Talking heads: Alan Cooklin and Eia Asen reflect on the history of the multi-family model at the Marlborough Family Service in London

Alan Cooklin, Eia Asen, Chris Mannings & Marta Costa-Caballero

Eia Asen is the current clinical director of the Marlborough Family Service in London and a consultant child and adolescent psychiatrist and systemic psychotherapist. Alan Cooklin, now consultant psychiatrist at Camden & Islington NHS Foundation Trust, had preceded him in the post. They are here in conversation with each other about the past 40 years of multi-family work at the Marlborough, in the presence of Chris Mannings and Marta Costa-Caballero, family therapists in the Marlborough Family Education Service.

Chris: What are your early memories of multi-family work at the Marlborough?

Alan: The first multi-family groups were a nightmare. We started back in 1974 or 1975 in the old basement and didn’t have the first idea what we were going to do. My ideas in those days were from group-analytic psychotherapy. So we thought we would just have all these families and would make group interpretations, although this was not actually the way the multi-family groups I had known in the Young People’s Unit of the Royal Edinburgh Hospital had run. Nevertheless, that was my initial and rather crazy idea.

Eia: But how did you come to think about putting families together in Edinburgh. Or here? How did you deal with rules, such as people aren’t meant to talk to each other outside the group? You broke every single rule!

Alan: Well, as far as multi-family groups are concerned. We didn’t believe in that rule anyway. The Edinburgh group started because John Evans, who had been at the Cassel Hospital in Richmond, Surrey, had this idea, and it was a really very simple, clear idea of running the unit. He arranged it so these sometimes quite psychotic young people had to go to school or to work in the afternoon. Every single young person who was in that in-patient unit, and there were fifteen beds, had to be in the multi-family group, and the parents had to come every week wherever they lived in Scotland. It was a long way for some of them.

Eia: And how old were the kids?

Alan: From thirteen up to nineteen; basically with teenagers. I don’t really know how he came up with his group model, but he got a lot of his ideas from Tom Main at the Cassel. They had run groups more along the lines of traditional groups that just happened to have families in them. But, in John’s mind, part of the idea was explicitly to give a role to the nurses. So the young senior registrars, who were a young woman named Wendy Acton and me, each had a psychotherapy group with these young people; seven or eight of them. And they would all sit in silence and say, “This is a bloody waste of time”, and they would mostly comment on me and what I was up to. John Evans supervised these groups and, quite separately, he also supervised the multi-family groups. However, we weren’t allowed to know what was going on in those groups, explicitly to keep them as the nurses’ domain. I suspect some of my fascination was why I was being kept out, but these kids would sit in my group and say, “What a fucking waste of time. The only thing that’s any bloody good is the family groups”. The message was that these multi-family groups meant something to them, whereas they thought the traditional kind of psychotherapy was a load of cobblers. That’s what got me thinking there was something in it we needed to develop. Then we read Laqueur [1976] and others writing about multi-family work. But, as I said, our first effort at the Marlborough was a nightmare, with kids running up the fire escape, and onto the roof.

Eia: With their families or without?

Alan: The families didn’t bother to chase them. The whole event got out of control. We were three or four members of staff and probably five or six families. It was a wonderful learning experience, and we learned fast.

Eia: Not to do it again?

Alan: Not to do it like that! We had to get some structure into it. It was before I’d got really interested in structural family therapy and, in a way, that became a kind of life saver – to start thinking in structural family therapy terms about some of these systems. Dave Reeves had been a nurse in the young people’s unit in Edinburgh before he came here. He shared this role with Ross Lazar, who was a child psychotherapist. Dave had the advantage that he had had experience of multi-family groups, and was not inhibited by many of the psychoanalytic ideas and rules. So, together, they developed a structure for the groups. We learned that you need structure, and you need to think out how the groups are going to run. But it wasn’t really until you came, Eia, that that was formalised.

Chris: And what impressions did you have when you arrived?

