

Inter-professional Partnership: a case study

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Resumo: O estudo caso apresentado neste artigo aborda a colaboração entre profissionais de múltiplas áreas disciplinares. Este estudo descreve como foi realizada a parceria entre a equipa de enfermagem e a equipa de psicologia clínica nas visitas domiciliárias com famílias em risco. Igualmente, discute as dificuldades enfrentadas quando os profissionais não partilhavam os mesmos modelos de práticas colaborativas.

Palavras Chave: Parcerias, Multidisciplinariedade, Intervenção Precoce.

Abstract: The case study presented required partnership participation on early intervention. It outlines how the health visiting - clinical psychology partnership was effectively conducted and the difficulties encountered on occasions when the various professionals did not share similar philosophies or practices of collaborative partnership.

Key Words: Partnership, Partnership, Early Intervention

Résumé: L'étude de cas présentée dans cet article aborde la collaboration entre professionnels de multiples champs disciplinaires. Cette étude décrit la façon dont a été réalisé le partenariat entre l'équipe d'infirmiers et infirmières et l'équipe de psychologie clinique pour les visites à domicile avec des familles en situation de risque. Nous discuterons également les difficultés rencontrées lorsque les professionnels ne partageaient pas les mêmes modèles de pratiques collaboratives.

Mots clé : Partenariats, Multidisciplinarité, Intervention Précoce.



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Introduction

The case study that follows focuses on chosen sections of a three year joint clinical psychology-health visiting therapeutic intervention that was planned and delivered in partnership. The Primary Care Directorate in the trust where it took place was interested in evaluating the effects of close collaboration between the two professions, particularly in the field of prevention and early intervention. Health visitors often identified families that showed signs of vulnerability to difficulties in the psychological and emotional development of a child and in the parent-child relationship. Because of their trusted position within the family they were in a powerful position to effect change, yet sometimes lacked the skills to do so. Combining clinical psychology and health visiting skills into a joint service was seen as a worthwhile partnership to investigate.

Collaborative partnerships, including a review of the literature, difficulties of definition, and the need for their existence is the subject matter of Section B of this thesis. Not only are government directives very clear in their demand that the various professions work jointly and collaboratively (Home Office, 1991; Audit Commission, 1994; HMSO, 1995; DoH, 1998a), the research shows that in practice collaborative partnerships are, in situations such as those involving child protection, essential (DHSS, 1974; Brent Borough Council, 1985; Hallett & Birchall, 1995). Research also gives an indication as to why collaborative partnerships seem to be so difficult to achieve (Taylor & Tilley, 1989; Seaburn *et al.*, 1996; Lupton & Khan, 1998) and contains examples of where it has been possible (Holden *et al.*, 1989; Bradford, 1993; Plamping, 1997).

The collaborative partnership implemented in the trust where this case study took place included a range of initiatives. Health visitor access to consultation with the clinical psychologist was one such initiative. The consultation service provided the opportunity for health visitors to discuss cases in whatever depth they required. This could range from confirmation that their own assessment and intervention plan was the best available in a particular case, to discussing extremely complex situations and jointly formulating how best to proceed. 'Joint working' between clinical psychology and health visiting was sometimes decided (by both professionals) as the best way of intervening in a case, following the consultation session. 'Joint working' involved the health visitor and the clinical psychologist assessing and discussing the available information on a case, formulating possible hypotheses as to why the difficulties presented as they did, and agreeing a provisional plan of intervention. This plan included the identification of which aspects seemed to best be delivered by each profession, as well as how and when the tasks of inter-professional communication and continuing assessment of impact of intervention would take place. The provisional plan was then discussed with the family, their views and needs integrated to produce a working plan that would be subject to change as necessary.

The decision to intervene through 'joint working' was often taken in cases where the parents own parenting had been problematic. This was usually identified by the health visitor during the postnatal visits when routine family histories were taken, including client's relationships with their parents. On occasions clients themselves spoke about troubled relationships with their parents and related unresolved issues, often with awareness of how

this could hinder the emotional functioning of their newly formed family and the development of their children.

