

Effectiveness of child psychoanalytic psychotherapy in a clinical outpatient setting

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The objective of this study was to evaluate the outcome of child psychoanalytic psychotherapy in a clinical outpatient setting in a city in southern Brazil. Three psychological tests (Rorschach, Bender and WISC III) were administered to 23 children, aged 6–11 years old, and the Child Behaviour Check List (CBCL) was completed by the parents. All testing was completed before the beginning of the individual psychoanalytic psychotherapy. The same measures were repeated after 12 months of intervention. The 23 children who received individual psychoanalytic psychotherapy were compared with a control group who did not receive any kind of intervention. In the clinical group, the results indicated a statistically significant reduction of anxiety symptoms (0.002) and school problems (0.031), improvement in interpersonal relationships (0.022), and positive change in the following CBCL scales: withdrawn (0.010), thought problems (0.022), anxiety and depression (0.017), internalising (0.008) and total (0.003). An effect size of 0.696 was calculated based on the CBCL total scale before and after the intervention. The results revealed that child psychoanalytical psychotherapy is mostly effective in the treatment of female children who present internalising disorders.

Keywords: Child; psychotherapy; outcome; psychoanalysis; psychological evaluation; effectiveness

Introduction

Studies on child psychotherapy outcome are remarkably sparse despite the high prevalence of psychiatric disorders in childhood (around 20%). In fact, very few children receive treatment for their emotional needs and even fewer are the number of children that complete the treatment planned by the service (Kazdin, 1996; Fleitlich-Bilyk and Goodman, 2004). Longitudinal studies also demonstrate that psychiatric illness in childhood is a developmental precursor of negative outcomes like delinquency and other psychiatric problems in adulthood (Sourander *et al.*, 2006). The continuity of the dysfunction that begins in childhood and which can persist throughout life heightens the importance of outcome research in child psychotherapy, not only to reduce suffering of children, but also to prevent the development of psychiatric disorders later in life (Kazdin, 1991; Fonagy, 1997).

Experimental evidence on child psychotherapy outcomes has been best summarised in the form of meta-analytic reviews (e.g. Weisz *et al.*, 2005). Those reviews indicated that positive results are found for treatment versus no-treatment

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comparisons. The data also showed that only 8% of child psychotherapy outcome research utilises a psychodynamic approach. Despite being a widely applied method in clinical practice, it seems that not enough interest has been given to outcome investigations in the child psychoanalytic field (Fonagy, 2003). Nonetheless, changes in the health care system and the need to provide cost-effective treatments have led to a demand for forms of investigation that go beyond the clinical case study methods and explore the psychoanalytic process.

The most relevant evidence on child psychoanalytical psychotherapy comes from a chart review study of effectiveness of psychodynamic treatment for children carried out at the Anna Freud Centre in London (Target and Fonagy, 1994). Improvement rates were significantly higher for the emotional than the disruptive group. Length (long-term) and frequency (intensive) of the treatment were associated with positive results. A study in brief dynamic psychotherapy for children also reported that BPP is an efficient intervention for children who present emotional disorders (Muratori *et al.*, 2002).

A thematic review completed by Kennedy and Midgley (2007) revealed that most studies in child psychotherapy research are still exploratory, where the priority is on the development of measures, description of behaviours and processes occurring within therapy sessions. Exploratory studies are of limited value because they can only describe which treatment is best for whom, but cannot specify what or when the changes occurred.

Some studies have tried to move to more sophisticated levels of research and explore psychodynamic models of change in a meaningful empirical way. Carlberg (1999) studied the turning points in child psychotherapy. In the beginning of therapy, turning points were associated to therapeutic alliance, later with conflict and working through. Another study attempted to trace connections between quantitative outcome measures and the process of young people's therapy (Trowell *et al.*, 2003). Gorin (1993) explores aspects of the psychotherapy process which might contribute to outcome. The study found that the client participation in treatment was the strongest predictor of global change.