Eia: Alan, you recruited me in 1979. I’d been a reasonably promising psychiatrist with reasonable career prospects up to that point! I’d done a straightforward psychiatric training but I came with an interest in therapeutic communities and that whole movement from the 1960s to the mid-70s where patients lived together. Sometimes, their relatives arrived at what was then the Paddington Day Hospital. It made me think there was such potential for bringing other people into these groups rather than just having patients and staff. When you hired me, the first thing I remember was going down into what would become the Family Day Unit where you introduced me to the idea of group work with families. I don’t think the expression ‘multi-family group’ was even in use at the time, but this setting fed into my interest in therapeutic-community work. The person who was instrumental in getting the thinking of the day unit going was Ann Stevens who was very skilled and who trained some of the staff still here. There were also other very good
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people there, including Brenda McHugh and Neil Dawson who ended up running the education centre here, and still do. There was also an American psychotherapist called Robbie Stein. We were running these groups, but it was often unclear to me what the purpose of it was. In those days, the families came every day for years. They seemed to be ‘down-and-out families’ and I noticed they had quite a good time talking to each other but, being Germanic, I thought, "What is the purpose? What do we do here with them? Where is the structure?" You and I had many discussions about the structure and we drew on your friendship with Salvador Minuchin to help us.

Chris: How was the link with Minuchin forged?
Alan: As a new consultant at the Middlesex, I discovered they had something called the ‘honeymoon’ where they gave you £1000. I said, “I’m going to spend six weeks in the States with my £1000”, and I rang Minuchin and said, “Can I come and see you?” He was one of the people I was interested in. I’d read a couple of his papers on psychosomatic disorders. He’d already been to Edinburgh, and he’d made a big impression when I was still there in the early 1970s.

Eia: It was important to realise there were very few family therapists known at that point, Minuchin, Ackerman, Satir and a few others; the Milan people hadn’t really made it then.

Alan: But Minuchin particularly worked with this group, the families that all the agencies abhor.

Eia: The 1967 book ‘Families of the Slums’ was probably the book we read first and that’s how we came across Minuchin.

Alan: So, I had dinner at his house and was invited to watch him work in the Philadelphia Child Guidance Clinic. I then visited the MRI [Mental Research Institute], Palo Alto, California; then returned to Philadelphia for a week or so, literally trailing him.

Eia: When you got him here in 1977 or ’78, did he see the multi-family work?
Alan: Yes. I think we were doing it but we were focusing much more on trying to adopt his model. It was later when he had already sold us the structural family therapy model that he realised we actually had something to sell him, which were the multi-family groups. In Philadelphia, they had an in-patient unit for families but I don’t think they had really got a multi-family model for running them by then, although they were thinking about it.

Eia: If we wind the clock forward to 1980 when you had already been on your ‘honeymoon’, you decided to give me one as well. I went to Philadelphia and trained with Minuchin for six weeks, every day, from early morning to late evening. When I first arrived at the Marlborough, I was still psychoanalytically minded and, Alan, you had wanted to give me an intense ‘conversion’ experience. It worked. I got on well with Minuchin and in 1981 he came here for a whole year’s sabbatical, to write another book and also to indulge his love of the theatre. That was a key year for the Marlborough and, during that time he gave us supervision, mostly in our single-family work but he also became interested in watching some of our multi-family work. He was always interested in the very poor families who had suffered at the hands of the justice system. There were already quite a few of those cases floating around in our family day unit at the time. He observed some of our work and, in supervision, we talked about how you set boundaries, how you challenge hierarchies, how you get enactments going and he noticed you don’t have to ask for enactments in the unit, in a multi-family setting, because they happen spontaneously...

Alan: ... there were enactments all over the place!
Eia: And I remember having this discussion with him and saying, “Look here, this is what happens; you can actually intervene live without having to provoke an enactment”. He really helped us think about which structural interventions to make. In our discussions, it became clear we needed to create a structure for these families. So, Minuchin’s idea about creating a structure and my German obsessiveness, led to creating concrete structures, including tight timetables, which helped to build the initial multi-family programme for the family day unit. And you were an integral part of this, Alan, even though you may have forgotten it.

