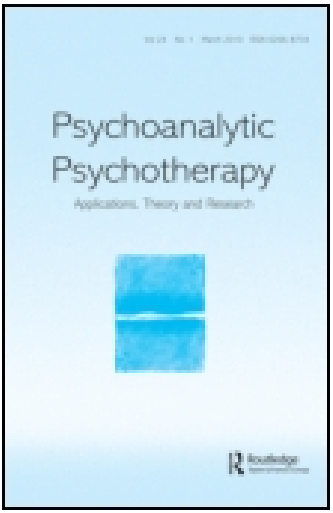

Psychoanalytic Psychotherapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rpps20

Evaluation of psychoanalytic psychotherapy with children: Therapists' assessments and predictions

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Published online: 18 Sep 2006.

To cite this article: Mary Boston, Dora Lush & Eve Grainger (1991) Evaluation of psychoanalytic psychotherapy with children: Therapists' assessments and predictions, Psychoanalytic Psychotherapy, 5:3, 191-234, DOI: 10.1080/02668739100700101

To link to this article: http://dx.doi.org/10.1080/02668739100700101

Psychoanalytic Psychotherapy **(1991) Vol 5 No 3,** 191–234

EVALUATION OF PSYCHOANALYTIC PSYCHOTHERAPY WITH CHILDREN: THERAPISTS' ASSESSMENTS AND PREDICTIONS

DORA LUSH, MARY BOSTON, & EVE GRAINGER

SUMMARY

Meaningful and clinically relevant evaluation of psychoanalytical psychotherapy requires new models for research. Such evaluation needs to take account of the complexities of personality and inner-world change as well as the more simply assessed changes in external behaviour.

A pilot study to develop a suitable methodology is described. These preliminary results are on a consecutive series of twenty in care and adopted children entering psychotherapy at the Tavistock Clinic. The project evolved from a previous study of psychotherapy with severely deprived children (Boston & Szur 1983), but the method could be used with any group of children in psychoanalytic psychotherapy, and possibly also, in an adapted form, with adults.

Therapists' initial aims and predictions are compared with later assessments of both external, and a wide range of internal, changes. Methods of validation are discussed and case-illustrations given.

INTRODUCTION

It is generally acknowledged that evaluating change resulting from psychotherapy is difficult and particularly so with children, where any changes resulting from therapy have to be disentangled from maturational and environmental factors (Rutter 1981, Stevenson 1986, Graham & Stevenson 1983). Moreover, if we are interested not only in symptom-removal and improvement in behaviour, but also in personality change, the problem becomes even more complex. How are we to demonstrate and measure changes in personality organisation and in the inner world which psychoanalytic psychotherapists are aiming to achieve and which they believe to be the only solid basis for symptom and behavioural improvement?

In addition to these major difficulties, there are the added problems of the long-term nature of the work, making any evaluation a lengthy process, with only small samples usually available. New styles of working in child and family clinics, where a therapeutic exploration with a family is often embarked on without any formal assessment of the traditional kind, make base-line measurement, against which change can be monitored, difficult to obtain. As Frude (1980) says,

> The clinic, especially the family clinic, must simply be regarded as a hostile environment [to research] in which attempts at total control and matching cannot be expected to survive (p 33).

It is in the nature of the intrapsychic processes which we are attempting to monitor in the course of psychotherapy that they are not directly observable in non-treatment control groups, quite apart from the insuperable ethical issues involved in random allocation to treatment. A fuller review of evaluation studies in general and in psychoanalytic child psychotherapy, and the complex methodological problems involved, has been undertaken by Boston (1989) and will not be repeated here.

These methodological difficulties are discouraging to psychotherapists and the split between the clinician and researcher will remain unless new models for research can be developed. Psychotherapists are accused of making subjective judgments about their work and of not being interested in providing objective evidence of its efficacy. Rutter (1986) talks of psychoanalysts'

> disregard of disconfirmatory data from outside of psychoanalysis and the lack of interest in the empirical testing of theory in the usual mode of science (p 827).

However, the traditional medical-research model, with its emphasis on control groups and double-blind trials may be inappropriate when dealing with what are essentially the subjective phenomena of psychotherapy — feelings, attitudes, states of well-being. Psychotherapists observe these emotional states as they occur in the transference and countertransference relationships with their patients. Such phenomena are inevitably highly subjective, but need they therefore be excluded from the realm of scientific investigation? We can perhaps learn something here from the new trends in child-development research where strictly 'objective' observation, with use of time-sampling and pre-coded categories, in which preconceived theories are eliminated, is giving way to more emphasis on observation of interactive and subjective phenomena. Participant observation, with use of the imagination, is recommended in preference to 'detached scientific observation' (1978). Emde & Sorce (1983) talk of using one's own emotions as a guide for understanding. So it would seem that in this field at least the countertransference is being accorded some scientific respectability.

A bridge between the research and clinical approaches seems to require some acknowledgement of the scientific status of intuitive observation, if the interest in inner experience is not to be confined to art, literature and therapy.

We need to devise ways of demonstrating psychodynamic change which will be convincing not only to the particular therapist and patient but to others. Feldman & Taylor (1980) suggest that useful and relevant judgments about changes in the quality and relationships of internal objects can be made on the basis of detailed examination of interview material. Malan (1963) emphasises the need for developing methods for the objective handling by researchers of subjective data.

Even in the medical field there is a move towards finding a different model for research on whole persons. Reason & Rowan (1981) point out that we cannot do research *on* people, only *with* people. Change develops out of the mutual interaction between researcher and subject. In her presidential address to the Psychiatry section of the Royal Society of Medicine, Porter (1986) emphasises

> the importance of identifying and evaluating intra-psychic change and alterations in interpersonal relationships as well as measuring symptoms

and concludes that

> other methods and models are needed ... particularly for evaluating process in psychotherapy (p 260).

Stevenson (1986), who in general advocates applying the traditional research model, acknowledges the difficulties of research on processes within psychotherapy, and suggests that the problem lies in establishing

> outcome measures that would do justice to the therapists' multiplicity of aims. It is the articulation of outcome objectives and the development of indicators that they have been achieved that represents the main hurdle (p 6).

The project to be described is intended to go some way towards meeting those requirements suggested by Stevenson.

BACKGROUND TO THE PROJECT

The present project arose from an earlier, descriptive study of psychotherapy with severely deprived children. This earlier study utilised the workshop method of clinical research as described by Rustin (1984). Detailed material on psychotherapy with children in care was presented and discussed at the workshop and some of this material was later published (Boston & Szur 1983). There had been initial doubts about the treatability of these children and practical and technical difficulties were encountered in their management. However, many of them were able to achieve, in time, a considerable amount of hopeful progress. This was evidenced by reports from current carers and social workers on the external relationships and behaviour of the children, and by the therapists' own observations of the process of change in the treatment material, reinforced and checked by discussion in the workshop.

