Problem behaviour exhibited by children and youngsters is both a "problem" – and an invitation to maintain the courage, the hope and the faith that it is possible to create relevant contexts for introducing and giving life to resource-filled stories.

In the film version of Jan Guillou’s novel “Evil”, the protagonist, Erik Ponti, is described by the headmaster of his High School. “You are truly evil!” In a way he was right: Erik represented evil. At the same time, however, it would have made a great difference, if the headmaster had also been interested in considering the context in which this evil manifested itself. In Erik’s case, that the young man had grown up as the victim of his stepfather’s unpredictable, inexplicable and uncontrollable violence. If he wanted to change his life, Erik was now forced to find his own path out of this evil. In Erik’s case, no one was interested in the context of his life and behaviour.

The transition in 1994 to the diagnostic system ICD-10 marked the shift to a descriptive phenomenologically based diagnostics, in which the individual had to fulfil specific criteria in order to be classified as belonging to a particular diagnostic group (WHO 1994).

This diagnostic system provides obvious advantages compared to the previous causality-based system – advantages I will briefly formulate in the following.

The particular difficulties, which the child or the youngster are in, are clearly presented – and therefore it becomes readily apparent, which specific needs that comes out of the description.

The child or teen only retains the diagnosis for as long as he or she continues to fulfil the criteria for given diagnosis. Even the diagnosis ”schizophrenia” can be ”grown” out of.

The criteria for determining whether or not agreed-upon treatment goals are reached become clear, ensuring far better possibilities for evaluating and controlling the quality of counselling, treatment and other forms of support.

At one time, ”environmental reaction” was a frequently used diagnosis amongst child and adolescent psychiatrists. It was a diagnosis intended to avoid stigmatizing the child, but was at the same time so imprecise, that it was unable to give any exact picture of the child in question. It referred instead to the child’s environment as the sole focus for intervention. Indirectly, this diagnosis inferred a direct causal connection between environment and behaviour, such that the child’s environment was considered to be the
direct cause of the child problems. In reality, such a causal explanation was far too linear and simplistic. One of the objectives of the new diagnostic system, therefore, was to eliminate the question of guilt (cause-effect) and replace it with more or less pure phenomenology. ICD-10 provides, therefore, clear advantages compared to the previous diagnostic system.

As a child and adolescent psychiatrist, I am personally satisfied with such a conceptual tool that allows me to recognize children and teenagers with diagnoses such as ADHD, Aspergers Syndrome, attachment disorders, personality disorders, etc., when I see them or hear about them in my practice, when consulting or supervising others. I know what they are referring to, when others talk about children and youngsters who could be seen as fulfilling the criteria described within these categories.

The primary objective of the diagnostic system is to optimize treatment. In ICD-10, the core of diagnosis itself, the description, is tied directly to the individual. The consequence of this is that in many ways treatment tied to individual diagnosis is reduced to a primary focus on the individual. It is therefore the individual child or youth who is the one to be treated.

The exciting curiosity arises especially in connection with all attempts at widening focus of behavioural problems, of increasing the field of interest to include not only the presenting problem itself, but the myriad relationships and contexts that problem behaviour is a part of, and thereby contributing to the creation of changes both for the individual and for all related relationships.

**The great challenge**

Erik Ponti says it so clearly in "Evil":

"You have no understanding of how everything is interconnected."

It is exactly these interconnections, the context, that puts evil into its proper perspective. It is the context, which in a way makes it understandable and which at the same time gives Erik Ponti a point of direction in his life. Erik decides that he will not repeat the violence. Quite the contrary, he decides, he will fight against the destructive influence violence has on people’s lives.

It is of central importance to understand problems in their natural contexts. To attempt to understand the good reasons that problems have grown to such an extent, that people see no other resource than to seek professional help. At the same time it is of cardinal importance to establish contexts, that in their own right create the best possibilities for loosening a deadlocked situation (Bateson 1972, Ølgaard 1991).

