist who finds a way of making meaningful contact with the mother, or the child psychotherapist focusing more on the parent–child relationship. I find also that the dialogue with an adult psychotherapist helps my capacity to process the complex material of the sessions. At times, our perceptions of the same meeting are very different. Then our struggle to understand our different responses to the same parents and children can reveal the underlying pathology. I recall working with an experienced male psychotherapist who was sitting on the edge of his chair by the end of the interview, preoccupied by the need not to provoke a furious teenage mother into hitting him. Sitting further away from her, and maybe because I was a woman, I was not so in touch with her violence and intimidation. Discussing this dynamic with my colleague afterwards, we realised how volatile this young mother was and decided not to proceed with the second interview with her baby. We thought she would become too agitated and cause distress to her child. We then discovered she had already phoned her solicitor to cancel any further meetings with us. She could not tolerate any further close involvement in a therapeutic process.

In these interviews, we see whether parents can use a therapeutic setting and are motivated to explore further what has caused them to neglect, abuse or fail to protect their child. Often, when we meet a single mother, there is a violent partner off the scene, and the concern is the mother’s failure to protect the child from the couple’s violence. Then, we see if the mother is able to explore why she repeatedly becomes involved in abusive relationships, a central issue in terms of protecting her child in future.

When we assess both parents, we can directly explore the couple relationship with them. A key issue will be their tolerance of looking at the dynamics of their relationship and how it has impacted on their parenting. This can be a delicate task when one has a sense that any shift in the balance of a relationship may disrupt the fragile equilibrium that they have achieved together. I am reminded of a couple, a mentally ill young woman with a young partner who had severely neglected their infant. In the interview there did not seem to be a way we could explore why they had ignored their baby’s needs because of their anxious preoccupation with each other. Each line of questioning provoked denial and increasing anger and anxiety. There was no space between them for any questioning of each other or differing views. It was clear that this couple, despite a desperate wish to take care of their infant again, did not have the resilience or insight into their own emotional needs to engage in a therapeutic assessment. In thinking about working with parents as a couple with their children, a key question is their ability to support each other as parents and think about
their child, rather than lose sight of the child because they are so absorbed in their own needs.

**Report writing**

When I am writing a court report, I think of the different audiences I am addressing. There are the parents, children’s services, health and the other experts. Finally I imagine myself talking to the judge, describing our view of the family and the parenting difficulties, and explaining why I believe these children have particular needs and, in my clinical view, how best these needs can be met. The skill is to find a voice, a way of writing, that is clear and free of jargon, but that puts across our psychoanalytic thinking in the way the judge, the social workers and the parents can understand.

In these reports, it is important to separate out fact and opinion. We begin with ‘the facts’ which are the narrative of the two interviews. (Although two of us were present, one would take responsibility to write the report and attend court as an expert if required.) The summary of the interviews is followed by the discussion which outlines our professional opinions. The discussion can include comments on the family history and its likely impact on the children, and our understanding of the family dynamics that led to the failure in parenting. We need to comment on the quality of attachment between children and parents, and the parents’ acceptance of responsibility for their difficulties and commitment to change. Finally, we include the potential risks and gains to the child of the different options available and his or her current and future needs. It is important to discuss why you differ and agree with other experts and the social services, looking at research evidence, as this can reduce the need to clarify these issues later or to argue them out in court. We conclude with our recommendations. Usually the options are either further assessment to see if the parents can improve their parenting, placement with extended family or adoption. Questions in the letter of instruction are dealt with at the end.

We often have to argue for resources because there are always funding issues lurking behind the debate in court. Financial constraints in health and social services mean there is often a strong push for solutions that are ‘quick and cheap’ but unlikely to solve the underlying problems. These might be a community-based assessment without therapeutic work despite evident unresolved emotional difficulties, or a short anger management course when more in-depth work is needed. While the family’s case is in the court arena, we can recommend appropriate clinical services for families, and sometimes ensure ongoing therapeutic help for parents and children. The danger is that children will be too quickly removed from their parents, without the parents being given sufficient help to see if they can improve their care, before the decision is made to place the children for adoption.

Following the exchange of reports, we may be asked to attend a meeting of experts to discuss areas of difference and see if some agreement can be
reached. Nowadays this meeting is often done by video link or telephone conferencing, to save all involved travelling long distances. The hope is that if a consensus is reached, there will be no need to discuss these issues in court. The meetings will be attended by solicitors and the professionals and a written record is kept. It is important to be clear when you are prepared to reconsider your views and when it is essential to stand by your opinions, even if they differ from other experts in the meeting. It may be that no amount of discussion will change the differing perspectives, and the issues need to go to court for the judge to decide.

**Going to court**

In my experience, preparing for court begins the day, or more often the evening, before when it has been confirmed that I am being called as a witness. Then I reread the key court papers to get a clear picture of the case as a whole. I can get quite anxious, thinking over what questions I will be asked and how I will respond. Once in court, I find my nerves calm as I am so preoccupied with trying to find out the present state of play. We can be booked in for a half day to appear as experts so we often arrive halfway through the proceedings and much may have happened in the discussions so far. At court, I’m greeted by the barrister and sometimes I’m updated on events or given another report to read before being called into court. It can be quite a lonely time as everyone is in groups and I often sit alone, very conscious that I need to remain independent of the differing parties. Before we are called to the courtroom, the barristers consult with the judge and sometimes he asks the experts to go to a room for a further discussion to see if particular unresolved issues can be ironed out and a new consensus achieved. I find these meetings uncomfortable as they are less boundaried than appearing in court. At times, I have felt under pressure to give way to ‘higher status’ medical opinions but the meetings are useful if a compromise can be reached, saving the time and stress of a court appearance for all involved.

Once in court, I am called to the witness stand to swear, or in my case affirm, the oath. Then the questioning begins, first by the barrister who has called me, often to argue on behalf of the parents if I am recommending a residential assessment. He will go through my report, summarising the key points for my agreement or asking for clarification. This is usually quite friendly and not too challenging. It is the cross-examination that can be tough as the other barristers representing the local Authority or the Children’s Guardian go through your evidence with a fine toothcomb looking for inconsistencies or unsubstantiated arguments. It is not personal, but it can feel like it, if your arguments are challenged. It also helps that I am representing a therapeutic pair or team, not just my own views. I answer briefly and to the point, but make sure I get my concerns across about the child. I concentrate on the fact that I am talking to the judge and often look
at him, to distance myself from the adversarial nature of the proceedings. His role is to listen and observe, writing notes, asking questions for clarification and keeping order in the court. I find this quiet, neutral presence helpful in maintaining my own presence of mind, a model of the thinking process that needs to be kept alive in court. In my mind, he represents the ‘best interests of the child’ and that is my concern. I always find I’m treated with great respect and my skills as a child psychotherapist are recognised. I have found most judges will accept a degree of uncertainty, a mixed picture, although in the end I will have to give a view on what I think should happen.

The parents are in court too, listening to every word. It is very painful to stand up in front of them and say that you cannot agree to a further assessment as their difficulties are too great to be resolved in the child’s timescales, and that you recommend a child goes for adoption. On the other hand, if I am recommending a further assessment, this is the point where I make it clear to the parents publicly the challenge they are taking on, and how they will have to change in the period of three months assessment for the Cassel to recommend rehabilitation. The parents may be relieved that we have been their advocates, but they will also need to recognise the strong body of evidence that has led to their child’s removal. Going through this court process with its strong dose of reality can move parents on to the point where they are able to make a therapeutic alliance, rather than just feel everyone is against them.

Residential assessment

Working through in a therapeutic residential setting

The judge’s decision may be that further assessment is needed. Then the family will be offered a day or residential setting like the Cassel for an assessment of up to three months. The aim is to observe the parents’ capacity to care for their children and change sufficiently to meet their children’s needs, in a supportive setting. At the Cassel, the model of assessment we have evolved is one where families ‘live and learn’ together in a therapeutic community and receive individual, family and couple psychotherapy.

One way of thinking about the residential assessment is that it provides an ‘intermediate space’, using Winnicott’s concept (1971) where parents can discover their potential as parents. It is a protected space, both physically and emotionally, a therapeutic community, where the parents are supported in learning to parent, but protected from the demands and conflicts of life in the external community. Becoming a parent is a process that involves being immersed in the relationship with an infant; or what Winnicott called ‘maternally preoccupied’ (1965). Ideally, parents can draw on their own early experience of being nurtured to respond empathically to their infant. If this parenting has been minimal or abusive, then the experience of caring
for a vulnerable, needy infant can be terrifying and bring a furious response from the helpless parents. In addition, most parents we see have been so preoccupied with their own emotional disturbance and conflicts that there has been no space for them to think about their developing relationship with their child. In the Family Service, all the parents and staff are preoccupied by this issue: ‘How can you turn around from neglect and abuse to become caring parents?’

Every day events are put under a microscope to be thought about and understood. For example, after a mother was criticised for tickling her baby between his legs and calling him ‘sexy’, she asked to talk about this in the weekly parents’ group led by a nurse and therapist. We began to explore the issue of tenderness and sexuality in the parents’ relationship with their infants. What does it mean when you call a baby sexy? Is it wrong? Would you tickle a baby between the legs? Is it really enjoyable being tickled or can it make the baby panic? The discussion provoked powerful responses from the parents who quickly suggested that we were saying the parent was sexually abusive. We encouraged them not to make a quick judgement or expect us to, but to think about their own experience as parents. Would they know what felt uncomfortable for their baby? Would they be able to protect their baby from an impulsive need for comfort or gratification?

Of course, this process of thinking about the experience of being a parent is often fiercely resisted because it means facing feelings of neediness, anger and guilt which the parent has avoided so far. The court order acts as an imperative which can bring a halt to this escapism. Carine Minne (2008) who works at Broadmoor Secure Hospital writes about the value of psychotherapy in a secure setting. Here patients have clear boundaries in which to begin to face the primitive passions that have led to their crimes. She describes how it can take a year for an offender to become a patient, to create a therapeutic alliance. We have a similar experience at the Cassel, though the alliance with families has to develop over a period of weeks during the assessment. The demands of the assessment order, the stringencies of 24-hour supervision in the early weeks, the daily routines: all put firm boundaries around the parent and child, so that some thinking and exploration can begin. The parents’ initial experience of being monitored and observed and their feelings explored is usually very persecuting and provokes outrage. But if they have sufficient determination to be with their child, then the parents may begin to allow someone to help. It may be the nursery nurse, family nurse or one of the psychotherapists who first makes meaningful contact with a distressed parent, but then the beginnings of a therapeutic alliance can emerge. There is always ambivalence about being a parent, the conflict between meeting one’s own needs and those of one’s child, but it is this balance we are constantly watching. We need to be reassured the child is continuing to develop well during the assessment, despite the parent’s limitations and the stresses of living in a strange setting without familiar parent figures around.
The residential assessment process at the Cassel involves working with several families as a group as well as individually, in a therapeutic community setting. The nurses work alongside psychotherapists, supporting the parents in their care of their children and encouraging them to work with each other in their struggle to regain parenting skills. Faced with the level of destructiveness and despair in their past which many parents bring with them, it is essential to help them discover their strengths and resilience. Kennedy (1987) emphasises the importance of everyday events in the families’ treatment. Trips to the duck pond and the organisation of the children’s teas assume as much importance as the therapeutic exploration of early trauma.

**Working as a team**

It is hard to work intensively with deeply disturbed and chaotic parents and not get caught in the daily crises. It is emotionally draining trying to face feelings with resistant parents. The clinical team can be made to feel inadequate or become furious in response to continual provocation by parents. The parents’ guilt, despair and anger quickly get projected into those around them. One’s own capacity to think can become undermined by this onslaught and then one can stop thinking. As a staff team, we attempt to deal with this emotional barrage by finding a level of humour and irony amid the drama and crises of daily life on the unit. I don’t think this is an institutional defence but a necessary balance. Reading Michael Parsons’ discussion on the logic of play and the importance of irony in psychotherapy reminded me of our way of working with families:

> Irony has this central importance in the psycho-analytic vision by virtue of the element of play it contains. The irony may be savage and the play may be tough, but none the less what irony does is to handle the negative, the potentially destructive and unbearable elements of experience and tame them, not by denying them, but playing with them. . . . play tames the negative.

(Parsons 2000: 139)

Through this intensive experience of working with the families, the team develops a hypothesis about the underlying dynamic and the causes of breakdown in the family. Clearly each family is unique, but Beate Schumacher, an adult psychotherapist working at the Cassel, has described a common pattern in her paper ‘I Can’t Live Without My Child. Motherhood as a Solution to Early Trauma’ (2008). She suggests that for many of the mothers we see, who have been abused and traumatised as children:

> having babies is an unconscious attempt at settling the trauma storms of their own childhoods . . . Motherhood is hoped to relieve their pain
It is a particular ‘solution’ to the suppurating ambivalence of their relationship with a maternal object — or really two maternal objects, a very much yearned for good one and an intensely hated bad one. Unable to reconcile this split psychologically, in fact altogether relying on the primitive defence of splitting to manage traumatic early experience, young women like these conceive of becoming mothers as concretely re-doing history.

(Schumacher 2008: 317)

Inevitably, the fantasy of ideal motherhood breaks down when the mother is faced with the exhausting reality of a real baby and his growing need to separate. When the mother experiences the baby as depriving her of the sense of fulfilment she was seeking, he can then be perceived as a persecutor, rather than an infant needing care and vulnerable to abuse. Schumacher argues that the essential therapeutic work is to enable the mother to mourn ‘the fantastic mother she wishes were her own and she wishes she were’. At the same time, she needs help to live with the frustrations of caring for a real baby, and the reality of being an imperfect mother. The work has three aspects: therapy with mother and infant; the nurse’s support of the daily care of the child; and the mother’s individual psychotherapy. The triangular model of adult and child psychotherapist and family nurse working together enables the reality of daily life to be linked to the emotional inner life of the child and the parent, and their developing relationship together.

**The child psychotherapist in the team**

In our part of this triangle, as child psychotherapists, our focus is on the child’s experience in the family. In parent–infant work we respond to the delicate changing balance of the parent and infant relationship, observing the difficulties, trying to get the parent to observe with us too, while intervening protectively if the infant is too distressed or disconnected. (For more discussion of parent–infant psychotherapy see Dowling 2006.) Children over three years old have individual sessions, a space where they can think about their troubled past and the anxiety caused by being reunited with their parents. In the profession, there is often reluctance for child psychotherapists to become involved in psychotherapy with children for a short and uncertain length of time. Yet I find children are often desperate for an adult to listen closely through these periods of uncertainty and understand the confusion and conflict of loyalties they have to face. This was true of Jackie aged eight, whom I saw once weekly for 12 weeks. She was being reunited with her volatile and disturbed mother to assess her mother’s capacity to care for her, a final attempt to see if they could live together again. She had been excited and hopeful in the outpatient assessment at the prospect of being reunited with her mother, but the reality was much more painful:
In her sessions, Jackie let me know she was relieved to be back with her mother, but so anxious it would go wrong. I could see her increasing disillusionment as her mother became caught up in repeating explosive rows with staff rather than caring for her. These feelings were reflected in her play in child psychotherapy. At first, she set up a sweet shop where she would have a regular supply of comforting treats. As the weeks progressed she became more practical and hopeful, selling clothes and the furniture needed to set up home. Then, as her mother’s mental health deteriorated, disillusionment set in. The shop was degraded to a secondhand shop and finally closed down. Her process of facing the reality of her mother’s inability to care for her paralleled our own recognition that change was not possible for this mother. This prepared the way for a decision to recommend that Jackie should be separated permanently following the assessment meeting.

These are very painful decisions and there are usually endless discussions, particularly within the treatment team as we process the likely outcome. However, for children like Jackie, assessments resolve the uncertainty about their future and make it possible for them to mourn the loss of the hoped for reunion with their parent and settle in a permanent home. Of course it is easier when the child is in a stable long-term foster home, so there is continuity for the child. What is hard is that there is often no funding for ongoing therapeutic work with the parents once their children have been removed, either at the Cassel or in the community, even if they have worked hard and proved able to use therapeutic work for themselves. This leaves them (and us) feeling that there is no foreseeable way to help them change for future children, even when some motivation is there. Sometimes, when mothers quickly become pregnant again after a child is adopted, I wonder if they are trying to renew their connection with an experience of a safe, containing setting, even if the outcome was negative.

**Concluding the assessment**

A formal meeting concludes the assessment at the Cassel. It brings together the treatment team’s view of the family and is attended by the outside professional network and the parents. As a child psychotherapist, I would have written my observations of the therapeutic assessment of the child and her parents. I read this report to the parents before the assessment meeting. This is very different from our usual therapeutic stance, when we try not to give judgements. Giving the parents a written record of our observations and thoughts about their parenting becomes part of the therapeutic dialogue. The very directness of the communication clarifies the issues and
the parents’ response, whether furious or thoughtful, enables further thought before the meeting.

As a clinical team, we would have discussed our recommendations before the meeting but we cannot quite know the outcome as the meeting will have a dynamic of its own. It is chaired by the consultant to the Family Service (or a senior member of the team) whose challenging task it is to contain anxiety, knowing that our recommendation will often be the defining voice in deciding whether the child’s future is with his parents. The parents hear these reports read out and are then asked to comment. It must be a strange, intense experience being talked about in a room full of people, with the family’s future in balance. Yet out of this some genuine understanding can sometimes emerge in the parents, some recognition of work done, or of vital issues avoided. It offers one last chance for the parents to engage with the assessment process before court, to reconsider their position and their child’s. Sometimes, too, the listening professionals can sense that some important shifts have happened and change their view of the parents. Then the parents can feel that they are returning to their own community, to a supportive network. The consultant concludes with a summary of the assessment and a recommendation which will form the basis of a report to court.

Thinking aloud

A colleague joked with me about the double meaning of my title, suggesting that what I meant to say was ‘Is thinking allowed?’ On reflection, her comment was very pertinent to the assessment of families in court proceedings where the sense of crisis, anxiety and pressure of time can undermine the thinking needed for understanding to emerge. So what does make thinking possible?

As a child psychotherapist, I find that my focus on the child’s perspective, his development and future needs, clarifies my thinking. This focus is vital in a system where the child’s view can get lost amid the competing claims of the adults involved in his world. Kennedy (2005: 213) recalls the guidelines for these clinical decisions set out by Anna Freud et al. (1973). They stress the child’s need for continuity of relationships, for the child’s timescale to be central and for the limitations of the law to be recognised. They add:

No-one – and psychoanalysis creates no exception – can forecast just what experiences, what events, what changes a child, or for that matter his adult custodian, will actually encounter. Nor can anyone predict in detail how the unfolding development of a child and his family will be reflected in the long run in the child’s personality and character formation.

(Freud et al. 1973: 51–52)
They stress that all we can do as practitioners is seek out the ‘least detrimental alternative’ for the child.

Accepting the limitations of the law, I have suggested it can provide the structure and ‘thinking space’ for crucial decisions about the child’s future. When we are working closely with a family, caught up in the struggle to understand the powerful and often primitive feelings that led to abuse or breakdown, the court process with its time limits and clear questions brings a necessary dose of reality to our work. What happened? How can we understand the dynamic? What can be done within reasonable time limits for the child? These concrete questions ground us in our therapeutic explorations and ensure we formulate the necessary recommendations despite our continuing uncertainties. Committing thoughts to paper, writing, discussing and debating them also helps elucidate the ideas that inform our therapeutic work.

Finally, what is needed is a clear clinical structure and an established team who together can contain the powerful and primitive anxieties that emerge when parents are struggling and children are at risk. They also offer peer support and consultation when dealing with challenging assessments and help contain anxiety by sharing in the decisions.

**Conclusion**

Assessing families for court as a child psychotherapist involves a familiar task of exploring the quality of relationships in the family and the parents’ capacity to meet their children’s needs. What is unusual for us as psychotherapists is the process of ‘thinking aloud’ at key stages: that is, writing and discussing with our patients our observations and thoughts about the therapeutic process and then being involved with them in a more public debate. Yet my experience is that these assessments for court can set in motion a therapeutic process in the parents and children. It can begin the process of self-exploration that will enable a family to return home together and effectively use the support of local services, which they were unable to do before.

**Note**

1 Although the current term is Children and Family Court Advisory Support Service (CAFCASS) worker, most professionals and parents continue to use the comprehensible ‘Children’s Guardian’ – *guardian ad litem* – the title of such workers until recently.

**References**


4 Anxiety, projection and the quest for magical fixes

When one is asked to assess risk

Marianne Parsons and Ann Horne

Requests for assessments of risk arrive not infrequently – indeed, can at times be hidden in otherwise seemingly straightforward referrals. The growing tendency in our culture to assume omnipotently that risk can be eliminated, with a concomitant ethos of litigation when it cannot, makes our response to such requests necessarily particularly measured. Additionally, as Lucas reminds us: ‘Management’s anxiety over containing disturbed behaviour has replaced asylum walls with ‘walls of paper’, namely the Care Programme Approach (CPA) form and the risk assessment form’ (Lucas 2006: 195), but ‘there is no foolproof way to prevent tragedies’ (Lucas 2003: 43). We would nevertheless stress our conviction that a psychoanalytic perspective does have a huge amount to add to our understanding of difficult and dangerous young people. This understanding is dynamic: while a good assessment of risk offers an invaluable prompt to people’s thinking about, perception and management of a young person, it cannot be an absolute, definitive statement. We are not in the area of solutions or magical fixes: rather, a good risk assessment, like a good consultation, enables others to progress and plan.

In this chapter we consider why referrers request risk assessments, offer some thoughts about risk and outline the processes that we have found useful in carrying out such assessments, including the writing of a risk assessment report. Our ideas are based on our experience in a specialist setting where the patient group – in both assessment and treatment situations – is expected to present risk. The prism offered by psychoanalytic understanding is thus useful in informing ongoing treatment as well as being necessary in assessing the patient.

When referrers request a risk assessment, it is usually because they have in their care a young person who is causing them such anxiety that they feel overwhelmed and helpless. Consciously, they may seek an ‘expert’ opinion in the hope that the risk can be quantified and that guidance about management will be provided. Sometimes they are already fully aware of the risk and seek an assessment from an ‘expert’ to add more weight to their requests – for example, for funding for placement – or, as in the case of courts, to help with understanding and decision making. The context
may also emerge as one of dispute within the referring agency, of polarised opinions as to risk, and the assessor should be aware of the undeclared invitation to become part of a schism, an enactment within the network of the split internal functioning of the patient. Less consciously, some referrers may feel so overwhelmed with anxiety and helplessness that they hope that someone else, or another agency, will take away their anxiety by taking responsibility for the patient and by providing solutions. Acknowledgement of the validity of the referrers’ anxiety is vital and can enable them to move on from a state of feeling helplessly paralysed to thinking more constructively again about what needs to be done.

Conducting a risk assessment offers an invaluable opportunity to create a more coherent narrative about the patient and his or her history from all the various fragments. One usually needs to request further details about the patient, and most often it is the developmental history and family background that will be missing or very fragmentary. It is not unusual, however, for the notes on a patient referred for risk assessment to be several inches thick – an accumulation of previous assessment reports, attempts to write chronologies of critical events and notes of review meetings as well as correspondence. Frequently, this seems to contain attempts to seek an outside voice and opinion rather than any attempt to talk with the patient, as treatment or therapeutic intervention notes are generally scanty. Sometimes it feels like attempting to control disquiet through increasing paperwork. Pulling all this material together into a logical framework and producing a coherent narrative about the patient is in itself a major part of the risk assessment procedure: it can offer the first step in containment, not only of the likely risk but also of the patient, whose needs can be expressed through raising increased anxiety within the network, and of the referrer who is subject to such projection.

We would emphasise that risk cannot be quantified definitively. There are factors that indicate levels of risk but the risk assessment report is not the end of the process. Risk assessment is more a matter of trying to pull together every possible bit of information about the young person’s current state of mind and past experiences, including the impressions of each person involved with the case, filtering this through the understanding that a psychoanalytic approach allows, and then feeding back in a digested form to the referrers and engaging with them in discussing the case. This will enable the referrers to feel more confident about what they probably already know at some level and will facilitate joined up thinking with all those involved with the case about how best to consider the general functioning and care of the patient as well as appropriate management and placement issues. How the network is to take on the task is part of the feedback and further planning discussion. Risk assessment is no use unless one offers engagement with the referrers about what might be the next steps. It is not an end in itself, either for agency or for patient.
Finally, some assessments of risk will be undertaken in the absence of the young person who is deemed to be a risk. In such circumstances consultation to the referring team is provided once the information is collated and such interviews as can be undertaken are complete. Where networks are anxious or paralysed, it is important that we are flexible in what we offer – indeed, as Teresa Bailey has shown, this is a not uncommon approach to adolescents in difficulties (Bailey 2006).

**Thinking about risk**

Many kinds of risk-taking behaviour draw the concern of those who work with young people. Here, we concentrate on those children and young people who act, whose behaviour puts others at physical risk by violence, assault, sexual attack and abuse. Inevitably, we have to focus in parallel on the risk to the young person whose acts endanger others – his own compulsion to attack will mask those areas of deficit and high anxiety, often unconscious, that have called the defensive position of presenting risk to others into play. More than any other type of young patient, the concerning adolescent also asks us to keep in mind the need to explore defences with great care as such defences are rigid and vulnerable (Parsons and Dermen 1999).

**Factors in the child**

There are key developmental areas to keep in mind when building a picture of the risk presented by a young person. The role of trauma is important. In this we mean often pre-verbal trauma, experienced at a pre-symbolic, pre-representational stage and in the absence of protective parents or carers. Recurring traumatic experiences lead to hypersensitivity to trauma in later development – the impact of what Khan (1963) termed ‘cumulative trauma’ – and to the likelihood of violent reaction to situations others might feel to be untraumatic. Equally, core complex phenomena – the search for idealised intimacy, terror of loss of self and violence in the service of achieving psychological safety and survival (Glasser 1979) – will frequently feature (as in Chapter 9 in this volume) and are essential when we come to think about triggers and placement. Too often we impose intimate relationships and settings on patients who seek but cannot tolerate them. Finally, we must be alert to phenomena that link to the ego ideal as well as to the superego. Too often referrers will describe a ‘psychopathic young person’ who shows ‘no remorse’ and ‘no sympathy for his victim’. For many of the abused and violated young men whom we see, shame and humiliation have been a repeated feature of their early lives: it is no accident that being ‘dissed’ (disrespected) and demanding respect (the opposite of shame) are often triggers to violence. This is developmentally early, when the self one would like to be is taking form, before the development of the superego and
conscience; there is as yet not an integrated sense of self, never mind an awareness of ‘other’ with whom one might feel sympathy, or any ability to perceive the wronged other person when the trigger was the ‘wrong’ felt to have been done to oneself. Psychopathy is an aspect of a developed character structure; the young person is in the course of development, a work in progress – and often still struggling with the psychological tasks of fairly early life.

The young person’s history will also give us information as to probable triggers. The behaviours and incidents must be considered in relation to the history as these will often contain patterns showing the impact and any escalation. The risk of further acts is less when the behaviour is object-specific and one can plan management in the light of this. Where a compulsion to repeat risk and danger from early experience is present, this is bound to escalate until containment of some kind is offered.

Finally, present functioning offers a great deal of information to the assessor. Strengths in ego functioning and a capacity for relations and curiosity about himself patently allow a more optimistic prognosis. How does the young person relate to the assessor? To key people in the network? How do they feel about him (countertransference)? Is the behaviour complained of ego syntonic – i.e. there is no sign of the patient being conflicted about his actions? For some young people, identification with the violent act is preferable to feeling as emotion inevitably involves recalling the unprocessed early humiliating experiences.

Factors in the environment

How the young person makes use of his environment is important in assessing the risk he presents. But one must also assess risk in terms of what the network can provide, whether thought and reflection is possible amongst those who are engaged with the young patient, what kind of support (e.g. consultation) might be available to the staff and whether this would enable countertransference feelings to be expressed and shared so that a rounded view of the patient becomes possible. Recommendations must include demands on the network, placement and environment.

The process

The referral

Referrals for an assessment of risk invariably come with high anxiety and a sense of urgency: the level of anxiety aroused in the network by the patient can at times be ascertained simply from reading the referral letter. We must then assess what information is included and what more is needed. The referrer should be contacted – preferably by telephone – as quickly as possible to begin to contain anxiety and to offer assurance that the
assessment process is underway. As the referrer is probably the main person trying to manage the anxiety aroused in the network by the patient, it is important to begin by offering some containment in this initial phone call. Just as, in Winnicott’s view, the father offers ‘holding’ to the mother so that she ‘hold’ the baby, so the assessor can do some of this for the referrer (Winnicott 1960).

At this point it may become clear that the professionals involved are already well aware of the extent of the risk, but have been unsuccessful in bids for funding for placement. This can be said more readily on the phone while it may not be written in the referral letter. Further written material can also be requested from the referrer – often more detail about the patient’s developmental and family background, but there may also be previous assessment reports (psychological, social work, educational, therapeutic, psychiatric, medical) or other documentation that can help flesh out the bare bones of the referral letter. If the start of the assessment has been delayed for funding reasons, the phone call to the referrer can be useful in gaining a more up-to-date picture of the patient and of the professionals’ concerns. As a Professionals Meeting is generally the first step in the procedure, one can ask the referrer who are the main players in the network to be invited to the Professionals Meeting, and possible dates could be considered. The referrer will also be able to talk more freely about the patient’s carers and the extent to which they will want to be involved, so that later meetings with them can be arranged as sensitively and tactfully as possible.

Between making the initial phone call to the referrer and convening the Professionals Meeting, the assessor should read all the additional information provided as carefully as possible. We have found it helpful at this stage to summarise the main points from the file, including any potentially significant aspects of the patient’s family background and developmental history. This will help in forming some initial developmental hypotheses and throw some light on the development of the patient’s anxieties that have led to the asocial behaviour. It is also very important to look for inconsistencies, questions or gaps in the information that should be raised for discussion at the Professionals Meeting.

It is not always possible to gain access to the statements of the victims of the young person but we would urge colleagues to try their hardest to do this (Minne 2003). It provides such immediacy as to the countertransference, keeps one vitally in mind of the risk present, and gives significant insight into how potently the young person feels the anxiety that has to be externalised on to another often in a violent way.

**The Professionals Meeting**

We have found it indispensable to convene a meeting of the network prior to seeing the patient. There may be great reluctance amongst those involved
– often a sign that desperation has turned to despair and that the hope is to pass over responsibility for the case. This makes it even more essential that such a meeting is held. It is important to resist seeing the young person until this is done, however harsh one is made to feel in insisting on it. The impact of the child on the network is such an important diagnostic tool.

In the Professionals Meeting the assessor will try to establish a safe setting in which it is possible to speak freely about anxieties and impressions of the patient and his carers and to engage together in trying to consider the needs of the patient and what might be in his best interests. Empathy with the professional workers’ anxieties is important, so that they can begin to feel less overwhelmed and helpless and more able to think together, but a degree of ‘thinking distance’ is also vital to preclude the assessor being drawn into the dance of the split network. The assessor is alert to points of disagreement amongst the professionals about the patient and/or the carers, as these often reflect their different identifications with aspects of the patient. Such varied identifications create splits in the network (Davies 1996). If these are not able to be thought about and processed, they can lead to unwitting enactments which seriously affect the capacity of the people involved to work together effectively. Conflicts may become entrenched if these identifications are strong, and the assessor will need to listen carefully to all the differing viewpoints and try to hold them in mind without taking sides. In effect, the assessor will take on the role of a kind of auxiliary ego to the group of professionals, considering all sides of the conflict, mediating and synthesising in the way a healthy ego tries to bring balance when faced with internal psychic conflict.

After expressing the hope that everyone involved will feel free to express their differing opinions, the assessor will invite each person to speak about their individual impressions of the patient. If the atmosphere in the meeting feels sufficiently safe, they may express thoughts or feelings that they have previously kept to themselves for fear of being thought mad or unprofessional. As the discussion progresses, differing views may be considered in terms of how the patient may be projecting aspects of his internal world. This can facilitate some understanding of the underlying dynamics of the case and throw light on the patient’s deep-rooted anxieties that fuel his dangerous behaviour. Inconsistencies are reflected on and gaps, for example, in the background history of the patient, can be raised. This may encourage relevant professionals to try to find further information to give the assessor a fuller picture.

Case example

Carrie, a 17-year-old girl, was referred for a paper risk assessment as she refused to be seen in person. She had been placed in a secure unit following a court case in which her older cousin had been convicted of
murder and sent to prison. Carrie was considered to be out of control and had a longstanding history of delinquency with 17 arrests for stealing, fraud and deception. She and her cousin had acted violently, had bullied, threatened and racially harassed others, and there seemed to be a connection between all this and the murder. As the girls were thought to have been prostituting themselves, Carrie was also considered at risk of being exploited. Carrie was about to be released from the secure unit and the referrer was anxious about her after-care.

In the Professionals Meeting the atmosphere was at first very tense and guarded. People were hesitant to say much though their tremendous anxiety was palpable. The assessor commented on how worrying this case was and how wise they were to make the referral. She then invited people to speak freely about their impressions of Carrie. At first, they repeated information already in the referral material, but finally, after a heavy silence, one professional admitted hesitantly that after a meeting with Carrie he often felt utterly shaken and needed to take time out from his other duties to try to regain his composure. Another professional then felt able to say that she had similar experiences and that being with the patient felt to her like being in the presence of Hannibal Lecter. Both were social workers not involved in the day-to-day care of Carrie; others who worked at the secure unit in regular contact with Carrie had a somewhat different sense of her. They described how sweet she was with them, especially when she wanted something, but they had also seen how sly and manipulative she could be and how she had flared up violently when something hadn’t gone her way. Previously fearing to voice this openly, one of these (male) professionals shyly admitted that Carrie had ‘slagged off’ the other worker. This enabled the other (female) worker to say that Carrie had confided in her how useless he was! As the professionals began to share their experiences of Carrie more openly, interested in hearing the differing points of view, it became clear to everyone that Carrie operated on the basis of ‘divide and rule’, cosying up to individuals in an attempt to form a collusive bond with them and turn them against others. We looked at how this might be Carrie’s attempt to reproduce the symbiotic narcissistic bond with her cousin (lost now her cousin was in prison), which acted as the springboard for their paranoid and destructive attacks on others. The link with Carrie’s experience of her warring parents was also rasied. Carrie’s sudden violent reactions to any hint of criticism or rejection led to discussion of her deep-rooted narcissistic problems and consequent quick tendency to feel humiliated and rejected. The assessor suggested that Carrie resorted to humiliating
others and being destructive as perhaps her only way, unconsciously, of feeling in control and avoiding feeling abandoned by maintaining a sadistic hold on others.

This led to consideration of the risk she posed to the community. The group felt more free to wonder about how dangerous she might become and under what kinds of circumstance (i.e. if she felt helplessly rejected, humiliated, criticised or abandoned), and they also explored how she might put herself at risk of sexual exploitation in her desperate search for a longed-for symbiotic attachment. In identification with her cousin, and to find a way to be close to her, might Carrie be at risk of committing murder or getting someone else to do that for her? We heard that Carrie had formed a close flirtatious friendship through corresponding with another murderer who was due for release soon and they had been planning a life together.

With all the extra material offered by this Professionals Meeting, it was the assessor’s task to put everything together into the risk assessment report, offering a coherent narrative of Carrie’s life and offending history and a psychoanalytic formulation (written accessibly and free of jargon) concerning the developmental factors that had led Carrie to her current highly disturbed state of mind. On the basis of all this the potential risks for the community and for Carrie’s own welfare could then be considered and recommendations could be made.

