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## A sinking heart: whose problem is it? Under-fives work in the surgery of a general practitioner

*Beverley Tydeman & Janine Sternberg*

**T**his chapter focuses on the application of the Tavistock Under Fives model to work in a community setting, a GP's surgery. Detailed case material is given from brief work undertaken with a 4-year-old girl and her extended family seen for four sessions, and we expand from this specific case to highlight key issues that arise in the application of this Under Fives model to a community context.

### *The pleasures and problems of working in a GP setting*

An increased awareness of children's mental health needs and the value of early intervention has developed as part of primary care provision. Child psychotherapists have a contribution to make in supporting primary health care teams, which include GPs, health visitors, and practice nurses, alongside child psychologists and other early years professionals. The child psychotherapist's contribution to the GP service involves direct work with families with young children, as well as indirect work focused on supporting practitioners. This indirect work offers training, supervision, and consultation to help the primary care team extend their range of responses to these families. Parents will approach their GP with a number of problems for which they would never imagine needing referral to a psychological service or hospital

department. The Tavistock Under Fives model is particularly well suited to a primary care context that offers help to these families, providing a “thinking space” in an easily accessible community base.

Working at the interface with primary care requires the clinician to have “a flexibility of approach and an ability to think quickly” (Tydeman & Kiernan, 2005). There is as much for the clinician to learn about primary care as there is for the primary health care team to learn about the psychotherapeutic way of thinking. The surgery milieu itself can be therapeutic for patients, as all comers have to be seen and it is an accepted place for bringing aches and pains, for being listened to and taken care of. Many consultations in GP surgeries are for mental health or social reasons—people may be lonely and deprived at various points in their lives and may present with somatic complaints, when what they need is to belong and to be understood. GPs have a few minutes to give to each patient (Balint & Norrell, 1973), and the quality of those minutes can vary enormously, from routine care that is fast and efficient to close emotional contact. In contrast, the child psychotherapist, working in a practice, will expect to spend about an hour with each family, giving the opportunity for things to unfold at a different pace.

Referrals are made by GPs, health visitors, or practice nurses, and a first appointment is offered as soon as possible; a rapid response is an essential part of the service because concerns about a very young child can feel desperate to those involved. When a baby has been vomiting too much or been unable to sleep or feed, or a toddler has not defecated for several days and the parents are at the end of their tether, the service can seem like crisis intervention. The aim is to offer an informal and responsive service. For this reason it is common for the clinician to telephone the family to make the first appointment. Apart from the practical advantages of this approach, the experience of speaking, albeit briefly, to the clinician who is offering to see them can help dispel parents’ anxieties and make the service more accessible. Usually families are seen within a few weeks of making contact.

Feedback is provided to the referrers, doctors, health visitors, and others attached to the practice, usually within the practice-team meeting, to share experiences and any additional information. Confidentiality is shared by the team, and this is explained to patients at the start of the contact. Often the health visitors may decide to follow up a family who has not attended an initial appointment. The feedback also enables members of other disciplines to understand and engage

in the thinking process. The team hear about the attention to detail and willingness to grapple with negative perceptions and experiences. The reflective process that takes place in the team helps each member to recognize his or her own emotional responses to the patients.

Families may return after a first set of sessions, needing some more input, perhaps for a different family member, or later in the development of the originally referred child. This pattern reflects the way families use the GP practice.

### *The atmosphere of the setting*

Waiting rooms are often full and noisy. The staff are under pressure, dealing with many different demands. The atmosphere is busy, rushed, intimate, and anxious. People are waiting, and they are in need; they expect to leave with something that makes them feel better. Using a medical room is unfamiliar territory for a psychotherapist more used to a neutral space. In the GP practice we often work in doctors' consulting rooms, which will have a high couch, various charts about height, weight, and safety, a device for taking blood pressure, a bin for sharps, and a computer—and all this together with a family with young children who need to be attended to. A clinician can feel less in control of the setting than in the usual consulting room. There are a limited number of toys in the room and also a supply of drawing materials. We take the view that the children are their parents' responsibility and try not to intervene with regard to what they are allowed to touch and jump on, although commenting on what we observe is part of trying to communicate our understanding of the situation. This is helpful in giving a picture of how well the parents are able to set boundaries and use their authority.

