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***Fiona Subotsky** Consultant Child and Adolescent Psychiatrist, **Alistair Santhouse** Registrar, Belgrave Department of Child and Family Psychiatry, King's College Hospital, South London and Maudsley NHS Trust, Denmark Hill, London SE5 9RS

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SHEENA POLLET, MARGARET BAMFORTH AND GLORIA COLLINS

Adult psychotherapy and child and family psychiatry

Ten years of working together for parents and infants

AIMS AND METHODS

This paper describes a 10-year alliance between an adult psychotherapy service and a child and adolescent mental health service to bring psychotherapeutically-informed help to families in difficulties early in the lives of their children.

RESULTS

It outlines staff training, the development of the unit into a significant training resource, the unit's underlying philosophy, its therapies and the key inter-relationships between teams and with health visitors to enable mutual teaming and the rapid access of families to assessment and treatment of the parent–child relationship.

CLINICAL IMPLICATIONS

Funding, future plans and the preventive and economic implications of such work are mentioned.

Psychotherapy departments have been urged to develop ways of working that render assessment processes more efficient and make psychological therapies available more widely and more equitably, while targeting those in greatest need (National Health Service Executive, 1996; Holmes, 1998). The Government recognises troubled families with young children as such a target (Home Office, 1998).

Since 1989, with the aim of secondary prevention, the psychotherapy team and children's mental health workers in Runcorn, Widnes and adjacent parts of rural Cheshire have allied to bring psychotherapeutically-informed help to families.

Conception

The alliance began when we were working as a general psychiatrist with special interest in psychotherapy, a child psychiatrist and nursing sister of an adult psychiatric admission ward. Joint work with a young mother and her toddler had shown us vividly how the mother's severe psychopathology impaired her capacities to foster her child's development and how little we could influence that process. We began to envisage a service able to help such families before the children's development became irreparably affected.

A community-based team would draw on expertise from psychotherapy and child and family psychiatry to target two groups: (a) families having difficulties early in their children's lives, including those where the mother was depressed postnatally; and (b) more chaotic families whose entrenched difficulties were inadequately addressed by existing services. Rapid access, outreach and joint working with other professionals would let the team benefit from others' expertise and spread psychotherapeutically-informed help most widely.

Birth

In 1989 an outdated hospital closed, releasing monies for community psychiatry and staff re-training. We

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received funding, including outreach and training budgets and the psychotherapy family unit (PFU) was established as a nurse-led team of three experienced adult mental health workers, supported by sessional input from both consultants. Our present complement is three nurses, one occupational therapist and a nursery nurse. Managerially, PFU is part of the adult services, but crucially, it has developed and functions between the child and adolescent mental health service (CAMHS) and the adult psychotherapy team. One building houses the three teams.

Training and development – continuous processes

At first the PFU therapists learned from the child and family workers and the two psychotherapists through much joint work and supervision: such learning is now mutual. Child psychiatry has taught us systemic family work, assessment of families and attachments, networking skills and awareness of child protection issues. Our psychiatric training helps us detect mental illness. Psychoanalytical psychotherapy teaches attention to boundaries, meaning, projective processes, transference and countertransference and helps us bear the impact of our work, including engaging with intense feelings in ourselves and others. To facilitate the application of psychotherapeutic skills in the PFU work, each PFU therapist always has two cases in supervised psychotherapy for the adult psychotherapy team. All therapists have gained introductory trainings in group analysis and family therapy. One has qualified in psychodynamic psychotherapy. One consultant obtained supervised experience in the Tavistock Clinic's Under Five's Service (Hopkins, 1992). The other trained in the Parent/Child game (Forehand & McMahon, 1981). As we learn, the PFU evolves, anchored by certain principles.

Core principles

The PFU focuses on the parent–child relationship, using psychoanalytical, systemic and cognitive approaches within time-limited contracts. We aim to keep both parent and child in mind: doing so requires discipline, but repays effort.

The help that families need and can use varies and timing that help is important. Several courses of care may be needed for a family's various components – family, sexual couple, parent(s), parent–child relationship, adult individual(s), child(ren). Each course of care is provided by the most appropriate team. The process of deciding among the teams and with the family which elements of the family need and wish help, in which order and from which team is valuable. It clarifies each team's responsibilities, helps address how family members' needs are negotiated and emphasises the need for appropriate boundaries around the family's various components and certain subject matter. Where these discussions become heated and agreement difficult this can reflect and illuminate processes in the family. Understanding this helps us tolerate our disagreements.

Where we consider a child may be at risk (not necessarily one within the immediate family), we address this and our responsibilities under the Children Act 1989 with the relevant adult(s). If uncertain about such matters, we seek the advice of CAMHS' Social Worker, preserving case anonymity until our responsibilities become clear. When the Act was introduced, we felt anxious and resentful at its intrusion into our therapeutic relationships. We have learned that when concerns for children's safety are aroused in us, similar concerns exist in the parent(s). Discussion thereof, although never easy, mostly affords relief. Rapport usually survives, or can be recovered.

Even if only mother and child attend, we ensure father and any partner are remembered in the work. (It happens that all the PFU staff are female. The male colleagues who join us for work experience show us the value of a male perspective and presence and, fortunately, that our current gender skew does not fundamentally affect the PFU's work.)

