Psychoanalytic Psychotherapy Assessment in a Child and Adolescent Mental Health Setting: An Exploratory Study

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ABSTRACT

Undertaking assessment is a significant component of a Child Psychotherapist's work within Child and Adolescent Mental Health Services (CAMHS), yet as an activity it has been relatively neglected in the research literature. This study made use of a small-scale, qualitative design to explore the nature and function of psychoanalytic assessment work within a single CAMHS team. After an initial audit of child psychotherapy assessment work, indepth interviews with 5 Child and Adolescent Psychotherapists, exploring the nature of assessment work, were analysed using Interpretative Phenomenological Analysis (IPA). Results suggested that assessment is a major part of the Child Psychotherapist's work, although there are different types of assessment done in different contexts. Among the participants there was a certain shared understanding of the psychoanalytic approach to assessment, although with significant differences in regard to process, technique (e.g. use of interpretation, the role of countertransference) and the reporting of assessments. The analysis also suggested tensions between the role of the assessor as an 'expert' and as a 'therapist'.

KEYWORDS

assessment, CAMHS, child psychotherapy, psychoanalytic approaches, qualitative research

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Clinical Child Psychology and Psychiatry Copyright © 2008 SAGE Publications
Vol 13(1): 139–155. DOI: 10.1177/1359104507086346 www.sagepublications.com

IN THE UK, the vast majority of Child and Adolescent Psychotherapists (around 90%) are based in Child and Adolescent Mental Health Services (CAMHS), delivering a wide range of services to young people and their families.[1] Although the work of the Child Psychotherapist has traditionally been identified primarily as long-term, individual psychotherapy, a recent survey of the profession (Sherwin-White, Shuttleworth, Tydeman, & Urwin, 2003) discovered a huge range of activity, including both brief and longer-term individual and group psychotherapy for children, parent–infant psychotherapy and work with carers, assessment, consultation, supervision and teaching. 'Traditional' models of ongoing, individual psychotherapy represented only about one-third of the average clinician's activity within their Services. The settings in which Child Psychotherapists were offering such work were equally diverse, including hospitals, adolescent units, GP clinics, social services, schools and therapeutic communities.

Yet such a range of activity has not been fully reflected in the literature about the work of Child Psychotherapists, which has often focused primarily on long-term, individual therapy. Despite an important recent publication (Rustin & Quagliata, 2004), one area of comparative neglect in the literature has been an exploration of the nature and process of child psychotherapy assessments, despite the fact that such assessments are both a core component of NHS work and have their own specific character, which in certain respects is quite different to assessment work carried out by other members of a multidisciplinary team, such as psychiatrists, educational psychologists and so on.

Audits of the child psychotherapy profession in the UK suggest that between 11 and 14 per cent of the Child Psychotherapist's time within the NHS is devoted to assessment work (Beedell & Payne, 1988; Sherwin-White et al., 2003). In some settings, the proportion is even higher, with a recent audit of a single CAMHS team within inner London suggesting that 45 per cent of referrals to Child Psychotherapists over a 5-year period were for assessment (Kam & Midgley, 2006).

In the study referred to earlier, an audit of referrals to child psychotherapy was followed by qualitative interviews with multidisciplinary members of the same CAMHS team. In exploring the decision-making process in regards to requesting a child psychotherapy assessment, the study suggested that there were certain core reasons why such a specific type of assessment or treatment might be requested (Kam & Midgley, 2006). Among the participants interviewed, there was a feeling that child psychotherapists create an 'intense context' which can facilitate a focus on 'what the child would be feeling inside'; a context in which the child psychotherapist can make use of close observation, with a focus on play, fantasy and the inner world, in order to help a child 'express their story' and begin to process experiences that might feel to the child unthinkable (p. 34). At the same time, this study indicated significant reasons why members of a multidisciplinary CAMHS team would sometimes hesitate about making a referral to child psychotherapy or see it as inappropriate.

The Kam and Midgley study did not attempt to investigate what actually happens once a referral for assessment by a child psychotherapist had taken place, but the research reported here can be seen as a follow-up to this previous investigation. The current study is an attempt to explore the range of assessment work undertaken by Child Psychotherapists within CAMHS teams in more detail, in order to try and reach a deeper understanding of the particular nature and function of assessment work carried out by Child Psychotherapists within the NHS.

A brief review of the literature: Assessment in psychoanalytic child psychotherapy

According to *Longman's Dictionary of Contemporary English* (2003), 'assessment is a process in which you make a judgment about a person or a situation or the judgment you make'. In this definition, 'assessment' refers both to a *process* and to the *result* of that process, a distinction that is a helpful one to maintain.