You came down to the unit every single day and supervised me in your inimitable way. Importantly, you wrote in one of your papers on the idea of multiple context-shifts throughout the day. So, for instance, a mother would be one of many members in a multi-family group from 11.00 until 11.30 am; from 11.30 she would take part in single-family work as the mother of her child; then from 12.00 she would be a member in a larger community as lunch was prepared, and later she might be a parent in a parents’ group and so on. These multiple transitions from one context to another undid traditional patterns the families had developed. That was actually your brilliant idea. It also meant the therapists had to keep changing their hats. So, sometimes we were therapists, sometimes cooks, sometimes ‘social policemen’ (as Gianfranco Cecchin pointed out to me); but, at all times, co-collaborators in activities. We spent plenty of time with the families, including day outings and even whole weekends: we used to hire a place by the sea in order to see more of the families in natural situations. Many of us went down and spent three or four days with the families. We were seeking out specific situations where potential crises could happen, like in real life. We also stayed close to a pub so the temptation of these parents to abandon their kids and get drunk was present.

Marta: All kinds of therapeutic boundaries were being challenged. How did it fit with what else was going on at the time?
Eia: We had plenty of enemies. I’m sure you remember, Alan, the first presentation of multi-family work we did at the Middlesex Hospital in 1982. Two very senior professionals walked out in the middle of our presentation. They were horrified at our challenging of the boundaries at the time. We also had difficulties getting referrals at some point because people didn’t really know what family therapy was. We weren’t so sure either.

Alan: There was that, but we also suffered from the same preciousness that many psychotherapies suffered from in the sense that we believed you had to bring the whole family and if you didn’t you were sent away. So, we were criticised as doctrinaire; it had to be the family and nothing else. It took a while for us to rethink that as well as facing the multiple questions about what constituted a family. You described the use of residential trips with families to re-create the patterns that are often their ‘undoing’. There were smaller events in which the same thing happened. I’ve seen your films of it: for example, using the local supermarket. It was the most wonderful test of whether the parents had learnt anything because the child would say, “I want that!” and put it in the basket and the parent would put it back on the shelf and the child would take it back again and the parent would put it back, and then the child would have a tantrum and scream on the floor, and then all the people in the supermarket would come round and think the parent was abusing the child. It was such a wonderful stressor as a test.

Eia: And it still goes on now. In those days, we were banned from all supermarkets. We struggled to find a supermarket that would allow us in. Sainsbury’s had our pictures on the wall – ‘Wanted’. The store detective did not like us much.

Alan: Going back to Minuchin, I have a slightly different memory of one bit. When he came for that year, he got very interested in multi-family groups. He said, “You know, I think you’re not getting the most out of
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**this**. There were two particular issues. Eia mentioned the multiple context-shifts but the other one was the idea of the surrogate family relationships where the child of one family could make a relationship with the parent of another. They could break boundaries they couldn’t do within the family. But Minuchin’s idea was that first we needed to increase the intensity of the interaction. I think he helped us make that happen, and it was you, Eia, who really achieved that. Second, we needed to make the intervention much shorter. A lot of these families had been coming for ages. My recollection was that it was Minuchin’s discussion with us that led to a more targeted and focused package of unit interventions.

**Eia:** Minuchin obviously had quite an effect on both of us. But this shift from initially having families with us for eighteen months, then shrinking it down to three months; that shift occurred through the questioning from the Milan people who came here in 1981 for the first time; Boscolo and Cecchin. I explained to them the beautiful system we had where families came to us for 18 months. I also explained we ran an on-call system because we didn’t want those families to be exposed to ‘linear’ psychiatrists or social workers. We didn’t want these parents of very disturbed children to be sectioned at night or at the weekend or for their children to be put in care. So, what the families could do is ring the hospital switchboard and one of us would be on call and go in on a Sunday or Saturday night, unpaid. The Milan people had just written that interesting paper on ‘The problem of the referring person’ [1980] and they challenged our view of trying to keep the context ‘pure’, us trying to keep these families out of the ordinary so-called linear relationships they enter into in the real world. That helped us to cut down our work to Monday to Friday, 9 to 5. Gianfranco and Luigi had successfully challenged us about why we were seeing them for so long and making them dependent.