On meeting the patient

When faced with a youngster who is a potential risk to society we can lose our usual balanced and open-minded approach to assessment because of our anxiety about his destructiveness, because of pressure from the referrer to come up with some ‘answers’ and through a general and profound difficulty in holding in mind all aspects of the young person. However, our attitude towards a risk assessment should not be very different from our approach to the general assessment of any patient. Our aim is to gain some understanding of the patient’s predicament, his underlying anxieties and fears and his defences against them (both in general and as expressed through his destructive behaviour). We use our understanding of traumatic developmental influences/pathogens and of transference and counter-transference, and we try to assess the quality and extent of his impulses, his ego strengths and weaknesses, and the nature and level of maturity of his object relationships and of his superego. We look at his capacity for recognising and processing affects, his capacity for reflective thought and curiosity about himself and his capacity for creativity, play and sublimatory activity. We are interested in his strengths and weaknesses, the balance
between internal progressive and regressive forces, and what it feels like to be him. In short, we try to get as full a picture as possible of the whole person and how his internal world has developed in relation to his past experiences, the way he has been treated and how he feels about himself.

More specifically perhaps when conducting a risk assessment, we will use our understanding of the development of destructiveness (Parsons and Dermen 1999) and our knowledge of the core complex (Glasser 1979) to look for the underlying roots of his anxiety, namely his sensitivity to helplessness, shame and humiliation, annihilation anxiety, separation and abandonment, intrusion, and engulfment. We will try to assess the extent of his sadomasochistic way of relating as a defence against core complex anxieties and consider the likely triggers to the dangerous eruption of self-preservation violence (Glasser 1998).

A youngster referred for risk assessment will inevitably feel anxious and in a state of resistance. Why should he want to talk to the assessor? He knows he's in trouble and that people are angry with him and he will be struggling to feel anything but persecuted, not only because of external disapproval but also internally from his superego. Although he might be said to feel no remorse, guilt or empathy with his victim, this may well be because his superego is so harsh that unconsciously he has had to shut his ears to its persecuting voice and defy its authority. The sense of shame and humiliation, in particular, has to be kept in mind by the assessing therapist, and this will have a profound influence on technique, especially in the first interview which, Antebi (2003) reminds us, must be managed carefully to enable the patient to develop trust and rapport. For this reason, the assessor needs to approach the youngster with an attitude of open-mindedness and show that she is interested in him as a whole person, not someone who is ‘just trouble’. This sounds obvious but needs stating. Greeting the youngster frankly, telling him that you hope in these meetings to understand something about what it feels like to be him, may set the scene for him to have a different and less threatening meeting than he’d expected. It is very important not to centre on his difficulties, especially in the first meeting, but rather to try to create an atmosphere in which he can feel less anxious about criticism and in the presence of someone who is interested and who isn’t judging him. You may mention something you heard about in the Professionals Meeting that he is good at, or some new venture, activity or skill which gives him pleasure. There are some patients who want immediately to talk of their offending behaviour – and not to include it as a possibility may be counterproductive as it then becomes unspeakable – but for most it is possible to say that you will think together about it during these meetings, otherwise you couldn’t think how to help, but you’d actually like to get to know him first as a youngster. The aim is to let him see that you recognise he has worthwhile and ‘normal’ abilities and interests, and thereby to try to lower his anxiety and raise his self-esteem. This will foster the possibility for some mutual engagement and form a
more positive foundation for the meetings, enabling him to feel safer in
subsequent conversations to speak more freely about his anxieties, fears
and problems.

**The first encounter**

The following example describes a traumatised and narcissistically vulner-
able adolescent who defensively needed to protect himself from acknowled-
ing that he was in need of help. His age-typical dread of regression and
intimacy was especially intense, and his story illustrates Winnicott’s thesis
that ‘at the root of the antisocial tendency there is always deprivation’
(Winnicott 1961).

David, aged 14, was referred because of disruptive, violent and sexual-
ised behaviour. He grabbed girls in a sexually aggressive way and said
he wanted to be a rapist when he grew up. He bullied boys at school
and was rude, violent and out of control. The school had excluded him
and social services wanted a risk assessment about his violence and
sexually aggressive behaviour in order to consider an educational
setting for him. David had a background of extreme neglect and
violence. He had sometimes witnessed his father hitting his mother
when she was having an epileptic fit, and the father had also been
violent to his four sons, especially to David. Father had watched
pornographic videos with David and it is likely that he had also wit-
nessed parental sex. The children were accommodated when David
was eight. The parents then separated; neither subsequently contacted
the children. David’s three younger brothers were all adopted but David
refused, still hoping to return to his mother one day even though she
had shown absolutely no interest in him. After several failed placements
because of very disturbed behaviour, David eventually settled with a
foster family whose children were in their early twenties.

David’s resistance to the risk assessment was clear from the start. He
complained that the long journey to the clinic was boring and that he
was tired. He said he didn’t know why he was here – he’d pinched girls’
bottoms at school but he’d been told off, it was all in the past and hadn’t
happened again. The assessor said, ‘Many people feel like you do
about coming to see me because they’re not sure what it’s all about and
think it’s a sort of punishment. But I just want to get to know you and
understand a bit about what it feels like to be David. Maybe the
meetings will even help you understand and like yourself a bit better
too, and later we can think together about what might help you to sort
some things out so that you can be happier.’ David remained hunched
up in his chair looking very bored, so she suggested quite light-heartedly that maybe he thought she was talking a load of tosh. He looked a bit surprised and said hesitantly, as if he wanted to be polite but also honest, that perhaps she was right, i.e. he did think she was talking tosh!

In the Professionals Meeting, the assessor had heard that David had recently started an after-school job, which he enjoyed, so she mentioned this. Curtly, he said he was quite happy now that he’d got this job on a farm after school and at weekends. He then fell silent. As he was still wary and resistant and conveying clearly that he didn’t want to engage, the assessor had to find a way to help him with his defences against shame and criticism. She showed great interest in his job and asked him to tell her about it, saying it sounded really interesting. As if relieved that he could talk about things he knew about and could do well, he started to speak very enthusiastically about the cows on the farm and how he had to milk them and care for them. The assessor said that she could see he was very attached to the animals and had a lot of skill in the way he treated them. He began to relax and seem less wary.

He spoke about a dog on the farm that was very fierce and everyone was terrified of it, but he knew how to deal with it and it had become his friend. The assessor praised his skill and wondered how he’d managed to approach the dog. She said that the dog was probably quite frightened – maybe it had been treated badly in the past and so was always ready to attack. The way David then described how you should approach a strange, frightened animal indicated movingly how the assessor should relate to him. ‘You should never make a big fuss or a lot of noise around an animal if it doesn’t know you, but you should approach it very slowly and gently and let it get to know you gradually until it feels safe. It might be scared at first but then it will become very attached to you.’ The assessor went on to ask a lot about the animals and how he managed them, and he grinned with pleasure when she admired his enthusiasm and capabilities. He was surprised when the session had to end and agreed quite willingly to come to the next meeting.

In the ensuing appointments, David talked more about the farm animals and about his proficiency in driving and mending the tractors. This conveyed his capacity for tenderness and reparation as well as pride in his phallic skills. The assessor’s appreciative listening helped him to begin to value himself more as someone who wasn’t only just ‘trouble’, and he was then able to risk being curious about other aspects of himself and his difficulties.
Not every assessment proceeds solidly with each meeting with the patient. Sometimes the capacity to think about the unthinkable enables a sudden leap in understanding, knowledge and possibilities.

Robert, aged 13, was referred for a risk assessment and advice as to placement. A very wild uncontained boy who seemed more like 15 or 16, he was violent (had threatened another boy with a knife in his children’s home), lashed out if people walked too close, stole and used sexually abusive language towards female staff. His father left when he was two months old. He came into care at four when his drug addict mother could no longer care for him. Plans for adoption fell through when his foster father died. Presenting a tough guy exterior with little affect, Robert thawed out (after initial extreme resistance) in the first diagnostic meeting, though he would only stay for 20 minutes. He did, however, say that he wanted to come again for a second meeting. Placed in a new children’s home in the West Country (though desperate to be in London) between the two meetings, at the start of the second he said again that he would only stay for 20 minutes. Without fully thinking it through, the assessor wondered whether someone had interfered with him sexually, as it seemed likely from the material. Robert said nothing but gave strong nonverbal signs that this was true. He left (precisely when 20 minutes were up!) and the sound of a big row emanated from the waiting room before he left with his social worker. Two hours later the social worker called. Robert had yelled at her that the therapist had shown him a letter from her saying he’d been abused. No such letter existed. Then he disclosed to her abuse by his father and uncle (previously not known by the network, but it came as no surprise) and, looking at her fixedly, sang rap songs on the train about boys renting their bums. After the disclosure he was very affectionate towards her. She thought he was relieved it was out in the open and that he was very confused about his sexuality, but he refused to return to complete the assessment.

Robert had reached a way of letting his network know why violence to him meant self-preservation (Glasser 1998).

**Meeting the carers**

There are two principal reasons for requesting a meeting with the carers of a young person who causes great anxiety. The first is the obvious one, to gauge the impact of the young person on the adults who feel responsibility for him or her. This is the territory of the countertransference. Drawing out
just how the carers are made to feel, and how such feelings can vary and polarise, gives vital evidence in building a picture of the emotional state of the young person. It is quite striking how often carers are ignored in the network. As a consequence many feel unsupported and denigrated, a split is engendered that becomes polarised (good social worker: poor carers) and cannot be addressed. The opportunity for further information of a psychological and factual nature and the chance to begin to address the splits is one that should not be missed. We have gained enormously useful facts and perceptions from the child’s carers. Equally, hearing from the carers often allows us to estimate vulnerability in the young person.

Importantly, it is also possible to offer carers some analytic understanding that can enrich their insight into the patient’s underlying anxieties; we may also with their input encourage the moves towards a more integrated listening network that will be necessary if the young person is to be safe.

Feeding back

Providing a written report is a necessary part of the risk assessment process. At the risk of appearing simplistic, this should contain the following:

1. Date and reason for referral; a note of who was seen and when, and of meetings held and who attended.
2. Family history and structure.
3. An overview of the patient’s present functioning in whatever settings he finds himself – home, school, residential placement.
4. As good a psychosocial history as can be garnered from the material available. Gaps should be indicated. An acquaintance with ICD-10 (WHO 1992), DSM-IV (APA 1994) and Anna Freud’s Diagnostic Profile (Freud 1965) is a ‘must’ for addressing areas of importance and being able to organise these in a report.
5. A psychoanalytic commentary on the history, pointing out experiences and actions that precede the present worrying behaviour and which are replicated or sought by the patient. This may be summarised additionally in a psychoanalytic formulation.
6. A history of the behaviour causing anxiety and which led to the referral. Descriptions of this with specific examples are useful, especially if there has been any escalation or change over time that can be demonstrated.
7. An assessment of risk – by and to the patient – including delineation of scenarios where risk might increase (based on the history and triggers noted) and where risk might decrease.
8. Recommendations:
   - placement and care plan
   - managing the risk – strategies and key issues
   - proposed interventions and caveats.
Such a report should be jargon-free and clear. We have found that it is better to err on the side of overstating recommendations. In work with difficult and concerning young people, the tendency to splits in the network can lead to important matters not being heard or read. It is also important as the report will be distributed and read prior to a final Professionals’ Meeting where it can be further clarified and key points emphasised.

The final meeting may not be the last contact between referrer and child psychotherapist. Indeed, leaving the door open for later consultation is extremely important. It does, however, allow opportunity to elaborate on the developmental formulation to promote further understanding about how and why the patient’s past experiences have led him to where he is now. Explaining about countertransference phenomena is important, helping the network trust their instincts and anxieties and use the urgency of these to stimulate their getting together to think in the interests of the young person. This capacity to think and not immediately act is critical: it may preclude knee-jerk disruptive responses. Indeed, we should again emphasise the importance of continuity of placement and of relationships, and of having and using a sense of history.

Conclusion

Risk assessment involves helping those involved with the case to live with and contain the continuing anxiety. It is about probability and making ‘educated guesses’. It doesn’t offer answers, but questions. There are no magical fixes – either for the patient or for the network. It opens up careful reflection about the patient’s anxieties, defences and difficulties in recognising, processing, moderating, containing affects and consequent impulses at a critical time when people in the network may feel under pressure to act rather than think, like the patient. Risk, however, fluctuates and no system is fail-safe. Encouraging the network to share information and the burden of care at all times helps greatly in developing the capacity to recognise early signals from the patient. Being alert to such signals may mean the patient does not have to heighten the risk in order to have his distress noticed. A network that can view itself as a team, taking ‘corporately held’ decisions, is more likely to contain and reflect, like the good parental couple (Antebi 2003). This can – and should – be mirrored in our conduct of the Professionals’ Meeting and in the feedback given with the assessment of risk.

References


5  Peculiarities and problems in assessing adolescents

Joelle Alfillé-Cook

Temper tantrums, day dreams, bragging, swaggering, sulking and weeping, lying and cheating – these are all the reactions of the small child faced by powers too strong for him, and these are the defences to which he returns when the strains of adolescence are more than he can face.

(Blos 1941: 280)

As we can see from Blos’s (1941) description of early adolescence (as cited by Muuss 1980), plus ça change, plus c’est la même chose. More recently the comedian Harry Enfield has managed to capture this early adolescent awkwardness in his character Kevin. Kevin seems to change overnight from his parents’ point of view, and indeed we have all experienced at one time or another how quickly hormones can affect us. Uncontrollable changes in mood and uncontrollable changes in the body leave the adolescent feeling helpless at times. Watching the adolescent’s struggles can be distressing, but the defences to which he resorts can induce painful feelings in others in an altogether different and less sympathy-inducing way.

Adolescence at times causes widespread anxiety among schools, parents, the wider community and the adolescents themselves. It is worth exploring why this happens. Characterised by action rather than reflection, adolescence touches the adolescent in all of us and revives some of the out-of-control feelings we all lived through both as young children and as adolescents. It can be experienced as a period of loss for parent and adolescent, due to the psychological separation necessarily involved, and gives rise to anxieties of being alone, just as in the separation–individuation process of early childhood when the toddler strives to become ‘me’.

If we think about our wider society and how adolescence is reported in the media, these recurring themes of loss and panic are evident. The adults mourn the idealised world of their own lost youth where parents and their values were respected and life seemed altogether more wholesome. Commentators complain about children growing up too fast. Look a little closer, however, and we find things have not changed so radically. There has always been some sort of sexual activity to greater or lesser degrees
behind the bike sheds; a minority of girls have always got pregnant; aggression has always had to find an outlet whether on the sports field or by identifying with different characters in the pages of a book, or more recently violent computer games; and there have always been some who have tipped into violence and delinquency, or promiscuity. But essentially, these are the conflicts of adolescence. Although it might be a moot point as to whether there are now more adolescents at the extremes of these conflicts, some adolescents and their parents are more able to deal with them than others, and this is in part what the child psychotherapist has to assess.

The task of adolescence

Before thinking about the actual work of assessing adolescents, it is important to set a context by thinking about the task of adolescence. Psychoanalytically, adolescence has long been seen as a reworking of the Oedipal complex and the first five years of life: a second individuation process or psychological weaning as Blos (1967) described it. ‘The ease with which the adolescent can achieve separation and individuation depends on the parents’ ability to relinquish their implicit parental control and revise their assumptions and requirements of their child as a growing adult’ (Wilson 1991: 446).

Adolescence is characterised by change and with all change comes anxiety. The adolescent as well as the adults close to him all find themselves in the midst of a tumult of emotions which are sometimes hard to keep up with. Gone are the certainties of latency with its relative calm and controllability, where parents arrange play dates with children of whom they approve and watch their own children defend against anxiety in ‘safe’ colouring-in books, or work through their worries symbolically by setting up teams to play football or spying games. Prior to puberty the latency child generally accepts without question the values and knowledge imparted by parents and parental figures such as teachers. However, once puberty hits and the internal pressures to loosen family ties increase, the adolescent turns towards the peer group in order to avoid intolerable Oedipal feelings and to explore his own identity. The peer group offers the opportunity ‘to share responsibility and irresponsibility, trying out different aspects of the self and perceiving these in others’ (Horne 1999: 39). Although the loss of influence may create panic and feelings of loss for parents, it is in fact an essential part of successfully negotiating the adolescent process.

The catalyst for such change is the developing body. The surge of hormones in adolescence sets in motion the development of a fully functioning sexual body which cannot be halted and consequently often causes feelings of being out of control and yet at the same time excitingly potent. Paul Upson captures the drama of these conflicts beautifully, pointing out the similarities between characteristics belonging to the infant and young child in the pre-Oedipal stages of development and those of the adolescent, yet with the:
crucial difference being that the adolescent can act on his thoughts, feelings and phantasies, i.e. what’s going on in his internal world . . . At its extreme, an adolescent can both give life and take it away: a boy can make a girl pregnant, she can have an abortion; both can physically hurt, harm, even kill themselves, and certainly inflict damage on their home, their surroundings, their parents and other people. So life and death issues are around quite literally in adolescence. . . . adolescents are both tremendously stimulated and excited by this feeling of power and control over life and death matters and, at the same time, absolutely terrified of it.

(Upson 1991: 51)

For parents watching their children mature, there can be similarly conflicting reactions. Oedipal conflicts that seemed to have found some sort of resolution during those latency years are reignited for parents as well as adolescents: the ghosts of parental adolescent experiences may also be awakened. The adolescent with a sexually maturing body must start to look outside the home for love objects in order not to act out the feared Oedipal struggle. As many of the conflicts are unconscious, they leave the adolescent confused as to why he feels this way. The boy trying to create some mental space between himself and his father may well find himself unreasonably disillusioned with him, finding fault where he saw none before, or else becoming acutely competitive. As a defence against his potency which could actually, as with Oedipus, lead to a sexual relationship with his mother, he might find himself denigrating her. All of a sudden the peer group becomes much more important – essentially his second family providing space for identification, comparison, rivalry and above all a reduction in closeness. Likewise, the adolescent girl must find intimacy outside the home and may find herself disillusioned with her parents. Her father, struggling with his own Oedipal feelings towards her, may resist her attempts to become attractive to other men and boys, while her mother may well end up being drawn into competition, envying her daughter’s youth. Battles between parents and adolescents over clothes seem to symbolise the conflict over who has control of this sexually maturing adolescent body. Battles over friendship groups and socialising symbolise the conflict for parents and adolescents about separation from the family.

Tonnesman (1980) writes of adolescence being a ‘normative crisis’ whereby, out of necessity, infantile objects are lost and subsequently mourned. During the mourning, the adolescent uses those around him to relive, or re-enact, early infantile relationships and memories which could not be processed at the time, in order to achieve mastery. Due to the giving up of attachments to the early objects and the reliance on parents and parental figures for ego support, the adolescent’s own ego can be seen as being temporarily weakened, leading to behaviour more characteristic of early childhood such as not looking after their bodies, throwing tantrums if
their needs are frustrated and an inability to keep time. Such regressions, although necessary to free the libido, can leave everyone feeling confused.

Similarly, Winnicott refers to the ‘adolescent doldrums’, the few years in which each individual has no way out except to wait. Unable to be certain about sexuality, identity or the shape of the future, for the adolescent ‘there is not yet the capacity to identify with parent figures without the loss of personal identity’. He warns against trying to cure the adolescent but suggests that ‘we hold on, playing for time instead of offering distractions and cures’ (Winnicott 1963: 244). It is a warning to be sure of the need for intervention before we become involved.

Defences used

During this recapitulation of the first five years of life which includes the task of reworking the Oedipal resolution in the light of the adolescent’s new-found sexual potency, primitive or early defence mechanisms often come into play. These include ‘magical thinking, projection and denial, as well as all kinds of obsessive-compulsive traits, habits and thoughts’ (Blos 1970: 71, cited by Muuss 1980). The need to act rather than reflect can be seen as a regression to the early infantile state where the infant uses his body to express his mental state, before progressing to language and then thought. For some adolescents, the dismantling of their thinking process is the only way they feel they can protect themselves from Oedipal thought and memory.

The adolescent can find himself in a state of flux, at times wanting the safety of the latency years, at other times frustrated by a lack of independence; on the one hand being excited by new-found power and potential independence, yet on the other hand being quite terrified by it and wanting to regress to a younger way of being. Although such a regression might be seen as a defensive manoeuvre, it is an entirely healthy part of normal adolescent development, enabling the push and pull of the adolescent conflict to be expressed.

In part, the child and adolescent psychotherapist’s job when undertaking an assessment is to try to find out how the adolescent is coping with these difficult conflictual pulls and to see if there is a general trend toward healthy adolescent development or whether there is a worrying breakdown in any area. At a later point, we will also look at suicide as an attempted defence or solution to feelings of unbearable vulnerability and rage. This is also important to have in mind when adolescents arrive in the clinic.

Referrals and pre-assessments

Whether working in clinic, school or any other setting, it is important to take notice of the source of a referral as well as the content, and allow space to think rather than just react. The anxiety engendered by adolescents
Peculiarities and problems in assessing adolescents

within their families or professional networks can lead to panic and action rather than a more thought out and measured response. Indeed, we might say that this is the projection on to the environment of the adolescent’s predilection for activity. Taking note of other professionals involved, for example, can be helpful, as multiple referrals to several agencies are sometimes made in the hope that one might come through. Alternatively, worried adults may collude with the defensive splitting used by the adolescent to manage intense feelings and go from professional to professional, turning each into a ‘bad object’ whilst imagining the next professional/treatment will be the good one, constantly looking for a magical solution. It is not uncommon for an adolescent who is in the middle of an assessment or treatment to come to his session with the news that he has just started a course of medication or cognitive behavioural therapy (CBT) without one professional being aware of the other’s involvement.

The child psychotherapist might also want to bear in mind the fact that it may not be the adolescent who is most in need of help. In some cases it is actually the parents who need support in coming to terms with the important changes underway. At other times it can be beneficial to help a school to identify normal healthy development, or to recognise and not take on the projections of the adolescent.

Whilst some adolescents just worry about where their newly found powers can take them, others actually try them out. Just as in any other assessment, but perhaps even more so with this group, risk has to be thought about before and during the assessment in order to ascertain who might be the best person for the work at this time. The tendency towards action means adolescents are more likely to self-harm, become delinquent or even commit suicide. It is essential to have a team, or at least access to colleagues, to help with the thinking around adolescent cases. As Anne Hurry states: ‘Work with adolescents can often give rise to particularly intense forms of counter-transference which it may be easier to recognise in others than in oneself’ (Hurry 1986: 34).

Pacing the assessment

There seems to be some consensus amongst those working with and writing about adolescents that it can be useful to assess over a period of time. There are several reasons for this. First, the assessor needs to be patient and try to establish the fluidity and general direction of adolescent progression. Regression, for example, can be a sign of both healthy and unhealthy development, as can resistance to regression (Blos 1967). As Laufer writes, the assessor is ‘faced constantly with the need to decide about one crucial question: is this adolescent’s behaviour or worries normal, or are they signs of present or future pathology?’ (Laufer 1995: 3).

Second, from the point of view of adolescent process, a series of appointments which asks for a more limited commitment is less likely to
trigger defences aimed at distancing the adolescent from parental figures. Parsons argues:

> Intermittent contact with the therapist allows the adolescent more easily to 'go with the flow' of the adolescent process. The young person who is age-appropriately engaged with the developmental tasks of adolescence struggles against [my italics] the regressive pull to childlike dependence on his parents.

(Parsons 1999: 228)

Or dependence on parental figures such as a therapist. It was precisely this decathecting from parents which made Anna Freud pessimistic about treatment for this age group, as any analyst or therapist would represent the parent (Freud 1958). A modified approach has therefore been sought.

A model for assessment such as the one used by the Brent Centre for Young People (BCYP), where adolescents are offered a series of appointments to think about current difficulties, and where there is a certain amount of flexibility in frequency and duration of contact, fits in very well with the adolescent process. At the end of each meeting the adolescent is given the choice of booking another appointment or not. In a very subtle way this hands over some of the responsibility for seeking help to the adolescent, but also gives him a measure of control. As omnipotence and denial are widely used defences during adolescence, it is as well for the therapist to bear in mind just how easily these defences can be triggered and then lead to an 'I don't need any help' state of mind in such an anxiety-filled space as an assessment. Extended assessments also enable the therapist to think with the adolescent about their 'dual wish: a wish to find some way out – even to change – and a longing to be able to retain or re-establish the old solutions and not to change' Hurry (1986: 36).

*In the waiting room: an example*

I went to meet a new patient in the waiting room. The patient and his mother sat close together, the mother almost sitting on the side of her chair as if trying to get closer to her son. He on the other hand looked awkward and surly, his head turned away. As I went towards them she looked up and smiled to greet me. I felt very aware that the appointment was for him and that it was important to greet him first, or at least at the same time as his mother, setting a boundary and sending a message that the interviewing space was for him. During the rather silent assessment it became clear that he was conflicted about being there. Although he denied that there was anything worth worrying about, he also managed to convey the seriousness of his problems and disturbance. There seemed to be difficulties in all areas of his life (peer
relationships, family relationships, his relationship with his body and academic progress). I was conscious of his antipathy towards me, perhaps finding me to be intrusive in the same way he had described his exceedingly anxious and worried parents. One might also say that by remaining silent he was inviting me to ask questions, replicating in the transference relationship his ambivalence about giving up his childhood objects.

At the end of the session I summed up what I thought he had told me and I took up his feelings that, despite some of the things he had told me, there was nothing wrong. I gave him the choice about whether or not to come back the next week but told him I thought it might be helpful to think more about what we had (minimally) talked about that day. I felt this feeling of choice would be very important for him as it seemed clear that part of his struggle was with needing physical and psychological distance from his family, as shown by his reaction, and perhaps my countertransference reaction, to his mother in the waiting room. I also felt that his excessive and exaggerated use of denial of the seriousness of his problems was indicative of fearfulness and needed careful handling in order to engage him.

During the assessment of adolescents, Laufer (1995: 4) asks us to look at three key areas in the potential patient’s life:

1. The relationship to his parents and whether or not he can own his thoughts and feelings and if necessary stick to them even if they may not approve.
2. Peer relationships and whether he has chosen friends who would enhance his efforts and wishes to become an adult.
3. The capacity to view oneself as a physically mature person – either masculine or feminine – with ownership of the body.

If over the period of assessment it becomes clear that there has been ‘a breakdown of the process of development’ (Laufer 1997: 77) in one or more of these three areas of the adolescent’s life, this is an indication that help is needed. It does not of course mean that the help offered will be accepted or successful. As Winnicott says: ‘We offer psychotherapy to those patients who feel a need for it, or who can easily be helped to see that psychotherapy is relevant’ (Winnicott 1963: 245). Again, this seems to support the case for a prolonged assessment, where the aim is to enable the adolescent to see the usefulness of talking about, reflecting on and exploring his thoughts and feelings. Bronstein and Flanders (1998) argue that it is of crucial import-
ance to work with these adolescents to enable them to own their need for help, by helping them develop some understanding that ‘their behaviour is symptomatic of something else; that feeling compelled to cut themselves, to binge and vomit or to drink has a meaning that is specific to each of them’.

Meeting the adolescent for the first time

As with any initial meeting, the first contact is always important. There has usually been contact with the institution before any meeting takes place. The first appointment letter is usually worded carefully to explain the setting (e.g. time, place and length of interview), the purpose (e.g. to explore current difficulties) and gives the name of the therapist. It can be a useful tool for the therapist to enable boundaries to be set, as well as giving the adolescent as much useful information as possible to reduce unnecessary anxiety. Although for some this may be the first contact that they have with mental health professionals, for others there might already have been consultations with the GP, counsellor, psychiatrist or relevant professional. Either way, this will be the start of a transference relationship and adolescents will come with preconceived ideas about whether you will be just like the friendly or useless GP they have in their minds. They may have unrealistically high hopes that all their problems can be magically whisked away, or else have no hope at all that anyone can understand, let alone help with their internal chaos. Some may be coming only under sufferance, believing the problem lies elsewhere – with parents or school – and may see the therapist as allied with the very people who they consider are the problem. Initial emotional reactions and thoughts about the adolescent first encountered in the waiting room are usually important tools for assessment. If we think about the defences used in this period, defences such as denial, projection and resorting to action, it is very easy for the therapist to get caught up and confused by their strength. Thinking back to first impressions can be a useful and essential anchor. Below are three examples of initial meetings and countertransference responses.

F arrives

F came striding towards me as I entered the waiting room, arm outstretched to shake hands. She had just parked her car in the staff car park. I felt confused and taken aback, for a moment wondering if this was a psychologist or some other professional I was supposed to be meeting. Everything about her projected confidence and togetherness, down to the smart suit and classic jewellery. For that split second I experienced confusion about my own identity (as the assessor) as well as hers. The subsequent session was full of denial about any internal problems, with external events being used to explain current anxieties.
Although at university, she found it impossible to move away from home to live in halls of residence, and had failed her finals, preventing her from taking the next step into adult life.

I found it helpful in this case to keep in mind my initial feeling of confused identities as this enabled me stay in touch with her difficulties of finding an adult identity outside the family, rather than get taken in by her strong defensive mask of competence.

**Encountering C**

My first impressions of C as I met him in the waiting room were of a rather smooth and attractive young man who might have been on his way out to a nightclub. He greeted me with an easy manner and I noticed his aftershave. In the room, however, he painted a picture of a painfully shy boy who limited himself socially and wanted help with his confidence. I felt sorry for him in quite a maternal way. In fact, much of his difficulty stemmed from his inability to separate from his mother. He wanted a wife just like her but described other times when he regressed to being cared for by her, like a young child. He was aware of enjoying such attentions but also felt disturbed by these feelings. In the course of this first session I had experienced the more seductive young man in the waiting room, as well as his defensive regression to little boy whom I wanted to mother. I was left wondering what he had made of the initial contact with the clinic and whether I had been identified as a mother figure before he had even met me. During the course of this brief contact I had perhaps represented the mother who was to be seduced by the sexually mature son with the aftershave, but his intense anxiety about this subsequently caused him to regress into seeming more like a little boy.

Although this lad attended a few sessions, he did not continue coming to the centre. In hindsight I can postulate that Hurry’s idea of a ‘dual wish’ (referred to earlier) was perhaps very much in evidence even in this first session.

**Mother and daughter**

I saw two ‘women’ sitting in the waiting room. I was expecting to meet a 14-year-old refugee girl. One was well presented with braided hair and bright clothes, the other dressed in nondescript dark clothing, looking anxious and drawn. I was not sure whom to address as neither looked like the girl I was expecting. As I approached the two, the woman in the...
bright clothes introduced me to the patient. A huge smile absolutely transformed the girl's face and made her look her 14 years and I experienced a huge sense of relief. In the consulting room she told me about the multiple traumas in her young life. It was a difficult session where I think she was able to allow me to see and experience her at her most desperate. After that session, however, the smiles returned whenever she saw me and it was important for me to remember my first impressions from the waiting room, of the sad looking girl who looked way beyond her years. It was also important to remember my feelings of relief when she smiled. It emerged during the course of the assessment that she spent a lot of time protecting others from the knowledge of her traumatic life as well as (understandably) trying to put it out of her own mind. This was not only due to the shame she felt about what had happened to her, but also worry about whether her despair could be tolerated.

**Assessing risk and suicide**

At the start of an assessment it is important to let the adolescent know that the sessions are confidential but that information about serious risk has to be shared. With younger adolescents this would be with parents/carers, whilst with older adolescents it would be important to let the GP know, or else to refer on to a psychiatrist who has access to inpatient care. Although this may introduce some mistrust in the therapist, especially where the adolescent is resistant to the therapist informing the parents/school or GP of her concerns or recommendations, it can equally be a relief for the young person that an adult has recognised the depths of his troubles and taken his problems seriously. At the Brent Centre we also inform the adolescent of our use of the team to help us decide on our recommendation for further treatment.

Adolescents at risk of harming themselves or others may need a multi-disciplinary team of professionals to be involved, in order to keep them safe. This will at times include the physical boundaries of an inpatient unit, usually accessed by a child psychiatrist. If the adolescent is told that the assessment is ‘to see how the service can best be of help’, it makes referrals to another professional or institution possible to discuss.

In one case of a young lad who was thought to be at risk of harming others due to his uncontrollable angry outbursts both in school and in the community, the professionals involved with the case recommended a referral to the youth offending team. The purpose of this was to enable him to have access, while in the community, to the practical resources this team offered to keep young people out of trouble,
especially during holidays. Although he was at first angry and perhaps frightened at being seen as a potential offender, we were able to think in his sessions about his fear of his uncontrollable impulsive anger, and his earlier feelings that the only way anyone could control his anger would be to ‘lock him in a cage’ – i.e. put him in prison.

Egle Laufer (1995: 108) encourages therapists to ask adolescents whether they think of killing themselves, as this can lessen the anxiety and reluctance to examine what may be ‘regarded as a shameful secret’. If the adolescent expresses a clear plan in his mind, the therapist needs to be concerned, and may well need to act on this concern. Anne Hurry’s paper (1978), looking at the motives and reasons for suicidal behaviour in an adolescent girl, reviews the literature and finds there can be many over-determined reasons for suicidal behaviour such as:

- identification with a suicidal relative
- feelings of having lost a loved person (through the actual death of this person or feelings of rejection/abandonment by them)
- internalisation of parents’ destructive wishes towards them as a child
- a wish to separate and show ultimate independence from parents or else fuse or merge with them
- a defence against overwhelming aggressive feelings towards loved and hated objects by turning the aggression towards the self
- an overt expression of aggression towards parents by punishing them through the suicide and blaming them for it
- a defence against sexuality in adolescents whose Oedipal wishes are conscious in an ongoing way
- a punishment for these wishes being fulfilled in fantasy.

Whatever reason(s) a particular adolescent has, an attempted suicide is ultimately a massive attack (by those who have perhaps lacked appropriate containment of their aggression in infancy) on the sexually maturing body, the internal objects which include the internalised parents, as well as a violent attack on all those around, who are often fantasised as then feeling very guilty about not having cared enough. For any therapist working with this age group, there is a need to get help from other professionals ‘in order to stay in touch with the reality of the adolescent’s destructive impulses towards himself and towards the treatment, and not to collude with the adolescent in his denial’ (Laufer 1995: 107).

Addressing the issue of suicide from a further perspective, Rosalie Joffé points out that while adolescents feel ‘unbearably out of control, vulnerable and helpless, the idea of suicide gives them a sense of power over their own lives and a weapon against others’ (Joffé 1995: 54). For this reason, the therapist’s wish to prevent suicide is not always welcomed by the adolescent.
Assessment in schools

Working as a child psychotherapist in schools can be a rewarding and challenging, if sometimes a frustrating, experience. Often the adolescents in the school staff’s care cause panic, anger and anxiety within the school system. Just as an adolescent can feel helpless and terrified about his abilities to control the changes that occur in puberty, and worry about the capacity to control overwhelming feelings of anger, sexual urges or disappointment with parental and other figures, so the staff who are accompanying the adolescent on this tricky journey through adolescence can also feel helpless, terrified and disappointed.

It seems important for any child psychotherapist to devise her own means of creating mental space within the hectic life of the school so as to be able to reflect on those individuals who are causing concern. Some manage this by creating their own internal referral forms or by having weekly referral meetings with relevant staff members; others manage the process more informally. It is, however, very easy to get caught up in the panic engendered by the adolescent and rush into action – to see the pupil before the proper information has been gathered about current concerns, past history, involvement with other agencies and so on.

As I went to say goodbye to two members of staff before I went home, the head of year and pastoral assistant asked me if I had space to see one of their pupils. I had just had a session with another pupil where we had agreed to cut down to fortnightly sessions. With this on my mind, I said I did have a space but would need a consent form from the pupil’s parents. They told me her first name, said she really needed it and they would arrange it for next week. With this I left the office.