In this busy atmosphere the clinician may need to guard against the pressure to offer a premature formulation of the problem before things have had an opportunity to unfold. There may be an internal compulsion to give advice when it is asked for. This is probably similar to the pressure doctors feel to write a prescription so that the patient feels he or she has gained something from the visit.

Families are told in the first meeting that there is the possibility of up to five meetings. The first session focuses on the family's expectations, with an exploration of what they hope to gain from the service. The clinician will also explore with the children, if they are present, what they know about why they have come, making the

active participation of the children clear from the start. Although there are issues that clinicians are particularly interested in—the pregnancy, delivery, and early experiences—there is no attempt to take a history in a formalized way. The family are given the opportunity to tell their story with the focus on their anxieties.

### *Case example*

As is often the situation for clinicians working in a GP practice, this referral was initiated by a brief letter from the GP, followed by an informal conversation. Mrs P had frequently consulted her GP about 3-year-old Seeta's eating and sleeping problems. The GP said that she found Mrs P "very puzzling, it's as though she is somehow out of touch with her child". The GP said she gets "that heart-sinking feeling" when she is with this mother, and she often doesn't know what Mrs P wants when she has come to see her with relatively insignificant complaints. At the time of her referral Mrs P was pregnant with her second child.

#### First session

Mrs P came alone to the first meeting. She was a tall, attractive woman, dressed in an elegant, Westernized style; heavily pregnant. She was pleasant in her manner but made it clear that she was rather puzzled as to why the GP had suggested some meetings with me. She thought perhaps it was because the GP was worried about how her daughter, Seeta, would adapt to the new baby. I was told that Seeta had been a bit spoilt as the only child and treated like a princess. Mrs P told me in a matter-of-fact way that Seeta refused to eat any food prepared by her. She would, however, take food from her father or his parents, who were living with them. Mrs P was pleased that Mr P's family had come to London to be with them after their move.

Seeta was also used to sleeping in the same bed as her paternal grandmother. She slept lying on top of her grandmother's body, causing grandmother great discomfort. Mrs P had no idea why Seeta behaved in this way but said she was sure that Seeta would adjust well as she likes the idea of another baby. I suggested that sometimes there are mixed feelings, and as well as being pleased, Seeta may possibly feel worried or cross at times—she's used to being the only one, and now she is going to have to share her mother and wait her turn. It was possible that not taking food from her mother was connected to

Seeta's worry about her mother's mind being on the new baby and not exclusively on her.

What Mrs P was keener to talk about was her experience of having had to relinquish her country of origin, her family, and her professional role. She had done an MBA in India and had loved her job before becoming pregnant. Seeta had been born in India, and they had had to move to a town in the North of England when she was 18 months, because of Mr P's job. They had recently moved to London, and she had begun working again. She found it a good arrangement that her in-laws now lived with them. She was quite sure that she had no rivalrous feelings towards her mother-in-law, explaining that she was used to children being close to their grandparents and had grown up with the expectation that she would one day be a daughter-in-law. In fact it suited her, as she was eager to return to work as soon as possible after her maternity leave.

Towards the end of the meeting Mrs P mentioned that the next baby was a son. She told me how important having a son was in her culture, and she emphasized how delighted Mr P and his family were. I wondered with her whether she had experienced any change in Seeta's behaviour after becoming pregnant, and she acknowledged that she had experienced her as more controlling since the pregnancy had become obvious. She felt that Seeta was turning away from her and towards her father when he was there, or, alternatively, towards grandmother. When it was put to her that this might be Seeta's response to the new baby, Mrs P was dubious.

I suggested that it may be useful to go on thinking about these issues, and, more specifically, about Seeta's part in them, with all the family, including Mr P. Mrs P quietly accepted this, but she felt that Mr P would be too busy at work, because he works in insurance and travels a lot.

