Current use of treatment groups for parents and their preschool children

A snapshot of the service provision within the four Thames regions

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Despite the apparent advantages of group treatment for parents and their preschool children, this technique is not widely used in child psychiatry departments. Those units that have groups find them useful resources for the assessment and treatment of families with a wide variety of presenting problems. Experience is leading clinicians to run groups that are (a) time limited and closed; and (b) structured and focused in their work. Audit projects are being conducted in some centres to evaluate their usefulness, but no studies have been undertaken of groups using random allocation of patients. This should be done before their efficacy can be assured compared with other treatment models.

Treating families with preschool children in groups of parents and children makes intuitive sense for a number of reasons. First, many parents will have attended mother and toddler groups or play-groups and will be familiar and comfortable with this setting. Second, the staffing levels in a group mean that parents can be seen alone for some of the time, while the children have a separate activity. In individual work, disruptive children may need to be present for the whole of the session, making thinking and intimate discussion impossible. Third, many preschool children have problems around eating, and a group setting provides the opportunity to include a meal in the treatment package. Fourth, parents can see other parents and staff dealing with their children, and so learn by modelling different ways of handling problems. Fifth, children who have problems dealing with their peers can bring those difficulties live into the sessions. Group leaders get a chance to see the behaviour for themselves and tackle it during the groups. Also, parent training in groups has been shown to be as effective in producing change as individual work, as well as being more cost effective (Kovitz, 1976).

Therapists started to describe their experiences in such groups in the late '60s; Eva Frommer wrote about work at St Thomas's (1967) and Lindsay-German & Coleman (1971) described a group at the London Hospital. These groups were designed using psychodynamic thinking and provided play therapy for the children. They aimed to promote the relationship between mother and child by giving mothers a better understanding of their child's emotional needs, and a more realistic expectation of their abilities. Bentovim & Lansdown (1973) put together a description of seven groups, with some of the settings also providing treatment for older children.

The London Hospital group was subjected to a controlled evaluation of its effectiveness (Mitchel *et al*, 1975). This study is limited by its use of a control group gathered from families who refused the day unit treatment. It is also a retrospective study. It showed the intervention to be effective in improving behaviour problems at home, but not when the children subsequently attended school. This group later underwent a change in therapeutic style that seems to have been part of a trend. It began to employ a more structured programme, targeting specific areas of cognitive, social and emotional development.

Another group operating on more traditional lines was that at Great Ormond Street. Here a study was undertaken of efficacy (Woolacott *et al*, 1978); no significant difference was found between treatment and control groups after one year or when the children were eight-years-old. This led to a re-evaluation of the treatment programme and the introduction of a more goal-orientated approach to tackling individual behavioural or emotional problems.

The current survey aimed to discover the use of groups for parents and preschool children in departments of child psychiatry within the four

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Table 1. List of the ten units meeting the study's requirements

Out-patient units
Great Ormond Street
Bath Road, Hounslow
Camberwell Child Guidance
Central Middlesex Hospital
Edgware General Hospital
Roehampton Child Guidance
Day units
Monroe Centre
Emmanuel Miller Unit
Marlborough Family Resource Centre
Guy's Bloomfield Clinic

Thames regions, and to take a snapshot of methods of working and to highlight recent changes in therapeutic styles.

The study

All child psychiatry departments in the four Thames regions were contacted by letter. Consultants were asked if they, or another staff member, ran a group where parents and preschool children were seen together. A proportion of consultants who did not reply were contacted by telephone. The reason for not replying in all cases was that they did not know of such a group. Therefore, telephone follow-ups were not exhaustively carried out. The reply rate was 68%.

The group sites were visited where practically possible, and the conductors of the remaining groups contacted by telephone. A semi-structured interview was used to obtain similar information from all group leaders. This included practical details of the group structure and questions about staff background and therapeutic style. The advantages and disadvantages of the different methods used to run such groups were also discussed.

Inevitably, groups were identified that did not fit into the previously designated model (i.e. either child or parents not included), but information gained in this way helped form a wider picture of group treatment for preschool problems.

Findings

Information was gathered on ten groups. These are listed in Table 1. Clearly, the parent–child group approach is an uncommon way of working within child psychiatry departments. However, Social Services, the National Society for Prevention of Cruelty to Children (NSPCC) and National Children's Homes all have units working with family groups, and child psychiatrists may refer to these. There were also departments that did run groups from time to time, but as they were not involved with one at the time of the enquiry, they were not included in this study.

The groups

This small number of groups is very diverse and direct comparison cannot be made between them without qualifications. The outstanding difference is between those departments where the group treatment is a weekly session within a comprehensive out-patient service, and those where the whole unit is devoted to a families group programme. However, the assumption has been made that there will be some common issues for the groups, as their client groups have many similarities, and so the information about them is set side-by-side (Table 2) to illustrate the variety of approaches applied. (Every effort has been made to check the information given about individual units, however, the data given represents the answers to questions provided by one member of a team at one point in time, and should be read with this in mind.)

Clients

All the groups included children from 0–5-years-old and would accept the presence of older siblings in the holidays.

None of the groups was exclusively for mothers, and fathers were actively encouraged. Even in the units where parenting assessments are part of the package, a pragmatic view is taken about a working father's ability to attend. It is realised that employers are not generally sympathetic and that worry over losing a job is realistic.

Six of the groups at the time of the interview had children on the 'at-risk' register, and two were working with families where the children were accommodated by Social Services. Seven of the groups considered themselves to have a remit to assess and treat abusing families.