These observations led to the formulation of tentative hypotheses that psychotherapy might begin to modify the internal images of abandoning and rejecting parents, which most of these children had and which they projected on to current carers, precipitating further breakdowns of substitute care. It might therefore facilitate permanent placement, decreasing the placement-breakdown rate, as well as improve the general functioning, well-being and relationship of these children.

AIMS OF THE PROJECT

The study to be described has two main aims:

(1) to test our hypothesis that severely deprived children can benefit from psychotherapy and that their adjustment in family placements might be facilitated; and

(2) to devise a suitable methodology for evaluating psychoanalytic psychotherapy with children in general.

BENEFITING FROM PSYCHOTHERAPY AND FACILITATING FAMILY ADJUSTMENT

In order to try to obtain more systematic evidence relevant to our hypothesis than was possible in the earlier, descriptive, study of psychotherapy with severely deprived children, it was decided to embark on a new, more explicitly designed, prospective study of children in care entering psychotherapy; and to follow these children through to termination and follow-up.

The children in care in the present study have roughly similar backgrounds to the earlier series, though far more now are in foster care than in children's homes. We decided, in this series, to include also children known to be adopted at referral, because of the increasing tendency for severely deprived children to be offered adoptive placements. Some of the adopted children were, of course, adopted in early infancy, and this offered a further advantage in providing a possible 'within-group' comparison.

DEVELOPING A SUITABLE METHODOLOGY

We are not concerned with the relative efficacy of different treatments, but to make public the therapists' aims in psychotherapy for their particular patients and to develop ways of assessing to what extent these aims have been achieved and to see how well progress in psychotherapy can be predicted.

External changes in the patient's behaviour will be noted, but, more importantly, evidence of qualitative changes in personality organisation and structure of the inner world will be systematically described. This dimension is often missing from outcome studies, but we believe that description of the processes of change is essential for a valid assessment of the degree of improvement. Confidence in the future progress of patients will depend on the quality of internal development judged to have occurred, and not solely on external changes.

RESEARCH AND CLINICAL WORK

A further aim has been to develop a method of evaluation which does not interfere with ordinary clinical practice. It is a naturalistic study, using available clinical records and involving contact with clinical workers, but no direct research contact with patients.

RESOURCES

This is a pilot project based on limited resources (part-time workers and small research grants — see ACKNOWLEDGEMENTS, p 224). The research team regard it as

part of a search for appropriate methodology, and we are learning by experience which measures seem useful and how the procedures might be improved in the future.

If research is to become integrated with clinical practice it is likely that it will have to proceed in this experimental, though imperfect, way. The results to be presented are preliminary ones, relating particularly to therapists' assessments of their own work. It is hoped to report later on other aspects of the project.

METHOD

STAGE I. THE IDENTIFICATION OF THE STUDY GROUP

During a three-year period, all referrals to the Child & Family Department of children in care and of those known to be adopted were monitored in order to identify all those proceeding to individual psychotherapy. In addition, a two-year intake of similar referrals from the Adolescent Department was included.

A form (Form 1), asking for factual data on the child's age, placement, family background, significant historical factors, and ethnic matching in the placement, was issued to the person (known as case consultant), to whom the case was initially allocated for exploration. In addition, the case consultant was asked to indicate the outcome of the initial exploration, whatever that might be, and to state if any treatment or ongoing contact was planned, specifying the kind of intervention.

From this total group of 203 in care and adopted referrals, a consecutive series of fifty-one cases recommended for psychotherapy during the three-year period, who were between the ages of 2 and 18 inclusive was identified. In the event, only thirty-eight children started therapy. The reasons why thirteen of the fifty-one cases did not proceed to therapist varied. There were sometimes practical reasons, such as change of placement to one too far from the clinic; or it was considered that therapy should be delayed until decisions about placement were made. In one case, adoptive parents refused treatment and three adolescents refused to have therapy. In some cases there was no therapist available.

The thirty-eight constitute all those who actually started psychotherapy in the specified three-year period and were therefore unselected by the researchers. It will be asked whether they were a self-selected group, or whether they differed in motivation, placement, or background from the non-psychotherapy group. We attempted to investigate this issue by

(a) comparisons between the psychotherapy and non-psychotherapy groups in respect of age, sex, placement, and background; and

(b) a study of the thirteen of the original fifty-one recommended for psychotherapy who had not actually started it within two years. These constitute the contrast group.

(a) Comparisons between psychotherapy and non-psychotherapy group

There is a great variety of responses to these referrals by the clinical teams involved (eg consultation to professionals, work with natural parents, foster parents, and adopted parents and families). Psychotherapy for the child is recommended in only about twenty-five per cent of cases, but allocation to different interventions is determined not at random but by the needs of the particular cases, the practical possibilities as well as the preferences of the clinical team.

From the flow-charts requested with Form 1, indicating the number of moves or changes of placement during the course of the child's life, an **Index of Discontinuity of Past Care** was calculated for each child in the psychotherapy group, and for the first year's intake of others who attended, and for the contrast group. This was intended to be a rough guide to the kind of disruption of care the child had experienced. Points were given for numbers of moves of home, giving increased weight to those occurring earlier in life and to the strangeness of the new carers. Additional points were given for adverse factors of a traumatic kind, such as physical and sexual abuse, or murder of parents. (For details see APPENDIX I.)

In addition, the **Stability of the Current Placement** was rated on a five-point scale, 1 being the most stable (no moves likely) to 5 (further moves almost certain). (See APPENDIX II.)

These ratings were made independently from the forms by three different research workers, and then compared. Ninety-per-cent agreement was reached, and in the remaining ten per cent discrepancies were minor and recourse to the files for further information sufficed to obtain agreed ratings.

We checked if the psychotherapy cases had better backgrounds and placements than the rest of the referrals by comparing the indices of discontinuity and current placement ratings for the psychotherapy and non-psychotherapy groups (the first year's referrals of the latter). The groups were similar in sex and age distribution. Both had a wide range of index of discontinuity. There was very little difference in the stability of current placement ratings. We concluded that the psychotherapy group did not differ substantially in background or current placement from other adopted and in-care referrals.

(b) The Contrast group

We tried to investigate all the thirteen cases where psychotherapy was recommended but had not been carried out. As we had initial assessment material on these cases they were potentially a suitable comparison group, though not randomly selected.

Regarding discontinuity of past care and stability of current placement there was very little difference between their past care and that of the psychotherapy group. There was a small difference in the stability of their current placement, with the contrast group's placement being, on average, a little less stable.

We found only seven cases where information was available for at least two years after psychotherapy was recommended, and we investigated how these children

fared during this time (see under Results). Of these seven children, four did eventually start psychotherapy.

There was no information obtainable on the other six of the thirteen cases, mostly because they refused to return to the Clinic, or were referred elsewhere.