In terms of the wider child mental health field, many different therapeutic traditions have their own models of assessment (Lachar, 2003); more generally, the Department of Health (DoH) in the UK has recently created a *Framework of Assessment of Children in Need and their Families* (2000), within which professionals involved with the welfare of young people need to operate. After identifying three key aspects of any assessment ('the child's developmental needs', 'parenting capacity' and 'family and environmental factors'), the document suggests that the conclusion of any assessment should include the following:

- An analysis of the needs of the child and the parenting capacity to respond appropriately to those needs within their family context;
- identification of whether and, if so, where intervention will be required to secure the wellbeing of the child or young person;
- a realistic plan of action (including services to be provided), detailing who has responsibility for action, a timetable and a process for review.

In discussing these guidelines, Herbert (2005) makes the distinction between two sorts of formulation of problems: (a) For individual treatment intervention, or (b) for an assessment for the social, health or educational services or the courts. Such a distinction is of value when considering assessments within a Child and Adolescent Mental Health setting.

Within the field of psychoanalytic child psychotherapy, the literature on assessment has often revolved around the central concepts of 'diagnosis' and 'analysability', that is, the question of the fundamental nature of the child's difficulties, and which children were suitable for this particular form of treatment. The latter was a particular point of controversy from the earliest days of child psychoanalysis, with Anna Freud and Melanie Klein, the two most important early practitioners of child analysis, disagreeing about how young children could be to benefit from analytic treatment, and whether child analysis was appropriate only for children with specifically 'neurotic' disturbances, or whether it had wider uses. (For a review of this early history, see Holder, 2005.)

In later years, there was a gradual convergence of views on some of these issues, as witnessed in Anna Freud's (1970) writings on the 'widening scope of child psychoanalysis'. But issues of assessment continued to be debated. In her later writings and work at the Hampstead Child Therapy Clinic[2] Anna Freud herself, aware that assessment and diagnosis were often done in an ad hoc and impressionistic way, insisted upon a metapsychological rather than a symptomatic approach to diagnosis and assessment, noting that the enumeration of symptoms like fears or sleep disturbances 'remain strictly on the descriptive level, regardless of genetic roots, dynamic, structural and economic complications' and could lead to misdiagnosis, as 'similar symptoms may differ widely in respect to latent meaning and pathological significance' (p. 160).

The diagnostic profile was created by Anna Freud and her coworkers as a very comprehensive form of assessment that would lead to a clear formulation of the child's difficulties and treatment recommendations (Freud, 1965). In terms of process, this assessment process would include a number of meetings with the child's carers to obtain

a full 'social history'; a minimum of three unstructured, individual meetings between the child and a psychotherapist, and more structured assessments carried out by a separate professional, including projective tests and assessment of intellectual capacities. Gathering together the data from these different sources, the *Provisional Diagnostic Profile* included a statement of the problem, information about the reasons for referral, information about the child, his or her history and family, as well as an indepth focus on the 'internal world', including ego development, defence organization, instinctual development and fixations and regressions. Environmental and external factors were examined as well as the child's specific, innate factors. On this basis, a provisional diagnostic profile was established with treatment recommendations. (For published examples of such *Provisional Diagnostic Profiles*, see Kaplan, 1994; Parsons, 1994.)[3] Viviane Green (1994) has explained how such assessments attempted to synthesize an understanding of the subjective, internal world of the child and a view of the child from the 'outside', including wider understanding about developmental processes.

Developments in Kleinian and post Kleinian thinking about child psychotherapy assessment have taken a similar direction. A recent publication from the Tavistock Clinic, *Assessment in Child Psychotherapy* (Rustin & Quagliata, 2004), likewise insists on the importance of assessing both internal and external factors. Emphasis is placed 'on assessment of the child or young person *in context* – family, school or college, peer group, wider community' (p. 2). The aims of assessment have much in common with the diagnostic profile; in so far as it is necessary to gather data from different sources and to ensure that someone 'can reliably support the treatment of a child' (p. 6). The assessment of parent functioning has implicitly become part of the child's assessment (Rosenbaum, 1994), and it is common practice in child psychotherapy to offer therapeutic support to the parents of a child in treatment. The types of question that will be in the Child Psychotherapist's mind during the period of assessment have been usefully outlined by Wittenberg (1982):

- Do the child's problems interfere with his/her development?
- What is the child hoping to gain from treatment?
- Is the child able to maintain some capacity to look at his or her distress?
- Is there any indication of a capacity to struggle and be curious?
- If treatment is needed, which is the rigidity of the defensive system and the fragility of the underlying structure?
- Is the child able to contain anxieties over a period of time?
- Does the child's present life situation allow him or her regular treatment and who is there in the environment who will be able to support it?
- What kind of treatment would be recommended and what frequency of work will be appropriate?

Regarding the *process* of assessment, a number of authors have laid out what they consider to be the key components of a psychoanalytic child psychotherapy approach (e.g. Dyke, 1985; Wittenberg, 1982), while both Margaret Rustin (1982) and Margot Waddell (2002) have written wonderfully detailed accounts of particular assessments of young people, describing the importance of attention to preconceptions, transference and countertransference manifestations and the value of observation. Marianne Parsons (1999) helpfully sets out a common set of ideas about the stages and processes involved in a Child Psychotherapist's assessment, with particular focus on assessment for therapy. This would include initial family meetings, followed by two or three individual meetings with the child, in which the psychotherapist must find 'appropriate tools in relation to the child's problems and age to facilitate the expression of his inner world' (p. 221); this

implies mostly unstructured play interviews, during which the Child Psychotherapist 'attunes to and explores the child's inner world' (p. 221).

