CHILD AND FAMILY PSYCHIATRY IN AN IN-PATIENT THERAPEUTIC COMMUNITY

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The Cassel Hospital provides two ~~separate~~ less seperate types of service, i.e. for the in-patients and the out-patients.

The Out-Patient Department for Children and Parents runs on the lines of an adequately staffed family orientated Child Guidance Clinic, using the services of a Child Psychiatrist and Educational Psychologist, a Psychiatric Social Worker, a Child Psychotherapist and an Hon. Paediatrician. Special features include the following possibilities:

One or both parents being treated by HospitalPsychiatrists (or Psychiatric Social Worker).

Admission to the In-Patient Unit of the child and his family for investigation and/or treatment.

The use of the Hospital Nursery School.

Families in Hospital. There is an establishment for eight in-patient families, i.e. about sixteen parents and sixteen children. Other in-patients include up to twenty single adults and twenty adolescents. The combined use of the social approach (therapeutic community) and the individual approach (psychoanalytically orientated psychotherapy) provides the basis for the work of assessment and treatment. (Main 1946).

The History of Admitting Children and Families to this Hospital:

The Mother as the Focus of treatment: In 1948 a mother was allowed to bring her young child: subsequently mothers were encouraged and then expected to bring their young children with them in an attempt to prevent adverse effects of seperation on the mother - and the child - and to understand some of the mother's personality problems as expressed in mothering, including the unconscious wish to seperate from the child. (Main 1958, Weddell 1957).

In 1955 the accent shifted to the attempts at understanding specific difficulties in mothering, central to the mother's current problems and often manifested in a crisis in relation to her baby, as in puerperal illness, or her toddlers. (Main 1958,

Lomas 1960, Weddell 1961).

Lomas, for instance. wrote of the unresolved relationship with internalised envious mothers, in certain young mothers suffering from puerperal illness.

During this period some approach was made to the child's personality in relation to the mother's pathology and treatment (Gluck and Wren 1959, and also the film "Play and Personality"), but essentially the attitude was "understand and help the mother - she will help her children". Gluck and Wren started systematic observation of children by a group of workers, whose roles they felt had to be "clearly defined and respected". They were able to see how, in play, children reproduced "what their mothers did to them". They made other valuable observations on how mothers' pathology and mothering can prevent her child's development towards independance; how the children can be used by the mothers to hide their problems and resist treatment and provide the staff with clues to mother's disturbance.

1962 Focus on the Child as well as the Mother - The Children's Unit.

In line with the developing experiences and idea, and because of the concern for the children who had "sick" mothers and were in psychiatric hospital, new appointments were made of a Child Psychiatrist, a Child Psychotherapist and an Hon. Paediatrician, whose aim it would be to cater specifically for the needs of the children. The Child Psychiatrist formed the Children's Unit, which soon came to include the Nurse, and later the Teacher in charge of the Hospital Nursery School (older children attend "outside" schools).

Functions of the Children's Unit comprised: Study of Children in the Hospital, including the advantages and disadvantages to them of this setting, e.g. security from parents' pathology, a new positive experience, mutual help and increasing insight of the mothers v. neglect, scape-goating, misuse of the children to express or deny mother's problem, to resist or prolong her treatment, diffusion of parental roles, etc. This would lead to altering the environment where necessary and possible, with the aim of it becoming more beneficial to the children.

Diagnosis of the vulnerable and "sick" children.

Treatment of selected children via the therapeutic community or via psychc-

therapy by the Child Psychotherapist.

Admission of some overtly "sick" children with their sick mothers, where it was felt that the couple could best be treated in this setting.

Study and Resolution of the Hospital's Resistances to the change of focus and to the emerging roles of the staff of the Children's Unit. For instance, the resistances to the referral of suitable children had to be discussed and "worked through" at the meetings of mothers, nurses and doctors treating the mothers, etc.

In her first paper Folkart (1964) emphasised that apart from thepossibilities of being affected by his mother's projections and identifications, being used by her to express or deny her problems, to resist her treatment and more adult functioning - the child is an individual in his own right, with his own inner life and internalised problems, his personal interpretations of and reactions to his mother, family and the environment in which he finds himself, with its helpful and painful aspects.

