The Use Of Lowenfeld Techniques In Individual Assessment
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Today's subject is particularly reliant on your input: either due to recent work practices having changed or because your own work is not being covered by the points raised in the following analysis. So it is important that you raise these for our consideration. In the process, I hope that we will all have a broadened view of the kinds of ways the child and family mental health services function in present day society here. Remember I maybe describing an "ideal" situation and often because of circumstances, the following points can rarely all be observed. Please consider that the following are mere pointers to a discussion and I would hope that we could dialogue throughout the day.

Question To Be Asked

1. For WHOM are you making the assessment, eg for:
    1. The Courts
    2. The Community Services: Health, Social Services
    3. The Education Department / School
    4. Your Team, including Specialist Services
    5. Private work, eg Parents

All these clients have different questions they want you to answer. This means that you may need to interview different people, in different combinations, but whichever your task is, an all round picture of the child's personal history in all the settings (eg. home & school) would be desirable.

2. For WHAT are you making the assessment: Examples:

(a) The Courts: One of the commonest requests maybe in acrimonious divorce cases, when you might be asked (1) to assess the most helpful or least damaging home environment for the child re Care & Control issues; (2) for a view on the access arrangements for the child etc.

(b) The Community Services: You might be asked to assess the (1) parental skills of the adult(s) with whom the child is resident, or those adult(s) who wish to take up responsibility for the child, eg adoption; (2) suitability or readiness (timing) for therapy of children under local authority care, eg in cases of abuse, and included in this; it may be helpful to think about what and how much can be done elsewhere: in

school or change of school, or at home (residential/ foster/ etc), for which an assessment of the strengths and weaknesses of these environments would need to be made.

(c) The Education Department / School: You might be asked to (1) make an assessment as part of a Section 5 Statement or Statementing Process; (2) assess whether a child or family would benefit from some form of treatment, and again, included in this, it may be helpful to think about what and how much can be done elsewhere: in school or change of school, the help of a welfare assistant, etc or at home, for which an assessment of the strengths and weaknesses of the school and/ or home environment would need to be made.

(d) Your Team, including any other Specialist Service: There might be a request for you to assess the child or family as part of a team assessment process, so a decision can be made regarding what to do next. eg whether to refer onto another Specialist Team or for individual or family work, and again, included in this. *it may be helpful to think about what and how much can be done elsewhere: in school or change of school, or at home. for which an assessment of the strengths and weaknesses of the environment would need to be made.

(e) Hospital: Conditions vary. from needle phobia to family distress due to terminal illness of a family member, not necessarily a child. and anything in between, or what other follow up services maybe needed by or helpful to the family. You may be the psychologist, the ward nurse or the hospital play therapist or any other professional within the paediatric ward.

All the above considerations apply, but it is important to consider the views of all the people involved, by which I mean not only the view of the person who is terminally ill, but also those of the members of the medical team who has contact with the patient and the patient‘s family, as well as that of each member of the rest of the family. The views of this group have an impact on everyone concerned. You may have a family in denial; you may have a patient who knows the score, but has to manage this difficult situation out of consideration for the family's feelings. You may have medical colleagues who refuse to give up or who have given up hope when the patient or family think otherwise.

These are just a few of the possible scenarios you could be encountering when colleagues or the patient’s family or even the patient personally come with a request for help.

This list is, of course, neither exhaustive nor mutually exclusive under the categories described. In any case, the Assessment must be done with regard to the two above questions in mind.

Other Issues involved in Assessment or Individual Work with Children
Treatment Issues: Treatment goals and Resources

Who or what defines the treatment goals? Can these goals be realistically met by you? What are the resources to meet this goal (eg in relationship to your own work & in relation to the referrals in general: & how would this impact on the way you respond to the referral)? What is the best way of ensuring that these goals are being met? How would you review (and audit) the effectiveness of the treatment? What indications, if any, that this treatment should continue? What are the factors which would affect a decision on short-term or long-term work? What are the factors which would eg determine the interval between appointments?

Time & Timing: Who wants therapy for the child at this time? Is the child ready for therapy? What are the parents' attitude to therapy? Who or what are the supports for therapy? What are the practical difficulties, if any?

Thus all assessments are conditional to a great extent and should be grounded in reality. Indeed, an ideal solution, if there is such a thing. may not be any solution, since by definition we live in an imperfect world!

The Use of Lowenfeld Techniques in Individual Assessment

Bearing in mind the questions posed above, but before proceeding to your assessment proper. you may need some guidelines in your own mind about the time requirement for an assessment. Depending on the kind of assessment you are being asked to make, your first decision may have to be a totally practical one, ie one of time. How much time will be needed to make the assessment, or even How much time do you have?

