On working together: dilemmas for the trainer *[1]

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Just before she retired, I was having a discussion with one of my psychology colleagues about multidisciplinary teamwork in child mental health. She said to me, "just keep on talking about it until it comes back into fashion". I will take her advice, but now have to see how the model needs to change. In the new hard world, the dilemma for the trainer is how much to protect the trainee, in order to foster good clinical work. We look back gratefully on our own training and supervision and try to reproduce what was best in it. This is necessary, but it is not sufficient. Institutions are essentially conservative, and there is a risk that we will be forced into defensive and ever more reactionary postures by unfriendly governments who do not seem to care about us and only want to save money. The political and social environment is quite different now from the one in which we were ourselves trained, and we have to be careful to distinguish the secure learning base we want to achieve in our institutions now for the next generation of trainees, from a nostalgic longing for the circumstances of a generation ago. The question is, to what extent must trainees be prepared for the political struggle, as well as for the clinical one?

In this paper I will discuss some of the features of multidisciplinary teamwork. My own experience is as a psychiatrist in child and adolescent mental health, but I believe that the principle of combining different professional disciplines can be applied just as well in work with adults. Later on, I will speculate about the social and economic processes surrounding us, and end with a recommendation for trainers in this new hostile world. My main message is that we have to include consciousness of the political and historical context in our work and training. I am familiar with the conditions of work in British public services, and assume that something more or less similar can be found in other developed countries, in Europe, in North and South America, Japan, Australia and New Zealand. I also assume that multidisciplinary teamwork is necessary for good practice in mental health and that therefore trainees need to work in teams to learn how to do it. This model is one in which each staff member comes from a different discipline, from psychiatry, psychology, non-medical psychotherapy, social work, nursing and often others too, such as occupational or speech therapy. The trainees of each discipline are attached as apprentices to their trainer, and work with them in the team meetings, and sometimes in clinical work too, as co-therapists in groups or with families and couples. Besides that, they meet without the other team members, just the two of them, at least once a week for an hour's

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supervision, where the subject matter is the professional development and clinical work of the trainee. The important ingredient of this training is the preservation of separate professional identities, with enough overlap between them to share a common task. If they are not different then it isn't a multidisciplinary team at all, merely a gathering of like-minded colleagues; they could be a squad of soldiers, road diggers, or just a gang.

In contrast a multidisciplinary team is meant to be quite special. In the popular imagination, probably shared by politicians who believe they are in touch with the people, it is a wonderful organisation. An idealised portrayal of such a team, for example in an advertisement, would show some men and women, perhaps of different skin colour, or in different kinds of clothes, sitting around a table or in a circle of chairs, and they all seem to be very animated and interested. If there are trainees there, they look evidently younger and eagerly soak up the wisdom of their elders. This picture gives a reassuring impression of caring, co-operation and development. It is really an extension of the fantasy we all have about a happy family with a kindly helpful person, modelled on an idealised mother, or doctor, who has all the time in the world to listen to you and knows just what to do to make you better. Your team is not like this, however, and nor is mine. Those who plan and use our services might wish it to be so, but it is not. There are, as in any real family, constant tensions, between individuals and their chosen way of looking at things. Occasional relief comes in bursts of laughter, when someone makes a joke, usually ironic. Also, as in families, there is the problem of the dependent members of the group, who need nurturing. One of the key difficulties for planners of services is how to include trainees in the picture at all. In an economics driven model of the world in which value for money is the goal, trainees, like children, are a nuisance since they take up the productive time of the adult workers, who should be better employed doing the work for which they are being paid. Before dealing with that particular difficulty, I want to discuss the conditions necessary for good teamwork in community mental health, and the conditions which make such work very difficult, if not impossible.

