



Changing 'Multi-Problem Families' – Developing a Multi-Contextual Systemic Approach

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Abstract

Over the past 30 years the Marlborough Family Service in London has pioneered multi-family work with marginalized families presenting simultaneously with abuse and neglect, family violence, substance misuse, educational failure and mental illness. The approach is based on a systemic multi-contextual mode and this chapter describes the evolving work, including the establishment of the first permanent multiple family day setting, specifically designed for and solely dedicated to the work with seemingly 'hopeless' families. The ingredients of 'therapeutic assessments' of parents and families are outlined and the importance of initial network meetings with professionals and family members is emphasized.

Introduction

In the more than 30 years I have known and valued Walter Lorenz as a colleague and friend, he has always impressed me as a compassionate, multi-contextual 'Mensch': a gifted professional and individual, at home in different countries and in diverse models of work. We met in the child psychiatry department of a big teaching hospital in London in the 1970s. He was eager to broaden his social work inspired approach by understanding more about the psychology of children and their families. My interest in the social dimension of problems officially defined as being 'psychiatric', was stimulated by Walter's passion for disadvantaged and marginalized families and this chapter pays tribute to these early conversations and the emerging systemic approach to working with 'multi-problem families'. These are families which present simultaneously with violence and abuse, family break-up, major mental illness, substance and alcohol misuse, educational failure and social marginalisation. Most professionals shy away from these 'heart sink' families, yet working with them is often very rewarding and surprisingly successful. Much of the work described in this chapter has been developed by our multi-disciplinary team of the Marlborough Family Service which is a publicly funded combined Child and Adolescent mental health and Adult Psychotherapy service, with a systemic orientation and located right in the centre of London. Walter Lorenz has taken a keen interest in the evolution of this work from its infancy and, over the years, he has provided much encouragement to our team.

Developing systemic frameworks

Adopting a systemic approach means viewing the child (or adult) and his or her mental health issues in a variety of contexts. These include not only the immediate and the wider family, but also the social and cultural settings of which child and family are part. Systemically oriented clinicians examine the relationships between the child, the family and the professional 'team' which constructs and / or diagnoses psychological ill health. Professional networks which tend to grow around families with multiple problems are 'problem-generated systems', with overt as well as covert agenda that reflect the wider political contexts and ever-changing

priorities. Why 'systemic'? The notion of the family as a 'system' is both useful and problematic - problematic as the notion of 'the family as a system' can only serve as a metaphor and should not be mistaken for something 'real'. Useful, as the utilization of this concept can have clinical implications when describing families and related systems: families do have homeostatic tendencies and a variety of 'properties', such as hierarchies, boundaries, sub-groups, as well as overt and covert communication exchanges between specific members, coalitions, and so on. For clinicians it can be pragmatically helpful to see family members as behaving according to a set of explicit and implicit rules (however speculative), developed over time and often over generations, which govern their relationships and communications (Watzlawick et al 1967). If such rules can be 'discovered' or un-covered during therapy, and if they are believed to contribute to the presenting problem(s), then this has pragmatic implications for change - the rules can be questioned and challenged and new interactions can emerge.

Once upon time we had clinicians and theoreticians who described families as 'toxic' or 'schizophrenogenic' (Laing and Esterson 1971). The family was then seen as the breeding ground of alleged 'illness' and it was the view of R.D.Laing and his co-workers that what needed to be treated was the family – and not the 'identified patient'! The parents or family were, in effect, blamed for the illness or problems of their offspring. Not surprisingly, this did not make the emerging 'family therapy' a very popular treatment – and particularly not with families! Despite its almost revolutionary underlying ideas, the approach was very much embedded in the medical model: instead of genes 'causing' schizophrenia, it became the family that was seen as 'the cause of it all'. Though much has changed over the past three decades, the very term 'family therapy' remains rather controversial and may be misleading: 'therapy' implies the presence of illness or dysfunction, located in a person (or maybe even the family) rather than elsewhere, such as in social dysfunction and inequalities. Another criticism of the term 'family therapy' is that it is rather old-fashioned if one keeps in mind that, in the Western world, family forms have changed over the past 50 years considerably - no longer is the two-parent, heterosexual couple with their 'own' children the norm. In many countries we now have many families with single parents, or children living in gay or lesbian relationships or communes; we work with 'reconstituted' or 'blended' families, as well as with other forms of committed relationships and friendships which are not based on 'blood ties'. In the wake of globalization and political dislocation and economic migration, most clinicians have become increasingly confronted with families from other cultures, presenting with very different, culture-specific and often religion-based, belief systems. Increasingly clinicians working with families have had to acknowledge that their theories are essentially Eurocentric and that new models of practice needed to be evolved, learning from differences, rather than making different cultural practices fit into their Westernised models and interventions.