### *Discussion*

This first meeting left me with many disparate thoughts. I was confronted with a modern, professional Indian woman who had been displaced from her own culture and had newly arrived in London. What did I or the GP know about her origins and beliefs? The GP had made an assumption about the kind of mother she was—detached. How much had my thoughts been organized by this, or was I sufficiently open minded not to be judgmental? I wondered about the relevance of cultural issues on many levels and how much these might have

contributed to mother's relative lack of anxiety. Her mother-in-law seemed to take a central role in running the home, which suited her. She was genuine in not feeling displaced or envious, as the involvement of her mother-in-law in the home was part of her cultural experience. Cultural patterns and family traditions—for example, regarding sleeping arrangements—need to be kept in mind and respected, while at the same time we cannot lose sight of our understanding of what all children need for healthy development.

Working across cultures requires particular care regarding meaning. The “sinking heart” (Krause, 1989) is a description of a feeling state experienced by certain Indian sub-groups that can have many meanings, both physical and psychological. The heart is seen as the regulator of life forces throughout the body, and various emotional experiences can upset the balance of the regular heartbeat, thus causing distress and upset, which can result in a visit to the GP surgery. Life events, including migration as a disappointing experience, anxiety, confusion, agitation, and sorrow can all affect the person's sense of well-being in their “heart centre”.

The main task within this first session was to establish a relationship with Seeta's mother enabling her to feel sufficiently understood within her particular family and cultural context, together with trying to highlight possible aspects of her child's inner world. I felt I needed to wait and see how they interacted together in order to have a fuller picture of their relationship. I wondered whether anything in our initial discussion had interested or engaged mother enough for her to want to return.

### Second session

To my surprise the second meeting was attended by Seeta, her mother, and both grandparents. Mr P's absence was explained in terms of work commitments. Seeta was a tall, thin girl with large brown eyes, dressed in tights and a pretty dress, with her long dark hair adorned with hair bows and clips. Paternal grandmother was wearing an elegant sari. Seeta spent most of the session sitting on her grandmother's lap. Both grandparents were clearly devoted to her, and family life revolved around her. Mrs P was very quiet at this meeting, allowing her parents-in-law to make it evident where the authority, at least in terms of child rearing, lay. Although Seeta was across the room from where mother was sitting much of the time, I noticed that mother

looked at her warmly and, when Seeta did go over to her, welcomed her with open arms.

We explored together with the grandparents and Seeta why we were meeting. Seeta avoided eye contact with me. Her grandparents initially conveyed that they did not feel that Seeta's behaviour was cause for concern, although they spoke of her as a little underweight and wilful. We began to think together about what might be going on for Seeta. Her grandmother thought the way she slept on top of her might indicate a wish to return to being a baby inside the body, just like the baby inside her mother's tummy. As well as showing her understanding of Seeta, the grandmother was also able to communicate how physically painful this was becoming for her and how disruptive it was of her sleep.

Seeta put her thumb in her mouth and turned her head towards her mother, who stretched out her arms towards her. Seeta got off her grandmother's lap and went over to her mother, seating herself contentedly on mother's lap while Mrs P stroked her hair. I drew attention to what had just happened and how Seeta seemed to be responding to her grandmother's words. I was pleased to notice that mother clearly did have an important place within this family, and that she and Seeta had a relaxed affinity. I said to Seeta that it seemed she still had her place with her mother and she was lucky that she could move between her grandmother and her mother. Also, from what I had heard from her mother, she also had her father to turn to. I said I thought this would be especially helpful for her when her mother had the new baby also needing to sit on her lap.

Seeta remained silent throughout the contact, but she was listening. Grandmother, with her lap now free, was able to talk about the way that Seeta's "princess" position within the family would need to be limited with the arrival of the new baby. Grandfather was a quiet but benign presence who said that his wife had really been in pain with her back and she needed Seeta to be a bit more independent; maybe she could sleep next to "Ama" (the Indian word they used for grandmother, though they used the English word "Mum" for mother). I wondered with them whether Seeta was feeling worried about her own position and that this had made her behave in a more princess-like and controlling way. I suggested that the sleep and feeding problems may imply that she was behaving in a "baby-like" way, perhaps because of anxieties about losing her place as the "one and only baby". I said grandmother's intuitive comment seemed to indicate that Seeta

was trying to be the baby, but she was also going to be the big sister. By the tone of my voice I tried to convey to Seeta that we understood that she might be experiencing fears of loss and that it made sense that she wanted to hold on to things.