Like in adult psychoanalytic assessment, the therapist's emotional response or countertransference guides his or her understanding of the key problems. Parsons (1999) underlines that the assessment sessions must be handled with much delicacy:

> If a transference relationship is established, it is very important that the child is prepared for the probable loss of the diagnostician at the end of the assessment . . . it is important to recognize that the child's defences need to be kept intact or reinstated in order to help him to contain his anxiety and reduce the possibility of harmful acting-out. (p. 222).

The *purpose* of assessment, according to Parsons, is to understand the different aspects of what may underlie the referral problem: On the one hand, understand the role of the parents and evaluate their capacity to support their child's therapy, on the other hand, appreciate the child's developmental aspects and evaluate if, at the stage they have reached, psychotherapy is a treatment of choice or not. This would mean, for example, knowing that children during middle childhood are building up defences, whereas psychotherapy aims at undoing defences, and that adolescents, in a period of major changes, may have difficulties committing themselves to regular therapy sessions. It also means being aware when it may not be appropriate to offer individual treatment, even when there is no question about clinical need, and where other approaches, such as consultation to the network, may be more appropriate (Dyke, 1987).

Until recently, the Child Psychotherapist's assessment in other contexts (e.g. parenting assessments for court) has been given less attention than assessments for treatment. However, a number of authors have recently begun to describe such work (e.g. Amidon, 2006; Tydeman, 2006; Wall, 1997; Youell, 2006), and have begun to identify what the key 'tools' underlying this type of assessment may be (Sternberg, 2006). Noting the overlap (but also important differences) with assessment for treatment, Sternberg (2006) writes,

> Child psychotherapy has a fundamental tenet. It is the belief that children's play (except unusually with some children on the autistic spectrum) has symbolic meaning and gives the psychoanalytically trained observer the opportunity to understand something of the child's internal world; that is their 'unconscious' . . . Child Psychotherapists and others working within a psychoanalytic frame work, have been trained over years to pay attention to 'the internal world'; that is what the child thinks, feels or experiences rather than necessarily what may have actually happened or what 'is'. (p. 12)

The current study

As we have described, when 'assessment' is discussed in the child psychotherapy literature, it is normally in the context of assessing a child's suitability for psychotherapy. But assessment as it belongs to the work of psychotherapists in Child and Adolescent Mental Health Services, as the Sherwin-White et al. (2003) survey demonstrated, is varied: It can be an assessment for treatment but also for other purposes, such as for social services or for the courts. It seems therefore appropriate to investigate this topic in a NHS setting, to see the connections between the theoretical background, the training and the practice in real situations.

As the review of files and the reading of reports can only give limited information, we decided to use interviews with Child Psychotherapists as our primary method of data

collection, as they would provide first-hand information about the way psychotherapists both carry out and think about the process of assessment. Furthermore, as assessment is an activity in which all Child Psychotherapists within a CAMHS team participate, an interpretative phenomenological approach could be applied to the interviews to discover underlying themes in their common experience.

The aim of the study was therefore to explore the following questions:

- Is there a standard model of child psychotherapy assessment within a Child and Adolescent Mental Health setting? If not, what are the commonalities and differences in the Child Psychotherapists' approach to assessment?
- What is the relationship between assessment and diagnosis?
- Are different theoretical backgrounds reflected in the Child Psychotherapists' understanding of what is to be assessed?

Method

The data for this qualitative study were collected in a single inner-city, multidisciplinary CAMHS team, in which a previous study had explored the process of referral to child psychotherapy (Kam & Midgley, 2006). The main objective of this study was to reflect on commonalities and differences of approach to assessment in the same setting and to gain a deep understanding of Child Psychotherapists' individual experience of assessment. Therefore, the study was conducted on a small scale and focused on the work of the five Child Psychotherapists within that CAMHS team. The study occurred in two stages:

- *Stage 1*: An audit was made of the administrative lists of cases treated by the Child Psychotherapists over a period of 5 years (1998–2003). The number of assessments, their percentage in relation to the totality of cases and their distribution in different kinds of assessment was registered.
- *Stage 2*: A semistructured interview schedule was developed to explore the purpose of assessment, the writing-up of reports, training in assessment, how it was carried out and the decision-making process when completing an assessment. The transcripts of these interviews were analysed qualitatively, using the Interpretative Phenomenological Analysis approach (IPA; Smith & Osborn, 2005).