Once away from the school I realised I had absolutely no information on this pupil at all, and had not made any assessment as to how appropriate it would be for me to see her. Luckily all was not lost as email contact is always welcomed by this school. I was however, reminded about how easy it is to fall into the trap of not only identifying with the worried staff who want a pupil ‘sorted out’, but also feeling that the very discussion of an adolescent pupil’s difficulties would be too much to bear. Another explanation, of course, would be that I was fleeing the school as quickly as possible at the end of a week struggling with adolescent conflicts.

This brings me on to thinking about the dynamics between a therapist and members of staff. As with parents, there can often be an assumption that the therapist will have a magical solution – that those sent for ‘anger management’ will have their anger managed, or defiant pupils will no longer defy. When this does not happen in a timely fashion, there can often be unspoken disappointment with the therapist that will need to be
managed and aired – probably by the therapist herself, just as one would with a disillusioned patient. Another dynamic to be thought about is the competitive feelings engendered by ‘experts’ or specialists coming in to a school. For some staff, a referral is an admission of not being able to deal with a difficult or unhappy child, or that the pupil whom they would like to help does not want to confide in them. Again, it is up to the child psychotherapist to be sensitive to such feelings just as we would with a parent. Moses Laufer wrote about the importance of not colluding with parents who need to project the problems of the family on to the adolescent. Likewise in schools, the assessment of a pupil might conclude that ordinary adolescent conflicts exist, but that actually the issues lie with the teacher.

Along with managing the expectations of staff comes managing the expectations of the pupils. In my experience, pupils often come with the expectation of being offered techniques to help them, and can be surprised and sometimes disappointed that there are no concrete solutions but that you are there to help them think. For some, who just want to get rid of or evacuate their feelings and leave them with the therapist, the realisation that they are expected to take an active part in the thinking with the implicit message that they will need to take some responsibility for how they act and feel, is unwelcome. It can lead to avoidance of sessions by ‘forgetting’ to come, or being ‘ill’, and in group work it can lead to attempts to undermine the process with continued disruption of one kind or another. In such cases the therapist needs to be sensitive to what the adolescent can bear, and keep in mind that they have not always chosen to attend (unlike in a walk-in clinic) but have been, or at least feel they have been, sent. On a practical level, the therapist needs to think carefully with the school on a case by case basis, the best ways of introducing the assessment to the pupil and ways to contact the pupil if they miss a session, for example, in order to maintain boundaries without the process becoming too persecutory or intrusive.

Writing about the relationship between different professions in a hospital setting, Winnicott drew attention not only to the jealousy between staff, but also to the way in which some adolescents seem to foster a split (Winnicott 1963). He saw this as a reflection of tensions between the adolescent’s parents which had been displaced on to the staff – the displacement of the adolescent’s fear of allowing the parents to come together, in the unconscious phantasy system (p. 245). Although such psychoanalytic explanations may not be useful to staff, the similarities between what happens between the adolescent and parental figures at home and at school might usefully be compared and talked about.

One of the difficulties in this type of assessment work is the need to remain flexible. After all that has been said about not joining in with general panic about surrounding adolescent pupils, there are also benefits to being able to respond quickly. Staff can and do pick up worrying changes in their pupils that make them feel uneasy and this may well indicate swift assessment and potential referral on to a psychiatrist with access to inpatient care.
I was approached one morning by a head of year. She told me about a boy who was concerning her and whom they ‘could do nothing with’. She felt that over the past year there had been a significant downturn in both his behaviour and mood. She seemed on the one hand exasperated and cross, and yet on the other hand worried. Having told me how disruptive he could be in class, defying the teachers, refusing to sit down or work, she added that he reminded her of another pupil who had gone on to commit suicide. As I am only allowed to see children with parental permission, she telephoned the father there and then to get his consent. I took this as a measure of the anxiety he produced. It seemed the appointment could not wait until I would be back in school the next week. She said that on the previous day she had mentioned to the boy the possibility of talking to someone but had not arranged anything. As I waited by her office, a boy ambled up asking if I was ‘the psychologist’. I realised this must be him and assumed he’d been sent down by the head of year. However, it later turned out that she was still looking for him and, rather significantly, he had come to find me. After a few assessment sessions, it became obvious that referral to a psychiatrist was needed as she had access to a wider range of interventions for this crisis situation.

Conclusion

Adolescence is not an illness, but a developmental period. However, for even the most ‘normal’ adolescents there can be moments when they feel abnormal either in body or mind. Some deal with this on their own or with the help of peers or parents; others, however, will need professional help. One aim of the assessment is to try to sort out the internal versus the external factors affecting the adolescent, and then get the young people to take ownership of their difficulties. When assessing for therapy the therapist is also looking to see if the adolescent is interested in his internal world. When a therapist recommends ongoing once weekly, twice weekly or intensive psychotherapy, she has to have made the decision about whether the particular adolescent is ill enough to need it, but well enough to use it. A series of assessment sessions allows the adolescent and the child psychotherapist to explore the level of help needed by and tolerable to the adolescent.

References


Part II

Overlaps
I first came across Dilys Daws when I did my infant observation. During my first visit to the family after the baby had been born, the mother, whom I had met once already, told me that she didn’t know how to put her baby down. During the following months she explained at length the many different ideas they had for getting the baby off to sleep, and I found Dilys’s book *Through the Night* (1989) very helpful in understanding what was happening for these lovely, caring parents who were struggling to separate from their baby. I then met Dilys during my child psychotherapy training when she took clinical seminars and then again some years later when she was on an interview panel for a job I had applied for. So this was not the first time I had met Dilys, but it was the first time I’d had the privilege of talking to her and finding out about her career as a child and adult psychotherapist. Dilys has dedicated herself to the work of child psychotherapy as well as to the mental health of infants and their parents. The interview took place at Dilys’s home in March 2007.

*Caryn: As a way of starting can you tell me how you became interested in child psychotherapy?*

*Dilys: I came into it from my family background so it was an easier route for me than for many people. My father was a GP in Huddersfield working from home. It was a ‘family business’ – my mother answered the telephone, helped do the accounts, knew who all the patients were. Today she would be the practice manager. There was Freud on the dining room table! After the war my father trained as a child psychiatrist. I was about 12 years old, old enough to be really fascinated by what he was reading and talking about. I was also influenced by my mother’s ‘style’: her love of babies, her ability to listen and her creativity with family and home. I was interested in what they did, and with all the excitement of that sort of work I thought, ‘I want to do the same as Daddy.’

At secondary school I realised that I was good at the arts but not at science. I could learn science but I could never think about...
it and be creative. I had a nice time in the sixth form and decided to do something completely different and did social anthropology at Newnham College Cambridge. It was a really lovely thing to do. It was a very lively department – Meyer Fortes was the Professor and Edmond Leach the Reader. They were psychoanalytically minded so it was a really good start. After that I did a year as a research assistant to Meyer Fortes and then moved to London where I’d always wanted to live. My first job was as a research assistant at the Institute of Community Studies, which had Michael Young and other inventive minds of the late 1950s – looking at how people live and the interrelations between them and their social context. The work I did for Ann Cartwright was to pilot a study of patients’ experiences in hospital using a questionnaire. I got a real conversation going with people even though I had to stick to the prescribed questions and at the end people would say, ‘Thank you I feel much better.’ So that was a useful discovery in how talking about an experience could be helpful.

I then had the grandiose idea to connect psychoanalysis and social anthropology and I had introductions to a number of people – Elizabeth Spillius was very encouraging, but when I got to see the social scientist Marie Jahoda, she gave me the most sensible advice, ‘Go and do one of them properly.’ My father was again useful because he said, ‘Why don’t you go and be one of “Anna Freud’s young ladies”?’ which is what they were nicknamed at that time, and so I applied to the Hampstead Clinic. My interview with Ruth Thomas was my first therapeutic encounter and it was memorable, you know that thing of trying to work out who and what you are . . . but they didn’t accept me and advised me to get some experience with children and that’s when I went into teaching.

I got a job without having a teacher training – you could at that time just with a degree. On my first day as a supply teacher I was absolutely useless. The children asked, ‘Is this your first day Miss?’ and I snapped back, ‘No.’ If I had told the truth I’m sure they would have helped me. As it was the day was chaotic. I then taught at a boys’ secondary modern in Kilburn, which was a great experience of how to just manage myself with all these boys. I went back to the Hampstead Clinic and they asked me to get experience of younger children so I taught for a year in an infant school in Plaistow, which is when I got some proper training from an older woman, a teaching assistant who knew how to manage a class of two- to four-year olds. I went back again and was interviewed this time by Anna Freud, which terrified me because you got the analytic silence . . . and I didn’t know what to say. She asked me what I’d read and I thought if I say Freud will that seem as if I’m
sucking up to her or if I don’t . . . anyway I managed to say it. But, when I didn’t hear from them, I had to ring up and they said, ‘Oh no sorry, didn’t we tell you we haven’t taken you, try again next year.’ . . . In the meantime I’d heard about the Tavistock.

Caryn: You were determined.

Dilys: Yes, that’s right. I went back twice to the Hampstead Clinic and in fact that was fair enough because they said I hadn’t had enough experience, but the second time they implied they would take me if I paid for myself but I had the mindset that I shouldn’t have to do that. It was in the days of free university tuition and so I went to the selection procedure at the Tavistock, which was very interesting. I was interviewed by Dr Bowlby, and there was also a group selection procedure and an object relations test. It lasted a whole day and I think I would have been devastated if I hadn’t got a place. I would have really been left feeling wanting, but I was selected. It was 1960 and I was 25, young by today’s standards.

Mattie Harris was running the course then. I hadn’t had any analysis and I didn’t know any analysts, and I didn’t even know the difference between the groups. I met with Dr Bowlby who said, ‘Why don’t you go to a friend of mine, Pearl King?’ She was an Independent analyst, then called ‘Middle Group’ and a really good choice for me. She agreed to take me on and said ‘When would you like to start?’ and I said ‘When I start the training, of course!’ and good for her she said ‘That’s fine’ – no argument from her at that point, which was rather interesting. She was a wise, slightly rebellious person, part of the establishment but also critical of it – so a bit like me, or I’m like her!

Caryn: It’s interesting that as a teenager you wanted to study something you could think about, and part of your work and writing has been about how to think with parents and professionals about babies.

Dilys: Yes – but I usually find that when I’ve written something down, I then move on and disagree with what I’ve said!

Caryn: Are there things that you’ve written and have now moved on from?

Dilys: Well, the preface to the second edition of *Through the Night* explains how my ideas of separation had become more complex, as I realised that putting the baby down was not as simple as I’d once thought. Parents nowadays keep their babies more close to them, they hold and carry them more and sleep with them more, and what I came to realise was that some manage to enjoy this closeness and at the same time let go of each other emotionally so they can enjoy sleep, whereas for others closeness becomes intrusive and then no one can get a good night’s sleep. I don’t of course
believe in separation at all costs. All babies need closeness and intimacy with their parents in the first place to aid attachment. Individuation and independence follow on from this.

Something else where I might have changed my view slightly is about leaving babies to cry. Since I’ve had grandchildren and had the pleasure of putting them to bed, it’s made me think how it can be very controlling not to allow them to cry a bit. Some babies do need to cry and protest a bit, to express something as they are settling down. They know that the adult is nearby and then feel they are not abandoned, and these babies can stop crying quite quickly.

Caryn: There are so many books now which focus on infants and sleeping and I wonder what effect you think these very different approaches might have on parents?

Dilys: First of all the books are in answer to a need. Lots of babies don’t sleep and lots of parents worry about their babies. Also it’s partly a generation of older parents. Penelope Leach wrote a piece called ‘Mothers as Managers’ (2004) which is about the need for mothers with high-powered jobs to be in control and their worry about getting things wrong. Books are an answer to that need and of course nowadays many mothers aren’t living near to their own mothers. There’s a large market for reading about lots of things – and where there are TV programmes telling people how to get it right, the more people feel they’re getting it wrong!

Some books and programmes are helpful in describing the experiences that people are having but some take over in a very controlling way. . . . ‘controlled crying’ is the key word to it – but *The Contented Little Baby Book* (Ford 1999) is my particular bugbear – I call it ‘The Submissive Baby’. I find it particularly annoying because Ford quotes me as if I support her point of view when actually she’s taken something out of context. She also quotes me as though I have used some of Joan Raphael-Leff’s key ideas without references. It appears as if I have stolen the ideas. It’s actually very unscientific.

Caryn: Is that where Joan Raphael-Leff writes about the regulator and facilitator mothers?

Dilys: Yes that was her lovely idea . . .

Caryn: Nowadays we take it for granted that the relationships between people in families affect babies, but how did you come to that idea in your work?

Dilys: Well I don’t think I noticed that I did. When I had my own babies I was in a network where people easily talked about their feelings to each other. My friends included other child psychotherapists and we were able to talk about how it felt to be mothers, but I started to think who I would talk to if I wasn’t in this network
I need to go back and fill you in with some more history – is that OK?

Caryn: Yes, fine.

Dilys: I trained with Juliet Hopkins and we’ve been friends and worked together ever since. We’re in a peer supervision group together and still talk about what we do. It was a three-year training then including the infant observation and it was so easy to get training cases – quite different from nowadays. This time the Tavistock forgot to tell me when I qualified . . . systems weren’t very good in those days! At the end of the three years I said to Mattie, ‘Do you think I’m going to qualify?’ and she said, ‘Oh, you have – didn’t we tell you?’

Then Juliet and I both stayed on for another year because three years wasn’t enough and we continued with our training cases and went on with our analyses. We both got married somewhere around then and my first husband was an Australian painter and we went to Australia for a year. I worked for five months in Adelaide in a CAMHS team and supervised everyone! It was a large clinic and the director had spent some time in London and was really interested in psychoanalysis. At that moment I knew more than ever before or since! – and I was more Kleinian than I am now. I supervised everybody in the clinic except one psychiatrist who refused – good for him!

I was asked to do an assessment of all referred children and did them in their homes, which was the usual practice in this clinic. I expect they were pre-selected to some extent but I thought they were all suitable for psychotherapy. In fact I didn’t actually know of any other type of treatment, or I thought psychotherapy was the best option – I didn’t know about differential diagnoses in those days, but it was a lovely consolidating time for me.

And that was the last bit of work I did for a while because in that year we had already travelled through India, Thailand, Cambodia, and on the way back through Mexico and America and when I got home I was five months pregnant. I took five years off except for some lecturing and writing, and being the Honorary Secretary of the ACP [Association of Child and Adolescent Psychotherapists] which was perfect as I could do that in the evenings as a way of being involved with the profession and still be almost a full-time mum. I went back to work one session a week at Paddington Green and did more lecturing when my children were five and three. Juliet and I applied for a position at the Child Guidance Training Centre (CGTC) as a job share but at the door we met Francis Tustin and obviously she got the job, but we both thought this was where we wanted to be, so the next time a job came up there in 1971 I applied for it but didn’t get it. They asked
me to apply for a job at the day unit but I didn’t really want to, it wasn’t my sort of job at all. I’ve never had an interest in severe disturbance. I’m much more interested in things going wrong for more ordinary families, but they were very insistent that I had to do this job and I was persuaded! They said I needn’t actually see the children, that I could work with the staff, which of course in the end wasn’t true.

Anyway I got really fond of these children and I did some quite good work but I had no real concept of their disorders. It was when Francis Tustin was writing about autism, and I didn’t get the hang of that at all, and I now realise that several of the children were on the autistic spectrum. I saw several non-communicating children and several with really odd behaviour but I didn’t produce any ideas about their disturbance or their disorder. However, I think I helped some through the relationship. I was startled when a six-year-old barely speaking boy with a very low IQ said to me as we said goodbye, ‘I’ll never have a friend again like you.’ I’ve always remembered him and perhaps he has remembered me. I think I did useful work with the teachers and helping people deal with each other in this difficult and disturbing place, but in the end I got stuck there in a non-creative way. In 1985 the CGTC merged with the Tavistock and at that point I said to Margaret Rustin that I would like to work ‘down the road’ as we called it. Margaret was good at helping people be in the right place, and when Valerie Sinason came along and actually wanted to work at the day unit then I swapped my sessions and I was much happier as a therapist in a team seeing families.

Going back again, when I had been at the day unit for three years, I asked the director, Dr John Bolland, if I could use a session to work at a baby clinic and he said very thoughtfully, ‘Take your time’, as there were no child psychotherapists doing this work in that setting, although there was of course the Anna Freud Well Baby Clinic. I went to visit various clinics and to see Catriona Hood, the psychoanalyst and former GP – she was working in a baby clinic and I sat in with her. She saw a woman whose baby had died and I thought, ‘I can’t do this.’ I had two young children – I was absolutely terrified but also interested. I eventually found the James Wigg practice where I still work today. It certainly wasn’t easy being there and it still isn’t, in spite of their warm welcome – I feel as an outsider you have to justify being there every time you go – to make the case afresh... but of course that might just be me. At the weekly baby clinic I started seeing families with babies with all sorts of problems and I realised that a large proportion were sleep problems. I’ve no idea how I worked out what to do – I just got on with it – but what was
amazing was that about 50 per cent, so quite a high proportion, slept better after the first or second meeting and I remember going back from the baby clinic to the CGTC where we used to have coffee together mid-morning and sometimes after lunch, it was wonderful – people had the time to sit together and talk, and one day I went into this room with a whole lot of staff who themselves were parents of young children and said, ‘I’ve just got a baby to sleep through the night’ and a chorus went up from these young parents saying, ‘Tell us how you did it!’

That was one of those lovely moments in life and Juliet said to me I should write about the work. It took time, I had two children and I was by then a single working mother, but I gave a paper on sleep (1985b) at a conference in Paris where Antoine Guedeney came to find me to say we had similar ideas. Antoine is now President of WAIMH [World Association of Infant Mental Health]. Since then we have done quite a bit of work together. In fact WAIMH has been a major influence on my work. There is a group or perhaps network of us around the world doing psychoanalytic parent–infant work, presenting together at WAIMH congresses and feeling we have become close friends. I must have started *Through the Night* soon after that. It took me three years to write the book, a year of reading and thinking, a year of writing the first draft and a year of finishing it off.

*Caryn:* One of the things you say in the book is ‘Solutions are as much the province of parents as of myself; my task is to help them restore their ability to think effectively so that they can provide an answer for their child.’ This seems to encapsulate your joint focus and collaboration with parents that I think is at the core in your work.

*Dilys:* Yes, in a way it’s my core philosophy, but of course anything I say, I don’t necessarily do. I say that I don’t give advice but I probably slip quite a bit in. It is important to say how enjoyable this work is – having the opportunity to talk with families about their infants at this crucial time in their lives feels really invaluable, and people need to really argue the case for early intervention.

*Caryn:* In *Through the Night* you refer a number of times to your work in this area as being brief focused work as if in some way you were excusing yourself for having made an extremely valuable intervention in just a couple of meetings.

*Dilys:* I probably was because ‘proper work’ when I started was five times a week. In the NHS that wasn’t feasible but there was this model in child psychotherapy that long-term intensive work was proper work. . . . I think I’ve always been excusing myself. . . . But of course child psychotherapy has changed enormously and this sort of work is now valued and recognised, and the Tavistock has always been a promoter of reaching out to the community.
Caryn: At the time you were doing something very different as well as writing about it.

Dilys: Yes, but now I think I didn’t write about it enough. I wrote about the clinical work and its context, but I didn’t write sufficiently about working in a GP practice. I wrote ‘Standing Next to the Weighing Scales’ (1985a) but I didn’t go on a campaign, nor did I write much in journals outside our own to spread the idea that there should be someone like me.

Caryn: Although you have been a vigorous campaigner for child psychotherapy and for infant mental health!

Dilys: Yes. I started being a campaigner with the Child Psychotherapy Trust (CPT). I started in a very low-key way raising funds for students when I stopped being chair of the ACP in 1979. However, I had been a single mother for ten years and I felt it was time I got married again, to let my teenage children feel free to leave home! I thought I’ve got to come off committees and have a different campaign . . . I met Eric Rayner who fortunately had a similar aim, and we fell in love and married in 1982. As well as what we have got from each other, I think that psychoanalysis and child psychotherapy have benefited from our relationship – we have encouraged each other in opening up ideas.

When the CPT started I was part of the first group of trustees. Juliet went to a party and met somebody who said, ‘I’ll give you £10,000 if you spend it’, so we appointed someone who told us how to start campaigning. This was Susanna Cheal, a wonderful woman. She helped us think how to promote the profession. She once said to me, ‘When child psychotherapists go into a room they wait for other people to start.’ It made me think we needed to be able to go into a room and say ‘What I want you to do is . . .’, which is quite a culture change. So what I did then was to try to turn the CPT, and the profession, into people who could do just that – to speak directly to the public, to politicians, civil servants and the media. For example, a journalist would ask a question and we would answer negatively, ‘No we don’t do that’, rather than say ‘Yes’ and describe what we did in positive ways. I have felt that there was so much knowledge locked up in our professional ideas that we were really good at sharing with each other, but that we rarely communicated to people outside.

We also learnt how to formulate the problems that were core to the profession. The main one was we knew that child psychotherapists had to fund their own training and that was why there weren’t many child psychotherapists; even though since 1974 the health service had an establishment for child psychotherapy, there wasn’t NHS funding for students. We all knew that but we hadn’t quite said, ‘This is the problem that has to be solved.’ We then
started meeting civil servants in charge of child mental health and lobbying ministers, which created an atmosphere in which there could be change. The ACP then negotiated regional training posts, a groundbreaking achievement. One of the pleasures of being in the CPT was working with people outside the mental health professions who had just as much passion for making life better for vulnerable children as we have.

Another of the aims was to spread child psychotherapy outside of London and that was my first contact with Monica Lanyado. She was working in Scotland and she rang me saying she’d heard about some research money from the ACPP [Association of Child Psychology and Psychiatry] whose committee I was on. I said, ‘We can do better than that’, and the CPT funded her for one session a week to start the Scottish Child Psychotherapy Training. We did lots of things like that, encouraging the whole idea of child psychotherapy around the country, and Eric was doing something similar in psychoanalysis, partly coincidentally but we were backing each other up and sharing ideas. I think one of my themes has been introducing people to one another – I call myself a compulsive introducer!

Caryn: What about the Trust’s booklets and leaflets?

Dilys: Well that again was due to Susanna Cheal. A senior civil servant from the Department of Health rang us on a Friday afternoon and said, ‘Can I come and see you now? I’ve got to spend some money by Monday.’ Susanna came up with the idea of these leaflets [www.understandingchildhood.net]. I was against it because I thought we needed any available money for students. I had a narrower vision than she had, but it was fortunate that she did. They have been a valuable resource and are still available through Louise Pankhurst who was a Director of the CPT.

Caryn: Can I ask you about the other major campaign that you headed: the Association for Infant Mental Health [AIMH(UK)]? I read that you said this idea was ‘inspiration born of boredom’, ‘one of the best ideas I’ve ever had’, and that this came to you on a long flight back from Australia.

Dilys: Literally. Eric and I went to speak at the Australian AIMH in 1995. It was really exciting. The way the professionals had got together was very fruitful and productive, so when I came back I wrote to people like Joan Raphael-Leff, Penelope Leach, Lynne Murray and various others.

I also based it partly on the French AIMH. At that time I belonged to a parent–infant psychotherapy group in France convened by Antoine Guedeny with Serge Lebovici at its core. There were a few people from other countries including Bertrand Cramer from Switzerland and Annette Watillon from Belgium, as well as
me from the UK. We met twice a year to present cases to each other and I used to say it was like 'swimming with sharks' – it was most terrifying. Even though my French used to be very good it had lapsed. They would occasionally translate things for me but the most embarrassing times were when they could see that I wanted to say something, and would pause so I could say it. It was usually about something which had been said five minutes before as it took me that length of time to catch up. So it was both an inspiring and humiliating experience – I used to dread getting ready to go to those meetings, but I got some lasting friendships and competitive inspiration out of it as well.

Caryn: You’ve met a lot of people in the world of infant mental health and I wonder if there is any writer or particular idea which made a real impression on you?

Dilys: The people close to home have had the greatest influence on me. In an everyday sense Juliet, who makes complex ideas simple to understand, e.g. her papers on infant–parent psychotherapy, and all my other colleagues in the Under Fives Service at the Tavistock. Winnicott was an inspiration, his idiosyncratic way of working with families and making unexpected conclusions. Selma Fraiberg, of course, although I didn’t read her until I had got stuck into the work. Mrs Bick’s infant observation seminars were always there in my thinking, and then Daniel Stern. I’ve never met him as an equal just as a fan! I was so bowled over when I read *The Interpersonal World of the Infant* that I introduced it to the tutors’ meeting at the Tavistock. The first response was that it was not psychoanalytic and someone said it didn’t mention projective identification. Now the Tavistock uses his ideas as much as anywhere else.

Caryn: And can you tease out what it was in his writing, which was creative for you?

Dilys: Yes, it was the connections he made between developmental observations and a kind of psychoanalytic thinking, and the real babies who were being described. There was also something about the research that was new and fresh for me and felt very energising. Don’t get me wrong, I love the clinical story and detailed infant observations, but you can get rather suffocated by the intense emotions of individual stories and the results from looking at a lot of babies can open up ideas.

Caryn: Following on from that, during your career there has been an enormous interest in infant research and development coming largely from psychologists such as Lynne Murray and Colwyn Trevarthan, and they have taken full advantage of the advances in technology such as using split screens and videoing. Do you think their research has affected your practice?
Dilys: Having access to the work of the developmentalists has enormously increased the breadth of what we do. It helps us to notice more about individual babies. Before, we had obviously noticed what was going on in the emotional atmosphere but adding in the details of cognitive behaviour can be really helpful. I haven’t learnt to use video myself and that’s just laziness! Had I worked in a group that did, I am sure I would have joined in. It can depend on who your friends and colleagues are and I wish I had some video material, as now at conferences the most interesting presentations are often the ones with video – it must be a joint attention thing.

Caryn: And video is being used therapeutically now with vulnerable and at-risk babies.

Dilys: I regret not having got into that use of technology. I don’t often work with very disturbed parents and infants, mostly with ones who initiate the referral with their own worry about their infant or their relationship.

Caryn: That fits in with what you were saying earlier about your interest not being with severe levels of disturbance.

Dilys: Yes, I think so. Maybe I can’t tolerate disturbance so easily but I can work with people who have lost their way. I have regrets about what I haven’t done... but on the other hand I’ve spread the idea of the work within our own profession and helped many other professionals to change from saying to parents, ‘Have you tried so and so?’ to ‘Tell me more about it.’ Perhaps the most useful thing that both Eric and I have done is to make psychoanalytic ideas seem simple and ordinary; he with the book Human Development and I by writing, and with workshops and consultations with a wide group of infant mental health workers.

Caryn: Yes, what you have done has enabled others to develop the work in different ways so that it can be used in these complex cases. This leads me on to yet another area of development, our increasing understanding of brain development in infancy.

Dilys: Well I’ve always thought that working with people actually affects your mental state and it reinforces the idea that helping things to go well early on really matters. I’ve been very interested in what Regina Pally (2000) wrote about how the work affects the therapist’s brain. I’ve thought for quite a long time that parent–infant psychotherapy, where we are touching on deep early processes, is very enjoyable and has a benign integrating effect on the therapist as well as more often mentioned stressful effects.

Caryn: Can you say more about that?

Dilys: Pally says the therapist gains from being part of and witnessing the integrative process and I feel I’ve been saying that in a simplistic way for a long time. She says that verbalising something enhances
brain connections and because of the plasticity of the brain it could have a profound effect on deeply engrained emotional responses. At the WAIMH Paris conference in July 2006 I spoke about this in a paper called ‘Enlivened or Burnt Out’. When we consult to professionals doing this work we are helping them tolerate the feelings: avoiding taking on emotions may lead to burn out.

Caryn: A slight change in direction now, and I hope not too personal but I wondered are you a good sleeper?

Dilys: Well I am when life’s not difficult so I don’t think that there was something I had to work out through writing the book in that way, and my own children mostly slept well. I think it was the pleasure of discovering that the way I was working out how to do parent–infant psychotherapy actually ‘cured’ a particular symptom quickly in some cases. Not a usual experience for a psychoanalytic psychotherapist!

Caryn: So the book and the ideas were really born out of your clinical experience?

Dilys: Yes definitely, but also Daniel Stern’s writing was influential. I read it at the right time. It’s interesting when people are able to put two ideas together, of psychoanalytic thinking and development. It’s like now people are starting to put adult mental health together with child mental health and noticing that adult patients have children and child patients may have parents with difficulties. It takes a certain while of working out one thing before you can add another system to it. Perhaps my interest in connecting different systems comes from my childhood in a Jewish family in a West Riding wool manufacturing town – with feelings of belonging and not belonging?

Caryn: You’re trained as an adult psychotherapist as well and I wondered how your work with infants might have influenced your adult work?

Dilys: I think that working with families helped me with positioning myself around an adult patient’s family and I also latched on to things in their early histories with their mothers, for example, but not necessarily more than other therapists. I suppose I was always alert to themes around separation. Also the supervision in my training as an adult psychotherapist helped me slow down in my parent–infant work. I called a recent conference paper ‘How To Do Brief Work Slowly’.

Caryn: Your career has taken you to many places around the world. Have you any particular memories of your travels?

Dilys: Going to Australia in 1995 and seeing the Australian AIMH was obviously very important and especially how Campbell Paul and Francis Salo have created a culture of work in infant mental
health, and as I’ve said that inspired me to start AIMH (UK). I also have striking memories of visiting Astrid Berg in Cape Town. I went with her to a baby clinic in the township Khayelitsha, and was inspired by the idea of a health clinic at all, never mind the psychotherapy part of it. It was very moving and makes one appreciate what we’ve got. One of the things I’ve noticed is ‘levels of provision’, and I’ve been contemptuous in places like the USA where there is so much money but they don’t have a proper NHS or health visitors. They have intensive home visitors funded by special programmes for targeted families but there isn’t a routine provision for ordinary families.

One of the things I talk about is the liberating effect on clinicians of having a health service. We have this network, and despite the many stresses of the NHS I think it gives us confidence and authority, and the ability to discuss patients and issues with each other. When I retired from the Tavistock I spoke to a scientific meeting there about ‘Psychoanalytic Thinking and the Public Service: How They Inspire Each Other’. I did a bit of private parent and infant work after I’d retired and didn’t really like doing it – it didn’t feel the same to me at all as doing it at the Tavistock or the baby clinic. Not being part of the network had a different feeling for me. A lot of the private referrals were quite ‘high flyers’ and quite often the disturbance in the family seemed to me to be due to that. There would be dads flying in from somewhere abroad to attend a meeting about their baby and I could see how much that was part of their problem, and yet it was somehow untouchable. Whereas I could challenge that sort of thing much more authoritatively in the Tavistock and now at the baby clinic where I still work. It’s something about the state actually saying all this, not just me here in the room. It was easy to do private work with people who knew what they’d come for and expected me to provide insight and help for them and their baby, but not with people who were coming in a rather hostile way. Child protection issues are also much easier to take up in an NHS setting.

Caryn: Thinking about your travels and different cultures, have you come across variations in how parents and infants manage separation?

Dilys: South Africa is the only place I’ve been to where I’ve discussed the effects of a different culture. Partly I think you get what you expect to get, that your ideas about child rearing are to do with your ideas of how an adult should be. So if you’ve got an idea of families being close then you expect to sleep with your baby but if you’re bringing children up to be independent then you encourage them to sleep separately. In South Africa I did prod them a bit because I felt there were myths, such as if you sleep with your baby then your baby sleeps fine, but they did admit that you can sleep
with your baby and have a baby that doesn’t sleep well – so it isn’t
that being with your mum guarantees you are secure and you sleep
well. A difficult relationship might intrude into sleep.

*Caryn:* Are you now touching on the theme in your writing of helping
parents voice their ambivalence and aggression?

*Dilys:* Yes, but without overdoing it, so it gives them licence to examine
it, without actually feeling it is condoned to be hostile to the baby.
I remember one couple that came, in rather an aggressive way
wanting help with a baby who was still in bed with them and not
sleeping well. I said, ‘She doesn’t get a chance to be by herself and
think her own thoughts’ – now that’s also quite an aggressive
thing to say, but they quite liked it. It’s about seeing the impor-
tance of managing to be on one’s own rather than thinking of it
only as having to cope with a deprivation.

*Caryn:* Have you noticed any difference in the problems that people come
with nowadays?

*Dilys:* I think families are more stressed with both parents having to
work because of high mortgages, commuting longer distances, and
starting a family in later life can be difficult.

With older children a huge difference has been the knowledge of
abuse. There obviously was abuse when I started work but we
knew much less about it, whereas nowadays we know to look for
it. There was a lot of very unsatisfactory, unresolved work because
we didn’t know how to get to the main issue. There were some
children who we thought just went on being borderline or psy-
chotic, they didn’t seem to improve with the therapy but we didn’t
know that they had been and still were being abused. It’s tragic to
look back on it, that we knew those children so well, except for the
main problem. The people who actually managed to realise what
was going on were brilliant.

The other change, which is good, is that there is more of a
feeling of equality between patients and professionals. There are
fewer parents coming along in a deferential way and they certainly
stick up for the rights of their children. They have a view that they
and their children should be seen by somebody, that it’s not a
privilege. Now this is in a settled population and obviously there’s
also been a dramatic change in the numbers of refugees, asylum
seekers and other people in very distressed states coming to the GP
practice I work in.

*Caryn:* The field of infant mental health has been embraced by attachment
theorists and they have introduced new concepts and developed a
new language about parent–infant relationships – I was thinking
terms like ‘mentalization’ and ‘parental reflective function’.
Now this union hasn’t always been a happy one. What have you
made of this development?
People like Peter Fonagy have put these ideas together very usefully. I’m not good on theory, it’s partly my lazy way of thinking, but you can think your own thoughts and borrow as you go along. You don’t have to keep it separate; it’s like a marriage isn’t it? You don’t always agree, and ideas can be conflicting. There is an enormous common purpose in what we’re all doing but I think in clinical work we link things in very individual ways.

One of the enormous changes in child psychotherapy is that now you really can’t tell where someone has been trained. I supervise students from nearly all the trainings in the UK and there is little difference in the things they are saying to children.

I wonder what effect that will have on the profession?

It’s about what makes you into a good psychotherapist – the years of training are very important but the precise content may be a starting point for people to find their own way. I think we respond more to what the child is actually talking about than we used to.

And the type of personal analysis you have?

I think you are very much influenced by your analyst’s ‘style’. It’s also important whether it’s sufficiently about you and how much you’re allowed to do of it. Where I’ve heard of people being miserable in analysis it is where the analyst has a particular point of view that they seem to want to go on about. My students used to tell me about fellow students where the analyst became the ‘problem’, where the transference was such that they really felt they were being given a hard time gratuitously by the analyst and the relationship got into a rut of some kind.

There was a pause in the conversation.

Thinking about your question just now about different theories made me think about AIMH. I deliberately set it up with different types of professional – not just psychoanalytic people, and then you’ve got to take on other points of view. It’s useful to learn to live with a wider group, not just your own cosy reference group.

Although you have retired from full-time work, it sounds like there are other things you’re still involved with, for example, lobbying for health visitors.