I’m part of PsykCentrum, a clinical cooperative of three psychologists and a child and adolescent psychiatrist in the city of Hillerød, Denmark. Here it is customary that children and youngsters come in the company of their siblings, parents and sometimes
grandparents - and often accompanied by pedagogues, teachers, social workers and other support figures. Every once-and-a-while they happen to come alone or participate in a part of a session alone, f.ex. in connection with exploratory tasks. By inviting others to participate in and to contribute to the process we professionals greatly increase our chances of understanding and thereby of relating to the many contexts, which form part and parcel of the problems of children and youngsters. At the same time, by encouraging others to participate in the process of change we increase their importance, in some cases an effect that in itself proves of decisive importance for the whole process of change.

Understanding and relating to the individual in context is in my view one of the great challenges. Descriptions gain their value based solely on the possibilities and potentials for change they reveal. This requires maintaining an open curiosity about one’s own pre-understandings and thus an irreversible and non-dogmatic attitude towards one’s own ideas about contexts and connections, which seem to leap into one’s field of focus (Hertz and Nielsen 1999, Hertz 2004). This is illustrated in the following example.

A twelve year old boy

This example concerns a 12 year old boy, raised in a family wracked by a violent divorce and a father in jail. The boy was placed in a special education/treatment school for three years. He reacted violently in this school and a psychiatric hospitalization was therefore considered. The boy himself wanted to be placed in a regular school and emphasized his anger at being placed in a special school as the reason for his problem behaviour.

His parents supported the boy. The school was exceedingly sceptical, but did not want to stand in the way of the experiment. The boy was placed in a normal class on trial and did far better than expected. After a few weeks, however, things went wrong. Because of this, the school called for a crisis-meeting to decide what to do. The Headmaster started the meeting by stating that the boy could not stay in the regular school system, such would be indefensible. The focus of the meeting remained fixed upon what had happened. The parents, who for a time had been in agreement as far as supporting their son, were once again divided. Was this the explanation? Mother was once again angry with the school system and felt the boy had been abandoned. The situation seemed deadlocked.

New information turned up. The boy, who had from the outset been informed that he was on trial, had been told, the day before things went wrong, that he was no longer on trial. Up to that point he had done his best, but had felt himself harassed by a group of boys, who “had something against him” – and he felt himself free to react, since he was no longer “on trial”.

This information, this new context, which made the course of events understandable, opened up for a different dialogue amongst all those present, about how the experiences from this process could be used to plan a more qualified attempt to place the boy in a class closer to the normal school system.

I could have been interested in the boy’s violent behaviour. I could have chosen to focus on the parents and their internal relationship’s importance for the boy. In fact during the aforementioned meeting, I was indeed interested in these themes. I was at the same time,
however, primarily engaged in seeking hope, seeking exactly those contexts, that could help us move forward. Hope happened to become the foreground figure, while the other themes formed the background. Child and adolescent psychiatrist Eia Asen, Marlborough Clinic, London formulates it very simply: "Hope and courage are the two decisive factors in treatment work." (Asen 2001)

I often begin meetings about serious problems by mentioning hope, hoping that we can help each other to find a path out of a deadlocked situation. Reality is created by those structures we choose to focus on. Individual examinations reveal individual connections and in the course of many years very well qualified evaluative tools for such individual examinations have been developed. The context for understanding the problem, however, is very limited. Focus is on the child or youngster. When other participants are included, something else happens. And when the focus is focusing on hope instead of the impact of the problems, something entirely else is happening. Reality is created through the use of language, based on our pre-understandings and based on the relationships we perceive as being central (Lundby 1998, Gergen 1997, Cecchin, Lane and Ray 1992)

Problems as invitations

I choose to see children’s problem behaviour not only as a problem, but as an invitation as well. When I meet a child in the company of significant others, I am very interested in attempting to understand and to relate to those good reasons why the problem has arisen. But at the same time, I am urgently focusing on whatever it is, that the child is attempting to invite us to participate in.

Lang are referring to Harré and his "social construction of emotions" (Harré 1992) and utilizes the expression: "Feelings have morality" (Lang 2002). We have to consider how to commit ourselves in relationship to others in a way that opens for best possibilities, best futures. To look for the possible intentionality of symptoms are ways to transform difficulties into also something meaningful, opening for new relationships. Circling around suicidal issues could f.ex. be seen as an invitation to co-create fellowship with others, e.g. not being that lonely.