Despite the development of studies like the ones described above, cognitive-behaviour therapies have a wider tradition evaluating psychotherapy outcome systematically (Roth and Fonagy, 2005) through randomised controlled trials (RCTs). The emphasis in these studies is on internal validity and some questions have been raised about the applicability of efficacy studies in clinical practice. The efficacy approach is hardly used by psychoanalytic-oriented psychotherapy outcome studies because there are no manuals for long-term treatments, the patients are not seen for a fixed number of sessions and control groups are very hard to form.

The aim of this study was to evaluate the effectiveness of individual child psychoanalytic psychotherapy (ICPP) in a clinical naturalistic outpatient setting in Porto Alegre, a city in southern Brazil. Results of psychotherapy were evaluated through measures of adjustment and symptomatology before (phase 1) and after (phase 2) 12 months of ICPP. The information was collected from multiple and relevant informants such as children, parents and therapists.

Method

Participants

Initially a group of 62 children between the ages of 6.0 and 10.11 years whose families came for psychological services in the participant clinic agreed to participate

in phase 1 of the study. Out of this initial sample, only 23 completed phase 2 of the study. The drop-out rate was 54%, which is considered within the normal range of dropouts expected in child psychotherapy (Kazdin, 1994, 1996).

A sample of 45 subjects (27 female and 18 male) was divided into an individual psychoanalytical psychotherapy group (23 subjects) and a control group (22 subjects) (Table 1). Each subject was evaluated twice over a period of 12 months. In the treatment group (G1), the 23 participants received ICPP for 12 months and completed phases 1 and 2. In the control group (G2), 22 children were randomly selected from public schools and were paired with G1 according to age, gender and total scale result in the Child Behaviour Check List. The inclusion criteria for G1 were: 1) aged 6–11; 2) referred for psychological treatment due to symptoms of psychological disorders; 3) children had received 12 months of ICPP. We excluded children who presented with pervasive developmental disorders (PDD) and an IQ of below 80. The inclusion criteria for the G2 were age 6–11 years old and not undergoing psychological treatment. The children from the control group did not receive treatment because most of the families lacked motivation to look for services in the community, despite being referred for treatment by the local school.

The results show that girls are the majority in both groups and the mean age is 8.3 years old. In G1, a larger number of children have completed the second grade (62.5%) when compared with G2.

Procedures

During clinic intake, parents from the G1 received a description of the study and gave consent to have their child evaluated. Study recruitment took place from May 2004 to July 2006. At the pre-treatment evaluation (phase 1), parents provided written consent and demographic data; they also separately completed a battery of measures, which will be described below. Phase 1 of the evaluation took place as soon as it could be scheduled after the clinic intake. In phase 2, which took place 12 months after phase 1, the same measures were completed by parents and children, and a progress report (appendix 1) was completed by the therapist. The study was conducted in compliance with the institutional review board of the Pontificia Universidade Católica do Rio Grande do Sul (PUCRS) and the participating clinic.

Subjects received the routine treatment offered by the participating clinic and were treated by a total of 14 therapists. Thirteen therapists were psychologists and one had a medical degree. They were all doing training in child and adolescent psychotherapy at the participating clinic during this study.

Table 1. Demographic characteristics.

	G1	%	G2	%	<i>p</i>
Gender					0.670**
Female	15	65.2	12	54.5	
Male	8	34.8	10	45.5	
Age	8.3 (1.7)		8.3 (1.9)		0.979*
Schooling					0.301**
Up to second grade	8	34.8	12	54.5	
Third and above	15	65.2	10	45.8	

Note: **t*-test. **Chi-square.

The ICPP offered in the service is based on a psychoanalytical approach. The patients were seen once or twice weekly, on an individual basis, face to face. No manual was used and that could be considered one of limitations of this study, but therapists were supervised by experienced child psychoanalytical psychotherapists on a weekly basis. ICPP in this study is defined as an interpretative treatment based on the psychoanalytical understanding of the child. Aims include symptom relief, behaviour modification, some degree of structural personality change and the return of the child's normal developmental impulses (Sours, 1996). The parents were seen on a monthly basis by the same therapist as the child. In those meetings, parenting issues and aspects of the psychotherapeutic process were discussed. When considered necessary, parents or the family were referred for more intensive work.

