CHAPTER FIVE

From Milan to the Tavistock: the influence of systemic training on child and adolescent psychiatrists

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Introduction

This chapter will describe a study involving child and adolescent psychiatric trainees that explored the impact of systemic training on their child psychiatric practice as consultants. The training aims to provide them with the knowledge and skills to practise systemically with the families and wider systems that they will encounter in their work as future consultants. The course has evolved over fifteen years, influenced by the changing contexts of both psychiatric and systemic training

Applied systemic practice

Applied systemic practice may be defined as the systemic understanding and skills that we bring to our work when we are not acting formally as systemic family therapists, but are making a clinical, managerial, training, or supervisory intervention in another role or setting. We consider that an important aspect of applied systemic practice is the introduction of systemic ideas to professionals from

other disciplines to enhance their practice in their fields. Before family therapy was established as a profession, family therapy training was seen as adding an important therapeutic paradigm to core professional skills. We suggest there is still a need to offer systemic skills to people who are not going to become career family therapists. There are those who do formal family therapy training while intending to remain in their core profession. However, for many professionals, such as social workers and doctors, there is a benefit in having the training tailor-made for the professional role in which they will apply the systemic training. One example was a course for general practitioners and primary health care professionals (Launer, 2002; Launer & Lindsey 1997) at the Tavistock Clinic. This systemic training, "Narrative-based Primary Care", enabled GPs and primary healthcare professionals to give meaning to their "five minute" consultations, using skills based on an understanding of context, curiosity, circularity, and co-created conversations. The subsequent dissemination of this course among general practitioners, consultants, and medical educators around the country demonstrates the contribution that systemic thinking can make to medical practice more generally.

Systemic training for child and adolescent psychiatrists

The original idea was to provide child psychiatrists with the tools to work as family therapists. In time, it became just as important that they learnt to apply systemic ideas to their daily work, irrespective of the task, be it working with a family, prescribing medication, consulting to the network, or preparation of a court report. The key concepts of systemic thinking taught included understanding the meaning of context, the use of curiosity and self-reflexivity, the distinction between linear and circular thinking, and interventive interviewing (Tomm, 1988). The training offered an alternative form of thinking and interviewing to the psychiatric model. As trainers, while we did not explicitly use the language, we addressed Campbell-inspired polarities between biological psychiatrist and systemic psychotherapist, between positivist scientist and postmodern constructivist, between certainty and doubt. We adopted a "both . . . and" perspective on the issues of psychiatric diagnosis, history taking, and intervention. Future psychiatrists need to be able to talk several "languages",

including "evidence-based" practice, have the capacity to put objectivity in parentheses, in Maturana's terms, and to hold a "not knowing" position alongside their learnt knowledge (Maturana, 1988). This entails the ability to tolerate uncertainty and cultivating curiosity in the interest of developing a co-created understanding in conversation with families and others.

Since many were already familiar with psychodynamic thinking, which informed their interviewing style, we found ourselves making clear distinctions from the psychodynamic model to enable the trainees to learn to practise systemically. As we became less defensive of the systemic model and conceived it as overarching, there was less room for conflict. We became flexible, finding it helpful, for example, to incorporate psychodynamic thinking as hypotheses into our family work.

Live supervision in a team context was a unique experience for most trainees, providing a transparency not common in their other clinical practice. The use of reflecting teams took the process of openness and the achievement of multiple voices in a co-created therapeutic process a step further. As in other psychotherapeutic endeavours, we were confronting the pain and distress of the people who came to see us, finding ways to make meaning of it for them and for ourselves. Live supervision allowed the impact of the work on us as practitioners to be explored and used to enrich our work together.

There were multi-layered contexts for the course, relating to its organisation, its uni-disciplinary nature, and the separation of personal–professional development training from the supervisory role, and to the broader psychiatric training and practice.

The group, diverse in terms of age, gender, and ethnicity, was uni-disciplinary. This ran counter to family therapy training tradition. All our trainees were working in multi-disciplinary teams elsewhere and so would have been open to the challenge of assumptions and prejudices by other professionals. Multi-disciplinary training is valued for the opportunity it provides for exploring difference and capitalising on the strength this brings to learning.