I’ve been trying to do something ever since health visiting got into difficulties some years ago. Health visitors are leaving because of all the cuts and they can’t stand not being able to do their job properly. The government is now putting money into reaching vulnerable families and there is a new intensive home visiting programme. I and others are using this as the opportunity to talk about the crisis in the universal health visiting situation and to try to have some impact on this.
For years I couldn’t get the health visitors that I worked with to tell me officially what they were telling me over coffee. They had had to sign confidentiality agreements. Now they seem able to go public. There is a real feeling of purpose and possibly just before the whole thing falls to pieces we might be able to make a case for the need for universal access to early interventions for families with infants.

Caryn: Finally, I was thinking about the different organisations and systems and how you managed to get hold of something and keep going and going with extraordinary determination.

Dilys: The social anthropology I started off with has helped me with my clinical work – being able to think about the social context as well as my patient’s internal world – and this has led on to thoughts about social justice. I’ve had some very simple attainable ideas, and it has been very enjoyable to meet with wider groups of people and have a joint purpose. My family has also been relieved that my reforming zeal has had an outlet outside the home!

Caryn: Shall we end there?

Dilys: Thank you – it’s generous of you bringing somebody else’s ideas out.

Caryn: It has been a real pleasure meeting you again, and hearing about your work. Thank you.

References


Website

www.understandingchildhood.net
7 Reflections on race and culture in therapeutic consultation and assessment

Iris Gibbs

Context

Consultation is primarily concerned with the establishment of a collaborative relationship. Its context is predominantly that of information exchange, clarification and the achievement of a shared understanding. Consultation is not analogous to counselling or therapy; it is a separate, discrete activity which in itself may be sufficient for the task in hand. However, the process of consultation is potentially therapeutic. For instance, beneficial outcomes may derive at its completion. It can also be a helpful preliminary to assessment and to ongoing therapeutic treatment.

Wilson (1999) comments on the efficacy of consultation when individuals or professional groups become stuck or where existing personal or established resources are not enough. Others refer to its containing function in Bion’s sense, its ability to allow reflection and to integrate diverse perspectives. Its enrichment of understanding can be empowering for professionals and clients alike, the concept of empowerment being particularly important where issues of race and culture are concerned.

The term ‘race’ when used as a noun refers to ancestry, breed or stock. It is often used with a biological meaning and carries an implicit assumption that people are different genetically based on skin colour. Questions are raised, however, about its usefulness in categorising humans and the way such categories are then used for labelling, allocating or denying psychological services.

Definitions of ‘culture’ can also give an impression of something fixed or static which individuals internalise en masse. A wider thinking necessitates an understanding of social, economic, political, religious and familial patterns of behaviour and ideas, and the way these enter the internal world of the individual. Individuals in this view are shaped by the interplay between biology and environment – including cultural factors – and play a part themselves in determining the cultural climate in which they live.

The consultation process represents good professional practice generally irrespective of racial and cultural considerations. However, for this group, particularly newly arrived immigrants and asylum seekers, there may be
complex health, social and psychological needs and language differences. Consultation therefore offers the chance to bring together a broad spectrum of opinion – cultural advisors, church, community leaders – to support the family as well as to enlighten the professionals regarding cultural norms. It can challenge assumptions and stereotypes – both personal and societal – about the particular group. It can alert professionals to the rituals and symbols used by the group and the purpose these serve. It may further educate professionals about cultural differences in child rearing such as extended family models, informal adoptions, private fostering, attitudes to gender and arrangements about marriage. It may highlight some of the cultural pitfalls in recognising and diagnosing depression and other forms of mental illness and in the presentation, manifestation and interpretation of illness and distress. This both improves the professionals’ knowledge and also helps in separating cultural norms from personal/psychological concerns. It may further draw attention to potential conflicts between the aspirations of individuals, the norms of their culture and the laws of the host country.

As professionals we also bring our own stereotypes and attitudes to the consultation and assessment process. It may be a result of omissions in our trainings and/or our own prejudices regarding particular groups. Further, professionals are not immune from political and media speculation and pronouncements about immigrant groups generally and the perceived social, economic and educational pressures they place on the host country. Rack (1982) writes that our capacity to offer a culturally sensitive service comes only when such stereotypes and attitudes are acknowledged and challenged, both personally and organisationally.

In the opinion of Rack (1982), thinking about race starts well before the consultation or assessment process. It is in our minds when we hear a difficult to pronounce name or mention of such terms as ‘asylum seeker’ or ‘refugee’. At times professionals can become overwhelmed by the complexity of working with difference and the temptation, at times, is not to enquire too closely into practices that are unfamiliar, or too readily accept cultural explanations. The tragic death of Victoria Climbie, who was brought to Britain by relatives and ill-treated, highlights the challenges health professionals face (Lamming 2003). It further highlights the importance of regular consultation and ongoing inter-agency collaboration in managing situations that are complex or unfamiliar. Whilst this cannot rule out further tragedies, it may help to guard against claims of organisational racism, and at the same time offer a better level of monitoring to a vulnerable child.

Consultation and the child psychotherapist

Most child psychotherapists spend part of their professional lives in consultation work. This includes the ongoing contact they routinely have with parents and core professionals when a child is in therapy. In its wider
usage ‘consultation’ can range from an informal conversation with a colleague, participation in network meetings, or being called as an expert in child care or court proceedings. The therapist herself may instigate the consultation process on receipt of a sparsely written referral. In the case of an asylum seeker, for example, referrals may give little information about the person’s previous life. Little may be known or considered regarding traumas such as those experienced by accident or war, or where the family is no longer buffered by an extended family, social or religious group (Eleftheriadou 1999). In Helman’s view, this can be a form of cultural bereavement (Helman 1995). Hunter (1999) draws attention to some of the skills a child psychotherapist may bring to the consultation process, which include:

- knowledge of child development and attachment relationships
- understanding of the impact of trauma, neglect and parental ill health on the developing child and his internal representations
- the capacity to help others understand the meaning of a child’s difficult behaviour.

Input from the child psychotherapist is very linked to her observational and theoretical trainings which consider both the individuality of the child and the child as part of a family unit in constant interaction. There is much debate, however, about the relevance of western-based trainings in conceptualising and working with race and cultural issues. Writers such as Boyd-Franklin (1989) highlight the scant regard most psychoanalytic theories give to the external impact of racism and discrimination on individuals. Over time this may become internalised as shame about oneself. In her view it is difficult to convey fully to someone who has not experienced it the insidious, pervasive and constant impact on people’s lives.

One of the challenges for therapists and other professionals is to allow themselves to hear this and tolerate the inevitable anger that might be levelled at them. However, to focus exclusively on external racism ignores an important fact that both the external and the internal needs to be taken into account in the journey towards change. We are also reminded that in some black and Asian backgrounds one can find a number of different responses to skin colour within the same family and cultural group, which may help to explain why some individuals may be singled out for family projection (Boyd-Franklin 1989).

Therapists and other health care professionals tread a difficult path in determining and respecting ‘good enough’ aspects of care in terms of the cultural norms and at the same time holding on to what they know about the universal aspects of child development and basic fundamental human rights.

Ultimately professionals are bound by the rules of the host culture regarding the safety and protection of children which may bring them into
conflict with the family culture. The issues of physical punishment and forced marriages are two such examples. The disproportionate numbers of ethnic minority referrals to CAHMS and the over-representation in the care system suggest that we are still some distance from finding an acceptable solution to this complex situation.

The challenge to therapists and other health professionals lies in continuing to believe that our input can make a positive difference to the lives of individuals and families. However, such work is not straightforward and many therapists will testify to the paralysis sometimes experienced as they struggle with difficult, overwhelming transferences. In such situations, access to personal therapy and/or skilled supervision will be vital to maintaining the therapeutic function.

The consultation process enables a number of concerns to be brought into the open, deliberated and decided upon. It considers the degree of client compliance and satisfaction, and the impact of decisions on the individual — physically, psychologically, behaviourally and in terms of social and family relationships. Street and Downey (1996) also draw attention to the importance of written conclusions in consultations. This is seen as having a higher status than the spoken word which may be misheard or misinterpreted. Written decisions can be read and reread and translated if necessary. In the view of these writers, it further confirms a key aspect of consultation, particularly therapeutic consultation, which is the client’s equal status and freedom to choose the next steps.

Assessment

This is a process of evaluation resulting in a professional judgement about a presenting problem. Parsons *et al.* (1999) underline its importance in guiding psychotherapists and other professionals towards a recommendation for intervention or treatment. In assessing children and families, the therapist considers a number of issues including the nature of the child’s disturbance, all aspects of the child’s internal and external world, developmental stage, capacity for and level of play, strengths as well as problems. An assessment also looks at the family system including verbal and non-verbal behaviours and communications between family members and the system’s ability to protect vulnerable children.

With immigrant families the issue of movement and the degree of acculturation are important considerations as both can affect the functioning of the family. The process of assessment may include the use of tools such as Ainsworth’s Strange Situation Test with toddlers, or the Diagnostic Profile (Freud 1965). Both need to be used and interpreted with caution, however, because of concerns that they may be biased in favour of western populations with different socialisation goals and views on health and illness.

In conducting her assessment the therapist will draw on any available consultation material. However, a percentage of referrals may be self-
referred, or in the case of a recent immigrant little may be known and the ability of the therapist to engage the family in the process of the assessment will be crucial (Gibbs 2005). Much will depend on the therapist’s stance of concern, interest, respect and non-judgemental attitude and her ability to work with the family’s structures.

The ability to gather the necessary information within the bounded assessment period can present challenges. Language differences may inhibit progress. There may also be reluctance or suspicion in the family regarding the disclosure of sensitive information. Some minority families may have had little experience of talking about problems outside the family or church (Fletchman-Smith 1993). Other commentators such as Eleftheriadou (1999) additionally point to anxiety in the therapist when confronted with the traumatic experiences of some families. If the therapist becomes cut off from the emotional content of family and session, it may lead to her compulsively asking questions rather than being able to tolerate the client’s distress.

There may also develop a problematic transference to the therapist based on cultural background. Bhugra and Bhui (1998) view a potential patient as having a potential therapist in mind well before the first interview. The extent to which transferences are taken up in an assessment is a subject of debate but, where it is interfering with the process, it will need to be addressed even in an assessment situation. When and how this is done depends on the individual therapist. Some therapists rush into this through anxiety, others are reluctant to mention it for fear of causing offence, even when it is evident from the material. The following is an example from my own practice.

C, a white 14-year-old young man, was referred to me for assessment. In responding to my queries, he spoke with a heavily accented voice which was a caricature of mine. I wondered about this – to some therapists it might have seemed an aggressive stance but in the countertransference I found myself thinking of the possible nature of the boy’s anxiety. I said that he perhaps had a worry that I would not understand or be able to help him, given our obvious difference. The change in his attitude was immediate and the assessment proceeded, developing into an ongoing therapeutic relationship.

Tang and Gardner’s (1999) view is that dissimilar racial or cultural backgrounds can threaten the therapeutic process, leading to impasse or premature termination. Talking about difference in their view is therefore crucial, as this can be fertile ground for splitting and projecting bad feelings. This may then become a form of defence or resistance to true exploration in the client. Posmentier (2006) puts forward another view,
which is that the illusion of similarity can sometimes be vital for the work and that highlighting difference may therefore foreclose that potential space where the patient is able to use fantasy to feel connected or similar to the therapist. She cited the case of a Caucasian patient in therapy with an Asian therapist and the patient’s distress when her therapist overemphasised their difference by wearing her native dress to work.

**Interviewing**

The goal of the clinical interview is conceived of as the mutual development together with the parents/carers of a clear and focused understanding of the core of the problem (Hirshberg 1993). Garcia-Coll and Meyer (1993) provide a list of questions and some helpful hints in conducting a socio-culturally sensitive assessment. First, the therapist needs to establish whether there is a problem that requires intervention. Second, questions as to why the problem exists and what can be done have to be addressed. Finally, consideration needs to be given to who is best equipped to help with the problem.

The first question acknowledges that different cultures vary widely in their views of what constitutes a problem and its severity: issues of separation/individuation, or of levels of aggression, are two areas which can be very differently perceived. On considering the question ‘why?’ it is imperative that the therapist pays attention to the family’s own ‘explanatory model’. This is good practice generally, but for minority groups it is seen as a good means of joining the family, facilitating rapport, enhancing communication, and thereby enabling socioculturally compatible treatments to be devised. This method can also reduce the risk of family/clinician conflict.

Culturally sensitive practices involve the family in deciding such matters as which members should be present for interview. There should be an acknowledgement of family roles in different cultures and the possibility that biological parents may not be the child’s primary carers or indeed the attachment figures. These significant figures may differ among themselves about the child’s development and behaviour as well as not share the clinician’s concerns. It is therefore important that the different views are heard, validated and incorporated into the assessment.

The question of self-identification is also relevant to the assessment process. This is particularly important when one considers the complex and sophisticated level of intercultural relationships that are now evident in modern society, especially in the richness of large multicultural cities. My own caseload comprises mixed heritage families – black and white – and also, but perhaps more unusual, combinations of Asian/African and Caribbean/African. It is not uncommon to find a range of responses when individuals are then asked about ethnic origin: in some West Indian families, members of the same family may identify themselves as Afro-Caribbean or
black British. This may relate as much to country of birth as to degree of acculturation.

The outcome of the assessment should produce a preliminary formulation and recommendation, a sense of the family’s current adaptive and defensive functioning and their capacity for change (Gibbs 2005). The therapist should also have a grasp of areas of concern or risk to the child, both personally and in his relationship with his family. Furthermore, the diagnostic formulation should neither be produced by the clinician, nor experienced by the parents as some ‘abstract or arcane intellectual concoction’ (Hirshberg 1993). Rather it should be the summary of what has been cooperatively learned and should be communicated in terms that the parents can readily understand.

Helping with the problem

The important question when thinking and planning the next step is who is best placed to work with individuals and families from different cultures. Much of the writing on this subject considers cross-cultural encounters where the therapist is white and the patient is from a minority group. There are, however, a small but growing number of therapists from minority groups who are working both across cultures and in same race therapeutic relationships. The particular challenges they face must also be considered.

White therapists working cross-culturally may have to deal with mistrust based on their clients’ perceptions of their dominance and power. Establishing an alliance may therefore take time. Tang and Gardner (1999) talk about a willingness in the therapist to extend herself. However, in doing so she needs to guard against missionary tendencies, against being tentative or subservient, or using slang in an effort to fit in with the family. In teaching the subject, I advocate an attitude in the therapist of ‘respectful curiosity’. This enables the individual and/or family to feel heard and that they have been taken seriously and the therapist to explore sensitively and clarify any unclear areas. In her listening, it is important that the therapist does not abandon tried and tested theories about children and their development: these transcend race and culture. Rather the emphasis should be on exploring and finding common ground.

The minority therapist also straddles a difficult position. For some white individuals and families, her colour or accent, as well as perceptions and assumptions about class and level of knowledge, may act as barriers to the assessment. For black and ethnic minority clients, there may be concerns about the therapist’s assumed lack of status and power. Ethnic matching of therapist and client can equally be positive as well as problematic – a shared race may reassure the client, especially where there is lack of trust in the dominant culture. It may help to establish a positive transference.

Problematic areas include therapists’ overidentification and setting oneself up as rescuer. Being overfamiliar and having a life history that is
too close may lead to loss of therapeutic objectivity; leaping to assumptions about shared meanings may foreclose exploration about differences. There may also be issues of confidentiality as the following example demonstrates.

Ms C and her infant son were referred for assessment because of bonding difficulties. We knew from the referral that mother was of Caribbean origin. I was allocated the family and experienced a sense of excitement and propriety about working with someone of a similar background. The reality was, however, different. On meeting Ms C, it was apparent that we originated from the same small island. This was not acknowledged by either of us, but it did have an impact on the interview process and ultimate outcome. I was overly cautious in approach without consciously realising it and Ms C was equally guarded in her responses. I offered another assessment appointment, realising that little had been achieved in terms of understanding the problem. Ms C did not attend, nor did she respond to other attempts to engage her. In reflecting on the interview, I was forced to confront Ms C’s transference and my own countertransference about our too close histories.

It is possible there were other reasons for the drop-out, but a contributing factor in this case was the reluctance to acknowledge sameness and explore its implications. The issue of closeness might also have been too close to the referral concerns regarding intimacy.

Garcia-Coll and Meyer’s view (1993) is that securing the best service is of primary interest to most families rather than what the clinician’s background might be. Further, in reviewing the mix of families and cultures referred for assessment, it would be impossible logistically to find a cultural match for every family, even if this was requested. For one of my patients, however, it was important that black and minority professionals were represented in the organisation for consultation on cultural concerns. I have never forgotten, many years ago, crossing the waiting area of my clinic and quietly being stopped by the self-effacing black patient of another therapist. She asked if I worked there. ‘Yes.’ She nodded and let me go, then straightened her back in her seat as if now sure she could have a presence there.

Tang and Gardner (1999), however, remind us that the minority therapist, by definition, is schooled in two cultures. Her training in western traditions may therefore differ from her cultural norms and may cause conflict in her work. The minority therapist may therefore be in a double-bind situation – like the black patient she may vary in terms of her view about her own racial identity and class. She may also be rejected by black families for any number of reasons including concerns about anonymity.
Personal and organisational support for the therapist, whatever her culture, is vital. The supervisor also needs to be well trained and skilled. As Eleftheriadou notes (1999), the countertransference can be equally powerful within the supervisory relationship. In terms of training, I would propose that much more needs to be done to integrate issues of race and culture into psychotherapeutic trainings. Students should be encouraged to observe babies from a range of cultural backgrounds as this educates them to the strengths and difficulties of the culture, as well as challenges their own prejudices and stereotypes. This was my experience in observing a baby from an African culture. The common feature was our race; everything else was unfamiliar and had to be experienced through the lens of the observation.

Conclusion

Much of what is written in this chapter about therapeutic consultation and assessment can be viewed as good practice, irrespective of race and culture. Starting where the family is – their explanatory model – is a theoretical concept well known and practised in child psychotherapy. However, Krause (1998) writing from a systemic perspective, queries whether race and culture can be sufficiently assessed through the narrow personal relationship between therapist and client, especially if they are from markedly different backgrounds. She sees a systemic or family therapy approach as fitting more comfortably with such families. My view is that an exclusively systemic approach may deny some individuals the opportunity to explore their own difficulties – familial and intra-psychic – in the privacy of a one-to-one relationship. Furthermore, a child psychotherapist who has experience of working with multidisciplinary teams and the range of approaches offered within these will have no difficulty in enlisting the expertise of others in assessing and determining the most appropriate intervention for the individual and/or family.

References


8  Death in the family
Post 9/11 at Pier 94 Manhattan

Victoria Hamilton

27 September 2001

This was Susan Coates’ and my first visit to Pier 94. We had originally been assigned to St. Paul’s Church, adjacent to the World Trade Center, but when we arrived there earlier in the day we realized that we were not really needed. There was a surfeit of volunteers. The church was very quiet, a sanctuary for firemen and police, a few of whom were resting or talking in low voices in the pews. Susan and I had walked along Broadway to the only cross street from which viewing was permitted of the horrific site of the former Trade Center. We walked in file, moved along quickly by national guardsmen. No cameras allowed. We then headed downwards through the deserted streets and court houses of the financial district until the dust and smell got to us. We both felt very sick. After a brief rest and tea we presented ourselves at Pier 94.

Pier 94, though somber, had a wonderfully welcoming and busy atmosphere. Within a few minutes, Susan and I nodded at each other, acknowledging, ‘This is our place.’ Perhaps we felt in a minor way some of the warmth and relief of the visiting families. Even though the Kiddie Corner was fairly chaotic, small, and makeshift in these early days, there beckoned the familiar red, blue, green and yellow nursery toys, the teddy bears, and the noise of children. Despite everything – the ‘Walk of Bears’, the shrines and the walls of photographs of the missing – the corner bustled with activity and the children – or enough of them – continued to play as usual. The children cheered us up, giving relief from much of the apprehension and foreboding that had settled in during the day.

While I escorted another worker to the area where gifts could be left after screening by the Mayor’s Department, Susan found herself talking with Mrs. Jordan, an African American woman in her late thirties or early forties. (As an aside, in these early days at the center, many people came to ask how they could send gifts of toys either from themselves or out-of-state friends. These generous urges were not easily satisfied, however, because of security regulations that were already overtaxing city personnel. One could see the overburdened look that greeted so many acts of kindness – every
toy and teddy bear had to be screened for potential terrorist activity.) Mrs. Jordan had brought along a friend and nine children. She had four of her own, ranging from a 13-year-old boy, Charles, to little Alexander who was about three. Some of the children had invited their friends to come along, adding to the size of the family group. Mrs. Jordan also brought her 18-year-old nephew and his friend who were in the army and were visiting from Hawaii. After Susan had talked with Mrs. Jordan and her friend for about an hour, I then moved to the edge of the sofa and picked up when Susan went for a break.

Mrs. Jordan had a serious, sad face, but exuded great strength and determination. We talked a bit about the children, and she told me that she was experiencing greatest difficulties with her 12-year-old daughter, Jessica. The other children were affectionate and not problematic in that they could be comforted, but Mrs. Jordan was worried about her daughter. Jessica and she had always been a bit distant, but now Jessica hardly talked to her. From across the room, Jessica looked much older than her 12 years. She was helping the younger children with their projects. Jessica had been very close to her uncle, Mrs. Jordan’s brother, who was ‘missing’ in the World Trade Center (WTC). Mrs. Jordan knew that Jessica was suffering a great deal. Mrs. Jordan commented reflectively that Jessica had been much attached to her uncle probably because she had lost her own father. Mrs. Jordan then told me that her husband had been murdered on September 11th, eleven years ago. The murderer had not been prosecuted. She talked about this awful event, but I am afraid I did not record the details at the time. I have found the specifics of this first day at Pier 94 hard to recall, though the pictures of Mrs. Jordan and her family in that cramped, sequestered alcove remain vivid in my mind. Mrs. Jordan thought that Jessica was also jealous of her older brother who was born while their father was alive, whereas she was born shortly after his death. Jessica’s brother was lucky, he had had a father, but she had missed out. Charles, with an open face, did look a happier child than his grown up younger sister.

I had been listening and asking a few questions for a quite a while. I felt somehow that Mrs. Jordan was such a natural conversationalist and so communicative that it was almost rude and abnormal not to say something more personal. I was prompted to say, ‘This is such a minor version of what you have been through, but I have some understanding as my husband died two years ago very suddenly.’ Without saying anything, Mrs. Jordan’s eyes filled with tears. Before that, she had seemed tremendously sad, but stalwart. It seemed that my loss immediately evoked tears of sympathy. In turn, looking into her eyes, I felt mine water too. Mrs. Jordan responded, ‘Do you have children?’ When I said that I did and spoke of my 23-year-old son, Mrs. Jordan started to talk about her nephew, Brazi from Hawaii, who was lolling over one of the chairs asleep. Brazi’s friend looked exhausted and a bit resentful as he perched uncomfortably on the same armchair until I suggested that we clear the sofa of toys. He stretched out
and was soon asleep. Mrs. Jordan said that in a month’s time her nephew and his friend, who had joined the army in Hawaii for educational reasons, were to be sent to Afghanistan. A pall fell over us again, thinking of such beautiful young men being cut down in battle. We agreed that children enable us to carry on. She, with her large brood, had little time to think until they were asleep when the dark night brought her back to the loss of her brother ten days before and the cruel memories of her murdered husband on September 11th eleven years ago. Soon, it was 7 o’clock, and Mrs. Jordan and her group of youngsters left reluctantly. We hugged and agreed that she would come back and we would talk more. ‘See, I can’t tear them away,’ she laughed.

On Tuesday December 11th I read a piece by Peter Finn in *The Washington Post* Foreign Service entitled ‘Wounded Army Captain Details Offensive Against Taliban’. The piece described how, on the morning of December 5th, the US Army 5th Special Forces Group were feeling pretty good about their advance towards Kandahar, having had a good night enjoying food from their care packages, when ‘the bomb came out of the blue and, you know, nailed us’. Sergeants from California and Honolulu were killed and wounded and the Afghans bore the main brunt of the misguided airstrike. I hope so much that Mrs. Jordan and struggling families like hers are not called again to suffer violent death.

**10 October 2001**

By now, the Kiddie Corner had been moved to a spacious yet sheltered corner of the Pier 94 encampment. There were more sofas, more toys and art equipment, and as usual volunteers outnumbered the visiting families. Now, volunteers were being asked to sign up in advance for specific shifts and some screening and advising of helpers was in place. Already the organizers were finding that eager volunteers did not always act appropriately, sometimes pressing the visiting families to tell their stories of loss and horror. Our brief was not to act as therapists but simply to listen, encourage and comfort. I had been there for a while joining in art projects at one of the crafts tables, while noticing a quiet middle-aged Spanish-looking lady with the most exquisitely sad, lined face who sat alone on a sofa. Although she was seated inwards, she frequently turned her head towards a table where a beautiful little three-year-old girl, Rachel, was enjoying herself playing with another volunteer. Rachel and the volunteer had clearly struck up a close and playful relationship. I approached Mrs. Hernandez, asking her if this was her first visit, or had she been here before. She said in broken English with some Spanish thrown in, ‘No, first time.’ She described how that morning, her son-in-law had driven to her house, told her and Rachel to get in the car as he would drop them off somewhere while he and his sister did ‘some business’ downtown. Mrs. Hernandez asked her son-in-law, Fernando, to wait while she changed her clothes and
prepared to leave. He said, ‘No, we can’t wait, the car is outside, and we have an appointment, we will be late.’ Mrs. Hernandez then looked down at her clothes, brushing her trousers with her hands and apologizing profusely for her appearance, the black sweatpants and anorak hastily thrown on. I told her she looked absolutely fine. But, of course, as she said, she would never go outside the house looking like this, she would always change. Mrs. Hernandez was neat and petite and expressed orderliness and old-fashioned respect for proper behaviour.

I asked Mrs. Hernandez if Fernando’s appointment was here in the building, where had he gone. She said, ‘I don’t know, he said he had to go somewhere very important. ‘Get in the car. We have to leave right now.’’ I later put it together that he had gone with his sister on one of the boats that left from Pier 94 to take and accompany the bereaved to the site of the World Trade Center to mourn or wait for their lost or missing relatives. Mrs. Hernandez then began to speak to me rapidly, most of the time in tears, folding her hands over and round in an agitated way. Her daughter, Martha, was just 39 years old and was in the WTC on September 11th. She was killed in the second tower on the 94th floor. She was the mother of two girls, one age six and the three-year-old Rachel. ‘Everyone in my family has died, I don’t know, all my life, die, die, die.’ I passed Mrs. Hernandez the tissues and her grief was excruciating. ‘My husband died age 35 on this day (today) over 30 years ago. He was murdered.’ Mrs. Hernandez now turned in her chair, her eyes darting across the room to the table where her granddaughter played. As she told her sad story, her face lit up when she looked at her grand-daughter. Many times, she asked Rachel if she wanted ‘milky’, ‘leche’. Rachel was not interested.

Mrs. Hernandez told me about her daughter Martha. On the morning of September 11th Martha was going to take the day off as they were going to go shopping for a special dress. Every morning Martha’s husband, Fernando, would drop off their six-year-old daughter, Rosa, at school and then take Rachel to her grandmother’s house for the day. However, Martha decided to go to work just for the morning, leaving to come home at 1 pm. They were all going to go shopping together. Since that dreadful day, Rosa has stayed with her father, and Rachel sleeps with her grandmother. They live on the same street, a few doors apart. Mrs. Hernandez’ other daughter and son live in Florida. The New York family planned to visit them in Florida for Christmas. Martha intended to work for another year at her job at the WTC, then move down to Florida with Fernando and family and her mother, Mrs. Hernandez. They were very much looking forward to getting a little house that they could afford in a more peaceful community. Mrs. Hernandez wept.

I asked her if she might still move to Florida. Mrs. Hernandez said, ‘I don’t think so, I can’t leave the children, can’t leave Rachel, I am her only one, she asks for me all the time, she has been with me every day since she was born.’ Mrs. Hernandez looked over to Rachel again who seemed so
lighthearted in comparison, and again asked her, ‘Do you want drinkie, leche, are you hungry?’ Rachel came up and said politely, ‘No thank you’ and darted back to her play. Several times, Mrs. Hernandez emphasized how polite the grandchildren were, that they were properly brought up, very nice children. Mrs. Hernandez called Rachel back a number of times for drink and food, always telling her to say ‘hullo’ to the lady (me) which Rachel politely did.

I asked Mrs. Hernandez where she now lived, and she told me in a very nice neighbourhood (somewhere north, I don’t recall as I don’t know New York very well). She has a lovely apartment in a very safe location, she has lived there for almost 30 years. All the neighbours know each other and look after each other. Now, in particular, she really does not want to move out of her home. She is near a park for the children. I asked Mrs. Hernandez if she was born in New York. ‘No, Cuba.’ She shook her head, ‘All my life is like this . . . everyone in my family has died.’ She told me of her father’s death, and how her mother was ‘smashed by a car’, crossing the street, I think. (Again, it was quite hard for me with a smattering of Spanish to follow all the details.) Mrs. Hernandez described with her arms her mother being thrown upwards and crashing down. Shortly after this death, Mrs. Hernandez took a boat and came to the United States. I asked her if she had any brothers and sisters here. ‘Yes, one brother, he lives in California. He is paralysed below the knee, in pain.’ Again, Mrs. Hernandez demonstrated on her own knee, saying that she too had knee pain. But he cannot walk. His wife is also paralysed below the knee. Interestingly, Mrs. Hernandez told me that normally she takes good care of herself, does exercises for her knees and keeps herself fit. ‘I have to, I walk everywhere.’

Mrs. Hernandez told me that her brother and his wife call her every day. When she first came to the US, Mrs. Hernandez lived in Los Angeles, moving to New York 45 years ago. I said that we had also lived in Los Angeles for 25 years, and we talked about the differences between the two cities. She said, ‘I like it where I am.’ I said I liked New York too.

Mrs. Hernandez now told me that she was 75! I was getting the picture of her age, just calculating all the years of the life she described, and the respective ages of the different generations. She agreed with me that she looks much younger, everyone tells her that – although now ‘I feel very old’. Her face could look very pale and drawn, and at other times her bright brown eyes and physical vitality cancelled out her age. I said, ‘I thought you were about 50.’ She told me that she had never remarried and went on to talk about the murder of her husband ‘on this day, 10th October 37 years ago’. ‘My daughter never knew her father, she was only a baby, two, when he was killed.’ I asked Mrs. Hernandez how he was killed. This was a long story, the gist of which was that Mr Hernandez had worked in a garage and he had $3000.00 on him, or in a till, when a large black man demanded the cash and shot him three times. Mr Hernandez called out for help, I think he may have dialed 911. Though the assailant was very large, Mr Hernandez
managed to push him back and I think wound him. The murderer ran away but, because Mr Hernandez had called out, other workers pursued him. ‘They got him but he (her husband) fell down at the same moment’ and died. ‘Terrible, terrible.’ ‘He is still in jail, whenever he comes up for parole, someone goes and stops him.’ Mrs. Hernandez shook her head. ‘Everyone dies, my family . . . I don’t know.’

It seemed quite a while since Mrs. Hernandez had called Rachel’s attention, and she told me that Rachel must be thirsty, ‘Rachel, you want milky, you want to eat?’ Rachel again declined, but as Mrs. Hernandez was worried, I offered to go and get some milk from the cafeteria outside. I asked her if she would like something, would she like to come with me. She indicated she would ‘stay here’ and would like some juice. I thought she did not want to be out of sight of Rachel. By the time I returned with a carton of milk, Mrs. Hernandez had seen a baby bottle in the dolls’ equipment. She asked, ‘Baby bottle?’ I said I thought it was a doll’s one, but that we could use it if she liked. We filled the bottle and Mrs. Hernandez asked if the milk could be warmed. It couldn’t, but she said, ‘Doesn’t matter.’ Rachel was called over and she took some of the milk. Again, she was told to ‘thank the lady, give her a kiss’ which Rachel dutifully and sweetly did.

I asked Mrs. Hernandez how Rachel and her other grand-daughter were doing. Mrs. Hernandez said that the older daughter goes to school, and stays with her father at night, but Mrs. Hernandez picks her up from school and feeds her and looks after her until the father, Fernando, picks her up to go home to sleep. Throughout our time together, Mrs. Hernandez looked at her watch anxiously, remarking, ‘They said they would be back by now . . . we will be late to pick up Rosa.’ I asked when Rosa got out of school, and reassured Mrs. Hernandez that there was still time as it was not yet 12. Mrs. Hernandez told me that she was sure that Rosa knew her mother was dead. They talk about the WTC disaster at school, and she knows that Rosa has seen pictures on television even though Mrs. Hernandez has moved the television and only watches at night when the children are asleep. Rosa won’t walk past a subway station entrance, she shudders. She knows that her mother took the subway to work on the fateful morning. Rachel still talks as if her mother is coming back, but Mrs. Hernandez thinks that she too probably knows her mother is dead. We agreed that children seem to know things. Rachel goes to the window every afternoon and waits for her Mommy, saying ‘There’s Mommy! When is she coming back?’ Apparently, Rosa had made some comment that Rachel still thinks Mommy is coming back. I asked Mrs. Hernandez if she thought she would tell the children that their mommy is not coming back, or ‘Do you think it is better not to say anything?’ Mrs. Hernandez sighed and with a gesture of resignation said, ‘I can’t do nothing. Their father won’t tell them, he says I must say nothing, he will tell them when he decides.’ We nodded. ‘He is the father.’

Again, Mrs. Hernandez asked me the time, and we wondered together where they could be. I suggested that he might even be in the building and
probably had a lot of things to take care of. Mrs. Hernandez then expressed great anxiety about not upsetting Fernando, her son-in-law. ‘Rachel needs me, I am the one she asks for, always Grandma, Grandma. I am the only one who dresses her, she eats only my food.’ Mrs. Hernandez then listed all Rachel’s favourite foods, what she likes for breakfast, etc. Mrs. Hernandez looked very despairing at the thought that something might happen with her son-in-law and cause her to lose the grandchildren. She reiterated several times how much the children wanted her, how she had looked after Rachel since she was born. The only reason that Martha, Mrs. Hernandez’ daughter, went to work was because she could leave her children with her own mother. ‘She trusted me, only me.’ I could feel that both Rachel and Mrs. Hernandez would be devastated if they were separated from one another, and had a growing sense of threat that all was not well between Mrs. Hernandez and Fernando. I imagined that Mrs. Hernandez could be a dispensable mother-in-law. What would happen if Fernando remarried?

I then asked Mrs. Hernandez how Fernando was managing; it must be so terrible for him, such an awful shock. She said, ‘OK, he is off work. He is with his family, he sees them a lot, he is very close with them . . . Terrible, terrible.’ At that point, Fernando and his sister appeared. Rachel looked pleased, and continued to play. Mrs. Hernandez introduced me. Fernando is a very good looking, suave man, well dressed and well presented. He was a little remote but smiled and thanked me. His sister was very friendly and seemed a very warm person. Both shook my hand. They then told me that they had been accompanied from the Pier downtown. I said I was so so sorry, and expressed my sympathy. We all shook hands again as Rachel was reluctantly pried away from the play table and the lovely volunteer who had been with her all morning. Rachel kissed me goodbye, and I asked Mrs. Hernandez to please return again. She said she would like to, but she has no car. Rachel then chose her teddy bear to take home. The first day Susan and I had visited, every passerby who asked was given a bear. Now, we were instructed to give the bears only to children who attended the center or who had lost family members. The bear supply was being abused in that the same people, adults, came by several days in a row to collect more bears. On a later occasion, a very sad young Asian woman asked for a bear and Susan Coates, defying orders, gave her one, feeling strongly that grown ups need the comfort of stuffed animals as much as children.