The Psychotherapy group

Three of the thirty-eight children starting psychotherapy stopped in less than three months. These have been omitted from the main study because the plan was to compare initial material with descriptions two years later. It was not anticipated that processes of change could be identified in a period as short as three months, especially as the initial material on the cases in general tended to be based on several weeks' work. Attempts will be made to discover how these children have progressed, but there are practical difficulties in obtaining information on drop-outs. One of the disadvantages of a naturalistic study is that it is necessary to make do with the information that is available.

The actual study group was thereby reduced to thirty-five, and in this paper preliminary results on the first twenty cases will be presented. These are the cases where therapists have returned assessments after a period of therapy. These include eight cases reassessed after two years but where treatment is continuing and twelve cases which have terminated (some in under the two-year period). We are still awaiting results on the remaining fifteen cases, who have not yet reached the appropriate stage.

STAGE II

The psychotherapy group having been identified, the case consultants were then given a questionnaire (Form 2, see APPENDIX III) which, in conjunction with any processed records of initial interviews, psychological tests or school reports available, constitutes the baseline data for each case. Form 2 is filled in as near to the completion of the exploration/assessment process as possible, either by the person assessing the case or by the psychotherapist at the start of psychotherapy. In most cases this was the same person, but in a few the assessment was not done by the person who subsequently took the child on. In accordance with our policy of interfering as little as possible with the ordinary clinical practice in the Department, we have tried to work with the existing records, except for the questionnaires to the therapists. We had to accept that formal assessment data, eg psychological tests or psychiatric interviews, were not always available. Established and validated interview schedules, such as the Rutter-Graham scales (Rutter, Tizard, & Whitmore 1970) were not appropriate to our purpose of highlighting the processes of psychotherapy. We therefore devised our own schedule. This allows space for the therapists to fill in reports on the child's behaviour by referrers, parents, or current carers, as well as for the therapist's own initial observations on a number of categories of external behaviour and personality qualities. The main purpose of the questionnaire is to allow clinical judgments to be described systematically and in detail. In addition,

therapists are asked to state their aims for the therapy, to specify the criteria which would need to be met for improvement to be judged to occur, and also to rate the anticipated progress on a five-point scale. (For further details of design of questionnaire, see below.)

STAGE III

At approximately two years after the start of psychotherapy, or at termination if it occurs earlier than this, a further form (Form 3, see APPENDIX IV) is given to the therapists, who are asked to rate the actual progress made on a six-point scale. (This includes an extra point for 'worse', inappropriate for rating of anticipated progress.) The questions on Form 3 cover similar areas to those of Form 2, so that the research team is in a position to assess any changes, and whether the criteria for improvement have been met, both in terms of external behaviour and also in terms of personality change and structure of the inner world.

If the case continues in psychotherapy, Form 3 is given again at termination, or two years later.

STAGE IV

This is the follow-up stage. Very limited information is available at present, as not many cases have proceeded this far. Difficulties in obtaining follow-up information are becoming evident. This interim report will not cover follow-up in a systematic way. We hope to report later when sufficient information is available.

Administration of forms

The forms were originally given to the therapists to fill in, with researchers offering to be available to discuss or help if required. We found that therapists varied a good deal in how easy or time-consuming they found it to fill in the forms. We therefore decided that Form 3, and in future Form 2, should be filled in during an interview with one member of the research team.

The Interview

The main purpose of the interview was for the interviewer to act as a 'live' manual of instructions to ensure that the questions on the form were clearly understood by the interviewees, and to prevent forms not being returned because of failure to understand the requirements. Inevitably, some anxiety was aroused in the interviewees because the form necessitated scrutiny of their work, albeit self-scrutiny, and this was true of psychotherapists of all stages of experience. It was felt to be particularly hard to rate the outcome of therapy, since this invariably involved some feeling of the therapist rating him or herself as a therapist. The position of the researcher as outside the clinical team, unfamiliar with the particular child described, was thought to have helped the therapist towards an objective assessment of the material.

However, despite the initial anxiety and the thoroughness of the forms, which

were experienced by all the interviewees as very rigorous, most therapists found filling in the form a useful opportunity to bring together their thoughts about their patients, and some interviewees even asked for copies of the form to help with their thinking about other patients. Strikingly, the interviewer did not feel that anxieties about confidentiality affected the interviewees' responses at all. However, all patients were, of course, given pseudonyms, and therapists were given a code letter to protect confidentiality; and this had already been explained to the interviewees.

The Psychotherapists

There are twenty-three different therapists participating in the project, seventeen in the twenty cases studied in this paper. Some are highly experienced staff members and some less experienced, in training, with opportunities for supervision or discussion with experienced staff. They are all trained in a similar method of therapy, the essence of which is the provision of a predictable setting (in terms of a regular time, place, and a space in the therapist's mind) in which attempts can be made to understand the communications of the patient, verbal or non-verbal, as they occur in the context of the developing relationship between patient and therapist. (For a fuller description of the method, see Boston & Daws 1988 and Boston & Szur 1983). The interaction is a non-directive one, with a small amount of non-specific play and drawing materials available to facilitate communication for younger children.

Design of questionnaire

The semi-structured questionnaire is devised to elicit both factual material and more subjective qualitative material, as in a number of follow-up studies of foster children and adopted children (eg Rowe 1984, Triseliotis 1980, Triseliotis & Russell 1984). Some questions need ticking or one-word answers only; others are more open-ended and therapists are encouraged to make their own formulations.

The aspects of personality functioning listed in the final version of the form were arrived at empirically, after a trial run of an earlier version in which several broad categories were suggested. These were based on Kleinian theoretical formulations and included items such as persecutory and depressive anxieties, the balance of introjective/projective processes, degree of splitting, and quality of internal objects. However, many more categories were suggested by the sixteen people who participated in this trial run.

Their completed forms were then analysed, question by question, and the answers grouped in clusters. There was some overlap in the answers to the more qualitative and open questions. The second revision of the form, currently in use, is based on the answers received on these sixteen cases returned in the first year. It delineates more specific areas of personality organisation to be commented on, trying to eliminate some of the overlap caused by the more open questions. (See Appendix IV.)

The answers to all questions on the forms are analysed, but for reasons of brevity

the qualitative material to be presented in this paper will be classified under six main headings:

Changes in the structure of the inner world and internal parental images
Perception of self and self-esteem
Toleration of mental pain
Capacity to think, learn, play and symbolise; access to imagination and phantasy
Relationships, depth of relationships, and concern for others
Types of anxieties

These descriptive categories highlight particularly relevant areas of observed change in this group of children.

The Rating scale

The purpose of the final rating scale on Form 3 was to give the therapist's judgment of the overall degree of progress made by the child in psychotherapy, taking into account the state of the child at the beginning. It is essentially an estimate of degree of change rather than a judgment about overall mental health or disturbance.