In order to illustrate my points further I have chosen to focus very briefly on children and youngsters being diagnosed as suffering from serious attachment disorders (what in the "old days" was referred to as “early frustration”) and Aspergers Syndrome/Autism Spectrum Disorder.

Attachment disorder

Children and youngsters with so-called serious attachment disorders are inviting significant adults around them to join them in abandoning those previously so frustrating experiences and thereby to establish an alternative assurance that it is possible to secure an acceptable future. Their sometimes very provocative relationship to others can be understood in this light, that they do challenge others in order to determine whether or not those around them are capable of remaining in the process together with them. (There is
no reason to attach closely to others, if the relationship isn’t going to last. It is therefore best to determine whether or not it can last right at the outset.)

This way of looking at things is a logical extension of Daniel Stern’s developmental psychology. He emphasizes how children are active participants in constructing their world in a constant dialogue and interactive process with others. According to Stern this is a life-long process. (Stern 1991, Stern 1997). Stern describes how the child collects special themes based on his or her experiences and interactions with significant others. Children with former insufficient security are thus looking for relationships that are able to create safety for the present and the future. His theory is built on an optimistic and constructionist philosophy which emphasizes the belief that it is never too late.

**Aspergers Syndrome /Autism Spectrum Disorder**

Children and youngsters with Aspergers Syndrome /Autism Spectrum Disorder can also be seen as children and youngsters inviting significant others to join them in establishing alternative social interaction and communication, where uncertainty and concern from those closest to them are replaced by a daily life focusing on creating boundaries, predictability, clarity, commitment and clear expectations.

In the wake of ICD-10 and in spite of the diagnostic system’s descriptive base, cause and effect explanations have still appeared. In the case of some diagnoses these causal explanations are founded in pure (neuro-) biological models of explanation. Aspergers Syndrome and ADHD are examples of such causal explanations, in which the (neuro-) biological context apparently supplants other contexts, as if the brain affects the psyche, but without the opposite being true. Thus the brain participates in the above-mentioned creative practice in a continuous interactive process between psyche and soma - throughout the course of one’s life, not the least of which are childhood and the teenage years.

Based in this theory, neurobiological changes can also be considered the consequence of ritualized repeated patterns of behaviour carried out during the course of years. This view demands that we professionals set a special focus on how we can help children, youngsters and their closest relations to an alternative social interaction and in this way take the invitations of these children and youngsters seriously.

The idea of seeing problem behaviours as invitations can also be considered a logical extension of resilience research’s focus on, what it is that helps people move forward and advance in life. The term “sense of coherence” is emphasized in resilience research as a central concept (Antonovsky 1999). Within this research tradition it is emphasized that resilience – the sense of coherence – is created in a continuous, interactive and dialogical process with significant others over time, such that the child or youngster experiences the growth of competency in the following ways:
- The experience of being able to understand the situation you find yourself in, in opposition to the experience of chaos

- The experience of being able to understand the meaning of what happens, what has happened and what will be happening

- The experience of being able to be the subject and the active part in one’s own life, in opposition to experiencing oneself as a victim

Viewing the problem behaviour of the child or youngster as an invitation matches resilience research’s focus on being the active part in one’s own life, in opposition to other theories, which are viewing the child as a victim of, for example, a deadlocked family dynamic or a neurological deficit. The positive intentions of the child or the youngster receive definite attention in line with the problematic presenting behaviour.

**The ethical challenge**

To use Løgstrups expression, we have here an ethical challenge, a focus on the decisive influence we professionals have when "the lives of others are given into our hands" (Løgstrup 1956). Descriptions join together to form and define those who they describe. It is of central importance, therefore, to insure that children’s and youngsters’ problem behaviours are understood in contexts that can help create the best points of departure for change (Nielsen 2004).

I choose to view problem behaviour as an invitation, because this view enables me in a concrete manner, to retain the hope, the courage and the belief that it can be possible to create relevant contexts to introduce and to give life to resource-filled and not problemsaturated stories, which in discussion otherwise can gradually come to dominate all else (White 2002).