I felt I had met a very courageous person in Mrs. Hernandez, a testament to the human spirit’s capacity to endure shock and loss over and over again. Mrs. Hernandez never complained, she simply described in a dignified, acknowledging manner, the sorrows of her life. I wondered whether, for many deprived and immigrant families, September 11th was a new disaster in a chain of violent deaths. It seemed more than coincidence that the first two adults I talked with extensively at Pier 94 came on the anniversaries of their husbands’ murders.
9 From intimacy to acting out

Assessment and consultation about a dangerous child

Ann Horne

This chapter describes the referral of a 14-year-old boy, the responses engendered by it, and expands on the transference and countertransference phenomena arising from a presentation of violence and a history of cumulative trauma. The referrer, a consultant forensic child and adolescent psychiatrist, requested an assessment that would provide ‘a psychodynamic formulation which we can use to help our continuing efforts to understand Martin and manage his case’. Subsequent consultation for the team was also required.

Funding agreement took five months. The logistics of Martin’s care had changed by then – not unexpectedly as the referral indicated a crisis in understanding and caring for him. Martin was resident in a specialist treatment centre. Two weeks after this letter was written, the government announced a consultation on the centre’s future and staff were informed a week before we visited that it would close – deeply unsettling for the team and for Martin. He had arrived there two and a half years previously, three months before his twelfth birthday, having been given a five-year sentence for two counts of arson and two further counts of arson with intent to endanger life. He was 11 years old when he committed the offences. In addition, four months prior to the referral he had attacked a staff member, a woman to whom he was close, with a plastic baseball bat. The attack was said to have ‘come out of the blue’ (as the referrer’s assessment stated: ‘He has behaved in a very violent manner, including a serious unprovoked attack, when he was apparently calm and content.’). The alarm system failed; no one else was in the unit at the time. Martin shouted, ‘Die, bitch, die!’ amongst other things during a prolonged attack. He received a conditional discharge for this offence and is said to have ‘shown no remorse’. Martin’s original sentence was almost over. The staff team was inclined to keep him on, feeling him to be both a risk and at risk. Our recommendations would matter.

Three assessments accompanied the referral – one prepared for the original court case and two others compiled very recently, patently arising from the crisis of the attack. One of those was from a specialist inpatient unit where the consultant would not admit Martin as he was not psychotic although he was perceived to be at high risk of developing formal mental
illness. He was deemed to ‘fulfil the criteria for the legal definition of psychopathic disorder’ but the hospital was unable to provide treatment for this so could not detain him. The final report had been written by the referrer for the centre and for the government department funding Martin’s placement, and included the recommendation of a psychoanalytic assessment.

One could contend that Martin should not be seen yet again; rather, a consultation to the staff would be more appropriate. I argued this at the time. But for me, it also resonated with memories of my time in a London CAMHS where, with an abundance of psychiatrists in training, it was possible when – in my case – an encopretic child was referred to propose, ‘This would be a very good case for the Registrar! We don’t see too many of these! He/she should really have the experience!’ So I was also aware of my capacity to opt out of certain cases – and of anxiety informing my response to this request about this child.

Why write of this case? Is it an externalisation of the anxiety I felt when the request came my way via a very experienced analyst colleague? Perhaps. There is the opportunity to think about the roots of violence and the few choices open to Martin in relation to his world and his perception of his objects – and I would argue strongly that, with the early and severe damage we find in so many of our young patients, it is essential that we embrace a range of ways of thinking about and working with potential violence. Martin is at the far end of a continuum but we see daily in CAMHS children who appear to be progressing unstoppably along it. But there is also a very simple message. We can find ourselves today struggling to hold on to the value of the psychoanalytic method and the particular understanding that psychodynamic theories bring. Sometimes it feels as if we are pressed to be anything and everything other than what we are. While an understanding of other modalities is essential for the child psychotherapist, the core that we convey in our specialism must neither be lost, nor should we apologise for it. It is what we bring and what we do well. As the centre sought for Martin, psychoanalysis can offer reasoned, reflective insight and a way forward.

I mention all this because decisions on the consultation/assessment continuum are often not clear-cut, however much we believe we have unambiguous principles and try to apply them. I don’t usually experience any difficulty in saying, ‘No I don’t think we should do an assessment – but can we help in this (other) way instead?’ It has become so necessary, especially in work with young people whose defences are action-based and whose environment does not allow therapy to be a treatment of choice. I would further stress that we all have limits and must allow ourselves to recognise what we can and cannot manage – without a superego that makes us doubt whether we are then ‘proper’ psychotherapists. We have to work in a fashion that allows us to continue to think, where our own anxiety does not preclude reflection. And with Martin, I was not sure that this was something I could manage.
As the weeks passed, it became apparent that meeting Martin was not only desired by the referrer but required by government. I felt that I was being gently bullied as a consequence of great anxiety that permeated quite high up the network. Some of that anxiety was certainly getting into me. Martin, moreover, was now expecting me and had said, rather imperiously, that my colleague and I might visit.

**Martin’s history**

There was sufficient in Martin’s history to give one pause. The younger of two brothers, his parents separated when he was 17 months old, his father maintaining contact. His very early developmental history and milestones are not available but he was said by the health visitor to have been beyond parental control while still under two. It was also known that his birth father was violent, the violence towards Martin’s mother continuing after their separation. A year later, Martin’s mother met Mr B who moved in within the week. They married within three months and had three further children. Concerns from the outside world coincide with this: at two years nine months Martin was showing problems in playgroup with oppositional behaviour and aggression towards peers. Both boys were put on the child protection register for physical neglect when Martin was four, but then removed as a result of Mr B’s aggressive attitude. Mr B was charged with arson of the family home when Martin was four years four months old; both boys were accommodated eight months later at their parents’ instigation as they could not cope with them. At this point the marital violence in that relationship came to light, as did Mr B’s locking the boys in their bedroom at night. Once more on the child protection register, they were separated, going to different foster families, and full care orders were gained. Martin experienced the breakdown of several placements – as the court report put it, ‘it became impossible for any foster family to cope with Martin’ and he was admitted to a children’s unit age six.

Here, he used to telephone the fire brigade, watching them arrive with the police. A failed attempt was made to rehabilitate him to his natural father. Once he had settled in the children’s unit, he was assessed for psychotherapy and over the 18 months before he was fostered Martin attended once weekly. The unit reports describe him as exhibiting sexualised behaviour towards adults and children. He had nightmares and sleep problems, was distrustful, destructive and ran away frequently. He was enuretic by night. Therapy reports comment that he viewed adults as persecutory, had jealous and murderous feelings and fantasised about omnipotence – not surprisingly. Martin’s sexualised behaviour arose in relation, he thought, to feelings of being controlled. However much the professional teams suspected at this time, Martin remained resolutely silent about his past. The containment of a good placement, a good special
school, regular psychotherapy and a coherent care plan allowed him a settled period.

He moved to live with his adoptive family aged eight, exactly two years after arriving in the unit. This entailed a considerable geographical relocation and the loss of his therapy. A family group of several children in Martin’s children’s unit had been fostered and then adopted by Mr and Mrs X. Martin had kept in touch and was also adopted a year after his move there. His older brother began to visit and moved in when Martin was nine, being adopted too when Martin was ten and a half.

I am very aware of giving considerable detail in this story. With this kind of child, one seeks reasons and possibly a sense of containment and control in the exactness and logistics of things because the emotions are unbearable. Or one seeks, in the detail, an avoidance of the whole. Such countertransference feelings are important in one’s assessment.

It was only when Martin was living with the Xs that he disclosed severe physical, emotional and sexual abuse to Mr X. It is important to keep in mind that it was to his foster (later adoptive) father that he felt able to speak about this for the first time. The details are gross and I will summarise: his mother forced Martin and his half sister to simulate sex; he witnessed adults (including his mother and Mr B) having sex; in the presence of another woman he engaged in sexual behaviour with his mother; he was involved in sexual activities with his mother and Mr B (being digitally penetrated by both and penetrated anally by Mr B whom he also had to fellate). In addition there was severe physical maltreatment including being hit with belts and punched. The children were utterly convinced that they would be killed if they told anyone about this.

Perhaps a comment on the X family, the adoptive parents. Mr and Mrs X had been married for over 20 years and were in their early sixties. It was a second marriage for both and there were children from the previous relationships. Over the years they had fostered and often adopted more than 20 children, a dozen from very terrible backgrounds. Family was important – there was little external socialising – and they lived in a large house in the countryside with sizeable grounds. Visiting professionals have unanimously praised the quality of care given to children and the progress they have made there.

**Offences**

Some three years after moving to live with the Xs, Martin began to set fires. He links this to having watched a firefighting demonstration just before his eleventh birthday and thinking ‘it would be fun’ to see the real thing. Although there were four episodes with which he was to be charged, at least five occurred, the amount of risk to others increasing each time. After the first two fires – to clothes on a washing line and a school – he thought that
his family ‘would dump me and not care about me. I was trying to get away from home and thought they would hurt me. They never had – though I lied to the police that Dad had hurt me’. In this conversation with Dr A, the exceptionally experienced forensic child and adolescent psychiatrist who prepared the court report, he added that he had set more fires ‘because I’d ruined everything and I wanted to get away from home’. He had gone into locked placements, pending sentence, where he felt ‘safe’.

The school was empty at the time but Dr A was struck by Martin’s persistence here and at a later fire – particularly for a child whose attention span was brief and whose distractibility was legend. The third fire was a summerhouse where he showed considerable persistence in ensuring it lit. He could see small animals in cages inside: the risk of harm is getting higher. The last two fires were in a porch (where homeless people often slept) and at a petrol station. Martin knew there was accelerant in the porch and had been told it could explode; the petrol station is sadly an escalation of severity.

Thinking about violence

What sense can we make of Martin’s position? Of prime importance is Mervin Glasser’s concept of the ‘core complex’, the vicious circle in which there is a search for an idealised intimate narcissistic relationship. On gaining closeness, the attendant anxieties of merging and loss of identity, of being consumed, arise with fears of annihilation and the infant reacts with self-preservative aggression against this engulfing mother – violence in the service of protecting the ego. This soon results in a sense of isolation and fear of abandonment that, in turn, provokes the search for closeness – and the journey around the circle continues (Glasser 1996b). The violence in the unit was an attack on a woman Martin was fond of and with whom he appeared to work particularly well. In my meeting with Martin, attitudes to his adoptive mother also recalled core complex phenomena. If we think about the exacerbation of the incidents of arson, we have to note that Martin was then in a family where he had found a benign father to whom he was able, for the first time, to disclose his abuse. There was a capacity to hold on to hope in relation to men, despite his abuse by Mr B. We recall the summoning of the fire brigade in the children’s home – the fireman with the hose, the phallic male who is creative and not abusive, who rescues rather than destroys. It seemed that Martin was able at that point to have a place in his father’s mind – the necessary process of disidentifying from the mother and being separate from her, aided by the father – but that this could not be sustained.

Interestingly, reports comment that Martin talked of his adoptive and his natural mother in a muddled, confusing way, conflating them (when distressed) seemingly into one malign maternal imago. Any key woman might then be drawn into being a part of this.
The extended adoptive family may have enabled him to negotiate intimacy better than in a more intense nuclear family – but eventually the intimacy becomes too much. He seeks help – summons the firemen – first in a way that is less dangerous to others, then he has to increase the risk to get any notice taken. Dr A noted in her report that he told her, ‘I wanted to get into trouble – into a mixed load of trouble – I knew the police would be involved and a lot of other things – I felt that I needed to be away from home – that’s exactly what I felt – I was fed up at the time, being around the house – it gets boring when you live there a long time.’ It sounds very much as if the core complex issues were becoming too hard to manage and, I suspect, his father was probably not available to counteract the internal devouring/abandoning mother. ‘I kept saying, “Fire brigade, you’re going to be out all day today!” as I was hiding in the bush’: such a need of an all-day man who has Martin in mind. Without him, identification with the aggressor (Freud 1968) perhaps becomes both a resolution and a fear. His internal fantasies of violence, in response to the core complex fear of loss of self, made him afraid and feel he had already ‘ruined everything’ – the thought was the deed. His arson was both a desperate search for help with his growing feelings of violence and a seeking of punishment as Freud describes (Freud 1916). Glasser reminds us of the importance of the admixture of internal world, internalisations and real experience:

A . . . shortcoming in many of the discussions of dangerousness is the absence of attention given to the contribution by the offender’s inner world: a man’s deprived background, his broken family, his violent parents and so on do not in themselves make him behave violently or in a sexually criminal way, although such factors may help both to structure his potential violence and to determine the triggers to his violent behaviour.

(Glasser 1996a: 273)

Sinason has alerted us to the particular vulnerability of boys who are sexualised by their mothers (Sinason 1996). Martin was used – treated as a part object – by his mother with devastating impact on the essential development of the protective sense of shame (Campbell 1994). His vulnerability to the engulfing internal mother, and the split internal humiliating and abandoning mother, causes his acting out to be directed against women and it is the need for and dread of closeness to them that triggers his rush to violence. Verbal abuse, often with very sexually disparaging language, is a common way of Martin’s expressing his anxiety but the symbolisation is not sufficient when the anxiety is not recognised as such – and he then has to act.

The nature of the violence is also important. This – at present – is violence in the service of the protection of the ego, Glasser’s self-preservative violence (Glasser 1998). One of the most helpful articles in this area is by Marianne Parsons and Sira Dermen where they argue:
the limitations of an exclusive preoccupation with aggression in working with violent youngsters. We suggest instead that violence be understood as an attempted solution to a trauma the individual has not been able to process, and we define this trauma as helplessness in the absence of a protective object. The youngster is both a perpetrator (in the external world and in his ideal image of himself) and also a victim (having been failed at a point of maximum helplessness and lacking an internalised protective membrane). He enacts this disjunction, causing harm to others and inviting punishment unconsciously from the law.

(Parsons and Dermen 1999: 345)

The ‘unprocessed trauma’ is akin to Hyatt Williams’ ‘psychically indigestible experience’ (Hyatt Williams 1997: 104). Boswell (1997), in a review of children detained under section 53 of the Children and Young Persons Act 1933 (the legislation under which Martin was detained), found that 72 per cent had suffered abuse of some kind or kinds.

The unhooking of ‘violence’ and ‘aggression’ allows us to think of what might be helpful. When we think ‘defence’ and ‘anxiety’ we tend to phrase our interventions very differently from when we think ‘aggression’ and ‘attack’. That is not to argue for therapy here; simply to remind us that ‘the appropriate therapy has to be directed to the neglected, defective side’ (Freud 1947: 42). We are into the realm, then, of structuring and attention to the ego, as Anne Hurry has so well elaborated (Hurry 1998). As Parsons and Dermen add:

The job of the child psychotherapist is to resist collusion either with the values of his ideal self (violence) or the demands of his harsh conscience (sadistic punishment); rather it is to understand his predicament, something he cannot do himself.

(Parsons and Dermen 1999: 345)

The authors have found that this approach – and internal understanding on the part of the therapist – enables emotional contact with patients who ‘find it singularly difficult to communicate effectively with others, or indeed with themselves, without resorting to violence’ (Parsons and Dermen 1999: 345).

When one thinks of trauma, deficit and lack of an internalised protective membrane, it gives one pause technically. Interpretations can be used to attack, retaliate, defeat and distance our patients as well as to heal. Edgcumbe (1971) is clear that interpretation alone is not sufficient for violent children and I find it encouraging that at the Colloquium on Violence hosted by the Anna Freud Centre in 1995 (see Perelberg 1995a) one workshop group raised the important question as to whether modification of classical technique was inevitable in work with violent patients. For those
of us working already with that adaptation of classical technique that is child psychotherapy, flexibility perhaps comes with less questioning.

**Martin’s functioning – and further theory**

My colleague examined the unit’s logs and records while I met Martin. There she found a rather different picture from the ‘out of the blue’ description of Martin’s attack on his worker. On arrival at the centre, he had been placed in a unit where he made some progress and seemed fairly settled. However, his peers here were older and he resisted work in education. He was moved to the unit on which the attack happened. There it was decided to engage him in work on his past abuse – despite clear warning in Dr A’s court report that such work should only be done if Martin requested it, with staff whom he selected and at his pace. ‘Life work’ was also attempted. The records note incidents of verbal violence, then threats to other people; the threats became threats to kill. Martin began to talk about fires – he would hurt others or destroy property with fire. On one occasion when he had to be restrained, he was confined to his room. The knowledge that he had been locked in and abused by Mr B seemed to have been forgotten, as were the reports of his being locked in while awaiting sentence and urinating in and trashing his room. He destroyed walls, floors and carpets. Sexualised derogatory remarks to women followed and occasional kicks and punches at staff members. The actual attack seemed the culmination of this. His victim was off work for a week and sustained quite serious injuries.

Transferred to a third unit, he thought and spoke of hurting staff. A teacher with whom he had no contact reminded him of his father and he offered money to other young people if they harmed her. One-to-one special observation was instituted on a daily basis; Martin’s activities and mobility were severely curtailed. During the period leading up to the assault Martin had attempted to secrete cutlery and to adapt furniture (which he had broken) into weapons. His threats to kill staff since then had been taken very seriously and reported to the police. He also talked of sexually assaulting staff and spent long periods of time in the lavatory with pictures torn from a catalogue – pictures of knives and chainsaws. He was thought to masturbate to these. He talked of killing himself, cut himself superficially, pushed things into electrical sockets and threw water over the television, hoping it would blow up and he would die.

It is not hard to see the serious decompensation resulting from Martin’s being induced to recall and review the trauma and humiliation of his past. In the month after the attack there was a violent incident each day. This settled with the close monitoring and lessened even more subsequently. Martin was allowed to choose who would monitor him as his escort each day and managed to develop a working relationship with Martina. Interestingly, the psychiatrist who assessed him for the inpatient unit felt that this increased his omnipotence and should be discontinued. Fortunately the
staff disagreed. His presentation to that psychiatrist had been remorseless and omnipotent; it seemed impossible to note the anxiety beneath it.

When thinking of Martin masturbating to a catalogue, one concludes that the only position available to him at this lowest point appeared to be identification with objects of violence. He had become one – the internal ‘ideal image’ as perpetrator mentioned by Parsons and Dermen (1999). In the colloquium, one workshop group offered a list of elements for conceptualising the descriptively violent individual. These included ‘inability to feel human about the other and the self’ (Perelberg 1995b: 165). Ferenczi first alerted us to this reaction to abuse: ‘The [abused] child changes into a mechanical obedient automaton’ (Ferenczi 1933: 163).

This is reminiscent of Cooper’s comments on the core trauma in perversion and ‘dehumanisation’, which he defines as a strategy to protect against human qualities of loving, vulnerability and unpredictability: ‘The core trauma in many if not all perversions is the experience of terrifying passivity in relation to the pre-Oedipal mother perceived as dangerously malignant’ (Cooper 1991: 23). Martin had just been reminded – in a persistent way – of the dangers of feeling human. His violence had become something to cathect, an identification. When thinking of his decompensating, one must also have in mind violence as a defence against psychosis and have grave concern as to his future.

**Encountering Martin**

Before arriving at Townsville, I had suggested that Martin be consulted as to whether we should meet alone or with a staff member whom he trusted. He had chosen Martina, his key worker who was also a group worker on his unit. (Perhaps Martina’s groupwork role helped deintensify her key worker role in Martin’s mind.) Our meeting lasted just over 40 minutes. He had been aware of our presence and it is to his credit that he managed a meeting of this duration. We introduced ourselves and he asked Martina to stay. He had been sedated – it emerged that this was the current way of coping with his destructiveness and a trial of anti-psychotic medication had been recommended by Dr A.

Martin chose to sit at the far end of a settee, nearest the door, on the arm of the settee, with Martina next to him. I was in a comfortable chair on the other side of Martina. Where dangerousness is an issue in therapeutic settings, one should allow the patient the seat nearest to the exit. For most violent patients, the anxiety aroused by a suddenly perceived threat to the ego leads to a violent reaction in the service of protecting the ego (Glasser 1998). Having an exit available thus frees the patient not to have to attack, but to preserve the ego by escape. Martin was astute in his choice.

Needless to say, there was very little in the way of explicit information to be gained from this encounter but a great deal about how Martin interacted with new people (especially those outwith his control and on whom he, in
some sense, relied for the future). He was able, in some detail, by talking to Martina but darting glances at me, to describe a crucial telephone call to his adoptive parents in which he had succeeded in letting them know that he did not wish contact at home at present. Martin spent some time on this and it became apparent that, in not wishing to go home, he was protecting both himself and his family from the possibilities of his violence. He had rehearsed saying ‘no’ with Martina who waited within earshot while he telephoned. The call had mainly gone well; his father had been sad but understanding. However, in the background his mother had constantly shouted that he should come home, saying how much they missed him and wanted to see him. Martin had experienced this as ‘totally winding me up!’ He was – in the recounting – extremely abusive and denigrating of her, a verbal version of the violence. I commented that he had managed to get his message heard and that his anger with his mum really appeared to be about her not being able to hear him like his dad had managed. He paused – I got a glance – then he turned back to Martina. I was struck that his mother’s stance was about her needs and wishes while his father appeared to be able to hear Martin’s needs.

Martin is said, in all reports, to lack concentration. In this meeting, he showed a very practised capacity to divert from the matter in hand by changing the subject or by affecting a state of not listening – almost a dissociated state – and then requesting that what had just been said be repeated. I simply survived it; I felt that were I to offer even a mild interjection I would lose him. He was performing in my presence and I was the audience, but the performance showed me how he kept himself safe in relation to his objects. Interestingly, it did not feel sadistic or aggressive and that arose from thinking ‘defence’ and not ‘aggression’.

Martin took great pride in his ability in maths. In this he likened himself to Martina and joshed her like an equal about it but also with pride in the identification. Such identifying removes difference, so removes separateness and danger. He liked the similarity of their names. He agreed when I said he might well feel at the mercy of the grown-ups, when he insisted on not knowing why I was there. Finally, he could not dare admit strong emotion. My comment about sadness at the closure of the centre elicited a denial of ever feeling sad. It was not to deny weakness; rather, a need to exclude affect or it would overwhelm.

Martin’s identification with Martina might seem adhesive to some. It did not appear to be the deceptive ‘simulation’ Glasser (1996a) has mentioned, nor yet to lie in the area of true/false self. Certainly issues of separateness and of intimacy were vital. I wonder if, in his seeking the ideal almost merged relationship of Glasser’s (1996b) ‘core complex’ vicious circle, one also needs to think about Martin seeking an idealised relationship as a way of ablating difference and separateness as the latter means harm and danger. Being the same also precludes the need for thinking – one knows because one is the same.
What psychoanalytic understanding offers

It is sometimes necessary to be made to experience what others experience to aid their belief that we do, in fact, comprehend it. It happens often with children and we are used in the clinical situation to putting this into words for them. Where events are overwhelming to the mature, professional adult, and when nothing seems to be available to dilute the intensity of the stressful experience, it is likely that whatever one offers will not suffice. With Martin, I think the process of dealing with my anxiety by planning a joint interview with Martina was important – for me, certainly, but also in modelling the necessity of taking on only what one could manage and still think. My colleague’s taking time to trawl through the records was similar – there is information to hand but you need to be given time and develop procedures to collate it and put it in the context of the young person’s history and trauma. Above all, having a perspective to add to the staff’s understanding but not having the expert answer allowed us to join in thinking together and offer a report that summarised this reflection.

Additionally, there is the initial matter of my reluctance to see Martin, enveloped in the question of an assessment too far or too intrusive. In work with violent young people, the countertransference is a key tool. My countertransference reaction was both the sense of what belonged to me and that which is created by both analyst and patient together (Heimann 1959/60). When one thinks in this latter way, the emphasis moves from simply being what I feel I can manage to what Martin might feel he can manage in the face of his anxiety – hence offering him the choice of how we met. The shift is – as often in technique – from thinking ‘attacking me’ to ‘anxious and needing to defend against me’. This was important information for the centre team.

Following discussion with the team, the provision of a report was essential. Partly, this enables the insights of psychoanalysis to be digested at a manageable pace; partly, it ensures that what is communicated is unambiguous. In the heat of anxiety, spoken words can be misheard and misunderstood and where young people like Martin are involved it is important that messages are clear. We translate this psychoanalytic insight so that it is comprehensible and can be used and understood – recommendations must have meaning to the recipients. I summarise the major detail:

1 Martin will require a secure environment for several years to come. He is a risk to others and is likely to increase the behaviours that indicate he can be a risk to himself. [I make no apologies for being so blunt – dissembling is not clever in complex cases.]
2 The danger points arise for Martin when he develops a relationship of closeness and intimacy with others – his arson attacks began when he was settled with his adoptive family and had a sense of wanting to
escape this; his attack on a staff member occurred when a good, close relationship had been established. Staff will have to be aware of the risks in this – he has a need to protect himself, by violent means, from a sense of over-closeness, and is trapped in a cycle of needing intimacy and then fearing the consequences – consequences that, in the past, have included losing his identity as a human little boy and being severely abused. It is important that staff have good consultation available to help them handle this aspect of Martin’s functioning.

3 Offering programmes to explore his early experience is not wise – Dr A stressed that any such work should come at Martin’s pace and follow his need to talk. I would agree very strongly with this. He has, so far, chosen two people to do this with – his adoptive father and his present key worker, Martina. He must not be pushed – the memories are overwhelming and humiliating and his only protection from these, at present, is violence. He will select his own person in his own time. Being available will be important, as will ensuring that the dangers of intimacy are recognised, catered for in the timing of sessions, and in having consultation available.

4 A senior person must hold an overview of Martin’s functioning and a group must be aware of the detail of his day-to-day ‘going on being’, sharing information and responsibility. This is essential not only for Martin’s progress but for staff safety. Martin’s history should be known by staff – the escalation of violence in the past has been predictable and is directly related to this.

5 Staff with whom Martin has developed a good relationship will need to keep alert to his feelings of abandonment at the closure of the centre and his anger at this, and to the potential for his acting out these feelings against staff (especially women to whom he feels close), himself and property. His difficulty in expressing emotion must not lead to thinking that he has no feelings on the matter.

6 Therapy should be offered to Martin. This should focus on the deficits in his psychological development and on strengthening his ‘ego functioning’ or sense of self. It will be long and very slow. Flexibility in the therapist will be essential, and flexibility about length of sessions, timing of sessions. Martin must be allowed to feel more in control of the pace, to feel safe enough about approaching emotions and emotional states – this should be discussed with him, otherwise he may turn it into a perverse control. A male therapist would be preferable.

7 Education has been a problem area for Martin. His lack of concentration is probably not due to any deficit (but I support the medical recommendation about a neurological examination: one would not wish to miss anything). Thinking is often, for young people like Martin, equated with remembering and flashback memories of childhood. He is overwhelmed by what comes into his mind and is therefore practised in ‘switching off’. Approaches that offer desensitisation could be explored.
In class, a focus on areas like maths, computers and IT might help as he can deal more readily with material at an abstract level.

8 Martin’s violence seems, from the records, to show a pattern of escalation that also happened with the arson attacks. Detailed notes on his emotional state must be kept and any pattern spotted as early as possible, otherwise he increases the violence. When such behaviour is perceived, Martin should be helped to see that people recognise that he is anxious and that his anxiety is rising, and he should be involved in plans about what he feels would be helpful. It is important that, in alerting him to his changing anxiety level, care is taken not to humiliate him but to choose a form of words perhaps agreed in advance – a signal.

9 This links to his inability to recognise emotional states. At present strong feelings of any kind are experienced by him as simply overwhelming and his sole repertoire for dealing with them is to be violent, to protect himself from them. Slow work should be done on naming emotions – as one would with a toddler, e.g. ‘That must have been annoying’ or ‘That was really pleasing’ – as a first step in gaining control. Again, careful wording is needed. Feelings, if they cannot be named and recognised (and he has no way of recognising feeling states until they become overwhelming) take on enormous and terrifying proportions and must then be decanted outside the self on to the outside world.

10 Martin has appreciated Martina’s support in asking his family for some distance at the moment. This is important, as it seems to be the first recognition that intimacy is a complex issue for him, and protects his family from his possible violence as a way of dealing with it. He also felt listened to. It is vital to keep in mind when thinking about family contact – we often assume contact is ‘a good thing’. It is not necessarily so when closeness is the issue that causes violence, and great care should be taken to listen to Martin. It is also important that his family is helped to understand this central, core complex issue: Martin’s mother, in particular, should be given time to think through her strategy with him and how she can be caring but not consuming.

Conclusion

This is the story of a very difficult boy and those who worry about and are burdened by his future. For many seemingly impossible children psychotherapy comes a long way down the list of interventions one might recommend. We can, at times, punish ourselves with a sense of omnipotence about our skills, a sense that we should be able to work with any kind of case. Other – especially at times more diluted – interventions may well be more appropriate choices in particular situations; but psychoanalysis has a huge amount to offer in understanding the origins of and
approach to such behaviours, in consultation and the creation of space for thought and reflection. It is, in this, a prism for viewing the internal world and its impact on the external world that is second to none. And when we don’t want to work with specific cases, and where it is because we cannot sustain a capacity for thought in the face of anxiety, we should give each other permission to take up a different role and view this as a creative response and not a failure.

References


Part III

Consultation and beyond
I am sitting in the familiar surrounding of the bright, pink-walled, turn-of-the-century community clinic; upstairs is the dentist and downstairs the GP clinic. In the next room babies scream as they are plunged into the hard, cold weighing scales; others lie warm-lapped, making sense of their new world whilst their mothers do similarly, talking with the health visitors. I think of Dily Daws standing at those ubiquitous weighing scales and think how my fellow child psychotherapists have longed to join her there (Daws 1985).

However, today is not the day to feel dispirited as a meeting has been called by the under fives team in the breath-holding hope that it will inspire our managers in health, education and social services to formalise our Under Fives Service and actually realise that ‘joined up’ services really do exist beyond a mission statement and, therefore, that our service should be protected from further cuts.

Every member of the core team is there: the social worker from the Children and Young People’s Service family centre, the educational psychologist, behavioural support teacher from the local education authority (LEA), the psychiatric nurse, psychologist, integrative psychotherapist and child psychotherapist from Child and Adolescent Mental Health Service (CAMHS), the health visitor and the parenting programme nursery nurse from the Primary Care Trust (PCT). At the heart of it, chairing the meeting, the lead child psychotherapist sits alongside the health visitor who was instrumental in establishing the parenting programme.

The Under Fives Service I work with grew out of the rich, fertile space created between this health visitor and the head of child psychotherapy for CAMHS, through the process of consultation. The essence of that early consultative, longstanding relationship – mutual professional respect and a belief that through thinking together with separate minds and expertise a deeper understanding becomes possible – has provided the Under Fives team with ‘good objects’, galvanising us to seek out a reassurance for ‘the continuity of going on being’ (Winnicott 1960: 54) for both ourselves and our clients. It is this service that is currently in jeopardy due to the latest round of cuts.
In the *Oxford Clarendon Press Dictionary* (1924) the definition for ‘to consult’ is: ‘take counsel (with), seek information or advice from (person or book), take into consideration or do one’s best for (person’s feelings, the interests of)’. What is particularly helpful about these definitions when applying them to the Under Fives Service is that they underline that we are working together to offer the best that we can, to bring about change for the children, parents and carers referred to us. We offer this help either through direct work or through consulting with those professionals involved with the children and families.

**Some practicalities**

In this Under Fives Service (the format varies throughout the country), the team is led by the principal child psychotherapist from CAMHS and meets fortnightly for a two-hour period. The first part of the meeting addresses the referrals. Currently there is no single referral pathway to this Under Fives Service. The procedure for referrals to the service is an evolving process. Children under five are initially referred to the several different organisations – the PCT, CAMHS, Children and Young People Service and LEA by doctors, hospitals, paediatricians, health visitors, schools and the Children and Young People’s Service (Social Care).

Each organisation has a different system and waiting time for offering help. This can mean that some referrers, anxious to elicit support for the child and family, may refer to a number of organisations at the same time. All children who are just five and under, whose referrals have been accepted by CAMHS, will be assessed within the Under Fives team. Once referrals are received there are cumbersome checks to ascertain whether clients wish their referral to remain confidential to the specific organisation or whether they are happy for the Under Fives team as a whole to consider their case. Most families find the thought of different professionals thinking together about their difficulties supportive and helpful. Only very occasionally can this feel too persecutory for some families.

When the team is able to think together about which intervention would best suit the family’s needs, it may decide that a different approach is needed from what we can offer. This may require an inter-agency referral which can quickly and efficiently be made within the team. Sometimes it is agreed that two agencies will co-work a case: for example, the educational psychologist may use play therapy with the child in school whilst a CAMHS clinician works with the parent to help to develop a better understanding of the emotional and behavioural needs of the child.

The second part of the meeting involves case discussion. From experience the team appreciates the process by which families’ unbearable difficulties are made bearable, ensuring that the child does not end up drifting, uncontained, from one service to the other. This thinking is facilitated by the child psychotherapists’ theoretical framework – it is the exploration of
co-professional’s countertransference experience within the working group that is particularly highly valued. One of the health visitors on the team recently commented that the meetings provided a rare opportunity to think in depth, not just in breadth, about the families being worked with.

**Recognising the past echoing in the present**

For many years now psychoanalytic psychotherapists have worked with both the child and parents together, in the consulting room (Burlingham and Freud 1944, Winnicott 1971, Fraiberg et al. 1975, Lebovici 1975, Daws 1989, Hopkins 1992, Stern 1995, Szur and Miller 1991, Cramer 2000, Onions 2009). Understanding that parents may experience the early forms of communication from the infant as persecutory and overwhelming, child psychotherapists offer brief and long-term parent–child psychotherapy to help untangle this web of blame. They strive to build on the positive qualities within the relationship (Hopkins 1992), to make the most of the developmental momentum of the child (Hurry 1998) and to utilise the parents’ heightened sensitivity and willingness to bring about change in this new fledgling relationship (Furman 1995). Onions describes the parent–infant work she carries out as being theoretically based in psychoanalytical theory, attachment theory, neuroscience and behavioural ideas (Onions 2009).

Parent–infant psychotherapy, utilising the clinical skills of child psychotherapists, is flourishing within institutions and organisations such as the Oxford Parent–Infant Project (PIP), the Tavistock Clinic Under Fives Service, the PIP at the Anna Freud Centre (Baradon et al. 2005), the Cassel Hospital (Dowling 2006) and Parent–Infant Clinic (Acquarone 2004). Within the broader community, in CAMHS, antenatal and postnatal services, and nursery and toddler groups, child psychotherapists are evolving fascinating and ground-breaking treatments in parent–infant psychotherapy and work with under fives (for more detail see Douglas and Brennan 2004; Pozzi-Monzo 2007).

The child psychotherapist’s training, which recognises the past echoing in the present, keeps the work in the Under Fives team firmly rooted in meeting the parent and child, with an understanding that intergenerational relationships support or haunt their current lives (Fraiberg et al. 1975). It is this understanding of the relationship between the parent and the child’s inner world, coupled with knowledge of the developmental needs of the child and the understanding of the transference–countertransference relationship, that is used to inform the thinking in the consultation process to and with co-professionals, in the fortnightly meetings of the team. This continual ebb and flow, between the child psychotherapist’s varied clinical practice and experience, and the consultation process, keeps the child’s emotional and developmental needs at the heart of work, and in the spirit of the organisation of the Under Fives work.
Just as our colleagues’ assessment and therapeutic skills become sharpened by this work, child psychotherapists continue to learn much through consultation with their professional colleagues about the impact of the external environment on the internal world of the child. The profound value of psychoanalytic practitioners going outside the consulting room, and into the practicalities of children’s day-to-day lives, has a long tradition. The impact of a harsh external environment was evident to Anna Freud in her work during the Second World War with children in the Hampstead War Nursery (Freud 1973). Winnicott’s theories were greatly influenced by his understanding of the impact of deprivation, poverty and the parents’ mental health on the child’s internal world, through his many years of work as a paediatrician in well-baby clinics, as well as his numerous talks to groups of allied professions of many different kinds (Winnicott 1960). In consultation, child psychotherapists need a Janus-like quality to their thinking, a capacity to look forwards and backwards in time as well as inwards and outwards within the internal and external relationships of the child’s world. Psychoanalytically informed consultation provides a space for reflection, a space to resist the panic of other’s needs, a space to dwell on gaining a greater understanding of the difficulties being encountered both within the relationship and beyond this within the organisation and the network.