Participants were the 5 Child Psychotherapists of the CAMHS team. This number fits well with the 'reasonable sample size for a project using IPA' recommended in the literature about qualitative research (Smith & Osborn, 2005, p. 54). The Child Psychotherapists of this clinic have different seniority level (1 Consultant, 3 specialist Child Psychotherapists and 1 Trainee); 3 had trained at the Tavistock Centre and 2 at the Anna Freud Centre, both in London. The interviews, which lasted between 45 and 90 minutes, were all carried out by one of the authors of this article (CP), who is not a clinician. This position appeared to be helpful in encouraging participants to articulate their approach to, and experience of, assessment in a clear way, in the presence of a curious interviewer who did not have too many preconceived ideas about the work. The interviews were spread over 2 months due to the tight time schedule of the participants. To respect the participants' anonymity, they are referred in the study as Interview Participant 1 to 5 following a random order.

The interviews were all tape recorded and transcribed. Following the procedure of an IPA analysis, each transcript was read several times in a search for subordinate and superordinate themes. The first readings focused on the manifest content of the

participants' answers to practical questions, such as how they come to do an assessment, what an assessment session involves and whether they have a model in mind. For each interview participant, a list of the answers was established with reference to the corresponding lines in the manuscripts. This was the basis for a summary of the commonalities and differences in doing assessments and constituted the first, descriptive level of the qualitative analysis. The next stage of analysis aimed to reach the more latent contents of the interviews, for example what assessment means for the interview participants and how they experience it.[4]

After each transcript had been analysed individually, the major themes were collected and master themes common to the five interviews were identified. An external investigator read the transcripts and searched them for themes parallel to and separately from the researcher, and findings were compared and discussed, leading to a refinement of the analysis. The preliminary findings were also given to each interview participant to comment on. Four of them communicated their comments which generally expressed their agreement with the findings. One participant's remark that the formulation of one theme was too extreme, though not incorrect, was taken into consideration and the results amended.

Results

The first part of the results section gives an overview of the quantity and the sorts of assessments carried out over a period of 5 years by the whole team of Child Psychotherapists of this particular CAMHS setting where the study took place. The second part of the Results section, which represents the main body of the study, presents the accounts the Child Psychotherapists give of their assessment work, both in terms of the purpose of the work (assessment as an outcome), and the process by which it is carried out (assessment as an activity). Direct quotations from the child psychotherapists are indicated according to which interview participant said these words (e.g. I.P. 4), although the themes discussed emerged from all interviews, unless specifically stated otherwise.

The range of child psychotherapy assessment cases

Over the 5-year period of the audit, assessments represented 45 per cent of the Child Psychotherapists' total amount of cases, far greater than any other single activity (Table 1). These figures show that assessment constitutes a major part of the work of the Child Psychotherapists within CAMHS, although there were various different types of activity that were termed 'assessment'.

When the 45 per cent of assessment was broken down further, there were various different types of assessment work, with assessments for court (38%) and generic family assessments (33%) the largest proportion of assessment work (Table 2). Although

Table 1. Type of cases taken by Child Psychotherapists within a 5-year period

CPT's type of work	%
Assessment	45
Individual psychotherapy	20
Ongoing family work	18
Parent work	10
Liaison-consultation	4
Parent–Infant work	2
Other	1

Table 2. Context of assessment and reasons for referral

Context of assessment	*% of work*	*Reasons for referral*
1. Referral list and referral meeting	33	Generic family assessment (as part of the multidisciplinary team, all CAMHS clinicians take part in this)
2. Court (letter of instruction from a firm of solicitors)	38	A state-of-mind assessment as part of a larger, multidisciplinary assessment of the family
3. Network, including other members of the multidisciplinary CAMHS team or social services	21	Request for a state-of-mind assessment as part of ongoing family or social work
4. Network, including other members of the multidisciplinary CAMHS team or social services	8	Request for child psychotherapy

generally the assessment work was divided equally among the different members of the child psychotherapy team, the court assessment work was predominantly done by the more senior members of the team, while the trainee did more assessments for individual psychotherapy.

In summary, the different sorts of assessments were: *Generic family assessments* which imply one (or more) sessions with the child and the family, usually at the point of initial referral to the CAMHS team, as part of the general intake procedures of the Service; *state of mind assessments*, requested specifically by another member of the multidisciplinary team, or the courts or social services, which did not necessarily lead to ongoing therapeutic work; and *assessments for possible long-term individual psychotherapy*, almost always coming as the result of an internal referral from another member of the CAMHS team (see Kam & Midgley, 2006).

Despite the range of assessment activity, the therapists spoke little in the interviews for this study about 'generic family assessments', which were not seen as specific to their child psychotherapy discipline (although other child psychotherapists, such as Mees, 2006, have suggested that there is a specific set of skills that child psychotherapists bring to such 'generic' assessments); rather, they focused on their assessments of individual children, both when they were being referred for individual psychotherapy and when the Child Psychotherapist was being asked to provide a 'state-of-mind' report for the courts, colleagues or social services. In what follows, it is this type of individual assessment, whether as an assessment for ongoing work or as a 'state of mind' assessment, which will be discussed.