With more than 50 % of our clients coming from different cultures, our team at the Marlborough Family Service had to learn to work with families from very diverse cultures and develop 'cross-cultural clinical competence'. It is obvious that the starting point for such competence has to be a healthy curiosity in, and respect for, 'the other' – followed by the examination of one's own assumptions about other cultures and the relevance of existing clinical practices for minority ethnic families. Institutional racism (McPherson 1999) is rampant in the field of mental health services, an often subtle form of discrimination against providing appropriate services for people from different cultures and of different ethnic or racial origins. This can manifest itself in clinicians via biased views and prejudices, in

seeming thoughtlessness, ignorance or indeed racist stereotypes. Some 15 years ago our own institution, then entirely composed of white middle-class staff with what we thought were non-racist and 'liberal' views and practices, negotiated some 'anti-racist training'. This was a traumatic event in many respects, as it revealed the 'hidden' or 'unconscious racist' in each of us clinicians. Reflecting on our own cultures of origin (which were at the time essentially English, Central European, Latin American and Australian), we became increasingly aware of the culture specificity and relativity of our concepts and approaches and how these dominated and 'colonised' clients from other cultures and their respective value systems and practices (Malik and Krause 2004). As a result, we began to actively recruit clinicians from cultures which reflected those of the families referred to us. We managed to convince health politicians to provide us with some additional financial funding to employ clinicians from different parts of Asia and Africa, with the task of them training us in culturally relevant practices. Our existing staff, in turn, provided these clinicians with systemic training and, over the years, a specialist though integrated service has emerged, once called 'Asian and Arab Family Counselling Service' and recently re-named as 'Marlborough Cultural Therapy Centre'.

From single family therapy to multi-family group work

Clinicians working systemically are generally known as 'family therapists'. They see it as their task to assist families to change their problematic interactions and communication patterns, including the ways they view and scapegoat one another. In doing their job, family and couple therapists use their considerable expertise to help families to manage what they seemingly can not manage by themselves. In practice, it is the therapist who is in the 'driving seat' and this often entirely appropriate. However, it is also often the case that the expert stance of therapists is inhibiting families to find their own solutions, so much so that the therapist's continued availability and help creates a problem in its own right, namely increasing dependence on expert advice and leading to further 'helplessness'. Multi-problem families are frequently 'multi-agency families' (Asen 2005), as they have a tendency to attract multiple helpers who not infrequently provide contradictory inputs, causing problems in their own right. We often encounter a pattern, with the family's seeming helplessness soon paralysing the professionals, with 'chronic' and entrenched relationships developing all round. Over the years we have learned that multi-problem / multi-agency families require a more comprehensive approach than the evidence based approaches traditional psychiatry and clinical psychology has to offer. The multi-family approach seemed to provide this 'extra' (Asen 2002).

The practice of providing therapeutic interventions for families in a group setting dates back some 50 years, when Laqueur et al (1964) worked with hospitalised schizophrenic patients in New York. The patients' relatives were invited into the hospital milieu and directly involved in discussions about home life and treatment issues. The aim was to improve intra-family communication and with several families being seen together in one large group, it soon became apparent that family members developed ideas 'across families' of how to address chronically stuck issues. The early multi-family groups were appropriately described as 'sheltered workshops in family communication' (Laqueur et al 1964), taking place fortnightly for 2 hours. Families exchanged ideas and experiences with members of other families, 'comparing notes', as it were, and learning from each other. This approach subsequently inspired other clinicians working with psychotic patients (McFarlane 1982; Anderson 1983; Kuipers et al 1992) who discovered that families found it helpful to see some of their interaction and communication patterns displayed in others. Clinicians found that changes not

only took place *during*, but also *after*, the family group sessions and these changes included decreasing family enmeshment, normalizing communication within and between families, managing acute crises and leading to re-socialization and stigma reversal.