Being in a consultative frame of mind

Within our Under Fives Service, by meeting in a ‘consultative frame of mind’ with a true respect for each other’s different ways of positively changing the child’s world, we think together about the children and their carers with whom we are working. During these meetings the child psychotherapists will be paying attention to what unconscious processes may be being brought into the arena, including:

- the families’ defences (such as splitting and projecting) being destructively played out in the network
- practitioners identifying with one of member of the family at the cost of a holistic view of the situation
- the transference and countertransference being evoked in the practitioner by the parent or child.

The child psychotherapist encourages the practitioners openly to describe these feelings and understand them as a way of alerting themselves to the inner state of the parent or child and so inform the work. Feelings of uselessness, rejection, repulsion or an incapacity to think are all common experiences and, through discussion, practitioners discover how these are often the nonverbal communications from clients of their own desperate condition and their expectation of how another will relate to them.
The team meeting is a place where thinking can flourish. The team leader, the principal child psychotherapist, ensures that the meeting is bound by the safety of the psychoanalytical setting of space, time, confidentiality and a faith that ‘answers are not always the solution’. Psychoanalytical thinking provides a framework in which to bear big emotions (Trowell and Bower 1995). This process is coupled with the multi-agency understanding of the highly complex social, educational, psychological and medical needs of the client. It is recognised that for some families a piece of brief work by one of our services may bring about the shifts needed. Others may need a longer service. For a few this may still not be sufficient so the team works carefully to pace the different services’ ways of working, to provide a more sustained, lengthy piece of multi-agency support. Whatever the decision may be of how to proceed in helping the child and family, the Under Fives practitioners know that they can return again and again to share their struggles in consultation with the team and should they find that they are not making the progress hoped for they know the team will see if another ‘port of entry’ (Stern 1995) may better engage the family.

Meeting with professionals from different agencies and disciplines is part of the everyday life of a CAMHS worker. I would like to describe three cases which were referred to the Under Fives Service where the team had agreed that the families could benefit from a parent–child psychotherapeutic approach and in doing so illustrate how the consultative role of the child psychotherapist offered a different way of thinking about the parent and child’s world. The first case illustrates how, from a brief one-off consultation with a special needs nursery, a new consultative relationship between the therapist and school began. The second describes an ongoing consultative process with Children and Young People’s Services. The third is a multifaceted consultation process involving different agencies at different times over a long period of time.

Case examples

Train tracks and black holes

There are times when positive outcomes from consultations in the Under Fives team can be dramatically quick. My fellow child psychotherapist and I had consulted with the parents of a little autistic boy, Dan, in the clinic and following this they recommended that his nursery ask for our advice in terms of understanding his behaviour in school. The nursery is a local authority special needs assessment nursery with highly experienced, sensitive staff. Up to five children attend a half-day session either in the morning or the afternoon. A nursery teacher and a nursery nurse work together with the group. Most of the children arrive with little language; already many have a diagnosis of autism or
pervasive developmental delay. Their behaviours convey their distress and the profound confusion of the world they are in. For many it is their first experience of being separated from their parent/s. The nursery provides a highly structured, predictable environment, offers consistent boundary setting for the child and works hard to encourage the children to communicate their needs to the staff.

The nursery staff wanted help in understanding why Dan stood at the door of the classroom, leading to the toilets, screaming ‘NO!’ Once he reached the toilet cubicle he was always fine. The day before this visit I had been working with a traumatised little boy who, although not autistic, exhibited some autistic defences. Trains and train tracks kept him occupied for hours. The train was constantly on the go. I asked him what would happen if the train stopped. With his eyes wide open in disbelief that I did not know, he declared that it would fall off the track into the black hole. From my countertransference I could understand the deep terror this held for him. That same week a little girl, playing with her puppets, had described how the giraffe was falling and falling down a big hole. During the treatment of this little girl I had found the writings of Tustin illuminating. In her long experience of supervising child psychotherapists and working with autistic children, Tustin had time and time again encountered the children’s terrifying experience of falling endlessly into a bottomless pit (Tustin 1992). Now in the nursery watching Dan standing screaming in terror at the door, the thought of these children’s ‘black hole’ came to my mind. Perhaps Dan too was experiencing a terrifying chasm between the safety of the classroom and the security of the toilet. I described how this may be Dan’s experience and that perhaps the nursery could think of a way to provide a bridge over this terrifying space. The teachers came up with the solution and Dan became able to leave the classroom for the toilet with no difficulty.

Paul Van Heeswyk writes:

It is in an attitude towards the area of puzzling child behaviour or symptomatology that the child psychotherapist may have a specific contribution to make within primary mental health work. I am thinking here of those cases where the child’s presenting difficulty seems to be a genuine and personal construction of the child alone, and is not an understandable reaction to parental difficulties, and where the problem does not seem to serve a clear function in the family.

(Van Heeswyk 2005: 259)

The consultation had been about offering a particular perspective on the inner world of the child which, when coupled with the imaginative
educational thinking of the nursery staff, actually brought about a safe passage for the little boy. Since this initial consultation I have met with the nursery teacher and nursery nurse termly. As many of the children are nonverbal or have grave difficulty in expressing themselves, it is more pertinent than ever to help the staff to wonder about the feelings which the children are trying to convey to them through the use of the counter-transference. An important part of the consultation is helping the staff to ‘reflect on the emotional demands of the children . . . upon themselves as well as the pressure of the organisation’ (Wilson 2003: 223).

This became particularly apt in one consultation when the nursery teacher wanted space to think about a new way in which they were working with the children. The teacher and the nursery nurse were offering one-to-one play based on early childhood games involving direct physical contact. The idea was to give the children the opportunity to learn new ways of relating and regulating the space between themselves and another. To the surprise of the staff all the children were passionately keen on this activity. Despite the staff offering each of the children three sessions a week, it never seemed enough. Limited by time, the staff was squeezing in a third session as and when the opportunity arrived. They were beginning to dread the sessions as they were so exhausting. We thought together about the role they were playing in offering the children a new developmental object and how the children’s thirst for this new way of relating was having such an emotional impact on them (Hurry 1998). Just as child psychotherapists have supervision to provide a space for reflection and the processing of these emotions, we thought about how the staff could provide weekly peer supervision to reflect on their sessions with one another.

We considered how the children could be helped to manage their ‘wanting more’ feelings and not suffer the rejection of being denied this by using a psychotherapeutic framework for the timing of sessions. Based on the principle of the precise timing of child psychotherapy sessions, we established that if the children could know exactly the days and times of their sessions within the rhythm of the school day, this consistent and predictable structure could begin to become internalised by the children. This would help them to develop a sense of a constant object and the concept of waiting for and anticipating something good. We agreed the staff could further help the children by verbalising how hard this waiting can feel. Recognising this as an important experience for the children enabled the staff to relinquish the third session and so make the sessions less of a burden for them and more enjoyable for all.

For me, observing and being a part of this nursery environment is greatly educative and rewarding. The creative ideas with which the nursery engages and entices these children to explore their world expand my understanding of child development which in turn enriches the help and support I can offer other professionals and parents.
Who will catch me?

In the following case study the child psychotherapist’s core understanding of the mother–infant dyad and the impact of the mother’s mental health on the emotional development of the child is at the heart of the consultation role. In writing about her consultation work to GPs, Daws aptly describes the challenges facing the child psychotherapist in this kind of work: ‘One of the problems for a child psychotherapist offering consultative work in such a setting is to decide when it is appropriate to help raise the anxiety level in colleagues and when to help settle it’ (Daws 1995: 66). This case explores how important the child psychotherapists’ direct work was to informing this very process of raising and settling anxieties within a consultation about a family to the Children and Young People’s Service.

In their therapy session, Holly is throwing the plastic mummy and baby animals with all the force a three-year-old can muster. Her mother Sarah is recounting the difficulties she has been facing with Holly’s father. Her voice has become weary and despairing. The child psychotherapist with whom I co-work these parent–child sessions wonders whether Holly is showing her mum how lost she feels and dropped from her mind. Sarah turns to Holly and says how sorry she is that she wasn’t listening to her; she kneels down. Holly brings two of the doll’s house cushions and places them on the floor side by side. ‘Lie down Mum, sleep,’ she commands. Sarah curls up and Holly moulds into her body. She suddenly hops up and gathers up each of the animals. She knows one of the babies is missing and looks carefully for it. Retrieving the baby she snuggles back into her mother cradling the animals in her arms. The silence is peaceful and Holly and Sarah are cocooned in the intimacy of the mother–child unification.

Nine months earlier when we tentatively showed Sarah, a single parent, how Holly was trying to find a way to experience being caught and held by her, Sarah’s own pain flooded her capacity to empathise with Holly and she could only retort: ‘Yeah that’s fine but who will catch me?’ Sessions with Holly and Sarah left us extremely alarmed as to Holly’s physical safety and emotional well-being. In consultative meetings with social care, the key role seemed to be highlighting the emotional abuse being inflicted on Holly and how acutely this was already presenting in Holly’s behaviour. A few months later Sarah placed Holly in care.

The network of Children and Young People’s Service, CAMHS, adult mental health and Sarah’s health visitor worked unstintingly to consult and protect the healthy part of Holly and Sarah’s relationship. Sarah felt desperate shame that she had failed to be able to mother Holly. We pointed
out to both Sarah and Social Care how important it had been for Holly that Sarah had recognised that she was not able to meet Holly’s needs at that time and had sought help, rather than fail Holly. Sarah had acted in a protective way. Sarah had been suffering from a deep depression since Holly was a baby but had not been able to acknowledge this as the cause of Holly’s self-preserving, destructive behaviour. Again and again Sarah had told us how she used to be a good mother.

In one session we described how there was an ocean of pain, anger and resentment between Sarah and Holly which stopped Sarah being able to reach out to Holly and that if she could mother her she would. But at this moment, due to her own mental health, she just could not. This seemed to alleviate the shame in Sarah and help her to understand the need for her to work with the adult mental health services. In consultation with Children and Young People’s Services, we used this same phrase to describe Sarah’s incapacity to mother Holly. We were able to begin to think together about ways to support Holly and Sarah’s relationship that sensitively placed the emotional well-being of both Sarah and Holly at the centre of the work.

It became clear from Holly and Sarah’s parent-child psychotherapy sessions that Sarah now wanted to catch Holly when she threw herself at her and to keep her in mind. My consultative role was to support the thinking around Holly’s return to Sarah. I joined with the social workers, Sarah, her health visitor, Holly’s foster carer and nursery teacher to plan carefully Holly’s return home. It was essential to ensure that Sarah was not overwhelmed and that her time with Holly felt manageable and positive. The adult mental services, CAMHS and Children and Young People’s Service continue to support the family. This working experience resonates with Lanyado’s view:

This working alliance of adults around the child . . . needs to have as its aim the creation of a parental couple or network constructively ‘holding’, thinking about and working to help the child. Where a working relationship surrounding a troubled child struggles to avoid splitting and polarisation, the result for the child is a very positive experience of being, and feeling, emotionally held in the minds of the key adults in their lives.

(Lanyado 2006: 219)

In Sarah and Holly’s case, as well as with many other fragile families, this joining together of the services to hold the parent and the child is vital if irretrievable breakdown is to be prevented. At the beginning, Sarah blamed everyone including Holly for the situation she found herself in; she was as critical of herself as she was of the rest of the world. Until she was able to experience being held herself, in a non-judgemental way, Sarah was never going to be able to consider Holly’s needs. As she said, ‘Who will catch her when she falls?’ The gathering of the agencies created a grandparental role,
an extended family of supportive, caring adults who sought to protect Holly through protecting the healthy aspect of Sarah’s relationship towards her whilst recognising the serious need to attend to the destructive despair within it.

When consulting in complex cases where many agencies need to be involved, the child psychotherapist maintains an awareness that some parents need to protect aspects of themselves they cannot face by the processes of splitting and projection. The fortnightly meeting of the under fives team provides a regular checkpoint at which to ensure that we as agencies are working constructively together, keeping in mind our different roles and how these may be perceived by the client. It also provides an essential secure base which sustains each professional’s capacity to persevere with demanding cases and know that the team will thoughtfully suggest other ways forward should they be needed. The concluding case very much required a multi-agency approach suffused with the knowledge and understanding of child psychotherapy.

**Another port of entry**

Carrie had fled a violent husband with her children, Thomas and Ella. Her struggle to manage the children’s behaviour had prompted the women’s refuge to refer her to the Children and Young People’s Service family centre for a parenting group. Carrie was still too traumatised to use the group successfully and gave up attending after a couple of sessions. Social Care referred the family to CAMHS and meanwhile the nursery nurse from the Positive Steps parenting programme began to work with the family in the home. The CAMHS referral was allocated to a primary mental health worker. Therefore it was anticipated that the case would need a brief intervention.

Both the nursery nurse and the primary mental health worker found their thinking and resourcefulness paralysed in the home setting. Back in consultation with the Under Fives team it was felt that this experience reflected the state of the mother’s internal world in response to the trauma she had suffered. Unfortunately the mother had not been able to continue her own therapy within the adult services. Another ‘port of entry’ was needed and it was agreed by the team that this be parent–child psychotherapy. Carrie, Ella and Thomas had each developed their own unique systems of defence against unbearable experiences of domestic violence. As well as working with the internal world of the family and how this impacted on the way they related to one another, it became imperative to address key environmental factors that were
‘impinging’ on the children – especially school life and the contact visits with their father. Consultations were set up with both the school and the Children and Young People’s Service.

In the latter case the children and young people service was threatening to withdraw supervision of the contact visits, despite the children’s fear of being abducted by their father and their fear that the parents would fight on meeting. Despite consultation, the Children and Young People’s Service, pushed by their own limited resources, recommended to the court that supervision be removed from contact. We needed to advise the court that this would have a detrimental effect on the children’s recovery, highlighting the case that if children are to recover from trauma they must have a nurturing, predictable and safe environment (Perry et al. 1995). The court ruled that contact visits would remain supervised.

Both the children were unleashing their chaotic, frightening worlds on the school who asked for our help. Ella’s way of coping had made her particularly omnipotent and consequently unpopular with staff and children alike. For Ella, feeling so unlikeable had placed her further on the defence and made her behaviour prickly and attacking. After consulting with the special education needs co-ordinator (SENCO) the latter felt that it would be helpful for all the staff to have a greater understanding of the impact of trauma on children’s emotional lives and she requested that I speak with the staff and advise them on strategies to use within the school.

Child psychotherapists bring their previous professions to their training. Prior to child psychotherapy I had worked within theatre and education and run in-service trainings for educational establishments, so was at ease in this setting. However, as a child psychotherapist in a consultative role, I was aware that the richest ideas were going to come from the staff’s expertise and knowledge of the children in their own school and therefore agreed to advise the staff on the impact of trauma on children’s states of being and to facilitate a ‘brainstorm’ to begin to establish a school practice that supported traumatised children within the classroom and the playground. Here I am reminded of Van Heeswyk’s reflection on helping parents as a child psychotherapist: ‘We humans are a problem-solving species and if, inadvertently, in the course of our work we take the recognition of this capacity away from our clients then they leave with less than they came’ (Van Heeswyk 2005: 256).

This seems equally important when working in consultation with other professionals. Just as the school used the consultation with the child psychotherapist to find new ways within the school system to support the
children, members of the Under Fives team used the consultative meetings to challenge their therapeutic practice and try to bring about change for the family.

Summary

In the first case example, the consultation solely depended on an understanding of the child’s unique ‘construction’ of his/her world. With the other two cases it was essential to be engaged with people from the different organisations working with the families. To return to Daws’ weighing scales, their significance is that they represent the everyday world of the mother and baby (Daws 1985). If Daws and other child psychotherapists had remained shut away behind closed doors, waiting for referrals to dribble in through the system rather than actively participating in the hubbub of the baby clinic and the larger world, the vast importance of the child’s emotional development (that cannot be weighed) would not be represented in the system.

We know, as child psychotherapists, that a small change in a relationship can be of enormous significance. We therefore need to participate fully in the machinations of organisations if we are to protect the wealth of practice already existing and ensure that it continues to thrive.

The arena of consultation offers child psychotherapists an opportunity to deepen their knowledge and understanding of children’s lives, and take up the challenge of truly holding the child’s external and internal world in mind. It also provides a stereoscopic vision with which to represent this world in the thinking of the funding system. It was through the original consultation of the child psychotherapist with the health visitor that the under fives service grew.

And that morning, in the pink-walled community clinic, to which the borough children’s directorate had been invited by the lead child psychotherapist to consult with our under fives team, the parenting programme was saved. Without consultation there could not have been this fortuitous ending.

References


11 The impact of listening on the listener

Consultation to the helping professions who work with sexually abused young people

Monica Lanyado

Some people are natural listeners. People like to talk to them and feel heard by them. They are the kinds of people who are suited to working in the ‘helping professions’. They are drawn to do the kind of work that others might find anything from not particularly interesting to incredibly demanding and distressing. There are many professional ways of helping other people – teaching, social work, occupational therapy, care work, psychotherapeutic work and so on. And it is probably fair to say that, in all of these professions, being in professionally appropriate and varying degrees of close contact with other people who are suffering in all kinds of ways is bound to have an impact on the listener.

Psychoanalytically trained psychotherapists are in a unique position in their understanding of this impact on the professional, due to detailed attention to and understanding of the transference–countertransference relationship. As a professional group, we spend a lot of time pondering the impact of one person’s emotional life on another and the many forms this kind of communication takes. Indeed we have refined the process into a particular type of listening – psychoanalytic listening – in which a form of free-flowing attention helps us to focus in on certain kinds of communication as indications of underlying unconscious communications.

This use of ourselves as a means of understanding others, together with the personal analysis or therapy that is central in training, enables us to become more able to stand being close to feelings, communications and experiences which many find intolerable. Most of our colleagues, many of whom work on a day-long basis with the patients we may see at the most for five 50-minute daily sessions in a week, do not have their own therapy to which they can bring all the alarming feelings and responses aroused in them by those they are trying to help. It is inevitable that they will need emotionally to protect themselves in some measure from becoming what is euphemistically called ‘too emotionally involved’ with those in their care, in order to survive the work on a day-to-day basis.

In this chapter, the focus is on a particular form of consultation to these colleagues which can be offered by child and adolescent psychotherapists. Some are offering work discussion groups to teachers in ordinary schools
(Jackson 2002, 2008). Others are offering a combined approach with staff and pupils in ordinary schools as well as specialised settings (Malberg 2008; Maltby 2008; Music and Hall 2008; Sayder 2008). This chapter will discuss the ‘impact on the listener’ of staff working with children and young people who are at the most disturbed end of the spectrum, and have been severely sexually abused and also, frequently, repeatedly traumatised and chronically neglected. In these circumstances, an approach which focuses on staff’s countertransference responses to children and relationships between staff, together with organisational dynamics, may be necessary for the intensity of the anxieties inherent in the work to be contained adequately.

These are children who have suffered a partial or total breakdown in the caring environment. They have often lost contact with their birth parents as a result of many kinds of severe abuse, neglect or abandonment and have been placed by the child care authorities with foster or adoptive parents, or in a children’s home. As well as their inevitable emotionally disturbed behaviour, they are likely to find it extremely difficult to form ordinary loving and trusting relationships with those adults who try to care for them. As a result they often have to be moved from one foster home to another when their aggressive and disturbed behaviour becomes intolerable for even the most understanding of carers. Adoptions fail for the same reasons. And not surprisingly, these children frequently experience great difficulties in school, which may lead to exclusion from one school after another, quite apart from all the changes of school which are the result of changing foster and adoption placements.

In the UK, often it is not until a child has reached these desperate circumstances of being uncontainable in a family home or ordinary school that the resources of a specialised therapeutic unit will be sought. By this time, the child’s emotional condition has often reached a state of such despair and violent breakdown that what would have been a difficult enough task earlier on in the child’s life has become close to impossible. There has to be a significant change to an environment in which the child’s emotional needs and disturbance are received by a group of well-trained and well-supported adults. The loving care of a single or two carers in a foster or adoptive home is simply not enough.

Needless to say, the cost of sending a child to this kind of unit is very high, and places in them are scarce. The staff of the unit, both personally and through a tranference relationship to the unit as a whole, stand in a kind of loco parentis to the child, particularly in residential units, but also, partially, in specialised day units. The therapeutic task is like trying to replant a failing seedling in a richer and more carefully controlled environment, in the hope that it may yet manage to grow into a reasonably mature plant.

The staff who work in these units are constantly on the receiving end of ferocious, violent and disturbing behaviour and communications – verbal and nonverbal. Whilst the work can be deeply satisfying, it can also be terrifying, potentially emotionally damaging and overwhelming. The
countertransference experienced in working with these children needs to be wisely attended to within the day-to-day functioning of the unit if good staff members are to be able to continue doing the work. If this does not happen adequately, the ability to sustain doing the work over time is bound to become compromised with staff becoming unhelpfully personally defended against the awful impact of the children’s communications. Unhelpful social defences in the unit’s organisational structure are also likely to develop as discussed later in this chapter (Menzies Lyth 1959, 1979, 1988, 1989).

Another possible outcome of the impact of the work is that good and dedicated workers become exhausted and burnt out. Worryingly, I do not think it is an overstatement to say that staff in such units are very much at risk and there can be an alarmingly high casualty rate of good staff who become seriously physically ill or emotionally burnt out, because they have listened so deeply to what those in their care have needed to communicate without the essential safeguard of a reflective space built into their daily working lives.

This chapter discusses the general impact on ‘the listener’ of what is ‘received’ in these demanding therapeutic relationships, and more specifically describes the process of consultation to a staff group in a residential unit in which many of the children, as is often the case, have been horribly sexually abused. These are children who have been incestuously abused at a very young age by parental figures and family members. Some have been involved in paedophile rings; their sexual acts have been filmed and have been found on the internet. The perversity of the details of the sexual acts that the children have witnessed and been forced to participate in evokes horror and disbelief that adults can behave in this way with children. Some of the adults responsible for these acts have been imprisoned. Others have been taken to court but there has not been enough legal evidence, despite the often overwhelming evidence from a clinician’s point of view. Others have not been prosecuted. Some of the adults have been imprisoned and released having served their sentences. Despite all that has happened, the children often remain ambivalently attached to their abusers in disturbing and perverse ways, unable to form more healthy relationships and attachments.

The sexualised behaviour and sexual experiences of primary school aged children, who would ordinarily be considered to be in Freud’s ‘latency’ period of sexual development, is particularly disturbing because, even in our highly sexualised society, it is so evidently unacceptable. Adolescents are expected to be intensely sexually aware and active so that the sexual trauma underlying sexually abused young people’s behaviour is not so immediately apparent despite extreme sexual acting out. But the impact on a member of staff of recognising that a seven-year-old boy is deliberately and repeatedly exposing his bottom to her, whilst looking at her in a clearly sexually seductive way, is shocking and needs to remain shocking, however
often it happens, if the underlying communication is to be truly received and heard. These are children who have been sexually abused from the start of life and they display and communicate to the therapeutic staff the scars of their experiences whenever they behave in these alarming ways.

Ordinary parental or adult compassionate touch has become so sexualised that, for many of the children in these units, no physical contact with an adult is possible without being experienced by the child as having a strong sexual component. Ordinary physical care – bathtime, bedtime, comforting – is contaminated in the same way. The difficulties of wisely caring for these children, so that gradually they are able to appreciate that not all adults are sexually predatory and that they can be touched and looked after physically and emotionally in a more ordinary way, are enormous and inevitably have a strong impact on the emotional lives of all who work with them. The way in which the staff group works together to help the children as well as to support and understand each other, weaving an interconnecting network of containment – a kind of ‘mesh’ around the children, will be crucial to the success or failure of the work (Ward and McMahon 1998; Ward et al. 2003).

There is a long tradition of therapeutic child care to which psychoanalytic psychotherapists have contributed through offering consultation and clinical supervision to the staff group (Dockar-Drysdale 1963, 1968, 1990; Menzies Lyth 1985; Reeves 2002, Sprince 2002; Wilson 1991, 1999, 2003). Winnicott consulted to Dockar-Drysdale for many years about her work and her application of his ideas to working with children in residential settings at the Mulberry Bush School and the Cotswold Community (Dockar-Drysdale 1990). However it is important to remember that the widespread nature of sexual abuse has only become recognised over the last 30 years. Those writing before the mid-1980s would only rarely have worked with children and young people who had experienced the kinds of abuse with which child and adolescent psychotherapists and therapeutic child care workers are now in daily contact. The ways in which the specific countertransference experience of staff is processed, individually and within staff groups and organisationally, requires particular attention and is described later. Child psychotherapists’ direct experience of the deeply disturbing nature of the countertransference when there has been severe sexual abuse enables them to be highly alert to the complex and distressing countertransferential feelings and experiences that staff in special units need help with processing.

Whilst this work is a natural progression from the clinical experience of trying to help these children through individual psychotherapy, it must be emphasised that additional supervision or training is essential in order to undertake the kind of consultation described below. The emphasis is on the staff group, not on discussion of the children themselves. This has echoes of our clinical work with the parents of children referred for psychotherapeutic help – particularly when work with the parents becomes the focus.
rather than direct intervention with the child (Bailey 2006). Clinical group supervision and individual supervision, in which children are discussed, may also be led by a child psychotherapist but will take place at another regular time in the staff timetable (Wilson 2003). Wilson describes the essence of this kind of consultation as residing ‘in its capacity to contain (Bion 1961) – to receive feelings and observations, to tolerate uncertainty, to allow for reflection and thought and ultimately to empower staff to move forward in their own way’ (Wilson 1999: 164).

For reasons of confidentiality – always a particularly difficult issue when effectively writing about colleagues – some of what follows is a composite picture which captures some of the key issues whilst disguising the identity of the colleagues involved. Staff working in these units often feel that they are trying to juggle ten fragile balls in the air, with any one of them coming dangerously close to being dropped and smashed at any given time. Catastrophe always feels alarmingly close. Certainly, my experience of consulting to these staff groups has this quality.

**Theoretical tools**

There are some ideas which I find particularly helpful in providing a theoretical framework when thinking about this nerve-racking but fascinating work. Before giving an example of the work in which they are embedded, I will enlarge on these ideas so that the example will hopefully make more sense.

**Making the implicit explicit**

As early as 1959 Menzies Lyth proposed ‘that the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety’. She adds: ‘Analagous hypotheses about the individual have long been widely accepted’ (Menzies Lyth 1959: 78). Menzies Lyth argued that the nature of the anxiety that needs to be contained will be intimately connected to the ‘primary task’ of the organisation. The more the organisation is involved with human relationships and the alleviation of suffering, the greater the level of anxiety that it has to contain and process. For example, working with the staff on a children’s orthopaedic ward, as Menzies Lyth describes in another classic paper ‘The Psychological Welfare of Children Making Long Stays in Hospital’ (1982), will entail containing and processing different anxieties from those encountered when working with a management group in manufacturing industry.

Her thesis is that the anxieties raised by the very nature of the primary task naturally give rise to defences within the individual and within the organisational structure itself. Some of these defences may be essential in order to function – for example, the kind of black humour that can surprisingly be found in the most humane caring environments. However,
social defences in organisations can become counterproductive, destructive and deeply resistant to change, just as they can in individuals. In the individual, this can lead to psychological problems. In organisations, this can lead to working environments which are awful to work in, with high staff turnover, stress-related illness and serious physical illness. As a result, some organisations may collapse, or limp along, unable adequately to carry out their primary task in a creative and flexible way.

In work with severely emotionally disturbed children and young people there is also a considerable risk of staff being physically attacked by those they try to care for, because aggression and violence are the children’s and young people’s established ways of responding to conflict and emotional pain. When staff anxiety is not adequately contained by the organisational structure, a corresponding increase in attacks on staff is one of the distressing outcomes. This anxiety, and the need to attend to the welfare of the staff as well as the welfare of the children, is as fundamental to the consultation process as the need to help parents of children in therapy to survive and grow in the process of being good-enough parents to their children.

Just as in individual work, where there is an underlying principle of trying to bring unconscious anxieties into consciousness so that there is the possibility of facing them, when consulting with a staff group in this way a very helpful axiom is the need to make what is implicitly being expressed by the group explicit, so that difficult feelings and relationships, and disturbing issues, can be shared in the group and in the room during the consultation (Menzies Lyth 2004). This helps to contain the ever-present propensity to action and unthought-through behaviour by even the most experienced of staff when working with such a troubled client group. As Wilson points out:

In the midst of their everyday ordinary exchanges with children they [staff] deal with a wide variety of children’s feelings, many of which are transferred onto them from past experiences. The residence becomes in effect an arena of transference enactment and residential care staff invariably find themselves all too easily perceived inappropriately, for example as depriving, abusive, neglectful or seductive.

(Wilson, 1999: 160)

The impact on staff of the perverse experience

Working with groups of severely sexually abused children and young people presents particularly disturbing anxieties which the staff have to learn to bear with, think about and process. Anxieties about severe sexual perversity and extreme defences against it are always present in the staff and staff dynamics in organisations trying to help recovery from this kind of trauma.

In Totem and Taboo Freud drew attention to the universal abhorrence of sexual abuse and incest and the ways (taboos) in which different societies
try to protect children from perverse adult sexuality (Freud 1912–13). Staff working in these units are not only faced all the time with alarmingly sexualised and inappropriate behaviour in many of the children and young people they work with, but they also know many of the details of, for example, what has happened to a young child who has been incestuously abused by a paedophile ring which included his or her parents. Every sexual taboo and boundary has been repeatedly broken.

This kind of knowledge comes with the child’s referral and arrival in the unit. But it also becomes ‘known’ in the much more powerful form of wordless projections into the staff of the coercion, disgust, horror and terror that the child has experienced. This is particularly likely to happen when sexual abuse has taken place before the child has had a full grasp of language. In addition, many of the children may be disturbingly sexually provocative to staff as a result of their abusive experiences. All forms of communication, particularly nonverbal forms, have to be received, thought about and processed by the individual staff members, as well as by the staff groups. These in turn need to be contained by a well-organised, clear, appropriately managed and structured working environment which provides regular opportunities to talk about and reflect on the impact of the work on the staff.

Some children may become able to make verbal disclosures about the abuse whilst in the unit. But words are woefully inadequate to communicate what needs to be emotionally communicated about their experiences, as adult sexual abuse survivors often testify. And what makes any disclosure authentic is the awful tiny details in what is eventually said, which can only be known from direct experience. Staff members have to be enabled to listen to these terrible communications as openly as possible and are inevitably much affected by them.

In addition, there is now always the anxiety that some member of staff may also be perverse and prey on the youngsters, undetected by colleagues. This is why the preservation of reflective spaces, where staff can think and talk about their experiences with the children, is so vital. However, it is in the very nature of the work that these reflective spaces will be constantly under unconscious and conscious ‘attack’ and risk of being eroded, due to the kind of attrition which is always present when working with such destructive unconscious and conscious processes. Whenever this starts to happen, it is a warning sign that disturbing communications and feelings are not being processed sufficiently and staff members are being left too much on their own to try to manage the day-to-day impact of the work, rather than doing this as a part of the working group.

To complicate matters further, there are also false allegations about staff, as well as physical attacks on staff, made by the children and young people. These must be followed up according to the procedures of the organisation. Often, bewilderingly for the staff involved, a false allegation or vicious physical attack can come from a child to whom they have been particularly
close. Whilst we can understand more about this dynamic through Glasser’s thinking about the ‘core complex’ and Chasseguet-Smirgel’s thinking about the ‘perverse core’, trying to provide sensitive therapeutic care against this backdrop is inevitably fraught with difficulties (Glasser 1979; Chasseguet-Smirgel 1985).

I find Chasseguet-Smirgel’s views on sexual perversion particularly relevant when trying to understand the nature of the anxiety that staff in these organisations are trying to find ways of living with, as sanely as possible. Startlingly, in her paper ‘Perversion and the Universal Law’ she argues that ‘there is a “perverse core” within each one of us that is capable of being activated under certain circumstances’. Her paper offers ‘an insight into what I see as the wider implications of something that, at first sight, is merely a deviation . . . of sexual behaviour’ (Chasseguet-Smirgel 1985: 1).

Whilst her paper is written from the perspective of psychoanalytic work with adult patients, the points that Chasseguet-Smirgel makes about the ways in which all thought, and mental and emotional processes, can become subtly but destructively perverted, eventually leading to a form of chaos in which ‘anything goes’, are a very accurate description of what life can feel like, when times are difficult, in the kinds of unit described below. This type of intense anxiety can directly be related to the experience of working with sexually abused children. Chaos and a primitive kind of lawlessness, in which no boundaries or distinctions between adults and children are sacrosanct, are always close to the surface – in individual psychotherapy as well as in their everyday lives.

These are children who will think nothing of violently attacking an adult for apparently the most minor of reasons, who denigrate adult experience and knowledge, and have no reason to expect adults to protect them rather than exploit them. The ordinary boundaries between adult responsibility and sexuality and child care have all been broken very early in their lives. In some cases, the basic laws of human nature are mocked and turned ‘upside down’, bringing chaos in their wake (for a clinical discussion of these issues see Lanyado 2004: 57-72). This gives an additional dimension to the impact of the abuse on the child: the very structure of his or her mind and experience of life has been distorted alongside the real sexually abusive experiences that have been suffered. Chasseguet-Smirgel in discussing these fundamental laws succinctly writes that ‘The bedrock of reality is created by the difference between the sexes and the difference between generations’ and emphasises that ‘erosion of the double difference between the sexes and the generations is the pervert’s objective’ (Chasseguet-Smirgel 1985: 2). It is a short step from these statements to an understanding of why psychotic group processes, in Bion’s terms, can become predominant in units such as these (Bion 1961). Sanity and reality – knowing ‘which way is up’, rather than succumbing to perverse thought and logic which attacks and destroys all order and rationality – are easily lost, together with the group’s primary task.
All of these anxieties have led to a climate of suspicion (which is in itself at times an extreme social defence against this anxiety), where there can be a managerial and procedural over-zealousness which is deeply traumatising to innocent and dedicated staff. Sometimes the anxiety is contained and processed. At other times, it is on the rampage in the psychotic manner that Bion (1961) describes, making units such as these feel at times very mad places in which to work. There is a frequently expressed anxiety that everything is about to collapse in the manner of the ‘nameless dread’ that Bion so evocatively portrays. Bion’s insights about the psychotic ways in which groups can function have been developed by Menzies Lyth who particularly emphasised this dynamic in an interview she gave towards the end of her life:

The paper [‘The Functioning of Social Systems’] is so shocking that people find it hard to take in. I’m sure it’s the same with Bion. The idea that people go about being psychotic all the time is a very dreadful thought that ordinary people can’t live with. I mean, even people in the trade can’t always live with it . . . What we now appreciate more is that it doesn’t matter what institution you go into, it’s going to have psychotic defences. Some are better than others.