The case study that follows is an example of how the collaborative partnership between clinical psychology and health visiting under the initiative of 'joint working' took form in practice. Its presentation focuses on two specific 'episodes' of intervention, chosen as examples of the therapeutic process that took place within the three year period of inter-professional joint working. The first episode incorporates the initial contact between health visitor and clinical psychologist, and the process of engaging the subject in direct work with the clinical psychologist. The second refers to the time when the subject's daughter was first returned to her care, a time when the practical responsibilities of being a mother brought back memories and feelings regarding her own abandonment. Through joint working it was possible to attend to both the day-to-day caring for the child and the raging feelings related to the past. The two episodes focus on the dovetailing work between the two professions. In each, goals and objectives for that particular part of the intervention are noted, as well as the way each professional facilitated specific aspects of the overall objective and with what effect. Particular reference is made to the amount and type of inter-professional communication that took place. A third section outlines some of the difficulties encountered as a result of the lack of a common definition of 'working together' between all the professionals that were involved with the case.

Case details

- Louise was a 26 year old mother of a 5 month old daughter at the time of referral.
- She had been diagnosed with Multiple Sclerosis (MS) 18 months prior to referral, the condition having been exacerbated by the birth of her child. At the time of referral she was confined to a wheelchair.
- Three weeks prior to referral, she had voluntarily asked Social Services to place her daughter in temporary foster care after her partner and father of the child had been violent towards herself, as a result of which she had left her home.
- Louise had confided in her Health Visitor details regarding her childhood. She had regularly been physically, sexually and emotionally abused by her mother and mother's various boyfriends.
- She was separated from her mother at the age of six, after a particularly horrific sexual abuse incident, when Louise was hospitalised as a result of the injuries sustained. The abuse was carried out by her mother.

- After this incident her mother was committed to a psychiatric institution and Louise taken into care by Social Services. Details as to the reason for the mothers committal are not known.
- For a number of years prior to that however, Louise, her mother and her two sisters had been living in Social Services accommodation, supervised by a foster mother.
- At the time of referral (from health visitor to clinical psychologist) Louise was experiencing the urge to self harm and asked for help. Many years before, whilst in the care of Social Services, Louise had been 'sent' to counselling because of her tendency to harm herself. Her experience of counselling was however negative and when the Health Visitor suggested that she consult with the clinical psychologist she was not prepared to consider such a recommendation. What she requested was that the Health Visitor, with whom she had developed a trusting relationship, help her with her re-emerging urge to self harm.
- The agencies, professionals and volunteers involved in this case over the three year period, for varying lengths and at different points in time, included:

Social Services:	Social Worker (Children & Families)
	Disability Care Manager
	Foster Parents
	Adoption officer
	Children in Need Senior
	Practitioner
Health:	GP
	Mental Health Team Psychiatrist
	Health Visitor
	Health Visitor assistant
	Clinical Psychologist
	District Nurse
	Physiotherapist

Occupational Therapist

Voluntary Sector: Home Start

MS Society

- During the course of the three years, there were times when Louise was severely incapacitated by fluctuations in MS symptoms. When symptoms were stable, she was able to cope, with some help, with her own care and that of her daughter. However, when the MS symptoms increased, depending on the severity, Louise could require 24 hour care if her toddler daughter was to remain in the home.

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Research findings on sexual abuse and self harm

Much has been written on childhood sexual abuse, its identification, evaluation, prevention and treatment. Relevant to this case, however, is the literature on the long term effects of childhood sexual abuse. Finkelhor & Browne (1988) refer to eight non-clinical studies showing that women with a history of child sexual abuse have identifiable mental health impairment when compared to those not sexually abused. These studies were done in normal populations using a variety of standard measures such as the Coopersmith Self-Esteem Inventory, the Centre for Environmental Studies Depression Scale and the Middlesex Hospital Health Survey. Mental health impairment referred to a variety of conditions including depression, self-destructive behaviour, anger and hostility, poor self-esteem, feelings of isolation and stigma, difficulty in trusting others, marital and relationship problems and a tendency towards revictimization.

In a review of the literature on the long-term effects of childhood sexual abuse Schetky (1990) summarised the findings. Depression in adulthood was found to be highly prevalent in victims of childhood sexual abuse as was their overrepresentation in psychiatric inpatient units. The abuse of drugs and alcohol was also found to be high amongst victim populations as was the incidence of self-destructive behaviour. Other long-term effects of childhood sexual abuse included post traumatic stress disorder and anxiety, dissociative disorders and conversion reactions, revictimisation and impaired interpersonal relationships and trust.