Referrals for the groups were largely medical, often filtered through the out-patient department of the unit in question. The Monroe Centre and the Marlborough Family Resource Centre seem to have referrals almost entirely from Social Services departments.

Target disorders

All groups tackled toddler behavioural problems to some extent.

The Great Ormond Street Hospital clinic is set up to treat feeding problems and the group at the Central Middlesex Hospital also targets eating problems. Seven of the groups include a meal in their programmes.

Table 2. Data used for comparison between different units

Unit	Numbers	Hours per week	Length of treatment	Open/Closed	Staffing
Out-patient units					
Great Ormond Street	6 families	3 (every 2 weeks)	6 months	Open	4
Bath Road, Hounslow	8 families	2	3–18 months	Open	4
Camberwell Child Guidance	8 children	1.5	10 weeks	Closed	4
Central Middlesex Hospital	4–5 families	2	<2 years	Open	3
Edgware General Hospital	4 families (run 2 × /week)	3	3–12 months	Open	3
Roehamptom Child Guidance	4–6 families	2	4–6 months	Open	4
Day units					
Monroe Centre[1]	3 families	10	3–12 months	Open	3
Emmanuel Miller Unit[1]	11 families or 15 people	9	6–18 months	Open	4 full time, 1.5 part-time
Marlborough Family Resource Centre[1]	9 families	24	6 weeks	Closed	3
Guy's Bloomfield Clinic[1]	5 families	5	16 weeks	Closed	3

1. These units have families attending more than one day a week.

The Marlborough Family Resource Centre and Monroe Centre specialise in assessing and treating families where abuse is an issue. The Hounslow group is also used for parenting assessments and rehabilitation work. The group at Edgware General Hospital has a history of treating autistic children and a speech therapist attends the group. The Roehampton group also specialises in language disorders.

Staff

By definition, clinical responsibility is held by a child psychiatrist, but neither senior or junior child psychiatrists play a large part in these groups. The Hounslow team have recently started to use their preschool group as a training opportunity for a registrar.

Nurses and nursery nurses form the largest group of staff, with social workers being the next most commonly involved.

Psychologists, psychotherapists, occupational therapists and speech therapists have some input.

Therapeutic orientation

Many of the group leaders saw themselves as using a mixture of approaches. All except the Marlborough, Hounslow and the Bloomfield clinics use some psychodynamic thinking. The Marlborough Centre specialises in family therapy and Hounslow and Great Ormond Street Hospital have a mainly behavioural approach.

Interestingly, little emphasis is placed on the group process, especially when thinking about the children's time together. All the 'day unit' style groups use individual family sessions to complement the group work, as do Hounslow, Great Ormond Street Hospital and Central Middlesex Hospital on occasions.

The Bloomfield Clinic and the Marlborough Family Resource Centre are using a technique where video tapes are made of the parent and child at significant times of the day (e.g. bath times). These tapes are shared with the parent and used to illustrate points of technique. Negotiated portions of tape can then be used in a parents' group setting to share lessons learned with others in the group.

Evaluation

The Bloomfield Clinic is conducting a research project to test the usefulness of its video technique. The Marlborough Family Resource Centre have published outcome data on cases treated in their programme. In a third of the families seen, a recommendation was made that children should be found permanent alternative families. In those families reunited, they found the reinjury rate to be very low.

Further work from the same unit has looked at reabuse rates in the 50 families that attended the programme from April 1992 to April 1994. These data are being prepared for publication. The Great Ormond Street Hospital group collect data on all referrals and have information on 200 cases. They give parents a battery of questionnaires at the

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beginning and end of treatment. These include very non-specific indicators of well-being such as the General Health Questionnaire and specialised ratings of eating behaviour.

None of the groups could present data to support the efficacy of their treatment using randomised allocation of cases at the time of this survey.

Comment

It is striking that despite the very different therapeutic modalities used in these settings, all the group conductors find seeing parents and children together invaluable, and give similar reasons for working in this way. The therapists frequently commented that they gained fresh insights into the interaction between parents and children after having introduced them to a group, or that they had made unexpected progress in cases where work had seemed to be stuck.

Not surprisingly, the value of whole family assessment is particularly notable when a parenting assessment is needed by social services for a court case. As well as being an effective use of staff time, it gives an insight into the mother or father's ability to socialise with the child. This is an important, and for some, difficult aspect of parenting. In such settings parents have to introduce their children to a new group of adults and children, and also manage their difficult behaviour in public and when under pressure. This mimics attendance at playgroup, school or any social gathering that families with behaviourally disordered children can find problematic. It also highlights a parent's ability to deal with professionals they may not agree with, in a way that is in the best interests of the child.

Watching a parent at play with his or her child gives valuable insights into that parent's own childhood experiences. For example, it was a common observation that adults who were deprived as children would take over the activity provided for their children and hungrily complete it themselves.

For children without the language to give accounts of their home experiences, direct observation can be very helpful in filling out an incomplete picture.

These groups also increase the range and power of treatment programmes. Talking about an incident that happened immediately prior to the session, and that was witnessed by the clinician can bring therapy alive. Behavioural techniques can be modelled in a realistic setting. It was the experience of all the group leaders interviewed that their groups were well received by parents, even most of those compelled to attend because of an imminent court case. The relief of seeing other parents struggling with the same problems can be an important ingredient in the mixture of factors that lead to positive change.

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