(PECOTIC 2002)

Working with the staff group

These processes are illustrated in the following example. I had regularly consulted to the small senior staff group (five educational and therapeutic child care staff), of a well-respected residential unit for children aged six to eleven, for a number of years at the time of this consultation. On the previous day the unit had received an unexpected but important visitor. Unfortunately, for a number of reasons both practical and because of ongoing issues in the unit, the staff had not been up to par and this had contributed to the children acting badly in front of the visitor. They had been verbally abusive and physically aggressive to each other and to the staff on duty.

Three of the senior staff (Helen, Dean and Michael) felt that the visitor had experienced a chaotic and highly oppositional children’s group and a staff group who had barely been in control of the situation. They knew that whilst there were some mitigating circumstances for the chaos, the unexpected visit and the children’s response had revealed the extent to which anxieties were generally not being adequately contained in the unit. Although they had been aware of this to a fair degree prior to the visit, they had not been able to see the severity of the problem until this time.

The sense of ‘trying to juggle ten balls’ is intense in these units. There can be times when there are not enough referrals and financial pressures necessitate not replacing staff if they leave – only to be followed by new
referrals for which there are then not enough experienced staff, at first, on
the unit. There can be an unfortunate time lag during which there are
serious concerns about understaffing, and overworked staff who can barely
manage to contain the children and young people in their care. New
children coming to the unit bring a burst of new anxiety and disturbance to
whatever precarious emotional balance prevails. New staff, however well
experienced, need a period of induction and have to cope with all the
anxieties of being a newcomer to the organisational system.

All of these issues have to be thought about alongside the day-to-day
therapeutic care of a number of severely disturbed children or young people
who can ‘blow’ violently and self-destructively at any time because of the
pain and distress they cannot manage in their internal worlds – and it is this
which remains the staff’s primary task. This had been the situation for this
senior staff group prior to the unexpected visitor.

Somewhat unusually for this well-established senior staff group, they
started by allocating blame for what had happened the day before to the
junior staff who had been on duty at the time. By doing this, the senior staff
were disowning and splitting off their sense of responsibility and feelings of
failure by projecting them outside the room, on to another group of people
– the junior staff. The fact that the senior staff were actually responsible for
managing, supporting and containing the anxiety of this junior staff group
did not enter into their thinking at this point as they were unable to face the
painful reality of their own responsibility.

On an inter-group dynamic level, the senior staff were now operating as
a basic assumption fight/flight group in which blame was allocated to
another group who had to be ‘taken on’ and ‘sorted out’, in other words
‘fought with’ (Bion 1961). The senior staff expressed frustration at more
junior staff for not internalising all that they, the senior staff, were trying
to pass on to them regarding boundaries and containment in the day-to-
day care of the young people. To me, this sounded like parents who were
at their wits’ end over trying to get their offspring to take some respon-
sibility. It was a very clear projection of the senior management team’s
inability to take responsibility for getting something wrong in their com-
munication with the junior staff. As I was more used to the senior staff
group being prepared to accept responsibility, I was rather surprised by the
strength of this projection which I suspected was a defence against some
unusually severe anxiety.

In their account of what had happened, I also noted a brief reference to
what sounded like a disagreement between two of the people in the room
over what they, as senior staff on duty at the time, had decided to do to try
to contain the situation. They seemed to be trying to avoid dealing with this
conflict by putting it outside the room as an inter-group conflict, between
the senior and the more junior staff. I pointed out to them that it was easy
to blame the more junior staff for not taking responsibility or containing
anxieties adequately, but this also applied to this senior staff group, who
were responsible for trying to contain their juniors’ anxiety. By saying this I was reminding the senior staff of something we often talked about – the value of the many layers of containment, ‘Russian doll-like’, that contributed to the overall structure and well-being of the unit.

I added that there was also a problem here in the room and that I thought Helen was still feeling angry with Dean about a particular decision they had taken yesterday to try to contain the escalating situation. She agreed that she was angry with him – and that she was also angry with herself for not insisting more that the way she had wanted to deal with the escalating situation was indeed the better way. She felt she had avoided conflict at the time – and indeed might have continued to do this in the group if I hadn’t made my comment.

Helen went into some detail about why she thought they had made the wrong decision and how this had not contained the junior staff in a difficult situation. She felt that this has resulted in the junior staff not feeling safe and that this in turn had intensified rather than contained the children’s anxieties which were at the root of the behaviour. Dean could listen to this a bit, but the recognition of the conflict between him and Helen was still hard to keep in the room. They both returned to projecting the conflict outside the room, thus creating a potentially unhelpful inter-group dynamic in their minds between themselves, in the room, and the more junior members of staff, outside the room, who were felt to have let the unit down. Helen also knew that Dean was going through a hard time personally and this added to her difficulty in addressing her anger. Underlying this was their profound sense of having let down the children, the junior staff, the unit – and indeed themselves.

One of the other members of the consultation group, John, who had not been present the day before, tried to help Helen and Dean to think a bit about why the senior staff group as a whole was having such difficulty helping the junior staff to internalise the importance of certain basic patterns of care of the young people. Through this, we got a bit closer again to thinking about why the senior group were having such difficulty motivating and containing the junior staff. Something unthinkable was approached again but the ‘blame’ was still largely put on the junior staff. However, this time Dean commented that another member of staff, Sue, who had also been at the unit the day before, had been unusually quiet in the consultation so far. What did she think about what had happened?

Sue said she was just ‘gutted’ by what had happened. She had gone home feeling awful. Dean now admitted, so had he. Sue felt that the visitor had seen what they as a senior staff had been unable to see, some poor practice that they should all have picked up much sooner. She keenly felt her responsibility in needing to change this, and in having been party to it creeping up on them as a team. This sounded heartfelt. To myself, I noted that the group’s sense of responsibility was re-entering the room, albeit at this stage located mostly within Sue who was expressing the more
depressive and reparative feelings, which Helen, Dean and Michael were still finding it too unbearable to stay in touch with more than briefly.

However, Sue’s comments were followed by a further refrain from Helen and Dean about how the junior staff were not doing their job properly. All this talk of people outside the room not doing their work properly alerted me to the fact that we, inside the room, were also not doing our work properly. So I said that I felt that the senior staff wanted to shift responsibility to outside this room when it seemed that, right now, all of us in the room (including me) were not doing our job properly. This was an attempt to bring the group back to its primary task – the difficult reality of caring for the children and facilitating the work of the junior staff. The senior staff seemed to be struggling with knowing how to motivate their staff sufficiently and, above all, how to contain the junior staff’s anxieties. The role of the consultant to help the group stay ‘on task’ and not be pulled off task by unconscious group dynamics which take over when anxiety is high, leading to basic assumption group dynamics, is well illustrated by this section of the consultation.

The response to my comment was a further apparently defensive response from Michael, Helen and Tim protesting about their genuine and serious concerns about a junior staff member’s increasingly unwise behaviour with the children. He didn’t seem to understand how to hold appropriate boundaries between his professional life and his personal life in his communications with the young people. There was an uncomfortable sexual element to what was either a genuine naivety in the mistakes he was making, or a real unhealthy blurring or even breaking of acceptable boundaries.

It had now become apparent to me that it was this intensified fear of a perverse sexuality being expressed in the unit which was currently particularly disturbing the staff, and which accounted for their unusual defensiveness. The previous ability of the staff group and organisation to contain and work with this ever-present anxiety had been severely challenged by the arrival at the unit of a child who had been abused by a paedophile ring, as well as by a very distressing disclosure of past sadistic sexual abuse by a child who had been in the unit for some time. I commented that I felt that the loosening of boundaries, which seemed to be moving in a potentially sexually perverse direction, painted a picture of the potential for anarchy, complete disintegration and chaos in the unit that the senior staff were finding it intolerable to recognise and try to bear thinking about.

This horrible and frightening feeling was now very alive in the room for all of us. It seemed that we as a group needed genuinely to know about and experience the terror of feeling that an apparently stable structure was descending into chaos and sexual perversity. This was what had been projected into the junior staff the previous day by the young people who felt uncontained and frightened at the best of times. The junior staff, rather than experiencing the supportive and thoughtful containment of the senior
staff, had felt the same terror and lack of containment and it was this that had led to the serious acting out of the children. The senior staff had let down the junior staff. Now that the fear of chaos and sexual perversity was so alive in the room, we could start to do the work that was needed to process and contain this anxiety.

This experience in the room was deeply sobering for all of us, but the recognition of this psychic reality enabled senior staff to own responsibility for what had happened and attempt to repair the damage that they felt had occurred because of their difficulty in being sufficiently in touch with the anxiety that their junior staff were feeling. These reparative feelings, which had only resided in Sue, were now very alive in each of the senior staff in the consultation – as well as within a much more helpful working group dynamic. They seemed to rally and find some determination to do better. They knew that they actually had the skills to contain powerful anxieties in the organisation. They now recognised that they had ‘been there’ before, but they had ‘lost it’ for a while, and needed to reconnect to their more competent and containing abilities again.

After the consultation, this was in fact what happened and the senior staff, motivating and supporting the junior staff, worked very hard to regain the organisation’s balance – which they managed to do for a while – until the next eruption of severe anxiety, which knocked them off course again and required further painful working through of the kind that this example illustrates. This is an inevitable part of the ebb and flow of the emotional life of such units. This very demanding work will always feel as if one of the ‘ten balls in the air’ is about to fall disastrously.

Further thoughts

What can we learn from this ‘snapshot’ in the midst of a lengthy consultation ‘movie’? I hope that the emphasis on bringing what is being expressed ‘outside the room’ into the room is clear, as is the need determinedly to keep on making what is implicit explicit. It is well known that the difficulty of containing a ‘nameless dread’ of a chaotic and crazy nature is very alive in any large group dynamic. Large group and inter-group communications can rapidly become quite mad – and this is with comparatively ‘sane’ adults making up the group. When the group is made up of deeply disturbed and sexually traumatised children and young people and those trying to help them to recover, this frightening dynamic will always be very close to the surface.

Organisations naturally grow their own structures and defences, each in their own rather idiosyncratic way, to try pragmatically to find the best possible ways of living and working with this kind of anxiety. In therapeutic units, these are anxieties that, by the very nature of the work, never go away and, if anything, are reintroduced each time a new child comes into the organisation. This is why it is so important that organisations such as
these have external consultants – who are sometimes child and adolescent psychotherapists – to help the staff keep on doing the work.

It can also be seen that part of the consultant’s role is to help the staff group keep to their primary task, so that wise reflective thinking about the children’s feelings and their impact on the staff can take place. The consultant helps the staff group to recognise when they are caught in primitive basic assumption group thinking and behaviour where external and psychic reality can be lost sight of, and thus the primary task of the group is not being attended to. In the example, the staff group found it very difficult to face the reality of their own failure to protect and contain the junior staff’s and thus the children’s anxieties, and resorted to a fight-flight group dynamic. They also found it very difficult to face the fact that one staff member was possibly behaving in a sexually inappropriate way with the children.

Whilst the staff were unable to face these realities, they were unable to carry out their primary task of helping and protecting the children. Helping the senior staff to face this reality enabled them to talk to the junior member of staff in a thoughtful way – and realise that being rather new to the work he was simply being naive and needed more careful supervision. They were also able to think creatively about how better to contain the anxieties of the more junior staff, and realised that there had been a lot of slippage in the supervisory structure – the senior staff’s responsibility – which needed to be rectified. They had recently had many balls in the air. It was the reflective spaces of the organisation that had borne the brunt of this.

The most difficult task in the face of the ever-present fear of psychotic madness, chaos and disintegration in this work is to try to stay sane and not get caught in the undertow of the destructive currents. The external consultant is less prone to this undertow – although far from immune – and continually tries to maintain this saner and more realistic view through the comments she makes to the staff. This enables them to find their way back to the primary task when they have gone off course.

A particularly thorny problem is how much the known personal lives of people in the group should become part of the more public workgroup process. In a group that works closely together – particularly if they have worked together over many years – much is known by one group member about another; but how appropriate or indeed essential is it to bring this into the working group process itself? This is a very difficult question and the balance between what is worked with in the group and what is worked with in more private spaces within the organisation varies enormously according to the philosophy of the organisation as well as the view of the consultant.

Wilson stresses: ‘It is of key importance that child psychotherapists are clear in their own minds that they are neither managers nor psychotherapists in this context’ (Wilson 1999: 165). Too much of an emphasis on
how personal issues and inter-staff relationships impinge on the organisation’s work can at times take the group far away from their primary task in a way that is ‘anti-task’. Too little attention can be rather like behaving as if there is not ‘an elephant in the room’. As with the use of interpretation in individual psychotherapy, the uniqueness of the therapeutic dyad, in this instance staff group and consultant, will dictate how much or how little is interpreted, and how. (For a useful discussion of this issue see Maltby 2008.)

For those who wish to do this kind of work, there is expertise available and individual supervision can be a valuable first step in developing appropriate new skills. Another option is to set up small ‘workshops’ where consultation work can be frankly and confidentially discussed, preferably with a more experienced group leader facilitating the discussion. It can be very alarming and disturbing to become aware of the madness that can lurk within the undercurrents of any organisation, particularly of the kind described above. We are all vulnerable in the midst of this if we do not have the opportunity to share these anxieties, thoughts and experiences with colleagues.

References


Tensions in the role of a clinician-manager

Gethsimani Vastardis

There is also a lot of courage involved; you’ve got to be able to do things which, on the face of it, may seem unpopular, upset people... You are not kind all the time, as a good manager.

(Menzies Lyth, interviewed in Pecotic 2008)

Introduction

There has been a continuing interest in using psychoanalytic thinking when considering the complexity of organisations, the dynamics within them and the ensuing stresses on groups and individuals, who are part of them. This interest has provided us with a helpful understanding of how institutions work, and the defences they mobilise to assuage anxieties arising within them. These include such well-known defence mechanisms as denial, resistance, splitting and projecting (Jaques 1955; Hinshelwood 1987, 1994; Menzies Lyth 1988; Halton 1995; Obholzer and Zagier Roberts 1995). The tendency to use such defences becomes more pronounced when the institution feels challenged and threatened (for example, by the freezing or cutting of posts). This is the experience, at the moment, of many mental health institutions, including community CAMH services. Understanding the unconscious workings of institutions can help us to cope better with life in our own institution and avoid succumbing to competing and irreconcilable tensions within it. Hopefully this will enable us to survive and enjoy our work without too much cost to the soul.

This chapter discusses the significant contribution made by the various elements of the child and adolescent psychotherapy training to our practice as child psychotherapists in community CAMH services, focusing on the role of the professional lead-manager and her responsibilities as a member of the service senior management team.

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Management, the multidisciplinary team and our patients

I hope to illustrate how our psychoanalytic background and experience of minute observation can provide us with frameworks which are indispensable to managing complicated and at times painful experiences. Such experiences occur because of severe and intense pressures. These can be simplistically organised around the pressure of meeting the expectations of management and of the agencies we liaise closely with, as well as recognising – and hopefully meeting – the needs of our patients. At the same time our interest in human contact compels us to be aware of the needs of our colleagues, both as individuals and as members of the multidisciplinary team. These pressures can be – or can certainly be experienced as – conflicting, and are inevitably compounded by inter-agency and interdisciplinary rivalries and tensions.

The child psychotherapist who occupies the roles of both clinician and manager is faced with the challenge of finding a way to inhabit both the child psychotherapy world and the world of her clinic senior management team. The former focuses primarily on the internal, psychic reality, and it is the place we feel more ‘at home’; the latter concentrates on the reality of the external world. Positioned at the interface of these worlds, she has to find the means to remain in touch with issues which the attachment to her emotional identity generates, without neglecting or overlooking the appropriate concerns that she should hold as a member of the senior management team (membership of which can cultivate and foster something like a ‘corporate’ identity). This is, however, more of an aspiration, as holding this tension in check successfully is not a task to be accomplished, but rather a continuous struggle. The reality is continuous harassment by opposing forces, which cannot easily be avoided or reconciled. The alternative would be to derive comfort from the erroneous safety of retreating to a tribal identity or capitulating to the Realpolitik of a corporate identity.

External and internal realities

Defining what is external and what is internal in such a setting proves much more complicated than in the consulting room. A preliminary, simplistic reading suggests that the external world is manifested through the excess of government papers cascading through the trust board, the chief executive and the medical director to the community CAMHS directors, managers of locality teams, professional leads, discipline heads, and individual clinicians. I could add to this list new initiatives such as New Ways of Working (NWW), Choice and Partnership Approach (CAPA) and never-ending demands for various focused trainings on child protection, risk assessment, Care Programme Approach (CPA), Common Assessment Framework (CAF), EPEX or RIO (systems of electronic data entering), Strengths and Difficulties Questionnaires (SDQs) and Children’s Global Assessment Scale (C-GAS) scoring, CAMHS Outcomes Research Consortium (CORC) data – and so on.
These initiatives and the requirements to score and evaluate outcomes have become part of the current climate in mental health teams. The onus is increasingly falling on us to prove to commissioners our beneficial work and to justify our right to employment. It is, therefore, becoming an essential aspect of our work to return, for example, satisfactory activity data and users’ service experience questionnaires. This task cannot be avoided if we want our profession to remain a vital presence in community CAMHS. It needs, however, to be infused with meaning and properly owned by all its members. Otherwise there is the danger that the above activities might be automatically equated with ‘good practice’ and the activity of measurement with success. The preoccupation with measurement and outcomes, unless meaningfully undertaken, might serve for the team the function of a retreat from overwhelming feelings; it may cloud the team’s vision and deflect it from its main task.

Illustration

The morale in a community CAMHS is low, the relationships between staff members brittle, the leadership weak, absent, indifferent or self-promoting. The waiting list is almost a year long for a first appointment! The suggestion was made by a member of the senior management team for SDQs to be sent both to the parents and the school with the letter advising the parents that the name of their child had gone on to the waiting list.

- Would these SDQs still be reflecting the child’s behaviour 6–12 months later?
- Might they have generated an expectation for a forthcoming appointment?
- Was the attention to the SDQs serving any useful function at this point in the referral process?

These were some of the concerns expressed in the senior management meeting. The reservations were overruled. Sending the SDQs, in other words ‘doing’ something about a child – and a parent – who would not be seen for months on end, served the purpose of alleviating some of the team’s anxiety and depression about their long waiting list. Attending to the SDQs was far easier than attending to the problematic leadership situation, the fragile team dynamics, the low morale and the need for external consultation.

The more society around us fragments (as reflected in the increasing number of referrals of families suffering from privation, deprivation, dislocation and multi-traumas), the more it seems there is a tendency to create
new systems and protocols – e.g. obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD)/attention deficit disorder (ADD) protocols – accompanied by new acronyms and new trainings. The latter are often half-day mandatory training events and, given the number of clinicians involved, are organised at a great expense to the trusts. Such training is often taught at a rather unsophisticated level with little regard, if any, to the nuances that the complicated lives and suffering of our patients deserve.

As for the systems and their acronyms, they seem to assume a totemic value. It is as if by magic the new ‘system’ of managing the waiting list or of allocating new cases or of structuring team meetings is cathected with the belief that it will bring the much longed for relief from anxiety. (Incidentally, I have wondered whether these acronyms serve also the purpose of creating some cohesion and solidarity in the team, as the team members gather around their cryptic language as if around a camp fire on a stormy night.)

Furthermore, there is an ever-increasing pressure on the team’s resources from referring agencies in the form of expanding numbers of referrals, requests for court reports, consultations and urgent assessments – some more appropriate than others. The list goes on.

When I think of the internal world, I am thinking of the conscious and unconscious internal reality of ourselves, our patients and our colleagues, both as individual clinicians and as members of the multidisciplinary team. However, this distinction, noted above, is too neat, because the shift between external and internal can be very swift, as one’s role alters depending on the setting – clinical governance group, business management group, child psychotherapy team, child psychotherapy workshop, team business meeting, team clinical discussion. So, the internal can be one’s agency, locality, team, discipline, training or theoretical orientation. This then defines the ‘external’ as the ‘other’ (agency, team, discipline and management). It is easy to imagine, therefore, how different settings demand a different approach or state of mind as to what constitutes the internal and what the external. I am reminded here of Alan Shuttleworth’s concept of dual citizenship introduced in his influential paper ‘Finding New Pathways in the Changing World of District Child Psychotherapy’ (Shuttleworth 1999). In this paper he invites child psychotherapists to accept the need to live on the borders of the worlds of psychoanalysis and district CAMHS. I would suggest that over and above the need for dual citizenship – or something more akin to European citizenship – we need to be using Philip Pullman’s (2001) ‘subtle knife’ to ‘cut’ windows and enter seamlessly the different settings and mindsets, as I describe above.

Role assignments in groups

Almost 40 years after the appearance of her seminal paper ‘The Functioning of Social Systems as a Defence Against Anxiety,’ Isabel Menzies
Lyth, in an interview given to Branca Pecotic (2008), paid tribute to Bion and his work with groups. She talked in a lively way about ‘role assignment in groups: how a group will unconsciously appoint somebody to do some job they want doing’.

It seems that child psychotherapists fit very well – sometimes too well – the caring and mothering role unconsciously allocated to them by management and their team. However, there is a danger lurking in this flattering assignment. We could risk seeing ourselves – and more importantly and dangerously, in these difficult times, risk being seen by others – as standing above the fray, unconcerned about the reality of financial difficulties, waiting lists and waiting time targets, performance indicators and outcomes. It is as if these concerns, and concerns about quality of care, cannot be held within one role. Unless very alert and vigilant, we might collude with this malignant ‘division of labour’ and the respective assignments. This further contributes to the divide and can generate a perilous chasm.

However, the divide we should aspire to span shifts continuously. Positioned at the interface between an external, political world and an internal, psychological and emotional one, we experience the intense tension that can be generated by the conflicting needs of our patient population, our multi-disciplinary team and of our management. Getting and staying in touch with this tension, without premature resort to an easy solution (which may not exist anyway), can be a very uncomfortable position. It can also feel an impossible and unenviable task – especially for the clinician-manager whose task is to communicate this underlying tension and its source to colleagues and managers. She should be prepared to communicate unsavoury truths to them and even be unpopular. She must be able to accept that sharing her insights will create discomfort for her managers and her team. She is, in fact, ‘paid to be a nuisance’.

Being able and willing to recognise these tensions and accepting, tolerating and working through them is the only way for a team to tackle the many tasks at hand and make meaningful contributions to the life of its patients and its own. For example, it can feel a very consolidating moment for a team to come to the realisation that it is not only the job of the team manager or the team leader to keep in mind the 13 weeks waiting target. Nor should it fall only on a child psychotherapist to be an advocate for our patients and their families and a guardian of good practice. They can both care about both.

Management as a containing function?

It seems to me that in a well-functioning service the management should perform the function of a containing parental figure working alongside the multidisciplinary team, looking after their needs (both personal and professional) and supporting them in their task of looking after their patients. In this basically Winnicottian model, each element is in touch with the
other. The manager, therefore, would need to be knowledgeable about the clinician’s task, to have an authentic insight into the complexities of the team’s work, if his or her management is to be efficient, effective and supportive. And yet, given this requirement, how many managers spend some of their time attending a referral or a team meeting?

**Illustration**

At a senior management team meeting at a community CAMHS the atmosphere is tense and anxious as once more the financial situation is grim and there has been talk about the need to make substantial savings. There is discussion about the number of referrals in the last quarter, the clinicians’ ‘activity’, the number of DNAs (did not attend), the number of cases on the waiting list and waiting times. Members of the team feel tired and demoralised that – despite their hard work – they cannot cope with the continuing clinical and administrative demands on their time. There are some questions from their manager regarding the high percentage of DNAs and low ‘throughput’. A discussion unfolds which draws some attention to the fact that this team’s catchment area has several pockets of great deprivation. The referred families, suffering from complex social and psychological problems, find it very hard to make their way to the clinic. Once engaged, they are likely to need help for a long time. One of the team members suggested that it might help their manager to gain some insight into the complexities of their task if he heard the story of some of their families. He could attend a referral meeting perhaps, or a clinical discussion at a team meeting? This idea was heard and politely sidestepped, not only by the manager but by the other clinicians too. Eventually people returned to thinking how best to enter the team’s activities, so their work is represented in the most favourable light.

This example cannot be a lonely exception. In health care systems managers keep their distance from both the clinicians and the patients. In fact, they are only in touch with patients if they need to investigate a complaint. (This has the flavour of the single mother – either literally or psychologically – who contacts the distant father to chastise the misbehaving, upset or unhappy child.) Thus management remains out of touch with the clinicians’ task and its difficulties and with the suffering of the families. (I am sure readers of this book will also recognise that sadly there is often no solid agreement, not even amongst clinicians, as to what the primary task of the multidisciplinary team is.)

What is fascinating in the example above is that it was not only the manager who avoided the possibility of contact with the patients; it seemed
to suit the clinicians too. It’s as if there was a tacit agreement that patients are only the clinicians’ territory and concerns about finance and performance belong only to the manager. It seems that some equilibrium would be threatened should the manager begin to have some first-hand experience of what a referral might sound like, or how clinicians think about their patients and their families’ stories. His lack of curiosity about the work was clearly needed to justify a sharp divide between caring clinicians and a cold manager, who is only interested in finance and performance.

As Obholzer points out, surely speaking to the experience of the majority of, if not all, clinicians, ‘the structure thus enables managers psychologically to turn a blind eye to the consequences of their actions’ (Obholzer and Zagier Roberts 1995). Some consequences are that clinicians might feel pushed into paying inadequate attention to the suffering of the families, their need for long-term work, or their need to attach to one worker (rather than being seen by a series of well-meaning but very short-term trainees). There is no doubt that some of our families can benefit from a short intervention, some even from a single therapeutic consultation. There are some, however, who have a rightful entitlement to much more space, both in terms of actual clinician’s time and also space in the therapist’s mind, for the development of a therapeutic relationship. It is essential that they take their time to tell their story, to experience being listened to, to have their loneliness alleviated, to experience the therapist’s concern, and to develop the ‘concern for the other’ themselves.

I will now discuss in some detail how the theoretical knowledge and clinical skills acquired through child psychotherapy training provide us with the necessary tools to manage this discomfort and help us think of creative solutions. I hope to demonstrate how these tools, honed in the consulting room, can stand us in good stead in the committee and staff room too.

‘Mani, you didn’t have your analysis just for you . . . but for your team too’

This comment was made to me by a consultant child psychiatrist following my chairing a very difficult team meeting. A guiding principle, which I have found helpful at times like this, is Hinshelwood’s (1987) warning that ‘we do not have a brief to be psychotherapists for our institutions’. I would add that we could think of our relationship with members of our team or our team as a whole in a similar way to the way we think of our relationship with a patient, but we do not treat it as such. (This is analogous to experiencing the transference in a session but choosing to keep it in mind rather than speak to it there and then.) We need to remember that we have neither the ‘forum’ nor the ‘licence’ for interpretative interventions (Hinshelwood 1994).

This attitude of mind can be particularly helpful at times like the present, when health care teams are bombarded by a range of demands on the one
hand and threats and uncertainties on the other. Halton (1995) reminds us that ‘whenever survival or self-esteem is threatened, there is a tendency to return to a more paranoid-schizoid way of functioning’. I hope that the following two examples illustrate how understanding the anxieties behind our colleagues’ defensive behaviour, which could easily have been experienced as attacking, can be helpful in protecting our relationship with them. This insight can only enhance the possibility of creative partnerships in the service of our patients’ best interests.

Example 1

S, a mixed race five-year-old girl and her mother, who is white British, had been attending an inner London CAMHS for some time. The challenging behaviour of S, coupled with her mother’s fragility and inadequate parenting, led the local social care team to implement a sudden removal of S to a specialist foster mother (Black British) about 50 miles away from London. S had never known her father, who was reported as Black British. It had been deemed important to the fostering and adoption team that S should begin to know something about her black identity. S’s therapist tried very hard to convince the social worker that S should have at least a few opportunities to understand what had happened and say ‘goodbye’ to her therapist. The social worker agreed that a certain number of sessions could take place on the same day and time as before. The mother’s therapist would also continue to see S’s mother to support her through this very turbulent time. Understandably, S was very upset and angry when she met her mother at the waiting room of the clinic – a very healthy response to this sudden separation. The social worker, however, suggested that the time of S’s session be changed, so S would not see her mother and be spared the upset. S’s tears put her social worker in touch with the upset her sudden removal from her mother had caused. It was very helpful and beneficial to recognise that the social worker’s suggestion sprang out of her unconscious guilt for this, and her own inability to tolerate S’s tears, which forced her to face the consequences of her precipitous action, which she would wish to deny. Furthermore, the child psychotherapist knew that there was an imminent review and possible reconfiguration in the social care system, which had created a lot of uncertainty. The fear of some looming dislocation had contributed to the social worker’s need to deny any feelings in her young client linked with dislocation. The child psychotherapist had a discussion with the social worker with the background thoughts in her mind. The discussion – with no explicit reference to the social worker’s situation – helped the social worker to modify her
response to S’s appropriate upset and unhappiness and agreed to respect the agreed time for the session, which would mean further contact with her mother.

**Example 2**

Mr and Mrs C and their two young children had fled persecution from a Middle East country. They were ‘brought’ to the clinic by their bright six-year-old son, A, who had started refusing to eat. He seemed to have found a very powerful way to claim his parents’ attention. He had been complaining that his parents devoted more time to his younger sister, B. B had tragically been left brain damaged following jaundice at birth, which was not treated appropriately in their country of origin. Mr and Mrs C were very depressed and emotionally unavailable, themselves dislocated and traumatised and ‘anorexic’ to life.

My colleague, X, and I were deeply immersed in listening to the story of this family. In this session the parents related the political assassination of the paternal uncle and talked about their little girl. The two clinicians had welcomed her presence in the session and there was a very moving and contemplative atmosphere, pregnant with sadness and longing for contact with their family of origin which had been left behind. However, this felt intolerable to X, who cut across this atmosphere with the question, ‘Are you on benefits?’ I felt this missile of a question was a further attack on this family’s continuity of being (Winnicott 1965) as their tragic story was cut short and was not given the time and space it warranted. In particular, the family needed the clinicians to witness their distress, to experience it and absorb some of its toxicity. It would be very easy to remain indignant with what felt like marked insensitivity on X’s part. It helped me to remind myself that this particular colleague took a lot of pride in his efficiency and helpfulness which was, of course, not much use in this grief stricken session. In fact, he had overidentified with our patients as victims, had become overwhelmed by their pain and despair and failed to manage the therapist–patient/client boundary. Furthermore, his image of himself as an effective professional was attacked by the impotence he felt when confronted by such a tragic story. The ‘offer’ of social security benefits was all he could summon to feel he was not totally impotent, that he could have a beneficial impact on this refugee family.

**The importance of timing**

Readers of this chapter will be well aware of the importance we have learned to attribute to timing and our interest in it. We always wonder
about the ‘why now?’ of a referral, for example, and we closely monitor the timing of therapeutic interventions and interpretations. Our close attention to an exact write-up of a session or a parent–infant observation is further testimony to our respect for sequence and rhythm as indispensable tools to gaining insights and understanding. Ancient Greek thinking had enormous respect for the concept of *kairos*, which stands for the propitious moment, the power of the moment seized. Detienne and Vernant quote Aristotle saying:

> In the art of navigation there can be no general knowledge applicable to every particular case, no certain knowledge of all the winds that furrow the waters of the sea. . . The excellence of a navigator cannot be measured by the scope of his knowledge but rather by his ability to foresee and uncover in advance the traps the sea sets for him which are at the same time the opportunities it offers to his intelligence as a pilot. (Detienne and Vernant 1978: 224)

It seems to me that there is a strong parallel between us and the pilot who, faced with unpredictable elements, needs to seize the auspicious moment to put his art of navigation into most effective use. Our child psychotherapy training equips us to navigate the rough seas of the suffering of our patients and weather the storms of working in mental health services. We need exquisite timing and judgement to exploit the force of waves and winds to our advantage, rather than being overcome by them. Plato remarks that no sailor can ‘know the secret of the wrath or benevolence of the wind’, so we must remain constantly vigilant and ‘spy out the fleeting opportunity to reverse the balance of forces’ (Detienne and Vernant 1978: 225).

**Conclusion**

I hope this chapter goes some way to demonstrate the invaluable contribution of the child psychotherapy training to thinking our way through the stormy political and clinical agendas of community CAMHS. We need to stay aware and alert if we are not to be pushed into accepting any unrealistic tasks that our team has been ‘tasked’ to tackle. The two main suggestions of this chapter are:

1. Like the mythical Antaios, who took his strength from touching Gaia, the ground, we use the principles of our training and clinical practice as the solid foundation from which we draw our strength to carry out the various duties and responsibilities which our position requires of us.

2. We stay connected with our emotional identity as child psychotherapists without forgetting the responsibilities that our ‘dual citizenship’ entails. Excessive commitment to one group, at the expense of the other, will compromise our ability to fulfil the entirety of our role. The number of
weeks patients wait on a waiting list is not just the manager’s concern, nor is the importance of being able to offer open-ended psychoanalytic psychotherapy to the deserving children and their parents and families only the child psychotherapists’ concern. Both national waiting time targets and the needs of our patients must be opened up for ownership by both managers and clinicians. As Hinshelwood (1987) put it, ‘an idealised [my emphasis] form of human contact can be preserved by splitting it off into suitable containing objects’. Child psychotherapists offer themselves as suitable targets for these projections. It is, however, very important to resist this idealisation, as denigration is bound to follow. This resolution also helps our senior management team members to remain connected with their own humanity.

References


Beyond consultation
Towards YoungMinds

Peter Wilson

Beyond consultation

With a training in psychoanalysis and a belief in psychological change through self-understanding, child psychotherapists engage in a variety of clinical activities focusing largely on the internal world of children and their families. Sooner or later, they are invited to provide consultation to other professionals in the field of child mental health. The main purpose is to help staff understand better the meaning of children’s behaviour and to enable them to make sense of the impact of children’s disturbance on their relationships with children and with each other.

During the early part of my career I was very much taken up with activities such as these. Following my training at the Hampstead Child Therapy Course and Clinic (now the Anna Freud Centre), I worked in several child guidance clinics and adolescent psychotherapy centres in London. I was involved in a great deal of assessment and therapeutic work with individual children, adolescents and their families. Increasingly, I was asked to consult to groups of professional workers, such as teachers and nursery school staff, educational welfare officers and child psychiatry registrars and senior registrars. I also served as a consultant for many years to the staff in a pioneering therapeutic community for disturbed adolescents. Much of my work focused on issues of transference and counter-transference, enabling staff to find ways of relating to the adolescents that were neither collusive nor punitive (Wilson 2003b).

However, as much as I clearly valued the importance of the internal world, I also found myself becoming increasingly disturbed by the external constraints that beset so many of the children and families I was seeing and that frustrated the efforts of so many professionals who were trying to help them. These children were suffering far too much the effects of disturbances in families who were unable to function as well as they might wish – some because of poverty, others because of lack of employment, others because of financial pressures or untreated mental health problems that compromised the time and attention they could give to their children. In addition, the professionals who consulted me were in many respects
overwhelmed by the circumstances in which they were working, over and above the therapeutic demands they were facing. The financial resources available to enable professionals to meet the needs of children and families in need were inadequate. Mental health services for children had traditionally fared much worse than mental health services for adults – and mental health services in general were underfunded compared with other services. Children’s services in social services departments struggled to cope with increasing pressures, particularly in child protection work. Voluntary organisations, particularly the smaller local ones, were constantly in a state of uncertainty in financing their operations.

With these preoccupations in mind, I began to think that I needed to extend my work beyond the customary realm of clinical and consultative work and move on to a more political level of activity, essentially to ‘do something’ about the unfavourable circumstances in which children, families and professionals alike lived. I also felt strongly that, whatever that political activity might be, it should be led not by conventional politicians or managers or policymakers but by clinicians – and preferably by clinicians with psychoanalytic knowledge.