1 denotes considerable progress;
2 denotes some progress;
3 denotes a little progress;
4 denotes doubtful progress (uncertain);
5 denotes poor progress;
6 denotes worse;

Definitions of the ratings are given with the forms. the rating can also be clarified with the interviewer.

The rating of anticipated progress, on Form 2, is a similar scale, with the omission of rating **6**, as therapy would not be embarked on if it were expected to make the child worse. We were interested to know how well therapists could predict the use their patients would make of psychotherapy. This might be important in assessment, especially where resources are limited. As many of these patients were extremely disturbed and deprived to start with, it was also important to be able to compare actual progress with the prognostic indications. The ratings in addition provided a means of making comparisons between the therapists' and independent assessors' judgments of improvement.

Reliability and validity

There are obvious difficulties about the reliability and validity of any newly-devised schedule. The overlap that remains on the qualitative items is useful as a measure of the internal consistency of the judgments (Oppenheim 1966). The internal consistency of the completed questionnaires was assessed independently by two researchers, who agreed in considering it good in all cases.

We have no way of knowing at this stage how far two different therapists would agree in completing the forms, except in a few cases where Form 2 happens to have

been filled in by two different people. In these cases there is good agreement. If resources become available it might be possible to plan a reliability study of the forms, tried out on a different group of children.

The degree of internal consistency of the responses to the forms and the variations in profiles of progress have led the researchers to have some confidence in the validity of the therapists' assessments. Anonymity given to therapists by code-names and by pseudonyms for the patients also facilitates frank and honest recording. It might be thought that therapists are prone to over-estimate the success of their work, but Kissel (1974) found that therapists' ratings of improvement were not as high as those of parents.

We have two checks on the validity of the therapists' responses:

— external reports on progress

— assessment of sessional material by an independent clinical rater

External reports on progress. Therapists' ratings are compared with reports available from parents or current carers, school, or social worker. External evidence is also afforded by factors such as the maintenance of foster placements, becoming fosterable, or adjusting to school.

Independent clinical ratings. In order to obtain further independent measures of the degree of change shown by these patients, processed records of early interviews are being compared with sessions at the later stage by an experienced therapist outside the Clinic, to whom both the patients and therapists are unknown. These ratings are done 'blind' in the sense that the clinical rater is told nothing about the cases, except the age and sex of the child, the frequency of therapy, and the position of the session in question in the course of the therapy. The clinical rater is given the initial sessions first and asked to fill in relevant parts of Form 2, including a rating of anticipated progress. When this is completed, later material is given for an assessment of change noted. Form 3 is filled in, including a rating of progress, and comments are invited.

RESULTS

THE PSYCHOTHERAPY GROUP

The information gathered on the twenty cases who have either terminated therapy or have had two years' therapy will be presented as follows:

A Factual data

B Qualitative data: (i) are therapists' criteria for improvement met? (ii) personality changes

C Illustrative case-notes

A Factual data

The first step in processing the material obtained from the completed forms was to abstract and tabulate all the factual data. There were great variations between

the cases. General results are given here; information on each child is in Appendix V.

Age and sex distribution

	Under-6 years	6–12 years	12+ years	Totals
Boys	1	3	4	8
Girls	0	6	6	12
Totals	1	9	10	20

There was a higher proportion of girls than in general child-guidance referrals, and also a higher proportion of older children, although only one was from the Adolescent Department.

Background: placement distribution

Adopted	Long-term fostered	Short-term fostered	Children's home or hostel
7	6	2	5

Stability of current placement

Rating	**1**	**2**	**3**	**4**	**5**
No. of children	8	3	2	2	5

Index of discontinuity

No. of points	9 or under	10 to 20	Over 20
No. of children	8	5	9

There is a higher proportion of children adopted or in long-term fostering in this group than in the total referrals of all the children adopted, fostered, or in care. This is not surprising, as stability of placement is a favourable factor when therapy is being considered; but the fact that five of the cases had the most unstable placement rating indicates that stability of placement is not always a requirement for therapy. Some of these children have a very low index of discontinuity of past care — as low as any of this group can have, as they have all had at least one move since birth. Most of the other cases had a very disturbed background with several moves, breakdown of placements, and additional adverse factors such as physical or sexual abuse. However, therapists were prepared to take them on.

Frequency of sessions

It is interesting, and perhaps rather sad, that the number of weekly sessions considered desirable was in fifteen cases greater than the number of weekly sessions the child received. This shows the belief in the benefit of more intensive therapy, but also shows that therapists are flexible and ready to give less frequent sessions if necessary. Only three of these children, although many were very disturbed, had more than once-weekly sessions throughout their treatment.

Length of therapy

	Under one year	One-to-two years
Terminated	3	9
Continuing	–	8

Thus twelve children had already stopped therapy by the two-year assessment time. Eight of these twelve children had initiated the termination themselves. Numbers are small, but it is possible that children who have a history of rejection find it preferable to forestall anticipated rejection by the therapist by leaving before the therapist sets a date for ending.

Prediction of progress and rating of outcome of therapy

In seventeen out of twenty cases, the therapists' ratings of predicted progress agreed well with their assessment of the outcome of the therapy. Only in three cases were there discrepancies of more than one point. In two of these the child did worse than expected, and in the other, much better. This suggests that therapists can often competently predict the outcome of therapy.

Therapists' final progress rating

Rating	**1**	**1–2**	**2**	**2–3**	**3**	**3–4**	**4**	**5**	**6**
No. of children	2	3	8	2	0	1	3	1	0

The researchers also rated the outcome of therapy using the material in the forms. These ratings agreed closely with those of the therapists.

Therapists of the three adolescents who started treatment but terminated quickly (not included in the twenty cases) were asked to rate progress — if any. They all said no change had occurred or marked them **4** (doubtful progress).

Summary of general results

Only four of the twenty cases did not do well in therapy. A girl of 13 had been in long-term fostering which broke down just before therapy started, leaving her shocked, distrustful, and unwilling to face mental pain. Two other cases — adolescent boys (**Derek** and another) — were both resistant from the start. Another child had to have therapy terminated because of external circumstances. However, it is heartening that the rest all showed some, and usually considerable, improvement; and this applies to the children in care as well as, less surprisingly, to the adopted ones.

Sub-group results

Conclusions cannot be drawn from these preliminary cases where so many variables are involved. Two children in children's homes or hostels did not do well. But two did. One adopted child did not respond to therapy, but the others did. Mostly, age does not seem to be a factor, but the 2-year-old would probably have died without therapy as he was deteriorating fast; and others would have been more

entrenched in the pattern of behaving like an institutionalised child or in confusion and inaccessibility. A hopeful sign is that several of the children with a high index of discontinuity of past care did well. Comparisons on frequency of sessions cannot be made here as most in this study received only weekly sessions and the children differed so much at the start of therapy. However, two of the three cases who had less than one year's therapy did well.

External evidence

Whenever possible, external evidence was obtained to compare with the therapists' findings. The following table gives a brief summary of reports from parents, social workers, schools, doctors, and others.