I commented that Seeta's responses to the anticipated new baby were very ordinary and not pathological at all. The expansion of the family unit creates opportunities as well as bringing adjustment difficulties. Becoming a big sister could give Seeta the opportunity to find in herself capacities that will promote her emotional development: she might be able to lie next to grandmother rather than on top of her, having internalized enough of a sense of how loved and valued she is within the family. She had not lost her mother; in this session she had found her. We agreed on one more meeting before the birth and a final one afterwards.

### *Discussion*

This extract highlights how a clinician uses observation to gain a clearer picture of what is going on. Commenting in the here-and-now on what had happened in the room when Seeta moved from "Ama's" (grandmother's) lap to her Mum's may have helped the family make some space for the changes ahead by linking mind and body, showing the possible meaning of behaviour. This seemed to be a positive move that became the focus of the session.

The focus of the work emerged as the link between the description of Seeta's symptoms and mother's pregnancy gradually became clear. Under other circumstances, with the opportunity for longer work, one might have wanted to attend to mother's style of mothering or differences within the couple about parenting, or to look in more depth with mother and her parents-in-law about the possible tensions created by living as an extended family. The focus in these sessions was on finding meaning in Seeta's behaviour by suggesting its possible link to her feelings about the new baby. She had a sense that things would never be the same again for her and was naturally fearful about this, especially at night. The particular circumstances of Seeta being able to turn to her grandmother in such a way would not have been available to a child living in a nuclear family, who would then have found other ways of dealing with the same conflicts.

In the first session, enabling Mrs P to convey her experience of becoming a mother, leaving her own family and country of origin,

and her struggle to encompass both maternal and professional roles gave her space to think about this in the context of her own childhood, which would be quite different from that of her own children who would be growing up in London. This is probably what brought her back to the surgery with her child and in-laws. Realizing what a central place she had in her child's emotional life might have helped her to focus more on Seeta's emotional experience and step back from feeling rejected by her daughter who had been refusing to take food from her.

The open manner in which I addressed Seeta's possible feelings of loss and displacement may have resonated with the family's own feelings of displacement in London and enabled them to feel some empathy with her. Grandmother had felt free enough to express herself and her complaint, helping to move Seeta along and to find her place on her mother's lap.

### Third session

Mrs P and Seeta attended this meeting. She explained that her husband would have liked to come but the demands of business kept him away, and that he was in fact a very involved father; she did not give the impression that she felt unsupported in her parenting. Mindful of her father's absence I explored what differentiation there was between mother's and father's activities with Seeta, encouraging her to tell me about special things she did with her father, to which she responded readily. Mrs P joined in, offering a reminder of her own special time when they read books together.

I heard from Mrs P about what a good son her husband is to his parents. They also have a daughter living in Goa who recently got married. Mrs P said that it was possible that her parents-in-law may have to leave and go to help her with her first baby; she was sad about this. I spoke about all the comings and goings and how hard that was for all of them. Mother spoke more about what it had been like when she first came over to England and how much time they had spent at airports flying backwards and forwards with Seeta who had been unwell, having to take lots of antibiotics. She had been unsettled and clingy, as well as being very bossy and not letting her mother out of her sight. Despite this, she is doted on by all of them.

Seeta stood close to mother's chair, touching her arm with her body. She did not attempt to clamber onto mother's by now very

heavily pregnant lap. Mrs P joked that perhaps Seeta had now forgiven her for having another baby and was quite looking forward to being a big sister. Although the concept of rivalry was still unacceptable in this family, perhaps having done some thinking about it had prepared them for the mixed feelings that lay ahead. Seeta smiled at me when her mother was taking pride in reporting her progress. I was told that she had now ceased to sleep on top of her grandmother, lying in the bed close to her instead.

We acknowledged that this was our penultimate meeting, with the last to take place after the baby's birth. At this point it seemed as if progress had been made, but there was uncertainty as to whether this could be sustained at the time of and after the baby's birth. Seeta still seemed shy in my presence, staying close to her mother, but she was able to make more eye contact with me, and she looked at and fingered the farm animals I had put out, although she did not play with them.