**Alan:** How did that fit with Sal’s view? Because he also said to shorten the time we see families.

**Eia:** Sal said it must be high intensity, then, change happens more quickly. He didn’t comment on our central involvement in the families’ lives; that came from our Milan friends and we changed our involvement radically from eighteen months to three months in 1982.

**Marta:** How would you say the multi-family model has evolved since those times?

**Eia:** Let’s say that, when we started, we were very much married to a structural approach and we used Minuchin’s 1974 book ‘Families and Family Therapy’ and applied it, effectively doing single-family work in a multi-family context. Then, we remembered our ideas about group dynamics and how you go about the process of change in groups. The Milan people helped us to introduce circular questioning into our planning meetings. We then brought in reflecting-team ideas, in quite a different way from how Tom Andersen did it, but we were influenced by those ideas. We used circular questioning among the treatment team, videotaped it, and then, as a kind of reflective team, played it back to the families who would then have an opportunity to comment on the reflections of the reflecting team, with the actual reflecting team being excluded from getting involved in a dialogue with the families. The team had to watch, through a one-way screen, how the families reflected on...
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Alan: I think that was the main turning point. Once the courts realised this was an instrument that could predict whether families could be rehabilitated or not, the work changed. We became mainstream, not in the medical world but in the medico-legal world, which was the interesting thing. There were a couple of other points I wanted to make. The first is that, in contrast to the Italians and the Americans, we tried to hold these different ways of thinking in our minds. There was no doubt the Marlborough was much more interventive than was common in the Milan team’s thinking, and we weren’t afraid of being interventive as we felt a responsibility to try and help people and change things. In those days, the Milan team would almost guard against this idea. They thought, “We want to consult, we don’t want to change things.”

Marta: How do you think it fits with the current climate in the NHS?

Eia: I always try to make the point that it’s actually a very cheap treatment. It fits into the climate of cuts. Interestingly enough, in the countries where it has been widely used like Germany and Denmark, multi-family work was introduced at a time when new governments had come to power and tried to make major cuts in the health service. People could see this is something that is feasible in times of shrinking budgets. There’s an obvious appeal in two therapists dealing with eight families.

Alan: I agree totally with Eia that it saves money. I think the problem is going to be, looking ahead, how it is going to fit with service-line management. It will fit with service-line management if you say you are running an anorectic multi-family group, and maybe if you say you’re running a family violence multi-family group. Where it’s going to be problematic is when your group is not focusing on a particular diagnostic category. It’s interesting what happened with Kidstime in my trust. A year ago, they wanted to close Kidstime. Now they think it’s the best thing since sliced bread. That might change if there are more cuts. What was interesting was they couldn’t work out which service line to put it in, acute services, psychotic services, recovery services. The problem with service-line management is that people are going to have terrible problems linking up across services.

Eia: Generally speaking, multi-family groups work well when the people attending have something in common, maybe the same diagnosis such as anorexia nervosa. An evidence base is emerging that it also works well with children who have been given the ever-so-fashionable diagnoses of ADHD, autistic spectrum disorder or Tourette’s. There is already a huge evidence base for the efficacy of multi-family therapy for schizophrenia and depression. Given that randomised controlled trials are usually condition-based or disorder-based, multi-family work sits quite nicely with that, as you wouldn’t put people together with very different problems or diagnoses. We think it works best when people have as many connection points as possible and that’s really where the overlap with self-help groups lies.