Table 1

Name	Therapists' progress rating	External reports on progress
ROBERT	5	Adoptive parents saw no change
LOIS	2	Adoptive mother confirmed improvement but thought further therapy might be necessary in future
SALLY	2	Adoptive mother thought improved but would like her to have more therapy
ARTHUR	2	Adoptive family reported much better behaviour and better relationship with adoptive sibling
ANGELA	1–2	Adoptive parents confirmed improvement. School agreed learning improved
MARY	2	Adoptive family pleased with progress but felt more needed to be done
JOHN	1	No external evidence
DORA	2	No external evidence
THELMA	2	Social worker and foster parents agreed improved
MATHEW	2–3	Excellent work at school. Gained university place. Learning much improved.
SYLVIA	3–4	Foster parents reported improved ability to play alone, concentrate and recover from tantrums, but they and school could not cope so Sylvia went to boarding-school
JULIAN	4	Foster father, but not school, reported improvement; but foster placement broke down for external reasons

Table 1 *(continued)*

Name	Therapists' progress rating	External reports on progress
ZELDA	1–2	Foster placement maintained. Foster parents reported improved relationships but still not fully integrated into family
SAM	1	Foster mother, psychiatrist, social worker, and school all thought him now a normal outgoing child able to learn and develop
SANDRA	2	Social worker reported improvement. No information from foster family
HILDA	4	Children's Home staff reported good relationships. Good reports from school
KATH	1–2	Social worker saw improvement in ability to deal with external reality
JAMES	1	Able to be fostered. Foster parents thought he was 'normally adjusted'. Social worker thought great improvement
EDNA	2	Able to be fostered. Foster parents and social workers confirm improvement in relationships with family and friends and in learning
DEREK	4–5	No information

In several of these cases, the external reports provide useful corroborative evidence confirming the improvement seen by the therapists. Sometimes, the therapist stresses different aspects from those emphasised by the social workers or foster parents, but there are no real cases of contradictory evidence. Often the therapists' views of what constitutes improvement was much stricter than those of other people. The changes often speak for themselves. Three previously unfosterable children were able to be fostered, breakdown of fostering was averted in two cases, and none of the adopted cases 'disrupted'.

Independent external clinical rater

Further validation was provided by the work of the external clinical rater whose findings largely confirmed those of the therapists. The degree of agreement on the first twelve cases available between therapist and independent rater on final-outcome rating is given below.

Final-outcome rating

Complete agreement	Agreement within one point	Two-point discrepancy	Three or more points' discrepancy
6	5	1	0

Contrast cases

Sixteen of the twenty psychotherapy cases studied made good progress. One cannot say how they would have managed without therapy, but a comparison with a non-treatment group is possible. As we have mentioned, there were thirteen cases where psychotherapy was recommended but was not available or not taken up. No follow-up information was available on six of these cases as they did not return to the clinic or were referred elsewhere. However, an examination was made of the seven children where information was available for at least two years after the psychotherapy recommendation had been made. This is not a strict control group but we could study how these children fared without therapy.

These cases were chosen for investigation because history subsequent to referral happened to be available. None of these children did well during the period of two years and over without psychotherapy. The reasons for not having therapy varied. Sometimes no therapist was available; or it was decided that stable placement should be found first. In one case, adoptive parents did not accept therapy until two years later. It is important to note that four of the seven children subsequently entered therapy.

The only common factors we could find in this group of seven were that therapy had been recommended but had not take place; and that their problems had not disappeared and they were still causing concern. Since sixteen of the twenty psychotherapy cases improved, the evidence suggests that it is the psychotherapy rather than environmental change or developmental progress that led to the improvement.

These cases go a little way towards illustrating — if not proving — that when psychotherapy is the treatment of choice these deprived and disturbed children are unlikely to prosper without it. Space precludes giving case-notes on all these children, but we include one in the illustrative case-notes.

QUALITATIVE DATA

The qualitative data cannot be tabulated easily but it is this material which shows the spectrum of changes which have occurred in the children.

(i) Are therapists' criteria for improvement met?

In Form 2, therapists were asked what their criteria for judgment of improvement would be in this case. In Form 3 they were asked whether they thought their criteria for improvement had been met. The following display illustrates how material from each case was collated.

EDNA

	Reasons for referral	Changes noted
Anticipated progress 3.	Difficulty in establishing relationships with adults. Sad and depressed. Depression masked by restlessness. Immature and demanding.	Improved. Made attachments to adults.
Outcome of therapy 2.		Improved. Only moments of depression. Less restless.
Researchers' opinion of outcome 2.	Extreme mood-swings with violent outbursts.	Greatly improved maturity but not yet age-appropriate. Improved. Less mood-swings, only occasional eruptions.
Therapy 26 mths continuing.	Deep insecurity	More secure but easily shaken.
	Impulse-driven and acting-out.	Improved. Less acting-out.
	Poor self-concept.	Improved self-concept. Still
	Craves affection.	craves affection. Improved.
	Poor concentration.	Learns more. Is fostered with
	To become fosterable.	family who can cope.
Summary: Considerable improvement in most areas but still long way to go.	*Reasons for recommending psychotherapy* Need for stability, consistency and container for overwhelming feelings.	Feels contained in therapy, occasional eruptions.
	Help with disorientation	Improved. Much less disorientation
	Achieve degree of integration	Improved. Much more integrated but long way to go.
	Meaningful one-to-one relationship with therapist.	Has meaningful relationship with therapist
	Become fosterable	Is fostered.

Criteria for improvement

External:	Improved ability to concentrate.	Improved.
	No more tantrums. Age-appropriate behaviour.	Improved but long way to go.
	Improved orientation and memory	Greatly improved. Can remember.
	Less manic behaviour and mood swings.	Improved but sometimes erupts.

	Ability to go to proper school and mix with peers. Be fostered and cope with siblings	Improved but still has tutor in school. Better with peers. Is fostered and copes with siblings.
Internal:	Beginning of integration.	Improved integration
	Be in touch with good object.	Improved. Less splitting.
	Remember. Hold things in mind.	Much improved.
	Experience of being contained.	Feels much more contained.

To summarise the data collated in this way on the first twenty cases to be processed, it is clear that in two cases the therapists' criteria for improvement were definitely not met, neither externally nor internally. With **Derek** this was anticipated, as therapy was embarked on with a very disturbed 16-year-old with a horrendous background, with considerable doubt about the possibilities of progress. In the event, the boy broke off after nine months, and little was achieved. The other failure, an adopted child with no history of discontinuity of care, was not anticipated. It had been thought he could make use of therapy and the result was disappointing.

In a third case, the result was also disappointing, although a slight amount of external improvement was reported. The outcome was thought to be mainly due to a breakdown of placement at the commencement of therapy, and inadequate external support. Another boy had to stop therapy before much could be achieved.