The rationale for our decision, as trainers of both child psychiatrists and family therapists, was to ensure that child psychiatrists acquired systemic skills by having systemic training integrated into their psychiatric training. We knew that few would commit themselves to the professional family therapy training. Our systemic course was probably unique among psychiatric training schemes.

Further, we knew of instances where challenging and undermining beliefs were expressed about the "medical model" and psychiatric practice to psychiatrists in multi-disciplinary training designed for people intending to make systemic family therapy their chosen profession. This might create an unsafe learning environment for our psychiatric trainees. This was not the only story, of course; other psychiatrists found their medical expertise valued alongside the others in the group.

By contrast, training a group of child psychiatrists enabled us to hold in mind and to explore freely the integration of systemic ideas and practice with other aspects of the child psychiatric role and task. We could set the idea of diagnosis in the context of family relationships and the wider mental health system, and discuss the implications of making or not making a diagnosis. For example, with a child with obsessive–compulsive disorder (OCD), we worked with the family members around their relationship to the child and the OCD and its meaning for them, at the same time offering medication and cognitive–behavioural therapy, the effect of which was also thought about in terms of its meaning for them as a family. We could explore the influence of our medical and psychiatric beliefs and assumptions on thinking about the meaning of the difficulties which families presented. As trainers, we could both challenge the potentially pathologising aspects of the psychiatric model and find it helpful as one way of conceptualising and communicating about a problem.

This was a safe setting in which to explore these issues, free from a sense of a more fundamental challenge to the trainees' role as doctors. We do not know whether, on the other hand, they might sometimes have been constrained in their thinking by the power inequalities between us; could they disagree with the supervisor if he is also the medical director overseeing the whole psychiatric training?

Personal–professional development (PPD) is fundamental to family therapy training (Hildebrand, 1998). The PPD sessions entailed exploration of genograms, trigger families, and intra- and interpersonal issues raised by the family work. It also addressed issues of professional identity, power, responsibility, and authority. PPD raised a dilemma in that, as supervisors, we were also assessors for the child psychiatric training. It was important that our future assessment of their suitability to qualify as child psychiatrists was not influenced in

their minds or in ours by a confusion of roles. It was essential to maintain the boundary of confidentiality around their personal discussions in PPD. By contrast with family therapy trainees, who come together weekly and work elsewhere, ours were participating in a full-time, 3–4 years' child psychiatric training together. To address these dilemmas and to safeguard our professional relationships, we asked a colleague systemic family therapist to provide PPD. This also added a third perspective to their experience. However, the arrangement created a challenge in the group when, as supervisors, we could not always understand the responses to particular clinical situations in terms of the trainees' personal experience. They sometimes chose to share the connections with us, or helped each other based on the understanding they had gained from the PPD sessions. We created other opportunities aside from the formal PPD to work on self-reflexivity together. A further issue was that some of our trainees were in psychoanalysis at the same time. This introduced a tension about the best place to explore personal family and professional identity issues. Despite these drawbacks, PPD remained central to developing self-reflexivity in a group context, to examine the fit between each trainee's self as a family member, as a professional with a family, and the connection between the two.

Another context was the Royal College of Psychiatrists' curriculum for training of child and adolescent psychiatrists in therapeutic modalities. In the past, trainees had been expected to learn a range of therapeutic modalities. In 1999, a revised curriculum viewed family systems therapy as a treatment modality alongside individual psychotherapy, behavioural, cognitive, and group therapy. They recommended basic experience in all modalities, basic competence in at least two areas, and encouragement to pursue specialist competence in one area. This fitted with our original ideas about the need for child psychiatrists to have family therapy training. In 2008, the competency-based curriculum (Royal College of Psychiatrists, 2008) for specialist training addressed training in psychological therapies using a skills-based approach, including many ideas that fit with the goals of systemic training. The therapist is expected to be a reflective practitioner, behaving respectfully and taking account of the power differentials in a therapeutic relationship. The therapist is responsible for maintaining boundaries, showing respect for others' contributions to a treatment package and being non-discriminatory. Three levels of

competence comprise "under supervision", "competent" (the ability to work independently expected of a consultant), and "mastery" (the expertise to supervise, teach, and develop new ideas). The competent practitioner will be able to deliver therapy, plan and conduct therapy under supervision, plan and conduct an appropriate course of therapy in two of the four core modalities, and be able to use supervision. Theoretical knowledge and technical ability is expected and an emphasis on engagement. It goes some way to recognise the wider applicability of therapeutic skills in the clinical encounter. Thus, it supported the shift that we had made from offering family therapy training to also equipping trainees with a systemic lens to view the whole range of their work as child psychiatrists.