A good team is not, as one might suppose, one in which everyone agrees. There would be no point in having one if that were the case. We know that the problems of mental health are so complex that different points of view are necessary to get a full picture. Therefore conflict is part of the design. These cooperative people are not cooperating all the time; they also argue, but more often they disagree in rather subtle ways, as if it were not meant to happen. I found this quite disturbing when I first began working in mental health. I noted that from time to time confrontations would occur in which things were said which were not meant to please. But this was unusual, as people in the caring professions, including psychotherapists, are often, as Henry Krystal (1988) has observed, surprisingly good at ignoring their own feelings. More frequently, I noticed that conflict in clinical teams was concealed in the same way as it is done in some families, by exaggerated efforts to agree while not doing so, to seem on the same side while being on the opposite one[2]. In families

[2] This pseudomutuality commonly breaks down when the team is faced with child sexual abuse. The powerful split in the minds of the abuser and abused ("it must have happened"/"it can't have happened") is replicated in the team, which becomes polarised (partitioned) around this issue. This team process may be the *only* clue that the case being discussed involves the breaking of a fundamental taboo (Kraemer, 1988).

where this happens we can expect to find psychosomatic disorder, though outward harmony prevails (and the parents stay married,(Stierlin &Weber,1989)). There is a cost to be paid for this peace in families, and much of it is, incidentally, evident in psychotherapeutic practice. In teams that avoid open conflict the cost is similar, in that certain problems cannot be experienced or thought about, but they do not go away. Such teams may become unstable, so that some members have to leave, or they may become dead and simply go through the motions of discussion, while no real dissent is allowed.

The stability of a good working team depends on both its internal organisation and the external conditions. The internal organisation is one that tolerates, or actually encourages, conflicts of opinion without fear of disaster. The writing on groups by Wilfred Bion (1961) developed a theme that had already fascinated historians and psychologists for many years, particularly in relation to the problem of morale of men in battle. While it is necessary to have discipline and leadership, Bion also showed how these are not simple qualities, and that the mood of a group tends towards very primitive assumptions which get in the way of the actual task in hand. Unless the task is simply that of a gang, for example to get rid of an enemy (whether internal or external) each member of a working group has to have some authority of his or her own. In short, each has to be able to hold an opinion, while at the same time being prepared to change it. This requires the capacity in each member to manage his or her own rivalrous feelings and other profounder anxieties, such as the fear of madness.

Not surpisingly, the external conditions that foster such a set up need to be really quite sophisticated, quite different from what we actually have. Most policies for mental health and social services practice in Britain, for example, constantly emphasise the need to co-operate with others, to work together, to have liaison between agencies, and so on. There are in fact two reports published by the Department of Health in the past few years called 'working together'[3]. This, however, is a policy dreamt up by the same people who have carefully disintegrated the public services over the past few years to such an extent that it is not longer advisable for friendly colleagues in neighbouring hospitals to talk to\each other about their working practices, their budgets, future plans, and so on, for fear of revealing commercial secrets. The true and explicit policy for all public services in Britain at the moment is that quality can only be maintained through competition. This applies in health and education as well as in public utilities such as transport, power, broadcasting and telecommunications. In those services that have not yet been privatised, such as schools and hospitals, the method of achieving this is seductive, but is actually a cynical abandonment of responsibility by government. Money, never enough, is handed out to small scale units, say a hospital or a school, which are then left to make their own decisions as to how it is to be spent. To this system is added an internal market in which units have to compete for funds held by local purchasers. This is nothing short of a planned disintegration of public services. In such an atmosphere, the instruction to co-operate sounds utterly unconvincing and hollow. The prevailing message is one of rivalry, not of

[3] a third arrived on my desk while I was giving this talk.

collaboration. The requirement to "work together" reaches us like a call from a far off headquarters, hopelessly out of touch with the realities of life at the front. Officials at the centre must have realised that the dismantling of public services has gone too far and desperately try to patch up the errors of their political masters with well-meaning ideas. In my field, child and adolescent mental health, the pressure to do so has come principally from child abuse scandals, in which children have been murdered in their homes. These horrors have been haunting governments with sickening regularity over the past twenty years. The resulting policies are, sadly, closer to the fantasy of advertisers, like the one I outlined earlier, than to the reality. In this dream, everybody liaises with everybody else, but there is no notion of the time, space or personal resources required to do this in a meaningful way. It is just a staged photograph. The result in many agencies is endless meetings, imbued with a cynical sense of futility, and a prevailing doubt that anything will be achieved there.