In nine cases, the therapists' criteria for improvement, both external and internal, were met. In one case (**Sam**), progress was spectacular; and two others had very satisfactory results, with therapy being terminated by mutual agreement before the two-year stage. With **James** the critera were met, but the therapist felt there was more to do when the child broke off after eighteen months. With **Edna**, and four others, the aims were achieved, but therapy is continuing as consolidation is needed.

In the remaining seven cases the aims were achieved to some extent, but more remained to be done. Therapy was continuing in two of these.

On the whole, the therapists' requirements for change were more exacting than those of referrers and carers who, in all but two cases, reported improvement in external behaviour.

(ii) *Personality changes*

The answers to other questions on both forms were listed as illustrated for the criteria for improvement. Only material from the forms is used here, not evidence from other sources, as part of the purpose is to illustrate how much information can be gained from the forms.

Some tentative generalisations are made here with the concomitant over-simplification this entails; but interesting, rich, and useful material emerges. Separation of answers in this way is to some extent artificial, as the different aspects of an individual

are intertwined. Mostly, if there is improvement in one aspect of the personality, other facets improve as well; but this is not always so. This method of looking at different aspects of personality functioning before and after therapy enables a more detailed evaluation of results to be obtained. Only some of the more pertinent answers are briefly discussed, under the six main headings mentioned previously.

Changes in the structure of the inner world and internal parental images

In view of our hypothesis that internal parental images of abandoning and rejecting parents might be modified by psychotherapy, we were particularly interested in what the therapists had said in the sections on changes in the inner world. Some therapists answered directly but others said very little, although evidence regarding the state of the inner world could be inferred from other items. Meaningful changes in relationships, cognitive ability, emotional accessibility, and the other functions analysed are unlikely to occur unless there is a concomitant change internally. So the researchers have taken note of direct answers such as 'her inner world is a turbulent sea', but have also looked at other indications.

Many of the fostered children have a deprived background with little past experience of good parental figures. In most cases there were now potentially caring people around, though the children could not always use them. Some changes in their inner world were needed to enable them to find good parental figures, as **Sam** did, even though his earlier life had been so traumatic.

As would be expected, the inner worlds too, of the two children who showed little change in their external behaviour, were thought to be unchanged. An early-adopted child, not deprived in the way that the in-care children were, surprisingly seemed stuck with a witch-like internal mother and pretty impotent internal parents. This inner constellation hardly shifted, and he remained persecuted, confused and insecure, not feeling part of his family. **Derek** also changed little, but all along he showed an attempt to cling to a hope of a good object which was lost. The therapist described this movingly as an island in a sea of rage, persecution and violence. The child whose placement collapsed at the start of therapy showed little inner change in the therapist's view, although she was getting on well with staff at the children's home. Another whose therapy had to stop early showed a little change in his inner world — less violence and disaster, and a little more hope.

The others in this series showed considerable internal change, evidenced by a greater sense of security and containment, and less fear of rejection and abandonment. A strengthening of internal resources was often described, but sometimes the therapists felt there was still a long way to go before the child could feel secure enough internally for therapy to be no longer necessary.

Sam's inner world — like his external behaviour — changed completely. His therapist wrote that his inner world was now peopled by good caring parents. In other cases, changes were less dramatic. One girl, for example, was said to have developed internally a more reliable container for unacceptable parts of herself, with consequent progress in integration and age-appropriate behaviour. **James**'s internal

world had been peopled by neglectful, abandoning parents, and he felt persecuted and lost. Some greater increase in trust was achieved with therapy which enabled him to relate better to foster parents, though the therapist felt there was still some way to go. Some others seemed to be still searching for more sustaining internal objects but in most there was some increase in trust, confidence and security.

Altogether there is evidence of hope in most of the children, even those with a deprived background. These few cases would suggest that even being adopted when very young does not necessarily ensure good internal parental figures, as the images of the original parents who have not kept the child persist. (This is certainly confirmed by experience in the Tavistock Clinic adoption and fostering workshop.) With the really deprived children, good fostering is often insufficient as it does not necessarily change the internal-parental images. By altering these images positively, therapy can enable children to use good external-parental figures and therefore to become more fosterable.

Perception of self and self-esteem

Answers here confirm the expectation that the children with the most deprived backgrounds tend to have poor self-esteem. Often they have been the recipients of conscious or unconscious hate and rejection, and have introjected images of themselves as deserving hate or rejection. Perception of self and self-esteem are, of course, bound up with other aspects of the personality, for example, the fear of abandonment often found in deprived children, as already mentioned. However, surprisingly, in view of the number of early-adopted children, only three of this series seemed to think quite well of themselves at the onset of therapy. In some cases, the low self-esteem was not openly voiced, but inferred as in the promiscuous self-abusive and self-destructive sexual acting-out of one adopted adolescent. Several children in the non-adopted group felt like outsiders, and inferior either in their families or in their peer-groups, or in both.

After therapy, there was often an improvement in the child's view of himself. For example, a sexually-abused child now felt she had rights. But this does seem to be an area where improvement does not come as easily as in some other aspects of the personality. Even when there is general improvement, including internal changes, in a few cases, the therapist said 'Still low in self-esteem' in Form 3. This probably indicated that more therapy was needed. For example, although **Zelda** improved considerably, she still saw herself as fundamentally damaged.

Toleration of mental pain

Many of the deprived children had lived through external events which would be very painful to think about. It is not surprising that when the therapists were asked about the children's toleration of mental pain, in nearly all cases the answer was that this was poor, but of course this might be true of any clinic sample. However, there was a change in most of the cases when Form 3 was filled in, showing increased toleration of mental pain.

Capacity to think, learn, play, and symbolise; and access to imagination and phantasy

These categories are the main aspects of intellectual functioning, and emotionally disturbed children are likely to have difficulties in these areas as well. There were great variations between the children in their ability to think, learn, play, imagine, and symbolise; and also in their degree of improvement. Generally, the patients who responded well to therapy tended to improve these functions too. To varying extents, well over half the children were experiencing some difficulties in these areas. They differed, of course. For example, **James** could play and use symbolism, but was not meeting his full potential in learning; others could not play. At the start of therapy, **Sam** appeared to have no mental activities; **Edna's** thought was fragmented and disoriented, and her memory was very poor. **Derek** seemed to have little capacity to think or symbolise.

Nearly all the cases showed improvement in this area. **Sam** changed from having no discernible mental activities to having normal capacity to think, learn, and symbolise; and used full imaginative play. In other cases, improvement occurred although less dramatically. Some of the children are still in therapy and it is hoped more improvement will take place. One boy's capacity to learn had greatly improved and he passed A-level examinations well; but in the therapy his learning was described as inconsistent. **Edna's** ability to think and remember improved greatly, but some confusion remained. However, generally, it is encouraging to see how mental activities, including access to imagination and phantasy are most reported to be improved.