The following are just some ideas to stimulate your own thoughts on the matter, with particular reference to your own work requirements and situation.

1. How many sessions do you need to make this assessment?

My own solution to this dilemma, at this initial stage when one is likely to be making such a decision without much information, is to offer ONE session of say an hour and a half (this is more time-saving than offering two one-hour sessions). This session may then be divided into two parts, the first for the child with the family, the second for the child on her own), to include in the appointment letter the idea of a possibility that further sessions may be required.

This is so you do not put yourself under undue pressure to come to any conclusions within one session; but if you can, nothing has been lost. One should not presume on the complexities of a case until one has had a look. If the child had been

referred to you directly for treatment, your first therapy session should be treated as your own assessment session, so that you can assess whether the child is indeed suitable for the kind of treatment you are able to offer. Experience will not do away with such assessments, but your judgements are likely to be made with greater confidence.

It is also necessary to add that seeing the child may not always be the most helpful first step. It is possible that it would be more useful to see the parents or family, or do a home visit, or even to make contact with the other professionals involved.

2. How to organise your assessment.

The first decision may have to make maybe “Who is going to be invited to this first appointment?” Do you need to see the child with any particular person?

If the presenting problem comes with a relationship difficulty, like the child who clings to mother and would not allow mother out of her sight, you may wish to see the child with the mother, although in this case you are unlikely to have any choice. But you may wish to see the “problem” in action, so you might send the appointment for the child to be seen on her own and watch what happens. A compromise would be to suggest you see the family together first and then to see the child on her own.

On the other hand, you might decide to see the whole family to see the family dynamics, to see if the clinginess is modified by the larger family, even if or particularly if she is an only child and the only other family member is the father. For a different reason you may actually choose to begin with the family. This is sometimes a good strategy if you are not sure where the problem is located or if the problem seems complex.

Equally possible, you may wish to see the parents first, particularly if the early history looks to be relevant but information scant. Sometimes you may wish to seek parental consent to talk to other professionals. It is usually best if these requests arise from a dialogue with the parents, so that they see the point of your request.

Whoever you start with, you will need to hold at the back of your mind the question “What do I need to know next?”. On the other hand, it is equally important not to stem the natural unfolding of your meeting.

Background to the Referral

Before you see the child on her own, you will hope to have as much information regarding all aspects of the child’s present circumstances, including the circumstances which precipitated the referral.

Do ask for **detailed descriptions of examples of the kind of things complained of.** It is important, for example, to know in what circumstance the aggressive behaviour had been observed and what the aggressive behaviour consisted of. It is insufficient for you just to be told that “he is aggressive to peers and adults alike". All this does is to leave you with your own ideas of what that sentence meant, and what you conjure up may not be what that boy (because the fact that the child was a boy is the only certainty in that sentence) actually did in the Circumstances which provoked that description of his behaviour. This fact needs to be pressed home both for ourselves and for our referring colleagues.

So alongside the information, you would also need to assess the prejudices and bias of your informants. I use the word prejudice and prejudices in the sense that we all have them, because our prejudices is what makes us uniquely individual. Prejudice is a natural way of functioning. We cannot function without them. It is our prejudices which enable us to make a response to the world around us. To make a response at all we have to be able to decide on a preference. to decide that something is better, more desirable, more appropriate, etc.

Prejudice has got a bad name because we tend only to think of it in negative terms, although according to my dictionary, one could use the term either in favour of or against anything. Prejudice merely means to judge or decide upon before hearing the whole case, or all sides, and we are all in this situation with regard to the other person and most situations.

So, this is what I mean by assessing the prejudices of your informants. I mean you need to take into account the fact that all information comes with a personal viewpoint, and the information is not value-free. The reason prejudice in this sense, is important for our purposes, is that information is not only coloured by personal bias, prejudice affects what we do; and how we act impinges on other people and activates their prejudices which in turn informs their actions or reactions. It is why we as therapists have to become aware of our own prejudices. and in our professional capacity, have to consciously temporarily suspend them or put them aside.

For the Individual Assessment:

Again. you need first to consider how many sessions you should offer. given the nature of the request. There maybe time constraints on your part. You may need to include the time spent in getting the necessary social, medical, school and personal history reports. For the personal history, this could form part of the assessment itself, for example, the first session could be offered to the parents or the family or a meeting/s with professional colleagues already involved in the case, whichever you deem to be the more appropriate or feasible in terms of obtaining the information you need.