The process of assessment

There was a fair degree of agreement between the different Child Psychotherapists about the *process* of a Child Psychotherapist's assessment, both in terms of the structure and the content. All agreed that they are interested both in the social reality of the child's experience and in the way this reality is translated into the child's inner world. Table 3 sums up the participants' views about the structure and focus of a child psychotherapy assessment (an 'X' indicates that this was a theme in that particular participant's interview).

The organizational aspects of assessment had common features for all Child Psychotherapists. Three sessions (ideally on a weekly basis) with the child, preceded by an initial

Table 3. The process of assessment

	Interview Participant 1	*Interview Participant 2*	*Interview Participant 3*	*Interview Participant 4*	*Interview Participant 5*
I. Number of Sessions with child	3 to 4	3 to 12	3 to 8	3	2 to 3 Exception: 12
Initial and Feedback meeting with parents/carers	X	X	X	X	X
II. Collection of information about the child	X	X	X	X	X
Focus on both external and internal world	X	X	X	X	X
Issue of confidentiality	No mention	No mention	No mention	X	No mention
III. Structured sessions	X	No	No	No	No
Unstructured sessions	X	X	X	X	X
IV. Awareness of transference	X	X	X	X	X
Interpretation in displacement	No mention	X	X	X	X
Transference interpretation	No mention	No	X	X	No
Use of countertransference	X	X	X	X	X
Attention to defences, conflicts and unconscious	X	X	X	X	X
V. Attention to 'psychological mindedness'	No mention	X	No mention	No	X
Focus on developmental stage	X	No mention	X	No mention	X

meeting and followed by a feedback meeting with the parents, carers and/or the network, was usual. Nevertheless, there were variations in the number of sessions depending on the purpose of the assessment.

The initial and feedback meetings with the family also belong to the regular pattern of assessments. In the first meeting, the idea is 'to get a feel for the family and also if possible to get a picture of the child's own life particularly in their infancy' (I.P.3); at the same time it gives the therapists the opportunity to introduce themselves to the parents or carers and to start to build up trust. Regarding the collection of information and the focus on the external and internal world, the five Child Psychotherapists shared the opinion that broad information about the child, from different sources, is a pre-requisite to assessment and helps to understand the child's inner world. How the issue of confidentiality is different in assessment from ongoing psychotherapy was explicitly mentioned by only one participant, when explaining how the usual expectations of confidentiality (unless there are child protection concerns) did not apply in the same way for assessments: 'I put as much detail as I possibly can on file so that I don't do my usual little talk about confidentiality in an assessment. I keep that for the therapy' (I.P. 4).

All participants had unstructured, play sessions with the child, by which was meant that 'the child can use the sessions . . . to do whatever he wants' (I.P. 3); the sessions themselves had the same steady external frame, that is, 'the same room in a protected

space, prearranged times', the same toys and material which serve as 'a baseline of clinical description in which [one] can note changes in the child's mental representations over time' (I.P.2). Only one participant included a single structured session during the process of state of mind assessments, making use of the 'narrative story stems' (Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003), a narrative-based method of structured assessment developed by Child Psychotherapists wishing to assess the impact of abuse on the internal world of the child and their attachment patterns.

The psychoanalytic concepts of transference and countertransference and their use as assessment tools were present in all interviews, but there were differences in the way the participants dealt with transference. Some interviewees spoke of their view that it was best not to make direct transference interpretation and to avoid making connections between the play situation and the child's own life; instead of this the therapist would make interpretations in displacement (i.e. remaining within the play situation rather than linking the material directly to the therapeutic relationship); two participants, however, said they would at times make a direct transference interpretation, linking the child's play to their relationship with the therapist him or herself: 'if it's required by what the child is bringing' (I.P.2) and because, in certain circumstances, it gives a child 'an experience of being heard emotionally' (I.P.4).

All the participants in this study mentioned that transference was very delicate to manipulate in the assessment context, because of the time-limited nature of the contact and the need to work with the emotional significance of the encounter without 'fostering' a deeper relationship. The context of assessment meant that the Child Psychotherapists did not actively solicit the transference, that is, they did not try to mobilize purposely the child's feelings towards the therapist. Nevertheless, it was impossible to avoid the fact that a child may develop a strong attachment to the therapist within a very short period.