Relationships and depth of relationships and concern for others

This is a crucial area, but overlaps to some extent with previous sections. In some cases in this study, where the child is living in a Children's Home, the opportunity to make deeper relationships is likely to be less favourable than in a good family. And children, for example in a short-term foster placement, are in a very different situation from children who have lived in an adoptive family since they were tiny babies. So cases must be examined individually, although we hope some generalisations can eventually be made. Although variation is great, all the children so far were described initially as having difficulties in relationships. **Sam** could not make a relationship with anyone. One girl was described as being close only to the grandmother of her former foster family; **Derek** felt his relationships with his foster-parents and his sister were irreparably damaged. Another girl made strong attachments which were followed by denigration of objects, and she felt insecure in the stability of relationships. Soon after this was reported, her long-term foster placement broke down.

Many difficulties in relationships with adoptive or foster parents were noted; jealousy and rivalry of other children, including siblings, was described very frequently; over half the children were described as having difficult relationships with their peers.

The picture of the relationships most of these children have on referral is not encouraging. But, after therapy, there is improvement in all cases, with the exception of the two failed-adolescent cases already mentioned. Indeed it was feared that **Derek** might become more violent. **Sam** had completely changed and was now loving to his adoptive mother and warm to other people. He was said to look for good in other people and to find it. Dora and her foster-mother were getting on better. The children who had been jealous and rivalrous of their siblings all found these relationships easier in varying degrees. Dora had a steady boyfriend and was choosing more stable young people as friends. **James**, as well as others, felt less persecuted by his peers. Generally, a much happier picture emerges with evidence of improved capacity to make deeper relationships currently and in the future.

A similar picture emerges when answers to the question regarding concern for other was analysed. A couple of the girls were over-concerned about mother or siblings, but more than half the children showed lack of concern for others. In most cases, improvement took place, as with other aspects of relationships.

It is important to add when this area is being reviewed, that most of the adoptive or foster-parents of these children were concurrently receiving some help and most felt it to be useful. The clinic staff also had contact with social workers, house-parents, and other professionals.

Types of anxieties

Many children referred for psychotherapy are beset by anxieties, although sometimes these are denied or repressed, and children in this study are no exception. In the forms, therapists were to say what they could about the child's feelings of persecution, confusion, and depression, and also about anxieties generally.

All the children had anxieties, persecutory anxiety being mentioned in nearly all the cases, but lessening of feelings of persecution was reported in most of the children at Form 3 stage. Confusion was mentioned in half the cases. The early history of some of these children was likely to leave them confused — inconsistent care and changes of caretakers. The confusion sometimes lasted into latency or adolescence. Edna was confused and disorientated; **Derek**, as well as feeling severely persecuted, was said to be so confused that he was almost deluded. In almost all cases, therapy helped to lessen the confusion, as one would hope and expect. Depressive anxieties — concern, or maybe over-concern, for others — were present in several cases. Again, this was helped in therapy, so that the concern for others became more appropriate. Depression about the self was common and seen in more than half the cases. Two children had talked about suicide, but were not thought to be suicidal when therapy finished. By the time Form 3 was filled in, most of the children were described as not depressed and most as feeling much more hopeful. This linked with the more positive self-image noted in many cases.

The most common specific anxiety mentioned was fear of abandonment or rejection. There is rejection or abandonment in the lives of all these children, as even those who were adopted at a few days old still had a mother who had failed

to keep them. One child, after her assessment, refused to change to another therapist, which seemed to be connected to a fear of abandonment. Dora was described as being extremely sensitive to rejection, separation, or abandonment, and Edna had the same fears.

However, in nearly all cases these fears were lessened after therapy. For example, the child who refused to change therapists was described in Form 3 as not being anxious about separation and as having also given up her previous obsessional worrying.

Other anxieties were noted less frequently. Dora was very anxious about her physical health. This did not vanish but she no longer needed to test out if she could become pregnant. Another girl became more confident about her school work.

Although some anxieties still persisted, sometimes with good external reasons, in most cases therapy was successful in lessening the inner persecution and confusion, thus enabling the children to deal more easily with external reality and its problems.

C Illustrative case-notes

So far, we have been examining individual items from the forms to compare the different children's responses. The following selection of short case-notes gives a whole picture of four of the children, based only on material from the forms but abbreviated.

Zelda was 7 years old when referred. She had been with the same foster-family since she was 4, soon after she was taken into care. But she was not truly integrated into the family and they were uncertain about adopting her. She had difficulties in relationships, being very controlling, and had learning difficulties. She was described as having 'sticky dependence' on people, latching on to their ideas, games, and so on. Foster-parents found her provocative and irritating. **Zelda's** history was troubled: her very young natural mother neglected her in spite of support from Social Services; other members of her family could not look after her so she was taken into care. She had been physically abused and her sexualised play when she first came to the foster-family suggested sexual abuse had occurred. Her index of discontinuity was high, at 25, and the stability of current placement was 2.

When Form 2 was filled in, the therapist thought **Zelda** felt insecure and uncontained: she had persecutory and confusional anxiety and strong passionate feelings that sometimes threatened to overwhelm her, and she would then become out of control. There were problems with her acting-out, especially at beginnings and ends of sessions. She was very vulnerable and often felt worthless and discarded, but she had managed to preserve some sense of good parenting. But she seemed like an institutionalised child, with shallow relationships, and it was hoped that therapy would help to deepen these and diminish her pervasive distrust so that she could achieve genuine dependence. Three-times-a-week therapy was the minimum considered necessary. As there had been a shift in her during the assessment period, the anticipated progress of therapy was rated as between 1 and 2.

Form 3 was filled in after thirty-two months of therapy, which was still continu-

ing. Therapist and researchers rated progress of therapy as between 1 and 2, as **Zelda** had improved considerably. Although she still sometimes felt persecuted, she seemed more receptive and less inclined to act out. Her relationships with foster-parents, siblings, and peers, were much better; and she was generally less dependent and 'adhesive'. Her thinking and learning had improved. She was beginning to have a concept of a more caring parent but this fluctuated with more frightening images of uncaring and threatening figures, against which she defended herself by mocking denigration. She was still rather insecure about her place in the family. The family acknowledge the improvement but are disappointed that she is not yet fully integrated into the family. However, her position as the only foster-child in the family still presents difficulties. But most of the Criteria for Judgment of Improvement have been met, and **Zelda** is happier, more independent, and secure. She can think instead of acting-out, and no longer seems the shallow, institutionalised child. Therapy seems to have prevented a breakdown in placement. This was a case where fostering alone was insufficient to enable the child to overcome the effects of the traumas of her early years.