Managing the delivery of psychological treatment within a complex network of agencies is another requirement. Our course addressed this by working with networks under supervision and bringing cases from the workplace for consultation. Participants learnt consultation skills while reflecting upon their current work in context. Cronen and Pearce's theory of the "coordinated management of meaning" (Cronen, 1994) was invaluable in understanding the complexity and interrelatedness of the multiple contexts in which the child psychiatrist works.

The significance given to good therapeutic practice by the Royal College curriculum marks a change in attitude to the importance of therapeutic intervention since 1999. The Child Psychiatry Faculty did previously value acquiring therapeutic skills, but the emphasis on competent practice and self-reflexivity is new. It is also reflective of changing attitudes towards "talking therapies" within the mental health field and the outside world. This may mean that trainees taking our course now feel more authorised to do so than previously. In the past, having specific therapy training fitted the cultural expectations of the Tavistock. Now, they will be gaining the skills expected of the modern child and adolescent psychiatrist. Our training practice at the Tavistock, undervalued by the "orthodox" psychiatric school for years is now validated.

A further contextual change was represented by *New Ways of Working for Psychiatrists* (Royal College of Psychiatrists and the National Institute for Mental Health, 2005), which promoted best use of the skills, knowledge and experience of consultant psychiatrists by concentrating on service users with the most complex needs, acting as

a consultant to multi-disciplinary teams, and "promoting distributed responsibility and leadership across teams to achieve a cultural shift in services". It invited a willingness to embrace change and to work flexibly with all stakeholders to achieve a "motivated workforce offering a high quality service". These ambitions are very systemic in their aspirations but involve a particular positioning of psychiatrists in the discourse about money, skill mix, and models of mental health. As psychiatrists, we had to consider how to position ourselves in relation to these changes in expectation in the external world and to help our trainees position themselves. As National Health Service (NHS) funding cuts target mental health services, we think the integration of psychiatric and systemic identities will provide survivor skills.

The contribution of systemic training to child psychiatric practice

In 2004, we decided to explore the effectiveness of the training from the perspective of our ex-trainees. Three or four trainees participate in the weekly half-day training, over a year, led by two consultant child and adolescent psychiatrists who are systemically trained. We invited thirteen male and female psychiatrists, most of whom were now consultants, to contribute. For reasons of confidentiality, no further details of the sample will be given. We designed a questionnaire to gain feedback about the effect of the training on the participants' current practice, curious to learn how they would rate, on a five-point scale, what we felt were the seven key components of the course (Table 1). In addition, we asked them to describe how these components had affected their daily practice as child and adolescent psychiatrists.

Results of the enquiry

The most popular components of the course were training in systemic interviewing, use of live supervision, training in a small peer group, and clinical work in a team. Teaching of the theoretical framework had more varied feedback. The trainees had relatively few opportunities to discuss their theory reading in seminars because of the time constraints of the course and its emphasis on clinical work. The use of

Table 1. The following is a list of components of the training that we would like you to evaluate with regard to the effect they have had on the quality of your daily practice as a child and adolescent psychiatrist on a scale of 1–5, with 1 as not useful at all, and 5 as very relevant indeed.

		On a scale of 1–5				
		1	2	3	4	5
1.	Training in a small peer group of child and adolescent psychiatrists	–	–	–	4	9
2.	Clinical work in a team	–	–	1	5	7
3.	Use of live supervision	–	–	1	2	10
4.	Use of video	–	1	4	6	2
5.	Teaching of theoretical framework	–	1	2	4	6
6.	Personal professional development	–	2	3	3	5
7.	Training in systemic interviewing	–	–	1	1	11

video was less popular, largely because it was so difficult for the trainees to find time to review the tapes and, thus, make use of the material. When there were opportunities for video review in the group, it was seen as a useful learning exercise for developing skills and facilitative of work with the families. There was a more varied response to the personal professional development sessions, influenced in part by some trainees who found PPD in conflict with their analyses.