The 22 subjects from G2 were recruited from a larger sample from a study on the CBCL. All the children were students from a public elementary school and were paired with the subjects from G1 in order to form a control group. Only one measure was used, the CBCL, over a 12-month interval.

Measures

Four assessment instruments were used for G1 in phases 1 and 2; the first completed by the parents and the others completed by the children. One instrument was used only in phase 2 by the child's therapist and that consisted of a progress report (appendix 1) on the case.

1) Child Behaviour Check List

The CBCL is an assessment instrument to obtain standardised reports of children's problem behaviour and competencies as observed by the parents and/or guardians. The CBCL has extensive normative data. Assessed are total behaviour problems, broad behaviour problems (internalising and externalising behaviour problems) and a more narrow-band of behaviour problems (e.g. withdrawn, somatic complaints, anxious/depressed, rule-breaking behaviour, aggressive behaviour, attention problems, thought problems). The six DSM-oriented scales are: affective problems, oppositional-defiant problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems and conduct problems (Achenbach, 1991).

2) Rorschach test

This test consists of 10 official inkblots. Five inkblots are black ink on white paper. Two are black and red ink on white paper. Three are multicoloured. After the individual has seen and responded to all the inkblots, the tester then gives them to him again one at a time to study. The test subject is asked to note where he sees what he originally saw and what makes it look like that. The blot can also be rotated. As the subject is examining the inkblots, the psychologist writes down everything the subject says or does, no matter how trivial. Methods of interpretation differ. In this study, we used the Exner and Weiner (1995) Comprehensive System. In the Exner and Weiner (1995) system, responses are scored with reference to their level of vagueness or synthesis of multiple images in the blot, the location of the response, which of a variety of determinants is used to produce the response (i.e. what makes

the inkblot look like what it is said to resemble), the form quality of the response (to what extent a response is faithful to how the actual inkblot looks), the contents of the response (what the respondent actually sees in the blot), the degree of mental organising activity that is involved in producing the response, and any illogical, incongruous, or incoherent aspects of responses. The authors chose this particular test because many of its variables have been used in previous studies (Stokes *et al.*, 2003; Fowler *et al.*, 2004) to predict response to treatment and to measure outcome results. These variables are able to measure the individual's resources and personality integrity.

3) *Bender–Gestalt test*

A psychological assessment instrument used to evaluate visual-motor functioning and visual perception skills in both children and adults. Scores on the test are used to identify possible organic brain damage and the degree of maturation of the nervous system. The Bender–Gestalt Test is used to evaluate visual maturity, visual motor integration skills, style of responding, reaction to frustration, ability to correct mistakes, planning and organisational skills, and motivation. Copying the nine figures requires fine motor skills, the ability to discriminate between visual stimuli, the capacity to integrate visual skills with motor skills, and the ability to shift attention from the original design to what is being drawn. The test was analysed through Koppitz (1987) and Kroeff (1988) scales of age maturation. The Bender–Gestalt test was used in this study as an instrument to screen organic variables as well as the visual-motor maturation of the children.

4) *Weschler Intelligence Scale for Children III (WISC III)*

An intelligence test for children between the ages of six and 16 inclusive that can be completed without reading or writing. The WISC generates an IQ score. The test comprises 10 core subtests and five supplemental ones. The supplemental subtests are used to accommodate children in certain rare cases, or to make up for spoiled results, which may occur from interruptions or other circumstances. Testers are allowed no more than two substitutions in any FSIQ test, or no more than one per index. These subtests then generate a Full Scale score (FSIQ) and four composite scores known as indices: Verbal Comprehension (VCI), Perceptual Reasoning (PRI), Processing Speed (PSI) and Working Memory (WMI). The data was evaluated according to the adaptation for a Brazilian sample completed by Vera Figueiredo (2002) and only the 10 core subtests were used.