Finkelhor & Browne (1988) propose that the injury of child sexual abuse can be broken down into four components, which they call traumagenic dynamics. The components comprise: traumatic sexualisation, betrayal, powerlessness and stigmatisation. They further propose that these dynamics alter the child's cognitive and emotional orientation to the world, creating trauma by distorting the child's self concept, world view and affective capacities.

Traumatic sexualisation takes place as a result of the inappropriate link that is created between sexual behaviour and other events. Often sexual behaviour is rewarded or exchanged for affection and attention; in this way the child learns that sexual behaviour can be used to manipulate others in order to get developmentally appropriate needs met. Traumatic sexualisation also takes place when certain parts of the child's anatomy become the subject of a fetish and as a result given distorted importance or meaning. Sexual abuse often happens in frightening and painful circumstances, creating the association between fear and pain and sexual activity. All these associations shape the child's sexuality in a developmentally inappropriate and interpersonally dysfunctional manner.

Betrayal refers to the dynamic in which children discover that someone on whom they have been virtually totally dependent, has caused them harm. The degree of betrayal experienced depends on the relationship between the child and the offender, and on the degree of incidence. Sexual abuse by trusted family members results in a greater sense of betrayal than abuse carried out by strangers. The betrayal is not only felt towards the perpetrator, but may also be experienced towards other family members that failed to protect the child.

Powerlessness refers to the dynamic that renders the victim powerless. When the child's will and desires are not taken into account, when the child's territory and body space are invaded, when the offender uses coercion and manipulation, all these render the child powerless. When force and threat are used in abuse, feelings of powerlessness are exacerbated, although these are not necessary to create feelings of powerlessness. Any situation in which a child feels trapped can create a sense of powerlessness.

Stigmatisation, the fourth dynamic, refers to the negative connotations, such as shame, badness and guilt, that are communicated to the victim child and that become incorporated into the child's self concept. These negative connotations can be introduced by the abuser, by the victim's family or by other people in the wider community. It can also emerge from the child's prior knowledge or sense that the sexual activity is considered deviant or taboo.

In the present case study, clear expression of all four dynamics were found. Many everyday events were sexualised (such as brushing teeth, eating bananas or sausages and even having a broom in the house) to the extent of producing incapacitating anxiety, as will be elaborated in Episode Two of this case study. Louise felt extremely betrayed by her mother, as she did by Social Services for not protecting her from the abuse. She felt disempowered, not only regarding her own life but also regarding what was happening to her daughter. The dynamic of stigmatisation was expressed in the form of guilt, shame and the feeling that she must have deserved all the abuse she received.

Self-mutilation, suicidal behaviour and compulsive exposure to danger are commonly found in adults with a history of sexual abuse (Herman, 1992; Miller 1994). Van der Kolk, Perry and Herman (1991) found a high correlation between severe childhood abuse and neglect, and adult self-destructive behaviour. They further link this adult behaviour pattern to a lack of secure attachments in childhood and to the tendency of severely traumatised individuals to dissociate. Miller (1994) proposes that self injury not only expresses rage and shame, and eases tension, but can also be a re-enactment of the experiences of childhood trauma. Schetky (1990) in her review of the literature on the long-term effects of childhood sexual

abuse came across studies that suggested a physiological basis for self-mutilation. Endorphins, which are substances produced by the body when in situations of prolonged stress, inhibit pain. These substances have been found in elevated quantities in humans following surgery, marathon running and self-mutilation. It is suggested that endorphins may have a calming and perhaps even an antidepressant effect, and as such self-mutilation could be used deliberately to reduce pain. In the present case study, Louise repeatedly expressed that self-mutilation reduced the tension she experienced. As she recalled the memories of abuse the tension would build up to levels that were only relieved through self-mutilation.

The First Episode: Engaging the client using another professional

This took place over five months, from the time when the health visitor first contacted the clinical psychologist to when Louise felt comfortable enough to have individual sessions with the psychologist. Louise's history contained strong indications as to why she had difficulty in trusting relationships generally and relationships with professionals in particular. From as far back as she could remember, the relationship with her mother was consistently characterised by abuse with no recollection of any emotional warmth or attachment. Louise was placed in a supposedly protective environment, a Social Services mother and baby home, yet the abuse continued unnoticed and she remained unprotected. On the basis of her history, it was assumed that trust and the sense of security in another person was something that Louise had not experienced.