Training in systemic interviewing

Using the Milan method in a post-Milan form, informed by social constructionist and narrative ideas, we taught hypothesising, circularity, and the use of curiosity, both formally and, mainly, through role-play practice in the early stages of the course.

> "Role play is very useful—I learn best when doing it myself."

We were open to discussions about alternative ways of conceptualising and intervening, but emphasised the need to practise the form of systemic interviewing which they had come to learn. Remaining neutral and curious and asking circular questions was a change from

their usual way of working. Taking a non-interpretative stance, following feedback, and being sensitive to the use of language needed practice.With most groups there was a shift about half-way through the year, when they had developed the ability to conduct a systemic interview. The use of the reflecting team (Andersen, 1987) was seen as supportive of the development of these skills and enabled participation in the therapy by more team members in a "hands on" fashion. We had a pre-session discussion, mid-session break, and a post-session discussion, often using a reflecting team for the supervisory process. Our aim was that each trainee would work with at least two cases over the course of the year.

Feedback about the benefit of training in systemic interviewing was positive.

> "This has been invaluable as a tool in my clinical skills sense."

and

> "Very helpful—will continue to be relevant in varied work group setting and family work."

Its value in understanding the therapist's role and in becoming more confident about facilitating change was commented upon.

> "I feel more confident now about ways of introducing change in family systems and my role in the room."

The need for ongoing supervision and practice to maintain the newly acquired skills was noted. Not everyone went on to work in settings that enabled their continuing family therapy practice.

> "I've found this skill quite hard to hold on to and could do with further practice."

Use of live supervision

Most trainees had not had live supervision previously. Considerable anxiety was usually expressed about it initially. Feedback confirmed that live supervision was challenging but that the benefits to learning in terms of being empowered and confident outweighed this. The

advantages of being able to respond differently to families at the time, rather than at a future session, were valued.

> "Though initially daunting—in the long term, not only was this a very empowering approach, but also enabled clinical difficulties to be tackled head on with direct help and support, e.g., how to confront parents who were behaving in an emotionally abusive fashion towards their son."

> "It helped build up confidence in one's own practice. Good to have immediate feedback/supervision."

Learning through observation was seen to be helpful. In order to focus on this, we asked different team members specifically to follow the process of therapy by observing members of the family or the therapist and recording key points.

> "Learn a lot watching other people."

> "Very helpful to note in detail reactions of family members and our own reactions to what went on in the room."

Supervision is a task that all child psychiatrists are asked to perform in their daily work. The experience of live supervision contributed to the trainees' development of this role, in addition to which we facilitated them in supervising each other as the course drew to an end.

> "The immediacy and honesty of the experience of live supervision has (both in front of and behind the screen) made me feel less daunted and more open about 'supervising' my own and others clinical work. I've still a long way to go with this!"

Training in a small peer group of child and adolescent psychiatrists

The comments about working in a small peer group supported our vision in establishing a uni-disciplinary training to integrate systemic thinking and practice with child psychiatric practice.

> "Most of our training is with colleagues from other disciplines, so this represented a unique opportunity and difference to think directly about a systemic approach to more speciality child psychiatric issues."

It also confirmed the advantage of being in a peer group for training purposes, which was, in some ways, less threatening than a multidisciplinary group.

> "This has advantages as a trainee at the Tavistock because it is within a peer group that we are familiar with and therefore feels comfortable."

It offered an opportunity to consider their roles and developing identities within a systemic framework of thought, which included exploration of beliefs, attitudes, and prejudices in relation to families and wider systems. We used reflecting teams for supervision and consultation and also for facilitating reflections on experiences of learning and training.

> "Excellent opportunity to share, learn and think with peers about our roles, and the particularities of our previous training and future work as psychiatrists."

> "Helped me feel clearer about my professional/discipline identity."

They enjoyed the chance to work together clinically, which was an almost unique experience within the training.

> "The common background of previous clinical experience was a good base from which to learn together and also helped in translating what was learnt into practice."

Clinical work in a team

Working in a clinical team was new for some and not for others, influencing how they saw the experience.

> "Very interesting to work clinically together as we didn't elsewhere in the clinic at the time."

And, by contrast,

> "Most of my placements allowed for this so not unique to the systemic training but I feel that being experienced in working as a team is one of most relevant things in my daily practice."