Data analysis

To check for possible differences between the treatment group (G1) and the control group (G2), the chi-square was used to investigate whether distributions of categorical variables differed from one another and the *t*-test was performed to assesses whether the means of the two groups (before and after the intervention) were statistically different from each other.

The results of each test were transported to the SPSS 11.0 (*Statistic Package for Social Sciences*). For all data analyses the probability level used was $p < 0.05$.

Results

The treatment group showed a significant reduction in total behaviour (0.003) and internalising problems (0.008) measured by the CBCL after 12 months of intervention. The same positive results were not observed in the control group. The intervention group (G1) also showed positive results in the anxiety and depression (0.017), withdrawn (0.010) and thought process (0.022) scales. The results are shown in Table 2.

Clinically this data can be translated as: children who received ICPP for 12 months worried less, cried less, reduced anxious feelings, improved interpersonal relationships and reduced somatic complaints. In summary, their overall behaviour improved.

The comparison between groups (G1 versus G2) is shown in Table 3.

These results showed that the children from the control group did not show the same improvements observed in the clinical group.

In the Rorschach test, two different analyses were performed. First, the *t*-test for continuous variables was applied. The results are presented in Table 4.

Secondly, based on the literature, variables considered important to evaluate psychotherapy outcome were selected (Weiner and Exner, 1991; Blatt and Ford, 1994; Hilsenroth *et al.*, 1995). Among the variables chosen are the ones that: 1)

Table 2. Child Behaviour Check List (CBCL) results.

	Mean	SD	<i>p</i>
Withdrawn test and	62.63	6.77	0.010
Withdrawn re-test	59.00	6.37	
Anxiety and depression test and	65.26	7.82	0.017
Anxiety and depression re-test	61.13	9.72	
Thought process test and	60.43	6.95	0.022
Thought process re-test	56.96	7.27	
Total Scale test and	65.91	8.33	0.003
Total scale re-test	62.04	8.35	
Internalising test and	63.22	7.56	0.008
Internalising re-test	66.26	8.05	

Table 3. Mean comparison in the Child Behaviour Check List (CBCL) results (G1 versus G2).

	G1			G2			<i>p</i> *	<i>p</i> **
	Basal	12 months	Δ	Basal	12 months	Δ		
Total scale	65.7 (± 8.0)	61.8 (± 8.0)	-3.7	64.1 (± 9.0)	61.9 (± 8.8)	-2.4	0.519	0.014
Internalising scale	66.6 (± 8.0)	63.2 (± 8.5)	-2.9	61.1 (± 8.9)	60.8 (± 9.7)	-0.9	0.035	0.023
Externalising scale	62.2 (± 7.6)	59.8 (± 9.2)	-2.4	61.4 (± 10.5)	59.2 (± 10.3)	-2.3	0.781	<0.001

Note: **t*-test. **Covariates of Delta values and basal values.

Table 4. Rorschach numerical results.

	Mean	SD	<i>p</i>
% D test	32.35	19.54	0.050
% D re-test	44.57	23.29	
% Dd test	13.13	13.62	0.001
% Dd re-test	1.83	0.39	
Som F test	5.09	3.94	0.021
Som F re-test	7.22	5.69	
Som Fo/+ test	4.79	3.86	0.045
Som Fo/+ re-test	6.74	5.96	
Som m + mf test	0.35	0.57	0.008
Som m + mf re-test	0.00	0.00	

Table 5. Rorschach categorical results.

	<i>p</i>
<i>EA x es</i> test	0.763
<i>EAx es</i> re-test	
Coping style test	0.574
Coping style re-test	
% som C test	0.207
% som C re-test	
<i>EB</i> test	0.508
<i>EB</i> re-test	
<i>H : (H) + (Hd) + Hd</i> test	0.022
<i>H : (H) + (Hd) + Hd</i> re-test	
Determinant <i>T</i> Test	0.043
Determinant <i>T</i> re-test	

evaluate the quality of interpersonal relationships (determinant T, variable EB and H: (H) + Hd + (Hd); 2) evaluate internal resources versus impingements (EA versus es) and 3) evaluate affect modulation (FC: CF + C).