I choose to consider the ICD-10 diagnostic system as the point of departure for ensuring not an “either-or” view, but a view encompassing ”both the one and the other”. Both a focus both on the problem as it initially presents itself and on the problem in context. A focus both on that which, all things considered, is measurable in relation to investment, and on that, which can prove itself to be important to include in order to reach our treatment objectives. Both the problematic outward behaviour and the positive intention – that which I call the invitation.

Experience shows that this "both-the-one-and-the-other” approach is also an excellent point of departure for economic and resource-demanding support, because the child’s or the youngster’s special needs are described at the same time as a plan is formulated, a plan that gives perspective to such support contributions – and in a way where the good intentions also are clearly mentioned and put forward.
The first page of your article is clear, about the shift to ICD-10, eliminating the issue of blame (not guilt). But many clinicians here use the more contextual DSM-IV - you would need to address whether your argument also applies to that and elaborate more. By 'pragmatic' I mean that you need to provide then a clinical example, on page 2, as to how this shift manifests itself in clinical practice (for example: "Ben was a 5 year old boy who was referred because of hyperactivity. His nursery and school suspected he was suffering from ADHD. There was enormous pressure on me to 'confirm' this diagnosis...." - then describe what happened and list the 'pros' and 'cons' of making an individual diagnosis, the ethical and scientific dilemmas, the issue of blame and responsibility, just in relation to this case history.). Returning then to the 'Evil' story is, for a Family Therapy Journal, too elementary and simple. I think you would need to
connect it to ongoing debates in current family therapy practice, perhaps social constructionism and narrative approaches. How does ICD-10 'fit' (or not) with those ideas - how can we engage in a 'double description' and bring in context. For a Family Therapy Journal you would need to connect it with systemic practice (and I know the article was written for a general audience - but I do not know of a journal here where this might fit). The example of the 12 year old boy is good and fits, but the discussion is not detailed enough as you don't elaborate on the issue of a traditional diagnosis vs diagnosis in context. The issue of 'hope' comes out of nowhere (to the reader) and would require a Peter Langian reference and perhaps needs to be contextualised within the field of 'Appreciative Inquiry'. This would then require a description of how you introduced (concretely) this idea during the school crisis meeting in your case example. The issue of 'courage' and where that fits is also not clear (flattered though I am by the reference to myself....). There is only one sentence in the following paragraph and another at the end that addresses this, but it's too short-hand.

I said before that in my view the central part of your paper should be 'problems as invitations'. For an Anglosaxon readership you need to explain your 'journey' under that section more clearly, you throw in too many brief sentences and words "social construction of emotions", "morality": where does this suddenly come from? It's too jumpy! Again, a clinical example would help under that section. Your section on 'attachment disorder' is extremely brief (and this diagnosis is hardly ever made in the British context). You have very interesting ideas there, but they need elaboration: more speculation why this term was invented, the advantages and disadvantages of using it. And then connect Stern's ideas with systemic approaches (English practitioners are much less familiar with his ideas than Scandinavians) - the "never too late" needs to be referenced with where in his work you find this optimism - and what evidence he provides for that belief.

When it comes to describing the phenomenon of the emergence of Asperger's syndrome I would want to first hear some comments about the larger context which seems to make this an increasing popular diagnosis. You write 3 paragraphs on it, no case example, no description of systemic practitioners' problems with making that diagnosis, no practical advice on how to handle it and give, to parents and school, a 'double description' that does not risk labelling the individual child 'for life'. The readership of family therapy journals generally hate the idea of Asperger's and ADHD and want to have some tools to frame it contextually whilst not alienating parents, teachers and 'traditional' child psychiatrists. This is where your article has a real 'market' and would have 'pragmatic' consequences. Instead you jump to 'coherence' - how do you achieve it? You come to it, a bit, in your last section on the ethical challenge, but you give no pragmatic advice on how to clinically manage the "both-the-one-and-the-other" approach.

So there is a lot of good stuff there but it needs filling in and more pragmatism and direct clinical advice.