Key objectives

1. Providing relationships that could be trusted was identified as the first key objective of the inter-professional partnership. This was seen as necessary on two counts: a trusting therapeutic relationship would facilitate the process whereby Louise would address her difficulties (Rogers, 1951) and secondly, the probability of breaking the intergenerational cycle of abuse would be increased if Louise was to develop trusting and supportive relationship with professionals and with members of the wider community (Egeland, 1988).
2. Her background also indicated that Louise repeatedly experienced being out of control regarding what happened to her, not only during childhood, but throughout her adult life. A second objective was therefore to enable Louise to take greater charge of events in her life.
3. A third objective was to develop the interpersonal relationship of trust and respect between health visitor and clinical psychologist. The literature on collaborative working highlights interpersonal relationships between professionals as one of the key factors in effective inter-professional partnership (Seaburn *et al.*, 1996; Lupton & Khan, 1998).

Developing the professional's interpersonal relationship

It was the first time that the two professionals concerned were working collaboratively on a case. The importance of interpersonal relationships in effective inter-professional working was kept in focus. Discussing possible ways of working while taking professional skills and responsibilities into account, was seen as the necessary starting point. Creatively exploring how best to facilitate what had been identified as the two key objectives in the therapeutic intervention, while ensuring that both professionals felt comfortable with their respective input, was of ongoing concern. Regular communication between the professionals was essential; this was at times merely information sharing, while at others it served to re-adjust the dovetailing of individual professional input. This process of communication enabled the professionals to understand each other in more detail and to continue the development of professional trust and respect.

Working through another professional

The first five sessions were held between health visitor and clinical psychologist alone over a period of 6 weeks. Much of the inter-professional interaction at this stage was in the form of advice and guidance to the health visitor on matters such as

- what information to collect,
- how to differentiate between the roles of conventional health visiting and the new therapeutic bridging role, and
- how to channel and contain what Louise presented to her in sessions. Louise often wanted to speak about specific experiences of abuse so as to “get it all out” (Louise’s words) leaving the health visitor extremely anxious as to how to respond.

Structure of time and content of sessions became one of the first important elements to address. Clear guidelines as to how the health visitor could help Louise contain the range of emotions she experienced became essential. These included:

- offering Louise fixed time duration of sessions,
- learning the skill of closing off a particular topic (e.g. an abuse incident) before the end of session,
- learning how to avoid topics she judged as not suitable to enter,
- the ability to differentiate and consistently communicate to Louise which topics she felt she could adequately address and which needed to be referred to the clinical psychologist.

By the sixth session Louise was prepared to include the clinical psychologist. Throughout the previous 6 weeks, sessions between Louise and the health visitor had addressed some of Louise's fears and also served to clarify the different roles and skills of the two professionals involved. Louise and the health visitor had also jointly worked out what difficulties Louise wanted to work on. Initially Louise was sceptical of the clinical psychologist and she directed her communication at the health visitor. At this stage the clinical psychologist always addressed Louise directly, did not take control of the content of the session, and kept reinforcing the second key objective, viz. that it was Louise's time to use as she decided. It was possible for the clinical psychologist to do this because she was not compelled to be there, in contrast to other professionals such as the health visitor and social worker. It had indeed been Louise's choice, albeit with persuasion from the health visitor, that she was consulting the clinical psychologist. The element of choice was used to the utmost to give Louise a degree of control. This would enable a change in concept and experience regarding her autonomy and control over what happened, at least in part of her life.

Developing trust and autonomy

Five joint sessions were held over two and a half months, concurrent with the health visitor's individual sessions with Louise and inter-professional sessions. The latter offered the opportunity for the health visitor to communicate the content of her sessions with Louise, for discussion to take place regarding possible reasons as to why Louise was responding as she was to the health visitor's input and for the formulation of what steps to take next. Throughout, Louise was aware of the inter-professional contact. The intention was to have open and honest communication with Louise and in this way enable her to experience trust in the inter-professional partnership.

During this time Louise tested the professionals in many ways. One of the most illustrative examples follows. About a month after the commencement of joint sessions Louise informed the health visitor that after much and careful consideration she had decided to end her life. She had realised that as a result of the MS she would never be fully able to take care of her daughter. Her daughter, who was at this stage in foster care, was happy and developing well. She was well attached to the foster parents and Louise's rationale was that her daughter would be better off without her, remaining in foster care. Louise also felt however, that to see her daughter being taken care of by others, when she so desperately wanted to do this herself, would be too painful to live with. The alternative she felt most comfortable with was to take her life. She wrote a letter to her daughter in which she clearly stated her feelings for her and explained why she had decided to take such action.