### *Discussion*

It was apparent that the relationship between the parents was one that left mother feeling supported. The father in her mind was a good and helpful man. Anticipating the departure of her in-laws, Mrs P was thoughtful about their possible move back to India to help with the arrival of their own daughter's first baby. Her parents-in-law had come to live with them and settled in London when Seeta was 2 years old. They were retired and dependent on their children, but also it was accepted that extended families support their children around the time of childbirth. Some Western families may have to use the professional network, particularly health visitors and GPs, as a quasi-extended family. Seeta had been able to stop sleeping on top of her grandmother, a move that may have been linked to what had taken place in the previous session.

### Fourth and last session

This took place when Raju, the new baby, was 8 weeks old. The grandparents accompanied Mrs P and Seeta again. Raju appeared to be a contented baby. I was told that he had taken well to the bottle; mother explained that she preferred not to breastfeed. Raju was in a pram, and when he woke towards the end of the time, Mrs P was quick to lift him out and comfort him by rocking him gently in her arms. While

she did so, Seeta went to her "Ama", who took Seeta's doll out of her bag. Seeta took this, held it against her chest, and rocked it. She looked taller, more grown up, and clearly full of pride when telling me her baby brother's name. I was told that Seeta had started playgroup. She was still restless at night. Mother looked exhausted, but exhilarated. Everyone exuded pride and a sense of achievement.

We began by noting that this would be the last meeting. All seemed relaxed with that idea. After admiring the baby, and hearing how the family were getting on, I was told by the grandfather that they were being called upon by their daughter to return to India to help with her first child, due to be born in a few months' time. Although they would keep a place within their son's London home, they would now have to divide their time and energies. I acknowledged their sense of loss (as well as gain) in not being an ongoing part of Seeta and Raju's daily life. Mrs P joined in, acknowledging what she, too, would lose. She said that she would be returning to work after twelve weeks' maternity leave.

Grandmother said that she felt in much better health, without so much physical pain, because Seeta was now sleeping in a small bed in the grandparents' room. She felt herself to be more able to refuse some of Seeta's demands, knowing that she was able to bear and cope with minor disappointments. Her heart was stronger and so was Seeta's. Mother commented on the way that Seeta seemed much more able to show her affection despite still being "Daddy's girl". I shared with the family my sense that there seemed to be no need for continuing contact with me. They had wanted to show me Raju and how well they were doing, but they had a sense of having moved on. As I frequently do in my work at the surgery, I reminded them that they would be welcome to return if they wanted to in the future.

### *Discussion*

The predominant communication in this last meeting was the sense of pleasure and pride for all of them. The family had grown now to include a healthy baby son. The delivery had gone well, and Mrs P seemed to have found more confidence in her own mothering and was able to express herself in a way that had not been possible when I first met her. She spoke of being upset at losing the support and practical help of her in-laws but of not being prepared to put her professional life on hold while she took care of her two young children. She would

have to get in hired help. She was not comfortable with breastfeeding, and it suited all of them to have sleeping arrangements that might seem unusual in Western families.

She was relieved and genuinely pleased that Seeta had such a strong tie to her grandmother and was concerned about how she would respond to the grandparents' return to India. Although she had been unsure why she had been referred in the first place, she seemed to realize that this was not a "vote of no confidence" in her capacities as a mother; on the contrary, she had flourished through taking up her maternal role more actively. The work had been less active with Seeta, who was very shy and hard to engage, but she had moved on too. Four meetings of under-fives work, spread out over a few months, had been all that was necessary to free things up for this family. The GP who had referred the case was pleased at the change in her relationship with mother, as well as in the reduction of appointments that they sought for minor physical complaints.

I had wondered why the GP had initially felt a "sinking-heart" sensation in the presence of this mother, which led to her making the referral. This leads us to the question of whose problem it is when a child is referred. It may have been that it was the GP's uncertainty about how to help this mother and her daughter. It is possible that it may have been a communication of Mrs P's own state of mind that the GP was picking up. Perhaps she was communicating in her frequent visits to the surgery some sense of heaviness, being pregnant with another child in a foreign city, far from home.

### *Things move fast*

The way that the dynamics had shifted within this family after only a few meetings is a familiar pattern. Often the child's "symptoms" represent a conflict in the relationships within the family. The brevity of the contact creates the opportunity to focus on realistic goals that are achievable. In Seeta's case the whole system seemed to have been freed up to move on. Seeta had become something of a tyrant, using her grandparents to gratify her in a way her mother could or would not. It also seems likely that father had joined with his parents in indulging Seeta, possibly seeking to compensate for the warmth and physical affection that her mother was finding difficult to give her.