Through fuller understanding and seperation of the various factors involved, this work has freed the child from certain misconceptions of those around him and put him and his needs to the fore: it also clarified the role of the Child Psychotherapist in this unusual setting. The questions could now be asked: what belongs to the child, the mother, their relationship, the special setting of the hospital? Why and how is the child used and scape-goated? Why is he not referred for help, etc?

More specifically the questions we asked ourselves were:

How do different children experience an environment in which their mothers:

are considered sick;

have their own parent figures like doctors and nurses;

have to attend numerous meetings and "sessions";

and they, the children, are exposed to a confusing reality which includes intrusive, analytical atmosphere and current effects of the treatment of the mother.

How, through awareness and planning, can one reduce the negative effects of the environment and increase its benefits like:

protection of the child from mother's pahology (dilution of its impact);

positive contact with other friendly, less involved adults;

positive results of mother's treatment;

early diagnosis and treatment of the child's disturbance.

Some special needs of the child in this environment become apparent (Folkart 1967) e.g.

for the Nurse to support but not to take over from the mother;

for the Child Psychotherapist, in his framework, (apart from her usual function) to offer: privacy, and when necessary, a new "corrective" relationship;

clarification of external (v.internal) reality;

optimal contact with the mother, mother's nurse and Therapist;

for the child to attend the relatively neutral area of the Hospital Nursery School (to which we decided to admit a number of outside "normal" children).

1963 - Focus on the Interaction between the Mother and the Child

The Family Unit - Gradual co-operation if the Mother's Unit, which included the parents, Nurses and Doctors, and the Children's Unit, led to the merging of the two teams under the Child Psychiatrist and to the more systematic attention to the mother/child interaction on the conscious & unconscious levels, e.g. in the meetings of the child's and the mother's Therapists, co-ordinated by the Child Psychiatrist.

It soon becameclear that the description of most fathers as "healthy adults ledged" or even "social therapy beneficiaries" was misleading, and that the part they played in the family dynamics needed careful scrutiny. At first this applied to the role of the overtly or covertly "sick" father in relation to the mother and the child. Later on every father was considered in his own right, as well as a member of the family in treatment.

1965 - Focus on the Mother/Father interaction:

The functioning of the parents as a marital and parental pair was felt, and found to be, highly relevant in relation to their "sick" and "healthy" children. Conjoint treatment of husband and wife became increasingly employed, straining the therapeutic skills but leading to valuable findings. Whilst the community helped to relieve defensive manipulation of one partner by the other, and provided a certain degree of distance and objectivity about their social and emotional interaction, conjoint treatment allowed for the basic distress of the couple "to be

contained and examined within their relationship, with the advantages of simultaneous insight and change and avoidance of one partner resisting the progress of the other (especially when the neurosis of one was anchored in the complementary neurosis of the other)" (Nakhla, Folkart, Webster - "Families in a Psychiatric Hospital").

1966 - Focus on the Total Family Dynamics

At this point a stage was reached when suitable families were admitted for team diagnosis of the disturbance within the family and for the assessment of the foci and aims of treatment. It was hoped that this approach would avoid the scapegoating of one member, and the consequent guilt feelings in other members, a split between the family and the hospital staff, wasting of positive resources in the family (which could now contain its problem) and treating the wrong patient. Attention was paid to the individual pathology of different members of the family, their involvement with and use of each other, their roles, e.g. sexual, marital, parental, etc., reciprocity, mutuality of function, communication, etc. (Nakhla et al, see above).

1968 - The Family Unit at Present

The Staff of the Family Unit consists of one part-time Child Psychotherapist, responsible for the Unit, one full-time Child Psychotherapist, three Nurses with special training in relation to the therapeutic community, one qualified Nursery School Teacher (+ an Assistant) for in-patient and outside children aged from three to five years, one part-time Educational Psychologist and two Physicians (one G.P. and one Hon. Paediatrician).

The Child Psychiatrist studies the referrals for in-patient treatment of one or more family members, or the total family, usually from G.P.s, Psychiatric Hospitals, Mental Health Authorities and, increasingly, from Child Guidance Clinics. Even at this stage it may be possible to form a tentative opinion on whether the overt disturbance is in one member or in a group of members, e.g. mother/Father, mother /child, etc., and as regards the recent strains and precipitating factors. Special consideration is given to possibly intolerable interpersonal relationships between the family and the presenting patient and also between the referrer and the "patient".