The PFU encourages consultation early in the life of a family's children. Using home visits when appropriate, we ensure rapid access to assessment and brief focal work. By remaining quietly enthusiastic and readily available in whatever way is useful, we maintain strong links with colleagues in primary, secondary, tertiary care and social services (Daws, 1999).

The PFU's therapies

Early parent–child difficulties are typically with postnatal depression, bonding, sleeping, feeding, crying and oppositional behaviour. Fundamental to our work is our close collaboration with health visitors to alleviate distress and prevent developmental distortion by promoting the early detection and treatment of postnatal depression: the experimental attachment of a liaison health visitor to CAMHS has enhanced this alliance. The local health centre-based support groups for postnatally depressed women are each conducted jointly by a health visitor and a PFU therapist; their location facilitates informal consultation by primary care professionals. At follow-up, some women accept further help from the three teams for themselves, their partnerships or their families.

For early relationship difficulties, we also offer two brief focal therapies, one psychoanalytical, the other cognitive–behavioural. Our Brief Parent–Infant Clinic (BPI) is the core of our rapid-access focal work. Parents and children are offered up to six sessions for psychoanalytically-informed thinking about their situation. Our foci are meanings, feelings and connections between the problems and family members' internal worlds. Often we find unmourned losses, painful struggles with parental ambivalence and un-metabolised difficulties in the ordinary transitions to becoming a family (Hopkins, 1992). The six-session cognitive–behavioural Parent/Child game helps parents acquire greater skill and sensitivity in playing with

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their children and in managing a child's difficult behaviour. We may use the focal treatments consecutively, their order determined by the parents' readiness. Thereafter, some mothers proceed to an analytical mothers' group.

Families with more entrenched difficulties and sufficient motivation may join a family day therapeutic community programme, which centres on a family meal and includes relationship play (Binney *et al*, 1994), an analytical mothers' group and video-aided work on live parent–child interaction. The PFU also provides a marital and family therapy clinic for the adult population.

Linking the three teams

Tensions are inevitable between three multi-disciplinary teams when one is orientated to children, one to the parent–child relationship, one to adults. Several factors help keep these tensions creative and our working relationships healthy.

Important always, but especially during times of change, are the understanding of each other's work and respect for each other's professional expertise gained from joint working throughout our shared development. Clear boundaries are needed around each team with clear guidelines defining appropriate work for each, cross referrals and inter-team consultation. The PFU's adult mental health origins make one guideline central – if you wonder whether CAMHS could or should help, ask them now.

The composition of the various weekly intake meetings is crucial. A PFU therapist attends the intake meetings of CAMHS and adult psychotherapy. The child psychiatrist has a key role in PFU's intake meeting, where family referrals and assessments are discussed. She also attends the BPI supervision meeting, which the consultant psychotherapist leads. These arrangements have many advantages.

On receipt of an adult psychotherapy referral, we may suspect that the individual's difficulties have originated in the transition to parenthood, that a child may be at risk or that family therapy might be more appropriate. Then a prompt home visit by a PFU therapist, possibly with a CAMHS worker, may clarify matters quickly. Having this option is a great boon.

The presence of our several perspectives in each meeting enriches our understanding of referred cases and our plans for work with them. Much background information becomes available, even concerning referrals in a parent's own childhood and can help anticipate difficulties in engaging patients. Multiple referrals are short-circuited. The most appropriate first assessment can be planned, sometimes a joint one. We have more flexibility to help parents who have presented through their children engage in work on their own difficulties.

Funding, research and future hopes

Our funding is within Halton General Hospital Trust's block contract for mental health and is roughly half the psychotherapy budget, augmented by one consultant session from the Halton Community Trust's budget. If monies became available, we would appoint a child psychotherapist, then a qualified family therapist. Research projects are planned on our Parent/Child game and BPI work. We hope the links developing between the Trusts and Social Services may eventually permit a coordinated under-five's service.

Teaching resource

The PFU has become a valued teaching resource. The PFU members teach a family work module on the University of Liverpool's MSc in Occupational Therapy, train health visitors for postnatal depression listening visits and train colleagues in the Parent/Child game. Fellow professionals who join us for supervised experience, including specialist registrars in psychotherapy and child psychiatry, find that BPI work has great impact on their practice, teaching them the value for families and professionals of keeping both parent and child in mind. They experience the intense and conflicting raw emotions in early relationships, the demands these place on parents and the speed with which early help can often achieve significant improvement.

Working with disturbed young people and their families, we often find their early histories suggest BPI work might have helped. Balbernie (1999*a*,*b*) has outlined the huge financial costs to society of failing to intervene early to improve family life, infant mental health and development. He describes the well-researched early-intervention services which are an established part of American provision. We hope this brief account helps promote interest in such work in Britain.

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***Sheena Pollet** Consultant Psychotherapist, Halton General Hospital (NHS) Trust, **Margaret Bamforth** Consultant Child and Family Psychiatrist, Halton Community Trust, **Gloria Collins** *Unit Coordinator, Psychotherapy Family Unit, Thorn Road Clinic, Thorn Road, Runcorn, Cheshire WA7 5HQ*

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