The Rorschach results were divided into two categories: within the normal clinical range and outside the clinical normal range. Two non-parametric tests were performed: McNemar and Wilcoxon. The statistically significant results are presented in Table 5.

The results in the Rorschach test showed that the children who received ICPP showed improved interpersonal relationships, affect modulation as well as perception of reality.

In the Bender–Gestalt test and the WISC III, no statistically significant changes were found when comparing the results before and after intervention. In the progress report filled out by the therapist after 12 months of intervention, a significant reduction of the symptoms of anxiety and school-related problems was observed, confirming results from other testing.

Discussion

In this study, we prioritised the clinical representation of the sample. All the subjects in the clinical group were children whose families searched for psychological services in the participating clinic. The children presented various presenting

problems and diagnosis. The comparison between the treatment group and the control group allowed us to point out some significant differences in the course of the two groups. In the treatment group, positive significant changes were found, indicating that the children who received ICPP improved their overall behaviour. The same positive findings were not found in the control group, indicating that the intervention was effective for this particular sample.

Fonagy (1997) suggested five levels of outcome of child psychotherapy: 1) symptomatic; 2) adaptation to social environment; 3) cognitive and emotional capacities of the child; 4) transactional; and 5) service utilisation. In this study, we tried to evaluate the first three levels. In the symptomatic level, a reduction in the anxious and depressive symptoms as well as school-related problems was observed (CBCL and progress notes results). In terms of the adaptation of the child to the social environment, an improvement in interpersonal relationships and perception of reality was observed (Rorschach/CBCL results). In the third and last level evaluated, the findings suggested an improvement in affect modulation (Rorschach's results).

Similar results were found in an already mentioned retrospective study (Target and Fonagy, 1994), carried out at the Anna Freud Centre in London, in which the children who received ICPP presented improvement in symptoms of anxiety and depression, both internalising disorders. The duration (long-term) and frequency (more than one session a week) of the treatment were associated with positive results.

It is important to point out that with the reduction of anxiety symptoms, which is present in 9.9% of the children (Costello *et al.*, 2003) a significant reduction in school-related problems (as reported in the progress report written by the therapists) was also observed. This data suggests that some cognitive problems can be evident in the anxious child, as he/she tends to overestimate the danger of the situation (Flannery-Schroeder *et al.*, 2004). On the other hand, the less anxious child can use her cognitive potential more effectively, reducing the school-related problems.

The findings of this study also suggest that ICPP is mostly effective for female children (65.4% of the G1), who presented internalising disorders such as anxiety and depression. For this group, we calculated a moderate effect size (0.069). The same positive results were not found for male children who presented externalising disorders. These children (around 54%) dropped out of therapy prematurely (before 12 months) and did not complete the treatment plan. It has not been possible to determine which factors might have contributed to premature termination among this group of children. One of the reasons that might have influenced the high percentage of drop-out is that little work was done with the parents. In a recent study described by Pia Eresund (2007), psychodynamic psychotherapy for children with disruptive disorder was effective when the work was done with both parents and child. Collaboration with the school was also associated with positive effects. In this study, the parents were only seen once a month and no collaboration with the school took place. Furthermore, more boys are referred to psychological treatment than girls altogether and that could have contributed to a larger number of premature termination among boys in this study.

Unfortunately, most of the findings about premature termination are inconsistent throughout the literature. A thematic analysis of the first family interviews discovered that parents' motivations and expectations about the treatment, as well as the ability to think about feelings, could be associated with premature drop-out (Navradi and Midgley, 2006). In this study parents' expectations and motivation were not formally assessed, but the analysis of the progress notes and feedback from

therapists involved suggested that families who lack motivation in the initial sessions terminated treatment prematurely.

Limitations

There are limitations in all studies, but this study was particularly vulnerable because it was carried out in a clinic that had no research culture. At first, several therapists resisted participation and all the measures had to be applied gradually. An attempt to collect the progress notes to evaluate process of ICPP was made, but only 10% of the therapists agreed to share their notes. Confidentiality issues might have played a role, as well as the fact that some of the clinicians still gave little value to knowledge obtained through empirical research. In the participating clinic, the training is based in the supervision of clinical case studies and no seminar in empirical research is available.