Louise revealed her intentions to all the professionals involved with her at the time. Many were extremely uneasy regarding how to react to this knowledge. It evoked the protective instinct in most, and they searched for ways to prevent her taking such an action. There were no grounds on which the GP could have her sectioned, as her thinking was clear and her emotions appropriate. Three professionals approached the clinical psychologist specifically seeking advice as to how to respond.

Through this action, Louise created a situation whereby the health visitor and clinical psychologist had to show whether in practice they were congruent with what they said regarding Louise's decisions and control over events in her life. Were they actively going to attempt to change her mind or did they respect her decision? It also had the effect of getting most of the professionals to talk to one another, and in the process highlight the difference between working in partnership (between health visitor and clinical psychologist) and different professionals working 'together' on a case.

The joint health visitor - clinical psychologist approach was one of respect for Louise's decision. It was made clear to her that professional responsibility dictated that neither professional could have any part to play in the planning or execution of her plan, and that in a situation where they were confronted with a bleeding or overdosed person, they would do all in their power to save life. Yet they respected that Louise had the right to choose what to do with her life. They did, however, also see it as their responsibility to ensure that her decision would be as informed as possible. During a joint session they presented her with a number of questions to consider, in line with what they imagined her daughter might one day ask, in case Louise had not considered the possible consequences of her decision from that point of view. It was stated very clearly that the purpose of the exercise was not to provoke guilt or a change of mind. It was intended to make Louise question and reflect on how her daughter might one day view her actions.

The exercise had the desired effect, and Louise moved from a position of certainty to one of doubt as to what would be best for her daughter. The state of doubt was then used facilitate reflection and decision making. Louise often gave feedback to the health visitor after joint sessions. She repeatedly mentioned aspects that had impact on her. These included:

- the present experience of therapeutic intervention was very different to what she had experienced before. Some of the identified differences were:
- not being prescribed to, but rather being enabled to reflect,
- professionals not presuming to know how she felt,
- her feeling that she mattered; she was listened to,
- if commitments were made (by either professionals), they were kept,
- her experience of increasing trust in both health visitor and clinical psychologist and the related fear. Although this remained a recurring concern for Louise throughout the major part of the three year intervention, during this first phase the fear was so strong at times that she often wanted to end the therapeutic process.

A matter of trust

Throughout the five months of treatment the health visitor was the catalyst through which therapeutic change took place. She was the one person that as a result of the trust between them, was allowed to enter Louise's world. The inter-professional partnership in turn facilitated the extension of that trust to include the clinical psychologist. The focal point of this episode of intervention was trust. It was the elementary trust between Louise and the health visitor that enabled the inclusion of other 'trustworthy' people. It was the trust developed between the health visitor and the clinical psychologist that enabled the coming together of different professional skills that could more adequately respond to the needs Louise presented. It was the trust that consequently developed between Louise and the two professionals that enabled her to start addressing some of the dilemmas she was experiencing.

The Second Episode: Overcoming the memories of abuse

At the time of referral, Louise had voluntarily placed her daughter in temporary foster care, and contact between them took the form of weekly visits at the foster carer's home. Approximately eight months later discussions between Louise, Social Services and the health visitor took place to gradually increase contact between Louise and her daughter, with a view to full time return of child to mother. This episode of intervention, which lasted about 18 months, covered the period from when contact started to increase to when mother and daughter were in a settled and fairly stable relationship. Although the daughter was only returned to the full time care of Louise nine months after increased contact began, the interference of Louise's past in her ability to care for her daughter emerged as soon as she was faced with the responsibility of sole care, even for a very limited time. This episode exemplifies the process whereby health visitor and clinical psychologist, through their joint working, concurrently facilitated the essential, safe, day-to-day care of the child and enabled Louise to address some of her past experiences that hindered the implementation of that care.

Video re-play

Louise repeatedly referred to her memories of the abuse as 'video re-play'. The abuse by her mother had been so extensive that it seemed to intrude into every aspect of her life. Being faced with the situation of taking care of her own daughter triggered powerful memories of experiences between herself and her own mother. It was as if the 'video' was turned on and she was not able to switch it off. At such times her thoughts and feelings were similar to those experienced at the time when the abuse was carried out. Ordinary mother-child interaction such as changing a nappy, feeding, brushing teeth, bathing, cuddling and playing were all activities that caused Louise to 'video replay'. This potentially created a physical and psychological risk, in that if Louise was not able to focus on the needs of her daughter as a first priority, her daughter would be at risk of neglect.