A brief illustration of the dilemma: Together with a child psychotherapist, I meet regularly (every two weeks) with a group of nurses, doctors and some others who work in an intensive care unit for very small premature babies. It is in the very nature of hospital work that no meetings ever begin on time, from one meeting to another they are never attended by exactly the same people, and interruptions are frequent, because of phone calls, messages on paper brought in through the door and, of course, occasional emergencies. Yet the commitment of these workers is awesome. They have to deal with the most appalling catastrophes. Usually out of the blue, a couple expecting a baby suddenly find they have got one, but it has arrived far too soon, it is too small and very sick. The nurses, in particular, have a very clear idea of what they are doing, which is replacing the functions of the womb where the baby should have still been. It is a privilege for me to attend these meetings. We started this work a few months ago and, although I have been associated with the unit for many years, I was astonished by the helplessness of the staff in dealing with the reforms in the national health service. The commonest remarks were about the lack of money in the hospital to pay for the proper staffing of the unit. Therefore they are chronically overworked. One nurse spoke of her attempts to prevent management from having her home telephone number, so that she would not be called on her days off to come in and work overtime. Eventually she gave up, as her number, even when she changed it, would appear in the staff book each time she deleted it. The doctors too, as is probably better known, have appalling hours of work and in this job never get any sleep when they are on duty at night. But no one seemed to think that they could do anything about this. They even felt sorry, in a rather distant way, for the managers who kept telling them there was no more money. I was at once driven to enormous indignation on behalf of these workers. I had only one thought, which was to bring this situation to public knowledge, especially to the government that denies there is any problem in the funding of the health service.

Rather to my surprise, and confusion, I did not arouse similar passions in my colleagues. Some were afraid that to speak out would only make matter worse. If those responsible for purchasing paediatric services were to hear that morale was so low in this unit, they might be inclined to make contracts with others, thus putting this one out of business entirely. My psychotherapist colleague, however, made a different point. She said that the political issue was a necessary one to follow, but it was not sufficient. She was sure that while the staff's

loyalty and goodwill were indeed being exploited, their complaints about it concealed deeper and more fundamental anxieties about the job they were doing. She wanted to talk about babies, and the feelings that caring for these tiny creatures aroused in everyone. When we did so, the complaints stopped, although the political situation has not changed at all.

I tell this story partly to show what we are having to deal with in the NHS today, but also to illustrate the simple point that, whatever the qualities required in its members, an external condition for sensitive teamwork is stability and recognition. That is to say there has to be some idea of predictability in the organisation, that things will be recognisably similar in a year or two's time. And the workers have to know that what they are doing is understood and valued by the people who employ them and manage them. Neither of these conditions prevailed in the hospital. The changes in financing the health service are moving so fast that there is no guarantee that we will even have the same hospitals in place a year or two from now. Secondly the managers themselves change jobs every few months, and have barely any time to get to know the workforce. They rely, rather like government ministers, on information summarised for them in documents or on briefings provided by managers on site, none of which ensures that the quality of the work is known and understood higher up. Here, then, is a group of people who work together well, with a relatively small turnover of staff, yet their own minds, and mine with them, are taken off the task by a system of values that cannot recognise the quality of work, because it can only measure quantity, that is to say, money.