In the 1970s Alan Cooklin and his team at the Marlborough Family Service in London (Cooklin et al 1983; Asen et al 1982) started applying these ideas to multi-problem families. It was the poor results obtained with seemingly 'chaotic' and 'treatment resistant' families with dependent children that called for a new approach. This consisted of putting 6 – 8 'impossible' families together under one roof, for months on a daily basis, as a kind of 'therapeutic community of dysfunctional families'. Families with very similar problems were put 'all in the same boat together' and were encouraged to help others and to learn from each another. The idea then was that, by doing much useful 'therapeutic' work themselves, the clinicians and other 'helpers' would become less central and could slowly take a 'back seat'. A highly structured daily program with deliberately built-in 'controlled' crisis situations – similar to those they might encounter in their everyday life in their homes – forced these families to address daily living issues in a therapeutic context. The aim was to enable these families to identify new forms of 'self help' crisis management which no longer required the involvement of increasing numbers of professionals. The Marlborough Family Day Unit, an 'institution for change' (Cooklin et al 1983), was founded almost 30 years ago and some 2000 children and their families have been treated there since. At the outset, the work of the Marlborough Family Day Unit was very intensive and long: families attended eight hours per day and five days per week, often over a period of many months if not a whole year. However, subsequently the approach has undergone many changes and transitions, with therapeutic work now lasting on average 12 weeks and providing a balance between clinic-based and home-based work. Families attend initially for three or four days one week, for 6 hours, and subsequently less frequently, with home-based work to facilitate the transfer of experiences made in the clinic context to the home environment. This is followed by another intensive 3 or 4 whole days within the space of one week (Asen et al 2005). This setting acts as a kind of 'pressure cooker', providing intensive whole day experiences as well as exposure to other families.

During their attendance families have a structured timetable which requires them to make frequent transitions and changes throughout the day. There are formal groups, involving at various times all attending families together and, at other times, parents and children separately. There is a mixture of action-oriented and reflective work. A major principle of this work is openness and transparency, not only between the families but also between staff and families. The Family Day Unit is well equipped with cameras, permitting the recording of family interactions with the possibility of providing video-feedback sessions when families view themselves – and others – and reflect, from a 'meta-position', on how to make changes. Families can also take small video cameras home and make a 'home movie' about their life or specific issues. These may then be shown to the whole group of families who are often more expert at analyzing and commenting than extensively (and expensively) trained professionals! In this way families and their individual members become 'consultants' to other families. They support each other, they observe and comment on unhelpful patterns they see in each other. Families and their individual members form friendships and create a network of support for isolated families outside of the programme. Experienced 'graduate' families may avail themselves to engage new and sceptical families, offering advice and hope.

Transparency has to be a two-way process, requiring staff to share their views and observations openly. The 'Reflections Meeting', inspired by 'reflecting team' practices

(Andersen 1987), is an event which takes place in fortnightly intervals. The team of Family Day Unit workers, at present 4 staff, convenes a clinical meeting which is videotaped. In this clinical meeting the family workers exchange information and views about each family's dynamics, summarizing strengths and weaknesses observed during the previous weeks. This meeting lasts about 30 minutes and the videotape recording is given to another member of the Marlborough team who has not been part of the clinical meeting. This systemic clinician meets with all the parents (usually 10 – 12) to watch the videotape of the clinical meeting and to take note of the staff's views, opinions and reflections. The remote control for the video-recorder is given to one of the parents or other adults, a message that it is up to them to let the specific tape segment run for its entirety or to pause, so that specific points can be taken up. Most parents opt for stopping and re-starting the tape, as pausing the tape allows family members to respond immediately to the staff's views and reflect on these. It is the systemic clinician's task to get families to become curious about each other and to encourage them to provide advice, criticism and support for one another. The Family Day Unit workers are during the 'Reflections Meeting' not present in the room, but watch the meeting through a one-way screen. This has the effect of staff being placed in a 'pure' observing position, having to listen to the 'reflections' families make about their own 'reflections'. In this way staff become temporarily unavailable for being drawn into prolonged discussions with families, such as justifying their views. Instead they listen to the families' reflections without being able to immediately 'putting the record straight.' The parents, in turn, are encouraged by the systemic clinician working with them, to speculate on how staff might digest their reflections. The 'Reflections Meeting' is a popular event, at times more so with families than with staff. Families like the idea that not only they themselves but also staff can be observed at work. This adds considerably to the ethos of openness and transparency prevailing in the Family Day Unit. A subsequent 'post-reflections meeting', involving the systemic consultant and staff only, creates yet another layer of context: staff reflect on the families' reflections of the staff's reflections. And, to continue with the circular model, staff will let the families know about these reflections, prompting the families to reflect on these – and so on.....