They commented on the benefit of gaining multiple perspectives and the part team-working plays in the development of respectful listening.

> "Essential—more minds can be better than one in developing ideas about family. Learning to listen, respect colleagues' viewpoints etc."

The idea of the whole being greater than the sum of the parts was reflected in this comment on the ability to intervene more effectively in a team working together.

> "This enabled me to see the value of working in a team. It was helpful to be shown how the different perspectives of team members could be brought together in order to move things forward. Also a sense of how anxiety in relation to complex clinical situations can be thought about within a team has stayed with me."

Teaching of theoretical framework

At the start of the course, there was a more intensive overview of the theoretical framework, and thereafter, a slot for a reading seminar based on selected papers. We relied on trainees' ability to make time for this reading. Despite the limitations, it seemed as if the reading complemented the course in a helpful way.

> "I think this training really allowed me to become familiar with theory and I use it as a model to understand families."

> "Essential to understand context. Definitely helps me in my work and in communicating with some other disciplines here."

Personal professional development (PPD)

PPD produced a wider range of responses than the other course components. For some, it was a creative space to explore their responses to families and their own beliefs about family life and the wider professional issues.

> "This has been enormously helpful. It's helped shape a sense of professional identity and thinking about my own and other families has provided a personal perspective with which to approach the work."

For others, it seemed intrusive and replicative of work being done in their own psychoanalyses.

> "I did not find this as useful or accessible for me as the clinical work. Perhaps because I was concurrently gaining largely from thinking about many of these issues (more privately) in my own personal analysis. I was uncomfortable with sharing such personal information in a work setting."

Specific work around wider cultural contextual issues was unique to PPD work.

> "Allowed one to become clearer about trigger families and how to manage although being in analysis I think meant there was not much added to personal issues I'd already explored. But helpful in exploring issues of race, gender, religion."

PPD, more than any other aspect of the course, brought forth the interpersonal dynamics of the group, often, but not always, productively.

> "This had strengths and weaknesses. The positive aspect was spending time thinking about how one's family history correlated with one's practice, the difficulty was being dependent on one's peers in rather a vulnerable situation."

Use of video

The use of video always carries anxiety in the initial stages of training.

> "Some initial concern this may 'inhibit' families not a significant problem."

It was a useful tool to learn to use in a range of ways.

> "Although not used often in my daily practice I was glad to have experience so I feel able to use it when relevant."

> "Useful for supervision purposes and record keeping and seeing oneself (can be painful but helpful!) and tracking processes."

We also asked three further questions and gave space for any further comments or feedback.

Do you consider that you have maintained your systemic/family therapy practice?

With the exception of one trainee who went on to work as an individual psychoanalytic psychotherapist, the others saw themselves as applying systemic thinking and practice in their work, using words such as essential, integral, invaluable, and incorporated.

> "Yes, I see this as an essential part of my training and practice"
>
> "It has given me another method of clinical working—plus, perhaps more importantly for me at present, is part of my thinking now in work across systems and groups of all kinds."

Not everyone was practising as a family therapist, but they were using it as part of their daily work.

> "I use the skills in assessment interviews and in follow-up family interviews. Also useful in team meetings!"
>
> "I may still use interviewing techniques, still try to see all of the family and still make assessment of wider network that supports the family / child I see."

Some, who wanted to practise more formally, were finding it hard to access or create a systemic team and supervision.

Have you developed your systemic/family therapy practice?

Six of the trainees were continuing to participate actively in family therapy workshops or supervision; some had aspirations for the future or had conflicting work or personal priorities.

Are there ways in which you would like to continue to develop your systemic practice?

Three trainees wanted to do a formal training at some point; most felt the need for further opportunities to maintain their practice

Other comments or feedback

Of the twelve comments about the training, ten were extremely positive; the other two were feedback concerning the questionnaire. There

were two comments that focused on how systemic thinking and practice complements psychiatric practice.

> "I think systemic thinking and application are essential to good psychiatric practice. It is a useful framework that complements the essential bio-psychosocial model that we have been trained to use. It is helpful in formulation of cases and identifying interventions. Less useful when considering diagnosis or risk but certainly useful for risk management."
>
> "Systems theory counterbalances the influence that years of medical training have on the way we think. Helps us think of the many things that may explain the problems as opposed to the *one* thing (as we are trained to do in medicine)."