Now this illustration comes from a hospital, and from an area of work where the treatment is thought to be something ordered by the doctor, whatever the reality. Our psychotherapeutic mental health teams are different. Because there is no 'medicine', no physical treatment, at the centre of our vision, we are ultimately preoccupied with the search for meaning, with the attempt to make sense of what patients bring to us. We are forever telling stories, though some of them are beginning to sound rather different. In common with journalists, therapeutic clinicians know the power of narrative. But we also know how easy it is to fall in love with our own version of the story. Working as trainers in interdisciplinary teams should protect us from such single mindedness. If it does not do so, then it is a failure. The team's greatest asset is, after all, the opportunity for change, which means that each of us has to acknowledge that our own chosen point of view is only provisional, and that changing it is often a necessary and painful process, and one which itself requires considerable authority. Now the political and social changes that threaten us also represent another point of view, one which we can no longer ignore. This is the challenge. I do not see these changes as supportive of multidisciplinary work, but the matter cannot rest there. The example I gave from a neonatal intensive care unit might suggest that grumbling about the external world is simply a way of avoiding the primary task. I will not accept that. The two, the external and internal, are intimately linked, and if we try to preserve an ideal of work by ignoring the external we create a paranoid or sado-masochistic organisation, like some kind fundamentalist sect that thrives on its resolute opposition to the prevailing view of the world.

What is happening in the outside world is very complex, but in general can be described as some kind of breakdown. Even the most progressive and prosperous countries in Europe, such as the Scandinavian nations and the Netherlands are finding that they cannot afford to pay for the welfare state on the scale that they did before. The explanation for this, suggested by J.K.Galbraith (1992), is that the majority of the population[4] has actually improved its living standards as a result of the policies of former left wing and liberal governments in more prosperous times, and is no longer interested in paying for the poor and needy. In such an atmosphere it was inevitable that governments would begin to say the unsayable and question the assumptions of public service and welfare that had held more or less securely since the end of the second world war. Now it is possible to say quite openly that we will not pay for such services, as if they had become luxuries The needs of the health service are then described as a 'bottomless pit'. Meanwhile rates of direct taxation have of course fallen in many of these countries, mostly in favour of the better off. There is no longer any confidence in the idea of unstoppable economic growth. The very basis of our past social stability turns out to have been based on a myth. No institution is sacred, nothing is safe. Political enthusiasts may see this as a positive revolution, and long overdue at that. I have not met one person in the helping professions who sees it that way. The last great social change in Britain and Europe came after the second world war, and that was a time of hope and renewal. This is not. There is no consensus about what new kinds of social life we should be aiming for. The traditional notions of work and family relationships will not return, however politicians of left or right might wish it so.

In parallel with these economic developments there has been a near-revolution in family life. In the nineteen fifties the majority of families consisted of a married couple with the principal wage earner being the male. Divorce rates were low (in Britain and US they were actually falling) and there was full employment for males. Child abuse was virtually unheard of. It was not until the 1960s that paediatricians began to discover that children with peculiar patterns of bone fracture had in fact been repeatedly beaten, and not until the 1980s that we had to face the even more unbelievable phenomenon of child sexual abuse. At the same time rates of divorce have risen in an accelerating fashion, and many families now have step parents and step siblings, while both parents are alive, which was very rare in the past. (It is worth saying, however, that the majority of children in Britain, and no doubt in many other European countries as well, still live with both their parents, even if there are others added to the family. In clinical practice we see a disporportionate number of fractured families, which does not give us an accurate picture of the norm. It is also worth saying that divorce rates have been rising in countries such as USA and Britain for at least a hundred years (Goldthorpe, 1987), so that the brief post war fall - it lasted in the USA from 1948 to 1960 - was quite exceptional, but a tempting focus for nostalgic longings). Families are also more mobile than in the past, so that children are now less likely to live near their grandparents. Although many have a higher standard of living than forty years ago, visible signs of poverty are increasing, more homeless people and beggars on the streets being the most obvious examples. These are people who suffer from all the

[4] This argument may not apply to Britain, however, where two thirds of the population are below average earnings.

problems that concern us; family breakdown, child abuse, poverty, substance abuse, unemployment, racism and mental illness. They are the tip of an iceberg of social and personal damage. Finally the position of women in society has changed so that we can no longer take it for granted that their destiny is to be mothers and nothing else.