It was disappointing that Seeta's father did not attend any of our meetings. It is not unusual for fathers not to come, with child-rearing often being seen as predominantly, if not exclusively, the mother's

concern. This was not the case in Seeta's family, where the mother had a picture in her mind of father as making a significant contribution—in fact, one that allowed her to take a back seat. If anything, she seemed initially to be the one who had been marginalized from the child rearing. Through the sessions she seemed to find a more active position, which gave her pleasure.

While mindful of the number of families who do not have a resident father, the presence in mind of a helpful paternal figure is essential. It is not the child's biological father, or even necessarily another male presence, that is critical but, rather, the internal partner in the mother's mind and how this is conveyed to the child. Wherever possible both partners are encouraged to come to appointments from the beginning, acknowledging the importance of both of them. Sometimes the work facilitates the father to feel able to take a more potent role in family life. This creates a situation of shared parenthood, a partnership in which the child can be thought about from two different but complementary perspectives. In Seeta's family this perspective was broadened to include the grandparental view, and, with each member having their allotted role, multiple perspectives could be tolerated.

### *Finding the focus*

Brief work is both compact and complicated. The clinician needs a flexibility of approach, a lightness of touch, using the minimum necessary to get a family over the present difficulty. Awareness of the brief nature of the intervention means finding a few points of focus clustering around a central theme. This involves not exploring other issues that are raised by the family which might be usefully explored in longer-term work but do not relate to the mutually chosen central focus. It is necessary to find the focus and agree on it with the family, and it may take a while for this issue to emerge. As well as close observation of the family's behaviour and communications in the here-and-now of the session, detailed reports of incidents give a flavour of what has made specific events so painful, providing an indication of where the problems may reside, and how they might be resolved. Frequently the under-fives clinician encourages the parent to reflect on the child's birth, the early months, and any events in the adults' lives at those times that might have impacted on the family's emotional well-being.

After the second or third session the central theme will usually have been clarified, and a sense begins to emerge of whether the family will be able to make use of this approach. The family often makes

an intense connection to the service following the sharing of intimate details of family life with the clinician. The end is kept in mind from the beginning, with the clinician often referring to it, so that the family members are all aware of how much time remains. Endings are necessary and are often an opportunity for reflection; by showing how useful they can be, without minimizing the pain associated with them, the clinician gives the family a picture that can then be adapted usefully to situations involving many goodbyes and moving on to new phases of life and growth. Many of the issues that families bring to an under-fives service revolve around the problems caused when change is only seen in terms of loss and not also in terms of opportunity for new experiences.

### *Conclusion*

The clinician's task is to think about the meaning of the child's behaviour, or "symptom", in the present—what this child does and why, and how this makes the parents feel or react. What the child does is likely to be influenced by the unconscious expectations of the parents as well as by the child's own temperament. In the work with the parents, those expectations are made conscious by making links between different aspects of their narrative which they had not previously put together or by making links between the parent's narrative and the child's play in the room.

Through the questions asked, parents are encouraged to think about why and when particular behaviour occurs. Often the very act of thinking in this way is a surprise, and parents derive considerable pleasure from the understanding it brings. When approaching the under-fives clinician, families are in a state of heightened emotional arousal and find it hard to think for themselves. They need some thinking to be done on their behalf.

The primary care milieu in itself serves a therapeutic purpose. The psychotherapeutic presence helps all the workers who are under such pressure to be more fully themselves in their work (Balint, 1993; Elder, 1996), having an increased ability to access their own thoughtfulness and sensitivity. As Daws (2005) states, "A psychotherapist can perhaps back the primary care team in continuing to recognize the importance of the emotional and psychosomatic aspects of their work, and in keeping going over years of dealing with the cumulative experience of seeing patients with undefined needs" (p. 36). In this way we believe

that the clinician's presence helps both the patients and the staff, as the sense of a sinking heart is diminished when it can be thought about and understood.

*Note*

The work described was carried out by Beverley Tydeman; the discussion of the work is by both authors.