Over the past 30 years the Marlborough Family Day Unit in London has pioneered the establishment of the first permanent multiple family day setting, specifically designed for and solely dedicated to the work with seemingly 'hopeless' families. It has resulted in a significantly improved engagement with seemingly impossible families and helped to neutralise poor 'chronic' relationships with professionals. Whilst the main emphasis is on multiple family work, other therapeutic interventions are also used if and when required, such as single family work and individual interventions, including psychodynamic work. Projects based on this model have been developed in a number of different European countries, including Scandinavia, Germany, Belgium, Italy and France. Similar projects in other countries are being developed at present and the European Commission in Brussels has provided funding for this via a DAPHNE grant.

Therapeutic assessments of multi-problem families

Many of the families referred to our service are in court proceedings, with their children either having been removed because of neglect or abuse, or with there being a question as to whether the children should be separated from their families because they are considered to be at risk. Our service is then requested to provide independent 'Parenting Assessments' or 'Family Assessments' and these are commissioned by Social Services and other similar agencies, so as to assist the Court in its decision making. A major aim of these assessments is to examine the past, present and likely future risks of emotional, physical and sexual harm to

a child and to provide opinions and make recommendations as to how the child's best interests can be safeguarded in the short- and long-term. The assessments are child-focused but also take into consideration other significant persons and wider system dimensions: the parents, the extended family, the social and cultural setting, the professional network and other dimensions. The assessment format our team has developed does not merely consist of taking a static snap-shot 'photograph' of the current risks and interactions of the family and its individual members, but it is a dynamic and interactional process: it could be compared with a 'movie' made by the assessing professionals and the family together. The term 'movie' implies movement – and it is the ability to 'move' - to change - that we regard as being important when making recommendations about a child's permanent placement and contact levels. In order to assess the parents' or the family's ability it is, in our view, necessary to provide them with therapeutic interventions – such as brief therapy, advice and feedback - and then to observe whether sustained changes do take place (Asen and Schuff 2003). Any such changes need to address 'at risk' areas of family functioning and this will take time, usually a few months. Change tends to be a rather slow process, particularly with multi-problem families who have been entrenched in chronic problematic relationship patterns. However, children can not be expected to wait 'for ever' for their parents to make the required changes. Timescale issues with regard to children's permanency planning have to be kept in mind and hence these 'therapeutic assessments' tend to take some 3 months on average. Whereas permanent changes are unlikely to be made by the parents and families in such a relatively short time, predictions can nevertheless be made about their potential for change. The focus on the parents' *'ability'* to change helps to answer some of the important questions with regard to prognosis and likely outcome.

Prior to undertaking the actual work with multi-problem families, we convene a 'network meeting' which has to be attended by all the concerned parties. This includes the parents (or carers), their own 'network', as well as the various professionals involved, which – as a minimum – requires the presence of the social worker(s) and the child's representative (the 'guardian ad litem' in the British system). However, frequently other people can also attend the network meeting (and the subsequent review meetings), depending on the intensity of their involvement. These can include members of the extended family, advocates and family friends, solicitors, health visitors, psychiatrists, teachers and so on. The purpose of this meeting is to:

- draw a 'map' all professionals involved in the life of the family, including their specific concerns, tasks and positions;
- understand the relationships between the professionals and the family;
- share openly the concerns the different professionals have;
- ensure that the parents can respond and define what their own concerns and needs are;
- jointly agree on the areas of work, timescale issues and consequences of change – and what is to happen if there is no change.

For the network meeting to be useful for everyone, including the parents, any professional concerns about the parenting or child's welfare need to be expressed in clear language, comprehensible to everyone, including the parents. This may seem obvious but is frequently not the case. For example, the term 'attachment', to which many professionals feel quite

'attached', means precious little to most parents and it requires to be 'de-constructed' and explained in simple terms. Similarly, the term 'communication problem' can also mean all sorts of things: too little communication; too confusing; too aggressive or too emotionally abusive. Some parents rarely say anything positive to or about their child; or they ask the child to be the referee in their verbal fights and then blame the child for siding with the other parent. Not listening to each other, or to their child(ren) can be another so-called 'communication problem'. The clearer and the more concretely any concerns are defined during this initial network meeting, the more possible is it for the parents to comprehend what the professionals are worried about and the more possible for them to know what to act on and which changes they need to make. This then allows the assessing team to consider how to assist the family and its members to make the required changes. However, it is important to remember that it often is not only the parents who need to make changes, particularly when one encounters a 'stuck system', with entrenched difficulties between professionals and the family and all-round paralysis.