The explanation for these economic and social changes is harder to find, but if we clinicians do not have some hypotheses about them, we shall make serious errors in our work, and we shall fail to prepare our trainees for theirs. The simplest explanation is precisely the one identified by my colleagues in the hospital, lack of money. But there is also a lack of hope that there will ever be enough, that there will ever be justice or stability in society. There are no longer any powerful political theories for us to espouse, and little confidence in the political process, which is now exposed as a performance for the TV cameras. The certainties of left and right have evaporated. The choice is apparently now between fundamentalism or a cautious uncertainty. But I want to identify a reason for cautious optimism on the part of therapeutic professions, in case the growing convictions and understandings that we have gained during the same timespan are blown away in the storm of disillusionment.

Take, for example, our understanding of the needs of children. If you look back fifty years to the standards of child care, there is clearly a change for the better, at least in theory. Then children were simply sent away from their parents under threat of war or persecution as if that was the most natural thing to do. Sick children were put into hospitals for weeks at a time often with very limited visits from their parents, even less often than the brief daily contact chronicled by James Robertson in his 1953 film. Since then, there has been a growing awareness, both in the public mind and in scientific research, of the importance of childhood experience. Despite their theoretical differences, figures such as Anna Freud, Melanie Klein, John Bowlby and Donald Winnicott showed that it matters very much how you treat children, who can think about it and be affected by it from a very early age. Modern policy on the care of children is beginning to reflect this, even if it fails to be translated into practice. (The UK Children Act, for example, is generally regarded as progressive and child-centred legislation, yet, on the government's own figures (HMSO, 1992), a quarter of children in contemporary Britain live in poverty). More recently, a further understanding has emerged, but from a different source[5]. I think it has been due the greater freedom of women to speak out that the sexual abuse of their children could be believed for the first time, instead of being brushed aside as lies and mischief. These inconvenient revelations were not primarily the work of professionals though some lone social workers and others had to fight the ridicule and contempt of their colleagues to be heard. We need to be clear that the stability of the old society was dependent in part on concealment of domestic pain and abuse, and on far greater deference and fear of powerful figures, such as parents, teachers, police and churchmen, and of course psychotherapists, especially medical ones. People did behave better in public in those days, but we cannot assume they were less perverse in private. Society has since then been turned inside out. (A

[5] If there is a link between the post war development in psychotherapy and the voices of women it might be reflected in the theoretical shift from a linear view of mental suffering and its treatment to a more interactive and circular one, from a drive theory to an object relations one. You could say that this was a move from a male to a female point of view, or from an individual to a relationship one.

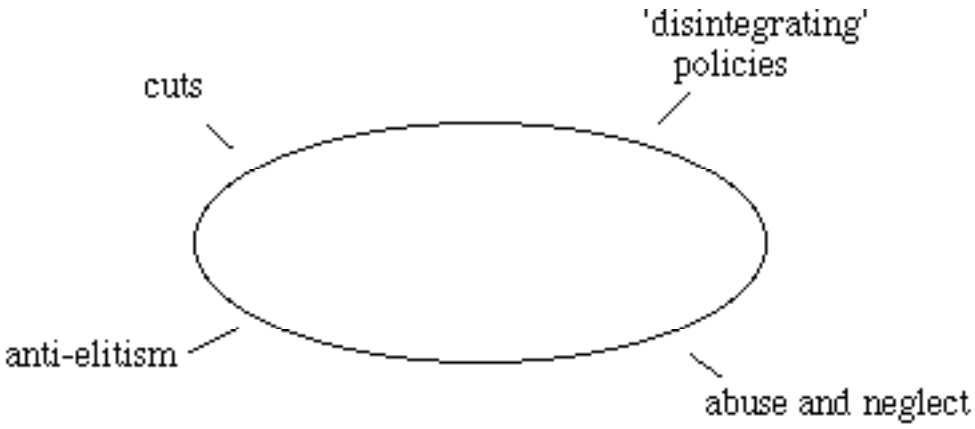
particular misconception is that child sexual abuse is something new, which then leads to the theory that family breakdown is the cause of it. This is not so. Child sexual abuse was almost certainly more prevalent in the past, and there is quite good systematic evidence to show that it is now declining (Feldman, 1991). Workers in child and adolescent mental health services had this phenomenon brutally thrust in our faces during the nineteen eighties. We gradually and painfully had to accept that we had been missing it all along. Adult services are beginning to go through this process now, ten years on)