An Out-Patient Assessment of the Family is undertaken in a great majority of those referred. The parents are always seen together, and possibly also seperately, by the Psychiatrist. The "sick" child is seen alone or with his mother, by the Child Psychotherapist. The questions of assessment, help to the referrer and admission to the hospital are discussed by the two interviewers and frequently a Nurse, who may have visited the home or may be asked to do so at this stage. The factors which favour admission (always a serious step and much more so when a whole family is concerned) are: multiple involvements within th family, combination of intra-psychic and interpersonal problems, intolerance of seperation and of merging, a threat of exclusion of one member, e.g. a child, husband or wife.

The Nurse's Home Visit, which precedes admission, provides valuable information about the family in their environment, presents realities of the hospital to the family and facilitates family/hospital relationships. Sophisticated observations at this level give invaluable guidance to family functioning and attitudes to treatment, and in making a decision concerning suitability for admission. (Webster 1966).

In-Patient Assessment is carried out within the first two or three weeks of the family in the hospital, by the whole team of the Family Unit. The Psychiatrist sees the parents together and then he may see them seperately. The Child Psychotherapist sees each child and especially the "sick" child. The Nurse relates to, nurses and observes the individuals, couples, e.g. mother/father, mother/child, and other sub-groups and the total family in the community; e.g. the adjustment during the first days, later in the Work Groups, at Mother's Meetings, at Husbands and Wives Group, etc. In suitable cases the Nursery School Teacher, the Psychologist and the Physician are involved.

The Triage i.e. the Diagnostic Conference, is attended by all the staff involved. Each member presents a written or verbal report. The usually rich information thus available, which includes the subject of staff-patient and inter-staff relationship reactive to the family, is then discussed w th a view to making a family diagnosis and determining the foci and aims of treatment. The question of whether in-patient treatment is advisable is seriously considered at every stage of the diagnostic

contact with the family. Renoval of a whole family from their natural environment and their placement in an in-patient community is always a major operation - likely to effect delicate self-regulating processes. The fact that individual therapy and treatment of more than one member of the family in the outside community have, in many instances been attempted before the referral to the Cassel Hospital, is not in itself sufficient; positive reasons for admission need to be balanced against the likely disadvantages and the current character of the hospital community - can weigh the scales on either side.

Treatment - According to the decision made at this stage husbands and wives may be treated together or seperately and, if the latter, by the same or two seperate Therapists. The "sick" child (and/or his "healthy" siblings) may or may not be treated by child psychotherapy and, if he is, mother's contact with the Child Psychotherapist will vary according to circumstances.

The problems and possibilities for the family in the community and their subsequent progress are discussed at Unit and other meetings, from the day of their admission to the time of their being given their leaving date, and the important period which follows.

Here are a few examples of a shift of emphasis away from the "primary patient" after the Triage or early in thetreatment.

(1) A girl of eight, suffering from school refusal and anorexia nervosa was transferred to us from a General Hospital and was joined by her family. Her father and two siblings were found to be disturbed (father psychologically deaf, one child in an epileptic colony because of "behaviour" problems, another immature, depressed, unable to cope with her away-from-home employment). Contact with the whole family revealed that the apparently "healthy" mother's depressive psychosis - her closely guarded secret since she was in a mental hospital at eighteen - was the central problem, disturbing and isolating all other members. Mother's treatment became the focus of attention, and the anorexia of the child ceased to exist soon after the family's admission.

(2) Two mother/only-child couples (father having died recently) were referred because of the accepted disturbance, mainly in one person. The interpenetration of pathology (which included shared phantasies about the father's death) proved to be

such that only the combination of support and nursing within the community, and individual treatment of each partner, with close collaboration of all staff involved, could be, and proved to be, effective.

(3) An adopted only child was felt by her mother to be "oversexed" from the beginning. Mother's anxieties became confirmed when the child was accused of sexualised relationships to the teachers. Sending the child away was felt to be the only solution for his mother (and the colluding father) who had clearly projected her problems into the child. Mother, as well as the child, was found to require individual treatment.