Following the network meeting, it should be possible to make a detailed plan of how to structure the work: how many sessions, for how long, who should be present and where the sessions should take place. We offer a variety of sessions: some with the parents / carers individually, others with the parental couple (if there is one), and also sessional work with parent(s) and child(ren). In these interviews we not only ask a series of questions and listen to the accounts of the parents (and of significant others), but we also observe – and question - what goes on between family members. At times we will ask family members to carry out - or 'enact' (Minuchin 1974) - specific tasks, so that we can obtain 'live samples' of problematic and 'risky' family interactions. However, we do not only make observations but feed these immediately back to the parents, highlighting positives and areas of competence, as well as 'negatives' – areas of concern - so that the parents can respond and consider making some of the required changes. This allows us to assess how the parents – and other family members - make use of feedback and whether and how they are able and willing to change. Since it is frequently unrealistic to expect parents to make spontaneous change themselves, particularly if they are stuck in chronic patterns of poor parenting, we need to consider providing supportive interventions, such as straight advice, 'parental coaching', counseling or some other form of more directive family work. Risk needs to be re-assessed subsequently, 'post-intervention' as it were, to determine whether it has remained the same, or has been increased or decreased. We have to keep in mind that parental behaviours, as are children's, are context dependent. Our team therefore makes many attempts to see parents in a variety of different contexts, not only in the clinic or consulting room, but in the family home, in school or nursery when picking up their child, on hospital wards, in supermarkets where families often have 'public' crises with their 'unruly' children - and in other settings which are relevant to the family, be that their mosque, church, temple or synagogue. This 'wide angle' lens approach, if combined with the 'close up' look at the individual parent and child, permits to assess the wider context of the family and its support system – and how they can assist and support the family. It is a major principle of therapeutic assessments to work with children and their carers in 'familiar' situations, such as in their home around mealtimes, when picking the children up from school or during a shopping trip.

Time and resource issues often do not permit intensive home- and community-based work for individual families. It is for this reason that multi-family day units can be considered as a pragmatic and economic context for intensive therapeutic assessments. Here it is possible to assess the practical parenting ability of a mother or father, in a kind of 'home away from

home'. It permits seeing the family in action: how the parents deal with the demands of everyday life; how they organize themselves and their children; how they make decisions and implement these; how they manage under stress; how they prepare meals; how they supervise the children; how they address physical safety issues; how they play; how they plan outings – and so on. A 'typical day in the life of the family' can be recreated in a multi-family setting so that naturalistic interactions can evolve. With other families present, the parents tend to feel less 'centre stage' and the 'spotlight' is not merely on them, but on others as well. Furthermore, multi-family settings also promote interactions *between* families. This allows assessing the parents' ability to make social contacts and form relationships, as well as assessing their capacity to supervise their children appropriately when meeting relative 'strangers'. Boundary issues are likely to emerge in a large group of families and it can be quite a stressful experience, with all the noise and activity of 15 children and 12 adults. Such levels of stress and intensity are not unwelcome as it requires parents to manage their often volatile emotions in difficult circumstances. This makes it much more difficult for parents who are well practiced in putting up a front, or presenting a 'normal' façade', for the sake of professionals. It is also a context in which parents and families can support each other, where they bring their own observations of other families and receive feed-back about their problematic or disturbed interactions from other families. Often parents see mirrored in other families precisely those issues that they find difficult to acknowledge themselves.

The formal evaluation of the efficacy of multiple family therapy is still in its infancy though local audit projects have shown that this form of intervention is very acceptable to multi-problem families. A number of prospective controlled outcome studies are on the way to evaluate the long-term effects of multiple family work. Therapeutic assessments allow us to form opinions as to whether families and their individual members are able to make changes and, equally important, whether they can sustain these over time. We have found that it is possible, usually within a time frame of three months, to come to informed opinions about the parent's and the family's ability to change and to make fairly reliable predictions about the ability to sustain these, or identify the risks as to why rehabilitation of an abused child with his parent(s) can not be considered. Our therapeutic assessments are much in demand by local courts and the (national) High Court. Recently the British Department of Health and the Chief Medical Officer have specifically mentioned our service as an example of good practice and recommended this as one of the 'expert witness' models to be considered nationally.

Outlook

The approach described in this chapter could be said to bridge the gap which often exists between social work practices and the clinical work of psychiatrists and psychologists. It is a multi-disciplinary model which integrates key elements and best practices from both social work and psychiatry / psychology. It reflects, to some extent, professional encounters some 30 years ago, when Walter Lorenz worked at the Maudsley Hospital in London and when he was influenced by – and began to influence – thinking and practices in child psychiatry settings. His work has since expanded admirably, in many different contexts, predominantly in the field of social work, but also in many different countries. Perhaps Walter's work might be described as being multi-contextual, multi-modal, multi-cultural and European.

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