Participants emphasized that it is difficult not to make use of the transference where it appears necessary: 'There is the risk of a child coming, the transference not being touched at all and the child becoming more and more uncontained and acting out more . . . they need to be understood' (I.P.5). Therefore the therapists address the child's emotional experience but the intervention is limited in time and participants spoke of the pain of having to 'drop' a child again:

> In the third session, there was a very, very distressing piece of play in which she was handing me the baby doll, and it was dropped and it had to be dropped and it kept being dropped as if to say, you know, I want you to look after my baby self and you've dropped it, you're dropping me. Which is true! (I.P.4)

In a case such as this, the therapist is not only aware of possibly 'retraumatizing' the child by inflicting again the disruption of a relationship, but also of causing painful disappointment because the child will know 'that there is this good thing, available to some children, but it's not for them' (I.P.4). In some cases, this leaves the therapist concerned about the overall impact of the assessment: 'Is it just going to increase their cynicism, and strengthen their defences, because it's going to intensify their envy?' (I.P.4)

As for the countertransference, all participants seemed to understand it in the way expressed in this sentence: '[The children] nudge you to feel certain feelings about them and then you have to think, "why did I have that kind of feeling?", so you're using your countertransference' (I.P.2). All interview participants mentioned the use of their countertransference in assessment as a specifically psychoanalytic tool that helped them to have a window into a child's inner world and to establish the kind of emotional

unconscious communication that enables them to make sense of what is going on in a child's mind:

> A huge part of the training is in one's own experience of being in analysis, having the unconscious made conscious really, understanding yourself, allowing you to tease out what is your own mind and what is the child's or adolescent's, and that's a huge part of the work because then you are able to really subtly monitor what is going on . . . If you are open to unconscious communication, you become a vehicle in a way, to make the unconscious known I suppose. (I.P.5)

The exploration of the unconscious was therefore seen to be the central aspect of a child psychotherapy assessment. Such a process was also felt to be useful for the whole multidisciplinary team in the course of difficult and emotionally demanding assessment work, such as for courts, to help ensure that the 'unconscious dynamics of the particular case doesn't get reenacted in the professional network' (I.P.2). Nevertheless, they were cautious about writing about countertransference feelings explicitly in their reports, especially when writing for the courts: 'I am more careful than I used to be about separating it out from observation . . . It is very clear the separation between what I felt and what I'm observing. I think that has been probably influenced by doing the work with the court' (I.P.1).

In their practice of assessment, the Child Psychotherapists had developed their own ways, rooted in their trainings either in the tradition of Anna Freud or Melanie Klein, but not necessarily identical to their trainings. The participants trained at the Anna Freud Centre referred to the *Diagnostic Profile* (Freud, 1965) as the framework that informed their process of assessment, whereas the therapists trained at the Tavistock Centre emphasized the minute changes in the emotional atmosphere of the unstructured sessions as their source of information. However, there were more commonalities than differences in their process of doing assessment.

The format in which assessments were presented appeared to vary considerably, although all interview participants insisted that they avoided using psychoanalytic jargon and that they wrote their reports in normal language to ensure good communication with their professional colleagues. A small sample of files of closed cases was consulted to examine how assessment reports were written up. They presented a considerable diversity depending on the purpose of the assessment and on the author. Four reports for the court written by two different therapists had the same structure, beginning with information about the author, followed by a precise description of the assessment setting. Following sections contained very detailed descriptions of the child, including his/her expectations of caregivers, his/her relationships to peers and siblings, his/her anxieties and ways of dealing with aggression. The impact of history on the child's emotional, behavioural and psychological development was attended to and the child's emotional needs were identified explicitly. These reports ended with recommendations for possible future treatment and placement of the child. They were the most complete reports of the sample, perhaps because of the context in which they were being written.

Three assessment reports with different aims, either to consider ongoing child psychotherapy or as part of a whole family assessment, presented many differences: One reported on a session made in the presence of the mother and contained some description of the child's behaviour; another was a narrative description of the child's answers and of her behaviour; the last report was a short section which was part of the larger report about the family. Except for the four detailed reports for the court no standardized model of assessment report writing could be discovered in the files.

The purpose of assessment

The analysis of the transcripts revealed two levels in the Child Psychotherapists' understanding of the purposes of assessment: On the one hand, as a child mental health expert, they saw their role as to offer a particular understanding of the child to the network; and on the other hand, as clinicians, they felt that the assessment itself should be considered a therapeutic engagement with the child.

As 'experts', the interview participants seemed to have a common implicit understanding of the aims of an assessment which did *not* include the provision of a specific diagnosis (psychiatric or otherwise). More specifically, although they saw assessment as an attempt partly to identify the nature of the child's difficulties, for none of them was the final aim of assessment to attribute a label to a possible mental illness. The assessment work focused essentially on the impact of environmental and family issues on a child's mind and on the resulting anxieties, distress, behavioural difficulties and aggressive behaviour, attachment and separation problems.

Figure 1 illustrates how the purpose of assessment is achieved through these steps at the more 'expert' level (above the central line) and at the more therapeutic level (beneath the central line). This, of course, is an artificial separation, as both levels are intertwined in reality. The aims of the Child Psychotherapists listed at each step are a summary of the information extracted from the transcripts. Except for the aims marked with an asterisk (*) which were named by only one or two participants, the others represent generally shared themes.

At the expert level, the purpose of the child psychotherapy assessment consists of forming a detailed picture of a child's internal world through integrating data about the external context and the child's experience with an understanding of the impact of the external circumstances on the child in terms of sense of self, attachment, trust and expectations of caregivers. Furthermore it consists of conveying this complex understanding in a clear language so as to represent best the child's interests.