In the following two examples of parents with disturbed children, conjoint treatment of the parental couple was considered to be of primary importance:-

(4) One couple was relating on the basis of each partner helping the deprived aspect of the other, and failing to do so, thus repeating the maternal deprivation of their respective childhoods. Their bright, "gifted" envied girl was declared to be difficult and "sick" and was cruelly treated by the mother. Their overprotected boy, considered to be "happy and affectionate", was found to be emotionally and intellectually retarded. The parents as a couple, and later the boy in his own right, required more urgent treatment than the very resilient girl, who was the referrer's main concern.

(5) Another couple with dovetailing problems relating to low self-esteem and unreal, grandiose aspirations placed their girl in a denigrated role, whilst pushing their exalted boy beyond his capacities. Conjoint treatment of the parents was considered to be the treatment of choice for this family.

Communication. It is clear from the above that communication via meetings and written reports of the various members of the staff is an essential aspect of work in this setting. As an example I shall give the Child Psychiatrist's commitments in the respect. He chairs the meeting of the Therapists of mother, father and the child, also the Study Group on Families in Hospital attended by the Child Psychotherapist, the Nurses and the Nursery School Teacher. (This last group has recently become the responsibility of the Child Psychotherapist). He also has individual meetings with the Therapists and the Nursery School Teacher. The contact

with the rest of the hospital is maintained by him attending the conferences of the Consultants and those of the whole in-patient and out-patient staff.

These meetings serve the purpose of supervision and co-ordination of the work but also for the discussion of staff problems in relation to specific situations and their effects on the community and the patients. They seem to provide an essential experience and training for family therapy.

Scope and Possibilities - The setting and the way of working provides wide scope as regards diagnosis, therapy and research. It has a potential for refining the fabric of family psychiatry, without diluting known skills, and for contributing new ideas on Child Psychiatry Units.

Facilities exist for research into:

(i) The study of children, mothering and mother/child relationships (including the effect of "sick" mothers on their children) through direct observation and simultaneous treatment.

(ii) The dynamics of total family and its sub-groups, based on direct observation and on treatment of individuals, couples or family as a whole.

(iii) The individual, family and community interactions, e.g. how individuals develop and express character traits and social roles on the basis of intrapsychic factors and family relationships and how these interact with the "culture" and dynamics of the larger group.

(iv) The development of new therapeutic techniques and the selection of suitable referrals, foci and aims of treatment (e.g. short in-patient stay, followed by out-patient treatment of families).

Discussion

Child Psychiatrists take pride in their comprehensive approach to mental health and illness.

They take into account (a) the individual's personality (assets and liabilities) including his inner world; (b) the social matrix around him especially his family; and (c) the interaction of the two in the course of time and the present.

Such an approach fosters (a) the appreciation of positive resources and

processes within the total framework and of the multiplicity of factors involved in pathology. Therefore, (b) the need of a thorough diagnosis and finding an appropriate focus and aims for treatment; and (c) humility as regards how much one person can do in this respect, and therefore, an orientation towards teamwork, for pooling insight by those who specialise in the social/educational and the psychodynamic/psychotherapeutic aspects of the situation. The team itself is like a developing organism with its own character, resources and problems; much conscious and unconscious work goes on to improve relationships and lines of communication, for a more satisfying and more satisfactory functioning.

The nets are thrown wide and deep, but are still coarse and much of what is relevant escapes. Refinements are continually being made. Much has been achieved in all areas - especially through the psycho-analytic treatment and study of the child - but perhaps least of all in understanding the family matrix and in being able to use such understanding. Recently, family dynamics and family process have been receiving more attention, adding a new dimension to the study of the conscious and unconscious present and past processes around and in the individual (social roles, pairs and triads, identity, etc).

Our language, our technique and our emotional and conceptual limitations make it difficult to harmonise these two approaches, individual and social, and this results in a tantalising tension which, however, is likely to lead to new levels of insight including fuller comprehension of family and other social roles.