Key objectives

There were two key objectives during this episode of care.

1. The physical and emotional safety of the child while in the care of her mother was paramount alongside the development of a secure attachment.
2. The second was to enable Louise to address those past experiences that evoked intense distress and facilitate the process of re-structuring the images and messages from the past. She needed to do this not only for herself but in order to focus on and satisfy the needs of her daughter.

These two objectives had to be approached in a manner not unlike a dance, one step in the one enabled movement in the other. It was agreed inter-professionally that the clinical psychologist would focus on the impact that past experience still had on Louise, while the health visitor would facilitate the practical aspects of mothering, whether through modelling, advice, encouragement or whatever other means were available. As each step was taken towards either objective, inter-professional dialogue was essential to remain informed of progress and to determine the next step together based upon shared opinion and information.

The 'dance' wasn't without obstacles. Increase in MS symptoms often impeded contact with her daughter. As a result Louise was not always able to keep to the timetable of increasing contact. The focus from Social Services, however, was on the daughter (by now just over one year old) and the need to get her in a stable home without delay. They were concerned that unless Louise could make positive strides in the process of offering her daughter a stable home, it would become increasingly difficult to consider the alternative, which was adoption. The pressure of time was strongly felt. Louise could not get her daughter back home until she was sufficiently in control of the impact of her past experiences, but Social Services were setting a definite time limit: either the daughter would be with Louise by her second birthday or they would proceed with the adoption process. All parties concerned were also well aware of the impact of stress on the fluctuation of MS symptoms. The objectives of this episode, although planned and delivered within the remit of the inter-professional partnership, had to take these other aspects into account.

The 'dance' between professionals

Some examples of situations that proved difficult for Louise follow. She experienced great discomfort with physically touching her daughter at times of nappy changes and bathing. Activities such as wiping or creaming the baby's bottom flooded her with memories of abuse. Many of these memories were associated with bathing and the bathroom. Everyday articles used in child care had negative associations for Louise because her mother had used them to sexually abuse her. She also found feeding her daughter specific foods provoked anxiety. Bananas, carrots and sausages all brought back memories of how these foods were

used in situations of sexual abuse. Giving her daughter a dummy evoked similar feelings. Teeth cleaning, the use of a toothbrush and visits to the dentist all triggered off memories of extensive and repeated abuse. The scale of the abuse was such that, among many other injuries, Louise suffered slits on the sides of her mouth on one occasion, which required medical attention and on another, the last occasion of abuse, she was admitted to hospital requiring 34 internal stitches.

Sessions with the clinical psychologist (30 over the 18 month period) focused on enabling Louise to re-visit the experiences of abuse and identify the components. For the most part, a particular pattern was followed in this process.

- Firstly, Louise chose whatever experience she most felt needed re-visiting. She would recall the memory, in whatever way she wished. No particular structure was used for this, although if at times it was felt that some recollections were difficult for Louise to verbalise, the psychologist would aid this either through questioning or commenting.
- Once Louise was 'in' the memory, the psychologist followed a semi-structured approach of questioning, to enable Louise to identify her thoughts and feelings relating to that incident. Apart from the often overwhelming feelings of fear for her own survival, her thoughts and feelings inevitably revolved around guilt and of having done something bad enough to deserve this type of treatment. The concept of self that was being created was that of a bad, evil and useless person, not worthy of her mother's love or positive attention; she also saw herself as inadequate because whatever she did to try to please her mother and avoid the abuse, she was not able to succeed.
- Once these internalised messages had been identified, the semi-structured questioning continued, now for the purpose of aiding Louise in questioning the validity of these messages. This enabled Louise to reflect on each incident from a different perspective. Examples of questioning at this stage were: "Why do you think your mother did this?", "What do you think you did to deserve this?", "What behaviour from any child that you know would warrant such treatment?". The result of such questions and answers was that Louise, by being enabled to make predominant use of her cognitive capacity rather than experience the memory at an emotional level, was able to change the concept she had of herself. She started seeing the reason for the abuse as resting with her mother rather than as a result of her own badness and uselessness.
- Louise aided by the clinical psychologist then formulated 'new' messages about herself that she cognitively saw as valid, even if at this stage they were not felt to be true.
- Practical ways of reinforcing the 'new' message were then discussed, to enable the more realistic self concept to become an ever increasing part of her life and interactions, and that in time she could believe them.