As one of the participants put it, suggesting also the tension between assessment and therapeutic need,

> So you might have a window into the world that they live in, how unsafe it is, how they don't trust, how they in fact fear adults, they can't relate to other children, they think that the only way they can get something is to use another human being, manipulating, their defences are rigid and unadapted, and then you might not see them again. (I.P.5)

The difficulties cited in this statement are all good indications for child psychotherapy; the therapist has identified the problems, but is aware at the same time that the child might not have the chance to be helped by psychotherapy beyond the assessment sessions. The reasons for that could be that the family cannot support therapy, or that the assessment is done because of a court requirement, or that the child is in the process of being adopted and will move to another area of the country where he may not have access to adequate therapeutic services.

This example shows the ambiguity of the task: On one side, there is an external demand for understanding a child's problem and envisaging future help for this child (the Child Psychotherapist as 'expert'); on the other side there is a Child Psychotherapist who meets the child in roughly the same conditions as for child psychotherapy treatment itself, but for a very limited time and with a different objective (the Child Psychotherapist as 'helper'). The tension that results from this situation is at the core of the therapists' own experiences of assessment.

	Expert level	
- Understand the external context - Look at environmental issues - Assess quality of parenting	- Assess impact of family and environment on child - Assess child's mental state and 'internal world' - Assess allegations of sexual abuse* - Make sense of the problems / symptoms - Determine urgency of intervention	- Produce assessment summary - Formulate the case - Avoid jargon - Make recommendations - Evaluate if environment can support treatment - Speak up for the child's interests in external settings, e.g. court
Child Psychotherapist and external circumstances	Child Psychotherapist and child's problems	Child Psychotherapist and feedback to external world
	Therapeutic level	
- Empower parents*	- Convey understanding of the child's inner world - Convey warmth and interest in child's experience - Offer a therapeutic intervention (e.g. through interpretation) - Offer a microcosm of future treatment* - Establish an (unconscious) contract with the child	- Translate one's own emotional response into thought (esp. for court) - Share responsibility and thinking with colleagues

Figure 1. The purpose of assessment.

An important tension between the two poles is due to the fact that expert work requires evidence and objective data, especially for court assessments, whereas the data collected in a therapy session are of a more subtle kind, based at the same time on observable behaviour and on the emotional quality of the child and the exchanges between the child and the therapist. One difficulty resides in the translation into thoughts and into common language of feelings and emotions, the informative validity of which is not yet as well recognized by certain institutions, such as the courts, as verifiable facts and grounded opinions. At the same time, it was recognized that such a challenge is an important one for Child Psychotherapists, if they are to be able to share their understanding with fellow professionals.

In terms of the impact of doing such assessment work on the therapists themselves, two statements made by participants in the study summarize the complexity of assessment

work. The first can apply to the work encompassing expertise and therapeutic intervention: 'I really feel that it uses all levels of my personality in a very satisfying way' (I.P.4). The second one refers to the two contrasted sides of the experience: 'I find assessments are very hard work, they can be fascinating but they are distressing, yes' (I.P.4).

Discussion

In the NHS setting where the study took place, there was no standardized model of child psychotherapy assessment due to the diversity of assessment aims; only 8 per cent of the assessment cases were specifically assessments for ongoing individual psychotherapy; the rest were for the social services, for other members of the team, or for the court. Only in this latter case did the written reports have a specific format, imposed by external demands and corresponding to particular requirements expected in the context of court work.

Nevertheless, the procedure of assessment itself presented many commonalities across the different Child Psychotherapists, and reflected to a great degree approaches to child psychotherapy assessment described elsewhere in the literature (e.g. Parsons, 1999). The attention to the child's external circumstances, to the parents and to the quality of parenting and the impact of these factors on the child's life were present in all interviews; the Child Psychotherapists tried to make a synthesis of what they knew, of what they observed and of what they understood and felt about each child they assessed.

Among the cases mentioned by the interview participants, there were assessments of children in foster care and in transition to adoption, of children whose parents had been forced by the court to attend an assessment to evaluate their parenting and an assessment of allegations of sexual abuse. Assessments for the court were never only of a child, but of the whole family (Reder, Duncan, & Lucey, 2003).

Unlike many forms of more general psychological assessment in child mental health settings (e.g. Kazdin, 2005; Lachar, 2003), standardized *measures* leading to psychiatric or other forms of *diagnosis* did not seem to be characteristic. The attention to external circumstances and the way these impacted on the child's internal world prevailed over attention to symptoms; none of the interview participants used diagnostic terms in a medical sense; there was no use of any psychiatric label, there was no reference even to psychoanalytic diagnostic terms like infantile neurosis, depressive anxiety or Oedipal conflict. Anna Freud's (1965) *Diagnostic Profile* was mentioned by two participants as a framework to think about a child's problems within his or her context and at the stage of development the child had reached, but the diagnostic categories used in the Profile were not referred to specifically.