Self-help groups have a tightly defined focus. So, for instance, family violence is not a diagnosis but it is very ‘marketable’ to social services, even in the new climate. The young-carers group (‘Kidstime’) you were talking about is a well-defined group where children with mentally ill parents have been put in a caring position that is age inappropriate and developmentally inappropriate and, for such a population, multi-family groups work. It is also the case that, in some in-patient child psychiatry services, in Germany and Switzerland for example, colleagues have instituted a mandatory multi-family group once a

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week, where families, no matter what their problems, one psychotic child, one with ADHD, two anorectics and so on, are put together in a multi-family group, weekly or fortnightly...

Alan: Like we used to do in Edinburgh...

Eia: ... and they’re quite difficult to run because of the diversity of problems but also because of the traditional roles in-patient staff find themselves in. They find it very difficult to delegate the responsibility even for that hour or two a week, to parents of whom they are very critical. It can involve a total role-reversal or giving up a familiar position. To make such a drastic paradigm-shift, even if only for two hours, is very difficult when, for the rest of the time, nursing staff or psychiatrists may feel they are better ‘parents’ than the biological parents.

Marta: So, do the cultural beliefs in each country influence the way multi-family work can be set up?

Eia: It’s not the cultural beliefs, no. Surprisingly, multi-family therapy works in very different cultures, albeit with some specific modifications. I think it’s more to do with the political scene. Organisations vary greatly and I think an increasing number of organisations can see that the involvement of parents, even in in-patient settings is very important.

Alan: I suppose that one culture we are talking about here is the culture of ‘professionalism’ and how professions see themselves. The profession of psychiatry was given the responsibility to give or deprive people of their liberty. It became very autocratic, much more so even than traditional medicine. If you look at nursing staff in psychiatric settings, they were much more concerned with morals and authority than physical medicine nurses. I think the multi-family model very powerfully challenges that particular ‘culture’. Because it shouldn’t work! It can’t work.

Marta: So, how has the multi-family model changed you as clinicians coming from a medical background?

Eia: We both come from medical backgrounds and doctors often feel from their training they have got something that no one else has got; they have got a particular role of expertise. Even if we medics don’t wear white coats, maybe there is something of the invisible white coat about our behaviours. So, when you are together with families and you create the context where you ask them to use their own resources and you do that year after year, you become more and more amazed at what families have got in themselves, their own resources and creativity. It makes you think our expertise should be primarily to provide the context in which the families can discover and utilise their own resources and make these available to other families. So, humility sets in very quickly when you do multi-family therapy. And when you sit in those meetings, you sometimes think, “I would never have had that idea myself. It’s so amazing”. Having seen so much of that kind of work, having participated in it and perhaps knowing how to establish these groups better than some other people, because we’ve done it for such a long time, our expertise now is not in knowing what’s best for families – and that is where it is at loggerheads with a traditional structural approach.

Marta: Does that influence the way you do your own individual family therapy sessions?

Eia: The short answer is, “Yes”...

Alan: Probably, yes. It’s very freeing working in multi-family groups; you learn all sorts of stuff yourself. You’re less central. It’s got its own life. I don’t totally agree with Eia that we just become conveners of the group and I’m thinking of Kidstime here. I don’t get used for my particular knowledge very often but it’s useful sometimes and people know it’s there. I don’t have to direct everything but I am one of the facilities that are available as a resource. That’s quite a nice model because it means you’re part of it and you can just enjoy it, without having to take on any special authority position but you’re available as having particular expertise.

Eia: I’m moving more and more away from that, probably unhealthy so...

Alan: Moving away from what?

Eia: Moving away from having any kind of expertise in a multi-family setting. It’s different in individual work perhaps. So, when people ask questions about drugs in the multi-family groups, I do for adults with schizophrenia, for instance, and they ask about research data or medication data, then I have a computer available and invite them to think about how we could find out the answers on the internet and who can do that and so on. So I try as hard as possible to use other people’s brains to help them find information.

Marta: Is the idea that you become more useful when you’re not part of people’s patterns?

Eia: I think multi-family work does affect your individual work. I’ve become more creative and done things I thought you could only do in multi-family work where you can be more outrageous and creative. I think that opportunity for creativity is one thing that’s kept us going – and the model going.

References