The course was seen as benefiting all aspects of the child psychiatrist's work, which also related in the trainee's mind to the specific focus of the course on their needs.

> "It can't be overestimated how important this was as a training experience. The families we saw were representative of the kind of families I continue to see and the way of thinking and working remains highly applicable in many areas not just clinical work. It's rare to be offered a therapeutic training that specifically focuses on the needs of trainee child psychiatrists."

It was seen as providing tools to tackle the most challenging aspects of their work.

> ". . . some of most useful experiences in it was how to handle and defuse difficult scenarios with families or engage difficult families without reaching an impasse. Allowed me to develop flexibility and creativity in these situations."

The timing of the course within the overall training was often debated.

> "I think it is an essential part of our training as child psychiatrists and the earlier the better. One year is a good period I feel as we have opportunities to expand in the training."

The opportunity for skills development in a group setting was probably unique in the training.

"This training was one of the most valuable experiences in my training, for its intense focus on interviewing skills and interactions and the opportunity to share experiences and learn together."

Discussion

The feedback was gratifying. It demonstrates what can be achieved in half a day over a year. The trainees are to some extent a self-selected group, highly motivated to participate and engage with the training. Even so, it is noteworthy that the training had contributed to their abilities to carry out their daily work as consultants. This was an important aim of the course, believing as we did that a systemic approach could enhance psychiatric practice and protect professionals from burn-out. It is known that this arises, among other factors, from lone working; systemic practice cannot happen in isolation. The course remains popular and relevant.

From our enquiries, it seems that many child psychiatry training schemes aim to have opportunities for trainees to achieve Level 2 in family therapy if they wish (i.e., competent to practise and to provide supervision on simple cases). This is probably an outcome of the competency-based curriculum described earlier. The pressures arising from that curriculum also mean that few trainees today will have time to do a masters training.

Building on Burton and Launer's (2003) work in teaching systemic supervision skills to medical educators, there has been an introduction of systemic skills or "conversations inviting change" in general practice and some local undergraduate medical trainings. Adult psychiatric trainings have shown little interest in developing systemic components to their training despite the evidence base for family intervention in many adult mental health predicaments. This is disappointing. If consultant psychiatrists have not been introduced to systemic ideas during their training they will be unlikely to value those ideas in their teams later. The relatively greater attention paid, for example, to pharmacological interventions perhaps inevitably tips the balance in that direction. Again, we would want to take a "both . . . and" position. Systemic ideas are potentially of enormous value when addressing pressing issues of treatment concordance or compliance, as well as addressing the contribution of the "family" to recovery.

As supervisors, this training was a constantly stimulating and challenging experience. We were in several roles at once. In general family therapy training, one is still also a psychiatrist, but this is not in the foreground. In this setting, we were conscious of the need to "perform" both as a systemic practitioner and also as a competent psychiatrist. There was a pressure that arose from the wish to ensure each trainee had a satisfying clinical experience of systemic practice and gained skills in a short period of time. We struggled with the balance of discussion and practice. Reflecting team work was a helpful tool, since it could address both and was appreciated by the families.

There were multi-layered contexts to this training. As supervisors, we had constantly to think about where we were positioning ourselves within these contexts and to help our trainees to see how the contexts were shaping the meaning of what we were doing together. We were working in the NHS; some families chose to come, others were sent, and others wanted the expert opinion they believed the Tavistock Clinic could provide. This was a local Child and Adolescent Mental Health Service (CAMHS), so the cases we saw reflected the range of child mental health and family problems.

We took a systemic approach to all our work, but always held a "both . . . and" position in relation to our thinking and practice. This allowed us, for example, where appropriate, to consider the use of psychoactive medication or cognitive–behavioural therapy (CBT) approaches within our overall systemic intervention. There might be disagreements as to the best way forward, when some felt that a child should be seen individually for psychotherapy or CBT rather than in the family group. At other times, the issues centred on the importance of seeing the case from a biological perspective diagnostically. Tension was created in cases where there seemed to be child protection concerns, arising out the question of whether and when to act and its impact on the therapeutic process. We tried to resolve these issues by holding on to our overarching systemic view, maintaining curiosity and asking questions, while offering what seemed to be the most appropriate intervention.