Sessions with the health visitor offered Louise the opportunity of desensitisation and re-learning in that situations that evoked negative thoughts and feelings were coupled with a trusting and caring person who encouraged Louise to experiment with new ways of executing a practical task, thereby enabling Louise to attach new thoughts and feelings to

that task. If Louise became upset during the process, the health visitor's empathy and warmth were of great value to her in promoting the healing process. Being informed of what had taken place in the session with the psychologist, the health visitor was also in an ideal position to reinforce any messages of self worth that had been identified.

Sessions with the health visitor often included aspects of play. For example, to address Louise's difficulties with regard to touching her daughter, play in a pool with her daughter wearing a swimming costume progressed to naked play in the bath. Feeding was also incorporated into sessions with the health visitor, one example being the transition from Louise having to cut up bananas into slices when feeding her daughter to being able to give her a whole banana to eat. Dental hygiene was a particularly difficult area as Louise's past images were strong and involved many different situations. The creation of new and positive images to associate with the brushing of teeth had to be equally strong and diverse. In this case the health visitor not only enabled new associations to be formed in connection with Louise's care of her daughter's teeth, she also went with Louise to the dentist, something that Louise had avoided for years and felt unable to face on her own. Two sessions (with the health visitor) were used to prepare for this visit, negotiating how much to reveal to the dentist, (for example "open wide" evoked immediate video re-play) and also what to use that was powerful enough to become a new association with dentist visits. Associations involving Louise's daughter were always the most powerful.

The frequency and depth of inter-professional communication required during this episode was great, at times taking up to two hours every week. The effect however was that Louise did manage to learn how to contain the memories of abuse, and was able to take unquestionably good care of her daughter.

The Third Section: Inter-professional Partnership vs Sharing Information and Exchanging Ideas

This section outlines some of the difficulties encountered in practice as a result of professionals different concepts and models of working together. Throughout the three year intervention various professionals were involved with Louise and her daughter. From time to time meetings were called, mainly by Social Services, to share inter-professional involvement and review the progress relating to Louise's daughter. These meetings included different professionals at varying times from both Health and Social Services agencies. On occasions the voluntary sector was also present.

Meetings between Health and Social Services professionals were convened, telephone contact often took place between the social worker and the health visitor and correspondence was exchanged between various Health and Social Services professionals. At first glance, it could be construed that the professionals were working together. When they met, they shared information and exchanged ideas. On closer analysis, however, the information they shared was each professionals' views, analysis, judgements, working practices and recommendations, formulated within the framework of that particular profession. When professionals came together, they informed each other of their work

with Louise. If there were aspects from another's way of thinking or working that was useful to consider, accommodate and/or adopt, each professional was at liberty to do so, and they often did.

Professionals involved in the case of Louise and her daughter had different concepts regarding the meaning of 'working together'. The differences were clearly evident in the way each set of professionals approached specific situations. To highlight these differences, the following will differentiate between 'inter-professional partnership' as against 'sharing information and exchanging ideas', which shows the two approaches taken.

The health visitor and clinical psychologist adopted an inter-professional partnership model in their approach, characterised by:

- joint assessment of presenting difficulties,
- sharing of professional views, models and opinions,
- joint formulation of hypotheses as to the dynamics of the presenting difficulties
- joint formulation of intervention plan
- joint implementation of intervention, dovetailing individual work and 'working through the other' when necessary
- ongoing communication as to the client's response to intervention
- ongoing adaptation of all the above as necessary in the light of emerging information

In comparison, the group comprising all the professionals involved with Louise and her daughter did not have a shared set of guidelines as to how to work together. In this group,

- each professional did their individual assessment,
- each professional or partnership (in the case of health visitor and clinical psychologist) formulated their intervention plan according to their own professional knowledge and skills,
- some professionals met from time to time and shared their views, opinions and recommendations,
- visits involving more than one professional were at times done for a specific purpose,
- there seemed to be a lack of recognition of the systemic implication of various professionals working on a case.