**Child Guidance Trust**

The concerns I had at that time were not of course new. The plight of children’s welfare generally in society was something that exercised the minds of many in education, health and social services and there were a number of major voluntary organisations campaigning for change. However, only one focused specifically on child and adolescent mental health; this was the Child Guidance Trust with which I became increasingly associated. It comprised child psychiatrists, educational psychologists, child psychotherapists and psychiatric social workers who worked in child guidance clinics across the country. It had its roots in the 1920s when the first child guidance clinics were set up in London and Glasgow. The early pioneers recognised the multifaceted nature of children’s emotional and psychological difficulties and accordingly the value of multidisciplinary collaboration.

The principles of practice that they promoted laid the foundation for the development of the child guidance movement which flourished in this country in the 1950s and 1960s. However, by the late 1970s it had lost momentum. To some extent, child guidance clinics lacked a sense of accountability to the communities they served; many became blinkered in their practice and were accused of being ivory towered in their thinking. There were indeed some choice specimens of complacency and arrogance in the field at that time but they were a minority. The real problem as I saw it was that the majority of child guidance clinics were hopelessly under-resourced, operating well below optimum size. There was no coherent internal management structure. Each profession in the multidisciplinary
team was answerable to separate authorities outside the clinics. Major changes in statutory legislation added to their decline, with social workers and educational psychologists being required to undertake duties beyond the mainstream of work in the clinics. Multidisciplinary work, though necessary, was difficult to co-ordinate, not least because issues relating to organisational leadership and accountability were complicated. Rivalries between different professionals were often quite entrenched: rivalries amongst different therapeutic approaches equally so. Finally, the sheer emotional pressure that pervaded so much of the work impinged on all concerned – so much so that the temptation for individuals and professional groups to retreat defensively into individual or professional isolation was ever present with the effect of undermining the collaborative vision of multidisciplinary work.

From the time of its inception, the Child Guidance Council had played a significant advisory role on government policy relating to children. Its successful co-operation with other mental health organisations during the war led to amalgamation as the National Institute of Mental Health (NAMH). In 1974 NAMH decided to concentrate on adult mental illness, rebranding itself MIND and dropping interest in the mental health of children. This constituted a major political and campaigning loss for child mental health. It was in this context that the Child Guidance Trust was formed and, despite the many tensions that existed within the field, a small group of resolute people persisted in a renewed determination to establish a national voice for child mental health and the advancement of multi-professional work. Most notable amongst this group over the years were Robina Addis, one of the early PSWs, influential in NAMH and a pioneer in child guidance work; Professor Fred Stone, Dr Jack Kahn and Dr Judith Trowell, child psychiatrists; Marion Bennathan, Michael Roe and Eva Holmes, educational psychologists and Wallace Hamilton and myself, child psychotherapists. In 1988, the trust changed its name to Young Minds: the National Association for Multi-professional Work in Child and Family Mental Health and established a new constitution that provided for a council with representatives from a variety of organisations and individuals. After much prodding and pushing, strongly steered by Marion Bennathan, and blessed with moments of serendipity, Young Minds was awarded a substantial grant from the Department of Health and I was appointed in 1992 as the full-time paid director of the organisation. (For branding and marketing purposes, the name of the organisation was later amended to YoungMinds and, when professional coherence could be taken more for granted, the descriptive tag that followed became The National Association for Child and Family Mental Health.)

The task ahead was daunting but exciting. The cause was compelling and its aims straightforward enough, if challenging:

- to encourage the provision of comprehensive, accessible and effective child and adolescent mental health services
to encourage public policymakers to take account of the mental health needs of children, young people and their families
• to promote a greater public awareness of the mental health and emotional needs of children, young people and their families.

The times moreover were propitious. In the USA, attentiveness to the mental health of children was growing and in England the government was showing a greater interest in mental illness. It was specifically listed amongst the targets laid out in its 1993 Health of the Nation mission statement. The Secretary of State for Health was Virginia Bottomley MP who had been for several years a psychiatric social worker working with me in child guidance clinics in London. Fortuitously too, Dr Robert Jezzard, who had also worked in the same child guidance clinics, was appointed Child Psychiatry Adviser in the Department of Health. In this climate it was perhaps not surprising that the government initiated, through the NHS Health Advisory Service, a major thematic review of child and adolescent mental health services. This was led by a consultant child psychiatrist, Dr Richard Williams, and proved to be a momentous piece of work culminating in the report Together We Stand (NHS Health Advisory Service 1995) that had considerable and lasting influence on policy affecting child and adolescent mental health services throughout the country.

The meaning of child mental health

Tackling the parameters

Whilst I was settling into my new role as Director of YoungMinds, I was invited to sit on the steering committee of this major thematic review. This offered me the opportunity to take stock of many of the issues that had been central in the interests of the Child Guidance Trust and to be part of a wide range of discussions considering the structuring and management of future services. It was in the midst of such discussions that I found myself increasingly interested in what it was that we were all so concerned about – namely child mental health. What did we mean by it? Who had it – and who didn’t? The term was part of YoungMinds’ official title and it was at the centre of the review. And yet there seemed little clarity about its definition. All too often, when the word ‘mental’ was mentioned, people immediately thought of illness, psychiatry and medication. The word effectively was caught in the grip of pathology. And yet, when it came down to it, in dictionary terms, the word referred to no more than that ‘which pertains to the mind’.

It seemed to me a priority to attempt to make sense of this apparently simple term ‘mental health’. Much to my surprise, however, I didn’t meet a great deal of enthusiasm for the subject. One distinguished consultant psychiatrist, for example, seemed irritated by my raising the matter as if it
were irrelevant to his more pressing issues in research and practice. A senior child psychotherapist also conveyed indifference, complaining in a review of an article I had written that it was ‘boring’ to make such an issue of it all. In general, people just seemed more comfortable with the thought of illness rather than health. It was as if their heads were so buried in the intricacies of treatment that they lost sight of what it was that they were treating for. In his recent book *Going Sane* Adam Phillips (2005) makes some interesting observations about this. He writes that there is ‘something in the whole notion of sanity that seems to make us averse to defining it’. In contrast with the drama of madness, he sees that the sane ‘don’t have any memorable lines’. He argues that for most people madness is much more fascinating, even bewitching:

For hundreds of years the mad have had institutions to care for them and to punish them in their always ambiguous status as ill and/or criminal. They have had experts of a variety of so-called disciplines to treat them, legal systems to contain them and, increasingly, focus groups to defend their rights. Architects have designed the kinds of buildings they are assumed to need. Pharmaceutical companies and Western governments since the Second World War have invested huge amounts of money in researching the causes and cures of madness; and new professions – most notably psychiatry and psychoanalysis – have been invented for its treatment. The mad, that is to say, mobilise people; they are great motivators. . . . Daunting statistics are regularly produced in the press about the prevalence of depression, schizophrenia, eating disorders, addiction . . . and yet the sane never receive any publicity. There are, as far as I know, no statistics available about them. The sane are not news.

(Phillips 2005: 36–37)

Thinking about sanity and madness, mental health and illness, the ‘true’ nature of each, is no doubt irritating and boring precisely because it is so perplexing. Laing and the anti-psychiatrists in the 1970s argued forcefully that disturbing mental phenomena are not necessarily manifestations of psychopathology but expressions of personal authenticity and integrity; sanity was no more than a compliant adaptation to the social order at the cost of impoverishing the complexity and idiosyncrasy of the individual. Counter to this was the view that sanity represented the accomplishments of positive child development towards a state of relative soundness, composition and harmony. There was in all of this debate a fundamental quandary relating to the interconnectedness between sanity and madness, mental health and illness. As Phillips puts it:

Sanity is used to refer either to what we most value about ourselves, or to what endangers what we most value about ourselves. But there is an
instructive confusion here because madness can be used in exactly the same way; it can refer to what we most treasure about ourselves, and to what most horrifies us about ourselves.

(Phillips 2005: 31)

Much of this debate has in the past focused on adults. The idea of child insanity, mental illness or its opposite, sits even more uncomfortably in the minds of adults. Somehow, in the past, children have been perceived by adults as outside their concern. However strong the parental impulse to care for and protect children, children in general are nevertheless seen at a distance, not fully human (not grown up). I wrote about this at some length in an annual review *Reframing Children's Services* published by the National Council of Voluntary Child Care Organisations:

They [the children] are all too easily patronised, sentimentalised, or minimised, not really to be taken seriously – to be seen and not heard. . . . Beneath it all appears to be a complex paradoxical fear in adults – both of children’s vulnerability and of their power. Children by their very presence evoke memories in adults of past childhood experience, with all of its intensity, dependency and helplessness. Children, too, by virtue of their will, determination and sheer energy pose a threat of potential disruptiveness – a growth of a wildness that has to be controlled. Children also have the capacity to observe and scrutinise the behaviour of adults, not infrequently critical, questioning and ultimately unnerving for many.

In the light of these considerations, it cannot be unexpected that the idea of children’s mental health has not been taken on as readily as it might. In the midst of so much ambivalence and despite substantial and undeniable advances in child protection, child welfare and education, there still hangs in the air an unpreparedness to treat children’s minds with respect – and indeed to take on board that children actually have feelings and thoughts, in response to what has happened to them, that make up their minds and influence their attitudes and behaviour during the course of their lives. There is still more than a hint of incredulity in many for example that what babies go through in their early lives has anything whatsoever to do with the adults that they become.

(Wilson 2002: 133)

There is no consensus or certainty in considering the concept of child mental health. Whose views of normality – or indeed of desirable behaviour – amongst the many that exist both within and between individuals and cultures, are to predominate? And yet, at the time that YoungMinds began, despite such complexity, concern was growing amongst many to find some way of getting to grips with the worries that they had about the minds of the young – particularly in a society that was introducing all kinds of new
demands and pressures on children in an age of massive technological change. Many of the ills of society, whether they had do with crime, domestic misery, abuse, substance misuse, poor educational achievement and waste – and to some extent poverty and unemployment – seemed to have their roots in a failure of young minds to be as potent and as effective as they might. Too many children and young people appeared to be living lives in which they felt overwhelmed by their misery, anger and fear – either retreating within themselves, becoming depressed and isolated or fighting back randomly, destructively, not always in their own best interests.

A workable definition of children’s mental health was necessary, especially to serve as a baseline for future political action. I remember holding a meeting of a small group of trustees and members in the first month or so at YoungMinds in which we attempted to tease out some of the essential features of a child’s mental health. This proved to be invaluable and I made good use of what I learnt there to contribute to the formulation of a definition that appeared at the beginning of the report of the Health Advisory Service thematic review (NHS HAS 1995). It was an achievement to have the ‘health’ aspect so well emphasised; the definition we arrived at did good service for many years in a variety of enquiries and publications. Our understanding of children’s mental health was formulated in terms of a series of capacities:

- first and foremost, the capacity to develop (psychologically, emotionally, intellectually, spiritually)
- second, to initiate, develop and sustain mutually satisfying personal relationships
- third, to become aware of others, to be empathic
- fourth, ‘to use psychological distress as a developmental process so as not to hinder or impair further development’.

This was not intended as a recipe for happiness nor a portrait of perfection or saintliness. Rather I saw child mental health as ‘essentially about ordinary living – about physical and emotional well-being, the capacity to live a full and creative life and the flexibility to deal with its ups and down. It is moreover, like physical health, not static; it ebbs and flows, functioning well and not so well and carrying, at any given time, its own difficulties or sticking points’ (Wilson 2002: 140).

YoungMinds

During the course of my time at YoungMinds, my staff and I were pre-occupied with three main activities that served our objectives well – information giving, advocacy and consultancy and training. All inter-related, each serving a particular purpose, but drawing on and giving inspiration to the others.
Information giving

From the very beginning, a central aim was to provide information on the matters that counted to professionals and the public alike in the broad field of child mental health. As soon as we began, we responded to calls from parents about whatever worries they might have about their children. Some of these were relatively mild, more or less within a range of normality, to do with early sleeping and eating difficulties, losses and bereavement and difficulties in attending school and learning. Others were more severe – major behaviour problems at school and in the home, significant depressed states, extreme social withdrawal, alcohol and drug misuse, self-harming and suicidal ideation and attempts.

One of our first paid positions was an information officer. She fielded most of these calls and I dealt with the more severe cases. Sometimes a telephone call or two was enough, but more often than not it was necessary to suggest to the parents that they seek further help from available services, such as the local child and adolescent mental health services (CAMHS), social services, educational psychology services, general practitioner services or relevant voluntary organisations. As the service became increasingly used, we built up a panel of child mental health specialists, mostly drawn from our membership and staff in child guidance clinics. A two-tier service became established: a front-line service, delivered at first by the information officer and later by a team of parent information service workers, and a back-up second tier consultative service for parents, referred on by the front-line service, who needed more time and professional help from the child mental health specialists.

There were limitations. No more than one or two second-tier telephone interviews of an hour’s duration could be provided. However, this seemed to be sufficient for many. In evaluations of the service at different times during its operation, most parents clearly valued being heard by someone whom they experienced as sympathetic and knowledgeable. As a result, they felt less hopeless, more confident, better informed and mobilised to access resources to help. Much of the value of the service resided in its relatively easy accessibility – parents felt more able to reach help initially by telephone than through more formal face-to-face contact in the established child mental health agencies. In no way did we claim to be meeting the full needs of the parents and families who called, but for many, at an opportune moment in their lives, we made a significant difference by offering ‘something else’. We became increasingly impressed by the curious blend of intimacy and anonymity that characterised the effective telephone interview.

I thought it essential that front-line workers should receive regular consultation on this work – and much credit needs to be given to Stella Dick, a psychotherapist, who provided invaluable assistance throughout the development of the service. There was also opportunity for those working in the second-tier service to meet regularly to share experiences.
Inevitably, alongside the development of this parents information service (responding at times to well over 3000 calls a year) it was necessary to produce a range of publications for the public on the kind of child mental health problems that existed and the various services that were available. A number of popular leaflets and booklets were published with titles such as ‘Tuning In to Our Babies’, ‘Entering Adulthood’, ‘Want to Know More about Psychosis?’, ‘Do You Know Someone who has been Sexually Abused?’, ‘Why Do Young Minds Matter?’ I wrote most of these in the beginning, with advice from others including YoungMinds members, and oversaw and approved later ones. This I saw as a crucially important activity, not only to impart accurate information to the public but also to convey something of the complexity of child mental health problems in simple straightforward language. The danger of trivialising them, as indeed of misrepresenting the work of the various agencies and professions, was always alarmingly present.

The most prominent publication was the YoungMinds Magazine. This became the organisation’s central medium of communication. The early editions were mainly taken up with the plight of multiprofessional work and in the third edition, Dr John Bowlby, on his eightieth birthday, wrote an interesting historical perspective of the child guidance movement. During the course of the next 20 years, particularly in recent years under the excellent editorship of Steve Flood, the newsletter developed from an inhouse publication into a public magazine in its own right with a highly reputable position in the marketplace. It was the only publication that consistently focused on the concerns of those in the broad field of child and adolescent mental health – a unique publication that provided continuity between more official publications. We deliberately wanted a magazine rather than a journal format – something manageable, informed, drawing on the wide experience of YoungMinds members and beyond, and accessible to a wide multidisciplinary and public readership. In January 2008 it reached its ninety-second edition. It contained within its span and variety a quite extraordinary record of the thinking and developments that occurred in the field of children’s mental health during what was a remarkable period of history.

**Advocacy**

A primary purpose of YoungMinds was to advocate for the cause of children’s mental health. This took several forms, notably responding to the many consultation documents and initiatives that increasingly emanated from government on matters relating to children’s welfare. It also entailed responding to journalists, producing a range of policy documents and making representation to government ministers and officials.

During the 1990s and well into this century, governments were prolific in initiatives engaging with juvenile crime, child protection, child poverty,
drug abuse, teenage pregnancy, social exclusion. In reading and responding to these documents, at every juncture we had the opportunity to bring child mental health more prominently onto every agenda. In addition, during this period, there were a series of substantial enquiries specifically looking into child and adolescent mental health services – and I sat on each steering committee. These included Together We Stand (NHS HAS 1995), Bright Futures (Mental Health Foundation 1999), Children in Mind (Audit Commission 1999) and the National Service Framework for Children, Young People and Maternity Services (Department of Health 2004).

As one report built upon the other, the message was becoming increasingly clear that the mental health of children was of key importance in considering the plight of children generally and that services for those with mental health problems were in large measure inadequate and fragmented. Service provision needed to embrace not only the treatment of children with mental health problems but also the promotion of children’s mental health in any given population and the prevention of problems that might emerge. The importance of early intervention was fully recognised as was the improved organisation of multiprofessional services in any given community. The recommendations and guidelines that have emerged more recently from the National Service Framework have encapsulated much of the thinking and work done during this creative period.

Responding to journalists in the media took a great deal of my time and that of my staff. For too long, it seemed to me, professionals in the field of child mental health had been too diffident to meddle with journalists in newspapers, on radio or on television – with only a handful of exceptions. As much as professionals rightly upheld the importance of the privacy and confidentiality of their work, I frequently felt that they were in effect hiding behind these values, as if afraid of exposing themselves or being caught out in some way. There was also a sense of arrogance, as if the public could not possibly understand the complexities of their work. I too had been guilty of a certain kind of preciousness – how fussy I had once been that I should not be misquoted or that I should have final editing (absurdly so, since journalists have no time in their rush to meet their deadlines) – but it increasingly struck me how shortsighted and self-defeating were such attitudes. I took the view that, if there was to be any significant political change, in a democracy the public needed to know and care much more about our work in order to exert influence on their politicians.

As far as I could see, the public did not know enough – and so I had no hesitation in courting journalists to hear more about our stories. At the very beginning, for example, when we launched our parents information service in Yorkshire, we managed to recruit a popular radio and television star, charming, outrageous and in many ways not the most probable ally, to open the launch. The impact on the media was immediate and, as a result, I found myself following up on numerous local radio stations across the country in five-minute ‘bites’ – reaching in effect a large number of
ordinary people in their cars or kitchens or bedrooms or wherever – talking
about children having feelings and thoughts and worries, about there being
a lack of proper services for those with problems and about the importance
of parents and the YoungMinds parents information service.

Similarly, a year or so later, we ran a six-month campaign on children
and violence. At the centre of this campaign we held a festival at the
National Film Theatre in London showing a series of films in which
children lived under the threat of violence or became violent themselves (as
in Peter Brook’s *Lord of the Flies*). The festival was reasonably well
attended but the overall publicity we drew from it was considerable. We
followed up with a series of papers (YoungMinds 1996) on different aspects
of violence as they impinged on children – bullying, sexual abuse, domestic
violence, war and screen violence – and held various events to publicise
each. YoungMinds and its cause became newsworthy.

The primary interests of journalists invariably centred around four main
questions: What is wrong with children? How many of them have prob-
lems? Has there been a general increase in these problems? And, if so, why?
Often these kind of questions occurred in sudden surges of intensity
following some tragedy or major event in the news affecting a young person
or a celebrity – an adolescent suicide, a child with an extreme eating
disorder, a well-publicised divorce, a teenage murder. By and large, I found
answering journalists’ questions – often in haste, without too much
warning – very worthwhile. They, the Joe Publics, were becoming increas-
ingly interested in the minds of young people and were raising concerns
about the state of service provision for them. It appeared too that they were
learning a thing or two. For example, when they heard me describing how
some children become depressed (not necessarily suffering from clinical
depression, but nevertheless feeling depressed in response to losses and
difficulties in their lives) many seemed incredulous – ‘Children get
depressed too?’ I used this phrase as the title of my YoungMinds leaflet on
childhood depression.

Perhaps one of the most powerful though unfortunate moments of
publicity occurred at the time of the murder of two-year-old Jamie Bulger by
two boys aged eight and ten in Liverpool in 1994. I fielded many enquiries
from journalists at that time and, on one occasion, sat on a panel in the
BBC’s evening current affairs programme *Newsnight*. A bishop and a
government minister were also present and they spoke volubly about the
nature of evil. I found myself the lone voice on the panel considering the
emotional and social backgrounds of the two boys and the possible effect of
that on their internal worlds and their behaviour. This appalling murder
sharpened people’s minds, some to think of ways to punish, others to wonder
why something like this could happen and how services had failed them.

Over time, YoungMinds became known to the public and journalists as a
source of information and ready comment. This proved very valuable in
helping to spread important news that was emerging from within the field.
We gave a great deal of publicity to two major epidemiological studies showing the prevalence rates of child mental health problems – the first, Rutter’s Isle of Wight study in 1975 (Rutter et al. 1975) which hadn’t received as much public notice as it should have done when it first appeared; and the Office of National Statistics studies beginning in 2000 (Meltzer et al. 2000). We also highlighted Rutter’s and Smith’s impressive book *Psycho-social Disorders in Young People* (1995) which contained evidence to suggest an increasing number of young people in the western world during the last 50 years were experiencing a wide range of mental health problems. The evidence from these studies was invaluable in backing up our claims that the mental health of children and young people was a most serious issue and that more should be done to improve services to help them.

To celebrate YoungMinds tenth anniversary, we published a manifesto setting out the path for our future advocacy work. Essentially, this was a compilation of the major issues and concerns that we had highlighted and pursued from the beginning. These included: support for parents in early childhood; help for schools; comprehensive adolescent services; young offenders; multi-agency co-ordination; accessible and relevant training; accountability; and an end to the postcode lottery of service provision. In the following years, we engaged in a range of activities to bring about changes heralded by the manifesto. We produced a number of useful briefing papers, for example, guidance for primary care trusts on how to commission a comprehensive CAMHS (Morley and Wilson 2002) and two papers on infant mental health and adolescent services (YoungMinds Policy 2003, 2004). We published a number of reports of research carried out by Cathy Street – *Whose Crisis?* was one of the titles (Street 2003), with another on services for the mental health of young people from black and minority ethnic groups (Street et al. 2005); and others on inpatient services for children and adolescents. We obtained significant funding to research into mental health services for late adolescents and young adults. This culminated eventually in an influential series of documents entitled *Stressed Out and Struggling* (YoungMinds 2005). We were also involved in many of the preliminary meetings to consider modifications to the Mental Health Act to benefit children with mental health problems.

Throughout my time as Director of YoungMinds, I took every opportunity to meet with ministers and officials in various government departments, most frequently Health, Education and the Home Office. I had a positive relationship with Virginia Bottomley while she was Secretary of State for Health and I met with most of the Junior Ministers of Health during their terms of office – approximately ten while I was in post. Each time, it was important to reiterate the major issues, the facts as we increasingly knew them about the scale of the problem and the actions that we thought the government should take. I also had one or two good contacts in the House of Lords and was the first to give evidence to a House of Commons Select Committee looking into child mental health in 2000. We
made our views known to MPs of other political parties and were actively involved with government officials in briefing, influencing policy and implementing various programmes in health and education.

**Consultation and training service**

As a result of the recommendations of the *Together We Stand* review and later reports, increasing pressure was placed on health and local authorities to take stock of their policies and service provision for the mental health of children, adolescents and their families. In the spirit of *Together We Stand*, the concept of a comprehensive CAMHS, based on the broad based definition of mental health that we had proposed, was clearly being put forward by the government. The message was unambiguous that it was the business of a wide range of professionals and practitioners in any community to contribute to the promotion of the mental health of children and adolescents in their communities and to the prevention and treatment of children’s mental health problems.

An explicit requirement was being made of health and local authorities to ascertain the extent of need in their areas and the services available within the statutory and voluntary sectors. On the basis of this information, it was their responsibility to determine priorities, allocate appropriate resources and set a clear strategic direction for future service development. This was in many respects new ground for many authorities and I saw immediately an opportunity for YoungMinds to exercise a consultative role, on the basis of our unique multidisciplinary membership and knowledge in the field. I remember travelling to a city in the North of England in response to a tentative request from a senior manager in a health authority, who seemed dismayed by the intensity of professional divisions in the multidisciplinary services and by diagnoses such as ‘oppositional defiant disorder’ that made little sense to him. He agreed – with some relief – that YoungMinds undertake a full review of services in his authority.

I asked Dr Zarinna Kurtz to join me. A highly gifted consultant in public health, she had developed a particular and unusual interest in child mental health and had written one of the earliest significant reports on the subject *With Health In Mind* (Kurtz 1992). Our service review proved to be a major piece of work, including numerous interviews with a wide range of people from different disciplines and agencies across the city, understanding the structure and processes of all the services involved and making recommendations for a coherent and comprehensive CAMHS.

With Zarinna Kurtz’s invaluable expertise, and later with Dinah Morley’s leadership and Bruce Irvine’s creative involvement in the YoungMinds consultation and training service, we at YoungMinds carried out a wide range of reviews around the country during the time I was in post. This was in many ways pioneering work. It was greatly valued by most of the authorities and agencies who engaged us, albeit that at times our recommendations were
controversial when we had to challenge established practices that were not
proving helpful nor in line with government guidelines. A report drawing
together the knowledge gained during this work was written by Dr Kurtz in
a YoungMinds publication on developing a comprehensive CAMHS (Kurtz
et al. 2006).

Inevitably, on the back of our consultative work and with a growing
reputation as a multidisciplinary organisation, we were asked to provide a
training service. Most of the trainings we provided were one-day events
designed to inform and enable a wide range of professionals and prac-
titioners to work with greater understanding of children and of child mental
health problems. In addition, we established with City University in London
one of the first two-year Masters degree trainings in child mental health.
Gradually, as consultative work with health and local authorities became
more widely accepted and other organisations began to provide similar
support, so the YoungMinds training function became more prominent.

YoungMinds and psychoanalysis

This chapter is essentially an account of my life as a child psychotherapist,
working beyond the threshold of clinical and consultative work in the later
period of my professional career. As the director of a multiprofessional
organisation, I became something else, something other than the con-
ventional child psychotherapist. My vision for YoungMinds had always
been that it should become in effect the public relations division of the whole
field of child and adolescent mental health services, actively communicating
with the wider public. Professional associations seemed not predominantly
interested in this; their primary focus was on advancing scientific enquiry or
attending to particular professional interests. With this in mind, I found
myself transforming into something of a publicist, a campaigner for child
mental health – and a politician, in the sense that what was at stake was the
public priority to be given to children’s mental health, and proper funding
and resourcing. I entered a world of management, strategy, budgets,
funding, political lobbying and public communications. I gave numerous
talks to a wide variety of audiences and contributed to many radio and
television programmes on matters relating to children’s mental health.

This transition from being a child psychotherapist to a kind of political
campaigner took time and at times was difficult. A different mode of
operating and communicating was required. In many respects it involved a
relinquishing of the interior of the individual mind to a grasping of the
exterior of the public agenda – but never an abandonment. Indeed, the
stronger my appreciation of the internal world of the child, the greater was
my conviction and confidence in taking forward the YoungMinds message.
There is much in our training and experience as child psychotherapists that
equips us – in terms of knowledge and ability to make sense of complex
interactions – to take on the wider challenge. Other child psychotherapists
of course took on public roles in different ways, but there remained in my view a need for our far greater political involvement. We do have a lot to say to improve the plight of children outside the consulting room.

From the very beginning I retained a small private practice and throughout the whole remarkable experience I did not lose a sense of myself as a psychoanalyst. For me, YoungMinds was an expression or application of my knowledge of psychoanalysis. This, I am aware, is a somewhat idiosyncratic belief – a belief that few I think might follow. After all, psychoanalysts cannot see in my story the patient on the couch or the child in the consulting room – and most non-psychoanalysts haven’t too much of a clue about what psychoanalysis is anyway. Nevertheless, I believe it was through my psychoanalytic training and understanding that I came to as distinct an appreciation as any of what it is that constitutes child mental health. In this, I was mindful too of what we might mean by adult mental health – again, a difficult concept, but for me as a psychoanalyst one that had to include notions of emotional maturity, responsibility, efficacy and integrity. Ericson (1963) also stressed the capacity for intimacy in an individual and the development of an ‘ethical strength to abide by his commitments’.

Psychoanalysis for me enriched my understanding of children – of their conscious and unconscious wishes and desires, their fears and conflicts and their ways of defending against anxieties. It enabled me to appreciate more the nature of infantile and childhood experience, the ever-widening range of feelings through the Oedipal drama and beyond into the realm of school and peer groups. I understood too more of the powerful influence of the past on how parents view and relate to their children. It was with this knowledge of child development and the dynamics of family life that I believe I was able to sustain my commitment to do as much as I could for the work of YoungMinds – often against the odds, particularly in the beginning. It helped too to have a psychoanalytic understanding of narcissism to see me through the fine sensibilities and precious imperatives of some I encountered in the multiprofessional and political worlds.

Psychoanalysis, in other words, was my anchor and my inspiration. I didn’t necessarily ‘speak it’ all the time. I rarely used the jargon and I never had any illusions that YoungMinds was a psychoanalytic organisation; its very strength was built on the diversity of its membership. However, I like to think that all of the conceptual thinking I had gained (from Freud on through the many writers of the twentieth century) and my self-awareness helped to steer my own thinking in all that I did. I wrote a small book towards the end of my time at YoungMinds – Young Minds in our Schools (Wilson 2003a). In many ways, it sums up much of what we were saying over the years about the important role of schools in promoting the mental health of children and adolescents. The third chapter is the one I like the best. It is entitled ‘And What of the Teachers?’ and describes the different kinds of interaction that can exist between pupil and teacher. It is essentially about transference and countertransference – although I chose
not to use these terms in the book. The public and too many professionals in the field, I found, were curiously allergic to them, as if they were strange and mystical notions that bore little relation to reality.

In making this point about the essence of psychoanalysis in my life as Director of YoungMinds, I am not suggesting that this should be a prerequisite of any person taking on this role – although I do think that any successor who does not have a coherent conceptual framework relating to clinical experience, and who has little knowledge of or respect for the history of YoungMinds, might find it difficult to foster the growth of the organisation. Of course, I could not have achieved what we at YoungMinds managed without the support of my trustees and the quite remarkable energy, imagination and professionalism of my staff. All played a significant part but special mention should be given to Judi Barker, Juliet Buckley, Steve Flood, Tarryn Hawley, Bruce Irvine, Jane Jacobsen, Imogen Le Patourel, Dinah Morley, Zarrina Kurtz, Robert Pike and Cathy Street – a multidisciplinary team.

**Conclusion**

**The achievement**

In the final analysis, the necessary question remains – what did we achieve? Fundamentally, I think we succeeded in creating a new reputable multidisciplinary voluntary organisation that focused on the mental health of children, adolescents and their families. When I began as Director, the term ‘child mental health’ was viewed with suspicion and unease. People shied away from the word ‘mental’ and supposed that children were being unfairly stigmatised by association. By the time I retired, the term was much more on the mantelpiece. Many professionals and an increasing public had got used to it. The idea of child mental health being everybody’s business caught on and stayed at the core of the comprehensive model of child and adolescent mental health services. In a recent study of the experience of teachers in the UK of child and adolescent mental health services, one of the findings was that teachers were much more aware of such services in their areas than they were in the mid-1990s (Rothi *et al.* 2005).

I think we also created an organisation that served well the multiprofessional cause. I always had it in mind that YoungMinds should stand for something over and above the identities of individual professions; that it should transcend the many differences and rivalries. It was something of a tribute to the cause that four times a year on Saturday mornings the YoungMinds Council met, with good attendance, to review the progress of the organisation and set the policy direction. I saw Council as sitting at the heart of the organisation; it comprised well over 25 representatives of different disciplines.

We put a great deal of effort into reaching the public through the media, moving beyond some of the reticence that had traditionally characterised
professional attitudes. I think that some people in my own profession thought that I was betraying in some way the dignity of the profession and the confidentiality of our practice by being so ready to publicise the work that was going on. However, there was no doubt in my mind that advocacy of the cause of child mental health was at the core of our enterprise. It was simply not enough for professionals to be talking to themselves. It is encouraging that now more professionals and professional organisations are prepared to make known their work and knowledge to the wider public.

YoungMinds services were important too. Our consultancy and training service obviously met a growing need and provided necessary income for the organisation. Our parents information service also met a need, although at times people questioned whether this was an appropriate use of our time. In the beginning, concerns were raised about the ethics of publicising a service that would encourage referrals to services that didn’t have the capacity to respond. My answer was that it was only through exposing the extent of need that there could be any possibility of bringing about change. Another objection was that the provision of a service such as this should properly be the responsibility of local authorities and that, by providing it ourselves, we were in effect letting the local authorities off the hook. My view was that it was only through demonstrating the usefulness of such a service that local authorities might eventually be stimulated to take action themselves. YoungMinds moreover had very good resources to service such a provision; it also benefited from the knowledge gained through the telephone calls of the kind of problems that parents were facing and the kind of services they were receiving throughout the country.

It is difficult to measure the impact of all the work on the general state of child mental health and on child mental health services in the country. There were so many other factors and forces shaping the course of events that it is impossible to trace one particular influence. During the time I was Director, the government introduced a wide range of creative and constructive measures and many other organisations became involved in carrying out reviews and consultations in this area. In 2001, a national CAMHS Support Service, with regional support teams, was set up to implement the new policies and guidelines – developing and extending in effect the work that YoungMinds had pioneered. Society itself was changing rapidly, adapting as best it could to new economic and social conditions, unprecedented global pressures and advancing technology.

There are many different views about the general well-being of children and young people today. A recent UNICEF report (2007) ranking child well-being has placed the UK bottom, twenty-first out of the 21 richest countries. Research showing an increase in the prevalence of adolescent mental health problems adds to a disturbing picture (Collishaw et al. 2004). Nevertheless, there is much to celebrate in the growing public awareness of the importance of children’s mental health and there is encouraging evidence that child mental health services have improved considerably in recent years.
Between 2002 and 2005 there was a 27 per cent increase in CAMHS staffing and a 40 per cent increase in the number of cases seen by CAMHS. The number of CAMHS specialist teams in England increased by 16 per cent. There has also been significant growth in reported budgets for CAMHS during this time (CAMHS mapping; NHS Confederation 2007).

There remains much more yet to do. The momentum that was created during my time at YoungMinds needs to be maintained: the implications of untreated mental health problems in children need to be better recognised and ever more resources need to be provided. Multidisciplinary work still presents major challenges across disciplines and agencies. For child psychotherapists and other ‘creative’ therapies, there are particular problems, largely unforeseen when I began at YoungMinds. The increasing demand for greater efficiency in service provision, the pressure to reduce waiting lists, the growing reliance on scientific psychiatry and psychology in providing evidence, and the surge of emphasis on primary provision (at tiers one and two) have led to a devaluing of certain forms of therapeutic practice, particularly in specialist tier three CAMHS.

I shall finish with a few lines I wrote shortly before I retired from YoungMinds. This followed our annual lecture given by Adam Phillips and our first YoungMinds book award – an award which we initiated with the invaluable support of Nicci Gerrard, a well-known author. I had a particular affection for this event since the award was intended to draw the professional and the literary worlds together to ‘recognise a book or memoir portraying to adults something of the unique subtlety of a child’s or young person’s experience’.

As I approach my retirement in February 2004, I let myself muse from time to time on what it – YoungMinds – has been all about, and continues to be all about. YoungMinds has carried forward the spirit of the child guidance movement that grew and reigned during the middle part of the last century and hung on, against the odds, towards its end. YoungMinds has served to rekindle the drive and purpose of this movement, and now it stands, amongst an increasing number of people, for the importance of children’s mental health and the necessity of improving services for children and young people of all ages. There is, of course, still much to do: persuading the public, disturbing the politicians, increasing the resources (money and know-how) and, not least, understanding better the nature of sanity – in ourselves, in our children, in today’s world. That’s what YoungMinds is about.

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