My own view is that anything less than 3 sessions maybe insufficient to get a useful picture for an appropriate assessment. More than 6 may not be the best use of one's time; 6 for me is also about right to assess the commitment which maybe needed by those concerned, including that of the family and the child.

In a hospital situation, all this may not be possible. So an initial judgement may have to be made as to what you can usefully accomplish. In some cases, you may have to limit your assessment to what is the most appropriate agent for you to refer onto in the family's locality.

An Individual Session with the Child:

In a straightforward session with a child, you would aim to do at least two things: (1) You will want a portrait of the child in action; (2) you will also want to know the child's view of her situation. 'In particular, why does the child or adolescent (age is no bar to having a different view from the referrer's) think 5/ he is coming to the Centre/Clinic today? Who does the child or adolescent think you are? What does the child or adolescent think you are going to do?

I remember one child telling me that she was coming to see me "so I could learn her to do better at school". Although this is a common reason given, what the child or adolescent actually thinks that means is another "matter! In the case of this child, her problems at school were secondary to her personal problems, which the school was not aware of, and how she viewed her personal problems would be difficult for this girl to express in a family setting.

In this process, you may also discover how her E is deployed, whether and how her E is blocked. You may even gain access to her Protosystem View, and perhaps gain insight to any problems this view may have created.

I am sure you will have recognised what this means. 80 to recap a little before proceeding: Ideally, it means the following:

(a) the gathering of the child's or adolescents personal and social history,

(b) the educational, medical and all relevant reports from agencies involved with the child's or adolescents welfare and education,

(c) that is, when you have as full a picture of the reality of the child's situation, you will then see the child: at the first session with the child, (because this process may take more than one session):

(1) you present the Mosaics to the child or adolescent, using the Mosaic Guidelines;

2) you note the child's or adolescents style of approach to the task,

(3) you mentally record what s/ he does and how 5/ he proceeds; ie you take in the Mosaic Process;

(4) depending on the child's or adolescents response, you are likely to elicit further information when you go through her/ his Mosaic process with her/him, often starting with what 5/ he has said about her/ his Mosaic Process and the final Mosaic Product. The Mosaic Guidelines will also be helpful here. From your own practice sessions, you will realise that this process does not necessarily follow a strict or logical path. Be ready to "Follow the child", as often the child or adolescent will initiate this process;

(5) You will next do "Picture Thinking". ie introduce the idea of World-making through the notion of Picture Thinking;

(6) You will then record the World Process following the World Guidelines given;

(7) One way of proceeding further would be to gather your thoughts under the 4 headings I have given you earlier; at least mentally, ie (i) Portrait f0 personality in action, the Style f0 approach to the outside world, (ii) Child's /Adolescent's view, (iii) view f0 E, and possibly (iv) Protosystem view.

Under headings **(i) Portrait & (ii) Child's or adolescent's view:** you would include Appearance and Manner. You would describe the manner of the child/adolescent's response to the Mosaics & the World material; you would note how s/he handles and structures the material, how s/he uses Space within the Mosaic tray, the World/sand tray as well as the room; and how s/he interacts with you. You would also try to elicit the meaning for the child/ adolescent of what s/he is using, doing, as well as what is happening in the trays (ie the multidimensional narrative of the action or simply what the action/s are), as s/he sees, feels or thinks it or whenever s/he is ready to and in whatever form s/he communxicates it, as presented in and through the Mosaic and World vocabulary.

Under (iii) E & (iv) Protosystem view: For E, you would note the movement or the lack of, within space of the Mosaic tray or sandtray, and in the Mosaic and World (ie both in its making and in the movement portrayed, as well as the overall placement, as well as in the room generally). For the Protosystem view, it is not always easy to discern (remember my case study), particularly in the first sessions. Here it is imperative for you to remember your own prejudices. Because of the idiosyncratic nature of Protosystem thinking, great care must be taken when making a judgement

about a Protosystem matter. Here, especially in the early sessions, silence is, if not golden, certainly the wiser course to take!

You may find that more than one session is necessary. It is time well spent, not least because the child will have gained from the experience itself. [cf Lowenfeld's finding as reported in her paper "The nature and use of the Lowenfeld World Technique in work with children and adults", in *The Journal of Psychology*, 1950, 30, 325-331.

- That the mere fact of making a series of worlds, and having them recorded, in itself brings about amelioration in the disturbances and discomforts of some children.

So in the following session/s the child may continue with the Mosaic or the World; but it may also be useful to introduce the child to the other expressive material in your room. Just follow the child. **The two most important words continue to be the Total Response.**