When an assessment was specifically for ongoing psychotherapy, there appeared to be some assumption that the referral itself – which, as previous research has indicated, often came at the end of a long period of prior therapeutic engagement by other members of the multidisciplinary team (Kam & Midgley, 2006) – implied the child was *in need* of psychological help. The criteria to decide whether a child could *make use of* psychotherapy were those named in recent psychoanalytic literature (Parsons, 1999; Rustin & Quagliata, 2004), that is, essentially the capacity of the family to support the therapeutic process and to a lesser extent the young patient's psychological mindedness or, for adolescents, the capacity to commit to a long-lasting intervention. Interestingly, no references were made during the interviews (carried out in 2005) to the National Institute of Clinical Excellence guidelines per se when participants discussed their assessments. This gap between research and practice reflects a great deal of literature indicating that there

is a profound dissonance between research and practice when it comes to clinical decision making (Dowie, 1996).

The reference to psychoanalysis and to psychoanalytic concepts permeated the interviews but the distinction between the Child Psychotherapists' different theoretical trainings was not obviously recognizable. The Child Psychotherapists' theoretical background was hardly detectable in the description of the process of assessment itself, though one can assume that it was carried out differently depending not only upon the personalities but also on the Child Psychotherapists' training.

The use for assessment by one of the participants of an instrument designed to assess quality of attachment – a theoretical framework which is widely used beyond the restricted field of psychoanalysis (Barth, Crea, John, Thoburn, & Quinton, 2005) – can be interpreted as an effort by Child Psychotherapists to find some common ground with those who are not familiar with psychoanalysis; it can also be understood as a way of securing more credibility for subtle details of their clinical judgment which cannot be explained easily because they are a matter of intuition and unconscious knowledge. A certain degree of reference to attachment terminology indicated the way in which there has been something of a coming together of psychoanalysis and attachment theory in recent years (e.g. Fonagy, 2001; Hopkins, 1999).

The impression that assessment work was a painful experience pervaded each interview, and was an aspect of the work that has not been widely written about in the literature on assessment. Throughout the process of assessment the Child Psychotherapists appear to rely on their feelings to gauge the situation; their feelings are in many ways the primary assessment tool (Sternberg, 2006). In an early version of our analysis of the interviews, we referred to the therapist's own pain in doing such work as a 'contaminant'. The feedback from one of the participants helped to clarify why such a term was not appropriate, and led to a revision of our interpretation. The participant told us,

> One should be wary of implying that emotional pain is a 'contaminant', since such a crucial part of our work is helping patients to acknowledge and endure their own pain, often through bearing a part of it ourselves, in the interests of facing up to emotional reality and through that, achieving some degree of mental health. (I.P.4)

Given that the current study focuses primarily on Child Psychotherapists' own *perceptions* of the assessment work that they do, further study of the way in which assessment is actually carried out and made use of in an NHS setting is clearly needed. Nevertheless, the current study has attempted to explore some of the ways in which child psychotherapy assessment work in an NHS setting takes place and what models of assessment are being used. Such understanding is essential in a multi-disciplinary CAMHS context in which communication and cooperation between different professionals is essential and the particular skills of various disciplines need to be utilized fully in order to provide the best possible service for children and their families.

Notes

1. The terms 'Child and Adolescent Psychotherapist' and 'Child Psychotherapist' will be used interchangeably in this article to refer to members of the Association of Child Psychotherapists, a 'core profession' within Child and Adolescent Mental Health Services in the UK, according to the government's *National Service Framework* (NSF; DoH, 2004). All trainings leading to ACP accreditation are psychoanalytically oriented, although with certain differences in theoretical orientation and approach.
2. Now the Anna Freud Centre.

3. With the gradual changes in psychoanalytic thinking, especially the increased awareness of the importance of 'object relations', a team of clinicians at the Anna Freud Centre developed a 'revised' *Diagnostic Profile* (Davids, Green, Joyce, & McLean, 2001), which took into account developments within both psychoanalytic thinking (e.g. the work of Winnicott) and developmental psychology (e.g. ideas from attachment theory).
4. This process of interpretative analysis consisted of noting in the left margin any idea or association suggested by the transcript and relevant to the way the Child Psychotherapists think and feel about assessment. Then themes which emerged from further readings were noted in the right margin. A list of all themes of the interview was established; clusters of themes were identified and checked for correctness by constant reference to corresponding lines in the transcript. In a next step, the major themes of each interview were identified as superordinates, whenever possible expressed in the interview participants' own words, as they captured best the essence of their experience. (For instance, a recurrent theme in the Child Psychotherapist's description of their specific professional skills to understand a child's state of mind was the use of their countertransference. One sentence of a participant: 'I put myself in implicitly' renders accurately the essence of the theme.) Each superordinate was related to a collection of subordinate themes that had appeared in each transcript and that seemed to capture categorical features of the super-ordinate. The subordinates in turn were related to the passages and lines to which they corresponded in the transcripts.

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