At the same time "adult psychiatry" has moved much nearer to "child psychiatry". The adult individual is no longer considered so fixed and unchangeable and linked with his past, and therapeutic possibilities only through a verbal approach to the sap of his unconscious life (although insight obtained through and into the transference/counter transference phenomena remains the most powerful therapeutic factor.) He is seen as still developing and going through developmental and other "crises" (late adolescence, marriage, pregnancy, "mid-life, middle-age, etc), with possibilities of change. His environment seems to matter more; also as an aspect of his positive resources. Energies locked up in his character traits and social identity can be approached through better understanding of his social roles

and functioning. Here his childhood and his present family dynamics, e.g. marital, parental etc., are most relevant. In his case, too, teamwork of individually and socially orientated workers, and finding suitable focus and aim of treatment, may be appropriate, providing the team is sufficiently sophisticated, has the capacity to understand transference manifestations and group-dynamic situations, has facilities for insight into its own "family" and "role" problems, and does not act in the service of diluting the psychotherapeutic approach. The problem is how to cope with the"division" between the individual and social aspects of personality, how to seek for the links and solution somewhere in the family dynamics, how to find a medium and technique which would allow for further investigation of his area of interaction, how to clarify what remains mysterious in the leaps from childhood to adulthood, from relationships to "traits" and "roles" and from living "traits" and "roles" to rigid and barren ones.

The combination of a "therapeutic community" (with its relatively democratic and rational structure and function) with group and individual psychotherapy (which confronts the individual with the links between his personal, family and social problems), go some way towards revitalising of obsolete, rigid social roles in line with the more basic needs of the individual. Special features of the environment are such as to encourage rational functioning, free communication, and awareness of the direction in which the problems lie, and which can be approached by therapeutic resources available (social or individual). Admission of whole families into this environment results in further refinement of diagnostic and therapeutic tools in relation to the individuals and groups: and a unique opportunity for observation and research into family dynamics and individual family interactions.

Changes can occur in the individuals, in the relationship of individuals within their family, of families to other families, of the group of families to the rest of the hospital community, and of the hospital community to the outside world - change in each area affecting the other. The individual can gain insight from his individual sessions and from understanding of, and change in, his family and other groups, and his role and function in them; and has an opportunity of applying this insight - and therefore, a greater degree of inner personal freedom - in action

within a living and changing, permitting and restraining community around him. These processes facilitate greater emotional understanding of the link between the individual and social aspects of the personality.

The guardians, facilitators, and participants in this process are the hospital staff, and especially the nurses and the doctors. Their two interdependent functions consist in maintaining the atmosphere, the flexibility of structure and of work of the community on the one hand, and helping to increase the insight by verbal and nonverbal means on the other. It is, therefore, essential that the roles and communications of the staff are clearer and more functional than usual, and there exist provisions through relevant meetings for obtaining insight into staff tensions, their relationships to each other, and to the patients.

The challenge to the staff's emotional and intellectual equipment is very great; individuals can be strained to their limits and the way they resolve their personal and interpersonal "family" tensions affects their own capacity to function in this setting, and acts as a form of training.

Conceptually, the setting and the pressures within it require, facilitate and almost forge a link between psychoanalytical ideas, and those of more socially orientated workers, especially in the field of group and family dynamics, e.g. Foulkes (inter-actional network"), Bateson ("double bind") Laing ("mystification"), Wynne ("pseudo-mutuality"), Ackerman family diagnosis and treatment) and Lidz ("marital schism and skew") and others.

Maternal attitudes like rejection, compensatory overprotection or perfectionism, projectionism and a variety of meanings and uses of the child, are amplified and given wider meaning by the understanding of family structure, male/female, husband/wife, mother/father, parent/child roles within it, communication or irrationality and denial of child's perceptions, etc.

The concepts of pathological character traits and social roles, especially as regards their family roots and social manifestations, seem to be central to the understanding of what this setting can offer, in a way of therapeutic possibilities. A clearer conceptual framework - based on past experiences and consequently on hard-won increased freedom of linking the personal and the social - could lead to a more

definite aim in diagnosis and treatment. For instance, it may lead to focusing on pathological social roles and to making a concerted approach - via community and individual therapy - towards insight into psycho-social functioning.

Main's more recent papers, especially "The Ailment" (1957) "Mutual Projection in a Marriage" (1966), "Knowledge, Learning and Freedom from Thought" (1967), seem to emerge from the possibilities of a new approach offered by the special medium of the hospital. They speak in a way which is novel, of psycho-analytical mechanisms in social interactions, character traits and object relationships, fluidity and solidification of ideas and roles.

A further concerted effort in this direction seems to me to be what is called for at this stage. It would include more explicit organisation and planning of the work as well as much hard conceptual thinking.

Summary

Evolution of work with parents and children in an in-patient therapeutic community is described. The framework which has emerged is discussed, especially as regards the possibilities it offers in the fields of child, family and group psychiatry.

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