What has broken down is the stability and predictability of the old society. To return to the original theme, the multidisciplinary team needs these conditions in the public service in order to survive. We cannot have the peaceful world of the 1950s returned to us but it is reasonable to expect some sense of direction in our institutions. By trying to stay where we are we will become as out of date as the old style nuclear family, with the father-psychiatrist at the head, the mother social worker or psychologist at his side, and other disciplines, non-medical psychotherapist, and psychiatric nurse all subordinate to the head, like children or household servants. Both the internal relationships of the members, and their view of the outside world, have to evolve. A great deal of work has been done in thinking about how teams can become less hierarchical, and many child and adolescent mental health clinics in Britain have shown that clinical work is enriched if senior team members can carry clinical responsibility for their own cases. Of course without a predetermined leader[6], the team is more likely to argue and to leave questions unresolved. This is an untidy way of doing things and only makes sense if the untidiness of mental disorder itself is acknowledged. Like the modern idea of companionate marriage and shared parenting, the modern model of teamwork exposes the difficulties that were hidden in the old hierarchical one. It is harder work because authority has to be earned by each individual taking part in the discussion rather than given as of right to the chief. (In any case, the 'democratic' team is still relatively unusual. In hospital general psychiatry, and even more so in other branches of medicine, the doctor still seems to be firmly in charge, though of course not everyone accepts that as readily as they used to.) But equal status of team members will not in itself help us to deal with the new world; for that we need to have an understanding of it - a political point of view. Under the threat of disbandment, which has actually happened to many child guidance clinics, our fine model of co-operative work can easily become a fossil; isolated and out of touch, like fundamentalists who idealise themselves as the only true believers, we are easy targets for enthusiastic reformers, who see only the great expense and complexity of such working together, and none of its virtues. (Actually it is very cheap. Compared to other health services, we have no drugs, no beds, no complicated equipment. We just need ourselves, our patients, time and space.) When this kind of teamwork is effective, staff and trainees like working together, they enjoy the tension and feel that they are learning new skills. For such workers, besides the dangers from the disintegrative policies of government there is another threat that comes from other colleagues in nearby agencies who are not managing to thrive, whose skills are being lost. Envy of good work is particularly dangerous in such times. Because

[6] This does not mean that the team is without direction. Meetings must always have someone in the chair, and both the quality and the level of experience of different disciplines and different individuals have to be acknowledged, (see Kraemer, 1995)

they maintain a boundary around themselves, well functioning teams are accused of being elite and inaccessible. Of course it is possible for these criticisms to be correct. A boundary is in itself no guarantee of liveliness.

External threats to the multidisciplinary team



By a curious irony we are back where we started, with the millennial sense of how to manage group morale in a time of war. It may be obscene to talk of the attack on public services in such terms, when there are real and bloody wars going on, wars in which people's lives are destroyed in irreversible and unforgivable ways. But there is, even without any blood being spilled, an unmistakable atmosphere of destruction on all sides. A few weeks ago I heard the chief executive of a London hospital talk of the possible closure of a department in a neighbouring hospital, which used to be an ally but is now a deadly rival. He said that the department in question was to be "taken out". This is precisely the terminology used by the US forces when referring to their so-called surgical strikes in the Gulf war.