Secondly, the high drop-out rate and small sample restricted the findings of this study. Despite the efforts to contact the families who dropped out prematurely, very little feedback was achieved. Maybe this study would have been more effective if measures were repeated in three phases – before, after six months and after 12 months of ICPP. The timing of outcome measures have probably impacted on the results as researchers involved in this study were limited by the number of children who remained in therapy after 12 months. The data suggests that 70% of the subjects remained in treatment after six months and if they were tested then, a larger sample would have been available.

Thirdly, there was very little control of the variables in the G2, which was conveniently formed to pair the treatment group; consequently, it was very heterogeneous. The reason for this is that there was no waiting list or alternative modality of treatment in the participating clinic and all the children were immediately treated (ICPP).

Fourthly, it was very difficult to ensure that the ICPP was carried out as intended, as no manual was used. Although some manuals of psychoanalytic child psychotherapy have been created (Kernberg and Chazan, 1991; Miller, 1993; Muratori *et al.*, 2003), clinical implications of their use in psychodynamic research were discussed. One of the most common criticisms is that in the psychodynamic approach there is usually more flexibility; when an intervention is not working, an alternative modality is used in order to attend to the child's needs (e.g. move from an individual to a family approach). Also psychodynamic psychotherapies value the spontaneity of the moment and perceive a detailed treatment plan of very little use for the therapeutic process. Furthermore, the practising clinician tends to focus on the process and short-term goals of the psychotherapeutic treatment and not only in the end result (Bohart *et al.*, 1998; Perepletchikova *et al.*, 2007). In this study, we tried to ensure the integrity of the treatment through weekly supervision of the material by experienced professionals in the field, but we could not ensure that the ICPP was carried out as initially planned.

Conclusion

Despite the attempts of research teams to close the gap between empirical research and the clinical work, in our experience outcome studies still meet with ambivalence amongst practitioners. One of the biggest challenges researchers encounter is translating the statistical results into clinical material. While this particular study

tried to spell out the results in a clinician-friendly way, readers who are not familiar with empirical research, might find difficult to understand the data. As a consequence, what is considered statistically significant can mean very little to many clinicians.

Another important challenge was to measure changes at an unconscious level, as well as the process involved in the treatment. All changes at a conscious level were attentively measured by the testing used, but little attempt was made to measure changes at an unconscious level. It seems that clinical case studies are still better equipped to evaluate the process of an intervention: the transference, the therapeutic alliance and the response of the patient to a particular interpretation. Unfortunately, they cannot be used to make generalisations and there is a lot of criticism about their limitations. As Michael Rustin points out, while clinical case study methods have led to impressive developments in knowledge and understanding of children, they provide little formal clarification at meta-levels of justification.

When we first started working in this study, we had no idea how hard it was going to be. After years working as clinicians and teaching young colleagues the practice of child psychotherapy, the journey into empirical research was a real challenge, especially as we had no funding for the project. We are well aware that our study was exploratory and clinically limited, but we sincerely hope it encourages further the development of process studies through the identifying the change mechanisms that take place in a psychoanalytic psychotherapeutic intervention. As Kazdin and Nock (2003) brilliantly pointed out, 'the development of clinically relevant research projects is the best investment for improving clinical practice and patient care' (p. 1117).

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Appendix 1

PATIENT PROGRESS NOTES

Name: _____

Age: _____

Treatment Duration: _____

Initial Complaints: _____

Initial Diagnosis:

After 12 months of intervention diagnosis:

Please compare the mental status of your patient from the beginning of treatment to after 12 months of intervention.

- (a) Function in general activities;
- (b) Impulse control and tolerance to frustration;
- (c) Affect Modulation;
- (d) Anxiety Control;
- (e) Interpersonal Relationships;
- (f) Defence Mechanisms;
- (g) Reality Perception;
- (h) Cognitive Functioning;
- (i) Symptoms.

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