One particular situation highlights the difficulties encountered in practice as a result of the above-mentioned divergent views. The professionals involved in this example included various Social Services professionals (social worker, senior practitioner and team leader) and Health professionals (health visitor and clinical psychologist). The focal point in this example was the return of the daughter to Louise's full time care. Being primarily responsible for the welfare of the daughter, Social Services required clear indication as to the progress of increased contact by Louise to the timetable. Due to Louise's fluctuating MS symptoms and as a result of the impact of past abuse on her availability to care for her daughter, this was not always possible.

In broad terms, the two sets of professionals shared a common goal: the return of the daughter to Louise's care. Yet the way achievement of that goal was approached, was very different. It was also clear that Louise's behaviour was interpreted differently by the two sets of professionals. Social Services saw the primary objective to be the placement of the daughter in a stable and secure family environment, by the age of two, whether that be with Louise or an adoptive family. They interpreted Louise's difficulties, whether physical or emotional, as indicative of her inability to offer that security and stability. In contrast the Health professionals judged Louise to have both the commitment and the ability to offer her daughter the secure and stable environment. Their objective was to facilitate this process as quickly as possible, yet keep the focus on the process of attachment rather than on a specific time frame within which it had to be achieved.

In order to achieve their goal, Social Services professionals saw it as an essential part of their plan of intervention, to initiate the process of finding an adoptive family for Louise's daughter. This process was to run in parallel with the one of facilitating her daughter's return home. The adoptive family would be used in the event of Louise not being able to accommodate her daughter by her second birthday. The Health professionals, however, were of the judgement that Louise would interpret Social Service's 'parallel' plan as indicative that she was not competent to take care of her daughter. Although the daughter was still in care under voluntary arrangements, Louise experienced Social Services as having the power to decide where her daughter was ultimately placed. Her low self concept and her doubt in her ability to be different to her mother, had been areas of focused work for a considerable length of time. Health professionals saw it as essential to continue reinforcing the positive progress achieved. To indicate that professionals had doubt in her ability would confirm her own lack of trust in herself, and undermine her progress. The Health professionals were also of the opinion that Louise's mothering ability was not in question and that the attachment between mother and daughter was good and secure. Although conscious of the time factor, they did not share the view of its importance held by Social Services. The differences in assessment of the situation, goal formulation and intervention plan between Health and Social Service professionals was evident. In order to facilitate a workable resolution of these differences it became necessary to involve an independent mediator, the Trust's Child Protection Officer.

The inter-professional partnership between health visiting and clinical psychology was possible because the organisation within which they worked encouraged inter-professional collaboration. This was ensured by creating the resources and the structures that enabled such innovative projects to take place. In contrast, no such opportunity existed between

Health and Social Services. Although individual professionals within the two organisations, were often willing to work collaboratively, they were not able to do so as a result of the organisational structures not being in place for this to happen. At present there are no structures to guide or facilitate the process of joint inter-agency assessment, formulation of objectives, intervention planning and implementation.

This case study, and in particular the last section, highlights the sharp contrast in models of inter-professional working. On the one hand the experience of effective collaboration between the health visitor and clinical psychologist was extremely positive. To witness Louise develop a sense of self worth, of autonomy and the ability to take care of herself and of her daughter, despite her background, was personally and professionally very rewarding. The experience of working collaboratively with another profession, the sharing of inter-professional knowledge and support and witnessing the positive effects on Louise as a result of the collaborative partnership confirmed the theoretical recommendations found in the literature.

On the other hand the difficulties experienced as a result of professionals involved in Louise's case working according to different models or concepts of 'working together', impeded the delivery of the health visitor-clinical psychologist therapeutic intervention. Following joint meetings, that included Health and Social Services professionals and Louise, it was common to have to use a session or two (with the clinical psychologist) to address the feelings of stigmatisation and powerlessness experienced by Louise as a result of comments made by some of the professionals at such meetings. The differences in thinking between Health and Social Services professionals was so great that at one point an independent mediator had to be called in to avoid a total breakdown of joint working.

In the absence of any formalised guidelines between agencies and professionals as to what constitutes collaborative working, when it is necessary and appropriate, and how to put it into practice, one of the only options available is to informally share and debate ideas on collaborative partnerships with other professionals. Raising awareness regarding the differences in definition, the essential components of collaborative working and the associated difficulties in its implementation is recommended in preparation for the establishing of formalised guidelines. Until the time when these are established, practical cases requiring collaborative working, will largely be left to chance.

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