It is no longer possible, if it ever was, to take a politically neutral stance as a child and adolescent mental health worker or psychotherapist. While many of the processes we deal with seem to bypass the merely social phenomena of the day, there is increasing pressure on our work to recognise not only the social origins of mental pain, but also the political

context of adult psychotherapy and of child & adolescent mental health services. As trainers in the public service, the obligation to do so is stronger than it might be in private practice. The sort of world in which our trainees will be working, into the next century, will be very different from today. Merely resisting the threats to services will not do. Nor can we expect a new government to welcome us with open arms. Political parties of all persuasions have the greatest difficulties with psychotherapy and child guidance because the messages we bring are ones their active members do not want to hear. We know that economic justice, or great national wealth, or an environmental revolution, or whatever else is greatly desired by political ideologies, will not in itself eradicate the painful disorders of attachment that are our daily work. A left, right, liberal or green party is not inclined to think deeply about this, because political individuals tend themselves to be in escape from their own personal lives. They do not want to know about the intense pressures and pains of parenthood that can in such subtle and pervasive ways lead to lifelong disorder in their offspring, even in those who become outwardly successful and socially competent.

Newer developments in infant psychology and psychiatry are showing with systematic rigour what clinicians had discovered in their practice (eg Brown & Harris, 1978; Parkes, 1991; Murray, 1992). There is the basis now for a powerful consensus of views which has to be translated into political and social policy. There is also a risk of losing this opportunity as we squabble amongst ourselves as to which kind of therapy is the best one - this is to fiddle while Rome burns, or to be enthralled by the narcissism of small differences, as Freud put it[7]. These are important and necessary discussions but they are to be held in private. Even heated debates between us about different styles of family life, about single parenthood and so on, can obscure our agreements, which I take to be an acceptance of the universal need to be attached to secure parental figures, in a secure place. In the near-vacuum of modern political short-term thinking we have to insert some idea of real human needs. The mistake of the optimistic post war years was to plan for people without involving them, to design services and habitations without understanding that the primary need is to belong, which is based on the security of ones first attachments. Instead a very weak but attractive concept, that of ownership, has taken hold, so that those who have, do not want to be parted from it, while being threatened by the increasing desperation of those who have not. This is a society of infants without parents, squabbling over toys when there are not enough to go round.

The apparent paradox is that while there is more sensitivity to the facts of attachment, not only in infancy but throughout life, there is a political recoil from these truths, in which dependency is seen as a dirty word. There is a powerful reaction in some intellectual and political circles that wants to take us back to an age of self-reliance and independence. Allied to this is the seductive notion of freedom of choice. This is really about the freedom of able-bodied individuals who have the wealth and wisdom to make choices. Most people, the ill and disabled, the unemployed, the old, children and young people, their mothers,

[7] "..it is precisely communities with adjoining territories, and related to each other in other ways as well, who are engaged in constant feuds and in ridiculing each other.." (Freud, 1930, p114)

and students, do not come into this category. Trainees in child mental health and the psychotherapies, even those who are paid a salary, are very dependent beings, and unless we actively encourage discussion of the political aspects of our work in supervision with them, they will remain overprotected and underprepared for the shock to come, when they have to fight for their own services, and for the next generation of trainees. This means that supervisors and tutors should be prepared to talk to trainees about their own, often frustrating, experiences as negotiators and managers.

Enormous public resources, medical, legal and social, are wastefully used up trying to deal with the after effects of loss, deprivation and abuse in families. We know this from our clinical work and from research, but that does not mean we have the means to solve it clinically, nor does it mean that we shall be heard. We have to develop our own political consciousness in response to this burden of knowledge. I think it is the duty of trainers in the psychotherapeutic disciplines to alert their trainees to it, and to show them that continuously developing clinical skills are the necessary basis of all our work, but that they cannot any more be sufficient. As John Bowlby put it so nicely only five years ago:

"Man and woman power devoted to the production of material goods counts a plus in all our economic indices. Man and woman power devoted to the production of happy, healthy, and self-reliant children in their own homes does not count at all. We have created a topsy-turvy world."(Bowlby, 1988, p2)

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