We had half a day to offer the best learning experience for our trainees while offering a clinical service. This meant that time had to be found outside the course when families needed urgent help. We faced the dilemma of how and whether to explain to families that the team behind the screen were all psychiatrists and debated how letters

should be signed, since we were intending to work as family therapists! As trainers, we were offering a new way of thinking and working to professionals who were already highly trained in their chosen profession. The process of relearning the ways they talked to families was anxiety provoking and challenging at times, although rewarding ultimately. Their seniority meant that they learnt quickly, but were also capable of critique based on their other knowledge, which pushed us as supervisors to clarify and extend our own understanding.

As systemic family therapy trainers, we find the feedback from our course has significance for training generally, especially in the light of developments in CAMHS services, particularly the government's commitment to "Improving Access to Psychological Therapies for Children and Young People" (www.iapt.nhs.uk). Family therapy might be a specific modality in future waves of IAPT implementation, but we would suggest that all therapists aiming to contribute to this initiative should be able to work in a systemically informed way. This could entail offering other specific interventions, like CBT or Webster–Stratton parent training from within a systemic framework. Family therapists can make this way of working accessible through their brief practice and training courses, supervision opportunities, and day workshops for all practitioners working with children, young people, and their families. In this way, practitioners, irrespective of profession, can potentially think and practise systemically, even though few will become family therapists. The important components of our post-Milan systemic training which can be replicated are that it is brief, focused, and skills based, contextualised, clinical, involving teamwork with both a clear theoretical model and interviewing method and the integration of other relevant models and interventions. It builds on the expertise and knowledge of the participants, enabling the integration of personal beliefs, meaning-making, and methods within an overarching reflective systemic framework.

Dedication

Caroline Lindsey

This chapter is dedicated to the memory of my friend and colleague, David Campbell. I met David in a role-play at the Tavistock–Ackerman Clinic Family Therapy Conference in 1974. We became

colleagues in the family therapy team in the Department for Children and Parents at the Tavistock Clinic in 1976. Our work together continued for the next thirty years, and, even during David's last illness, we shared our enthusiasm for jointly newly found skills in EMDR and talked about working together. I believe that the subject matter of this chapter—training child and adolescent psychiatrists in systemic practice—would have been dear to David's heart, since he was interested in making systemic thinking accessible to professionals working in diverse contexts. The clue to his ability to influence people from so many different fields lay in his non-judgemental attitude towards everyone he met, his compassionate and facilitating style, and sense of humour, which enabled him to teach and communicate with the very many people whose lives he influenced for the good. David's capacity for therapeutic optimism was part of the secret of his success as a therapist, trainer, and supervisor. His love of ideas and enthusiasm for seeking another way to think about an issue led to his great creativity and innovation in the field of systemic practice. His ability to take on new ideas was nowhere more evident than in his response to the introduction of the Milan Group's model of systemic family therapy. This had a far-reaching effect on our work at the Tavistock Clinic (Cecchin, 1987; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980). Together with Ros Draper, David and I established the Milan Systemic Training in Family Therapy. Later, David, Charlotte Burck, and I set up a systemic training for supervisors at the Tavistock Clinic and had the privilege to present our work at the Milan School for Systemic Therapy 25th Anniversary Conference. The key concepts and practices introduced during that period remain the foundation underpinning the systemic training offered to child and adolescent psychiatric trainees in the Tavistock training scheme.

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CHAPTER SIX

Towards a culture of contribution in supervisory practice: some thoughts about the position of the supervisor

Barry Mason

Introduction

In this chapter I wish to develop some previous thinking (Mason, 2005, 2010, 2011) about the expertise of systemic supervisors. In particular, I wish to highlight the need for supervisors to extend their range of feedback to supervisees, and some ways in which this might be done. At the same time, while I acknowledge that the term "culture of contribution" suggests a two-way process, consistent with Wiener's (1948) notion of mutual influence, I will (not least because of the need to keep the chapter to a certain length), particularly concentrate on the practice contribution of the supervisor. Further, I will illustrate some of my thinking with reference to the results of a small survey addressing feedback with members of a cohort of the advanced training programme in supervision at the Institute of Family Therapy in London.

Expertise

Almost twenty years ago (Mason, 1993, p. 192), I offered another way of looking at the "not knowing position" (Anderson & Goolishian,