Derek was a very damaged 16-year-old when he started therapy. Not enough details of his history were known to calculate an accurate index of discontinuity, but it would be very high – probably around 50, as **Derek** had had over twenty hospital admissions. He had been severely physically abused by his father and was taken into care when 4 years old. His stability of placement rating was low, at 5. **Derek** had been with the same foster-parents with his younger sister since he was 9. Foster-parents were planning to adopt both children, but then discovered that **Derek** had been sexually abusing his sister for three years. Foster-parents were concerned also that **Derek** would not talk to them. He went to a short-term placement and then an attempt was made to return him to his original foster-home. But this broke down. After this **Derek** began therapy. **Derek** gave the therapist the impression of someone who had had the stuffing knocked out of him. He could speak, but was unanimated, and there were long silences. He seemed to have good motivation and some capacity to change, but he was also suspicious and mistrustful, and had rigid defences. There was concern about possible violence in and out of therapy, and a possible renewal of sexual activity with his sister. **Derek** wished for a good relationship with his foster-parents and sister but felt he would be rejected by them. He thought he had damaged his sister's insides but could not cope with the guilt, and he became hostile to her. He had very little concern for others. He was worried that he would become like his abusive father. There was a feeling of a good object somewhere and he wanted help to combat the terrible violence inside himself. He was severely persecuted, confused, and felt hopeless. The therapist thought the main problem was that **Derek** did not seem to have an emotional life that could be got hold of — very poor emotional accessibility. He was very insecure and felt uncontained. He projected a great deal and his capacity to think and symbolise was poor.

Derek was severely traumatised but had not given up, and the therapist felt he had been given something good at some point. Therapy was recommended to help him cope with his violence and to stop him killing someone. Criteria for judgment of improvement were externally that **Derek** should hold a job and have a relationship with foster-parents and sister. Internally, the hope was recovery of the lost good object and its relationship with his vulnerable baby self. However, the prognosis was poor and the anticipated progress of therapy was between 4 and 5, one of the few low predictions in this study.

Although five-times-a-week therapy was thought necessary, only once-weekly was possible. Therapy lasted only nine months and was terminated by **Derek**. Attendance was regular at first, but deteriorated as the summer holiday approached. After the placement changes noted above, **Derek** went to a therapeutic hostel there was then insufficient external support for the therapy. As might be imagined, therapy was not easy, and many answers in Form 3 are the same as those in Form 2. **Derek** still seemed well motivated and communicated adequately at time, but he also showed resistance and rigid defences, denying his unconscious suspicion. Fear of his own violence played a great part in his resistance, and shutting out the therapist was used as a defence. There was a fear that he was becoming more violent, especially towards males, and he became more defiant to his social worker and male therapist. He remained persecuted, confused, and hopeless about his future. He liked the idea of belonging to a family but had no feeling for any individual. He had limited emotional responses but still yearned for a good object felt to be irreparably lost. In his inner world this feeling of trying to hold on to hope of a good object was described as an island in a sea of rage and persecution. He had minimal integration and very little toleration of mental pain, but the therapist saw him as sad and distressed, and not as a tough, hard kid. Not surprisingly, **Derek** has a very poor self-image of himself as damaged and damaging. The therapists and researchers rated progress of therapy as 4, but in spite of this the therapist said the therapy was potentially alive, but suffered from inadequate environmental holding.

This case, one of the few unsuccessful ones in this study, illustrates well the difficulty of treating a boy like **Derek** and the external support needed.

James is another child in the study with a deprived and troubled background. He was 9 when he started therapy, which was weekly for three months and then twice-weekly. Therapy lasted seventeen months. As often noted in this study, the therapist would have preferred more frequent sessions.

James was referred by Social Services because of their concern over previous fostering breakdowns. He was currently in a children's home, so stability of placement was poor, at 5, and index of discontinuity was high, at 21. His school was also pressing for therapy because of his aggressive behaviour and failure to use his full potential; and they eventually expelled him. He could not accept criticism and was self-destructive. In the assessment, **James** was found to have paranoid trends, poor self-esteem, and an inability to get on with peers or adults. He felt unprotected;

he was in touch with his natural parents but they could not give him the support he needed.

When Form 2 was filled in, **James** was able to play and was more in touch with his feelings than some of the other patients in this study. He could represent his internal world symbolically — feeling alone in a frightening world. He was overwhelmed by pain and loneliness, sometimes leading to suicidal thoughts. He had poor toleration of mental pain, felt uncontained and persecuted, and this led to aggressive behaviour. It was hoped psychotherapy would prepare **James** for fostering and help him with his mistrust of adults and his helpless and hopeless feelings which led to aggressive acting-out. There was hope of establishing a more secure containing object, more loving feelings, and also feelings of being more cared for. The anticipated progress of therapy was 2.

Therapy ended after seventeen months at best, as by this time he had settled in a new foster-home and was doing well at school. His wish to stop was supported by his foster-parents and social worker. His response to therapy was very good, and, as therapy progressed, he could use interpretations. However, he gradually became resistant to therapy after the foster placement. His behaviour improved, as did his relationships, although he was still sometimes excessively jealous of children. He was less confused, less anxious, less depressed, and he acted out less. He was more accessible emotionally and had an increased capacity to think and learn. There was more depth to his relationships, but he still feared getting too close to people and could become persecuted. He still had low self-esteem but felt more secure and contained. Although the therapist did not initiate termination of therapy, progress was marked as 1, as he had made considerable progress in personality development. The researchers rated progress as 1–2. **James** benefited considerably from therapy and has been maintained in a stable foster placement.

Sam is the youngest of the cases in this series, being only 2 years and 1 month old when he began therapy. He was also the most damaged child in the study. He was in a short-term foster-home so his stability of placement rating was therefore 5 and the index of discontinuity was 12. **Sam** had been very badly physically and emotionally abused by his schizophrenic mother until he was taken into care when he was fourteen months. He did not thrive in his foster-home and when referred at 2 years he was severely withdrawn, possibly autistic, devouring food but not absorbing it. His physical deterioration was such that it was feared he would die. He was not relating or responding to anyone; there was no eye contact, and he could not be cuddled. He could not play or talk, and the therapist felt he was in the grip of great persecutory anxiety.

Therapy was seen as the only hope and the aim was at first just for **Sam** to stay alive and begin to make contact with people and the world around him, and to help him feel life was worth living. The therapist felt none of the categories in the prediction scale was suitable, that prediction was unknown, but there was hope as **Sam** was so young. However, it was still felt it might be too late. Form 3 was

filled in after thirty-one months of therapy, which started at three times a week but then reduced to once a week for external reasons.

The change in **Sam**, as described in Form 3, is remarkable in spite of his attendance not always being good and traumatic events for him to cope with, such as the illness and death of his grandfather and his natural mother having more babies. **Sam** responded very well to therapy. At $4\frac{1}{2}$ years old, **Sam** was physically and emotionally healthy. His school found him delightful and foster-mother (aunt) and other people thought he was a normal child. He had caught up intellectually, spoke well, except for an occasional slight stutter, and was learning well. The therapist reported full symbolic play and imagination beyond his age. He had enormous capacity and drive to think. **Sam** was outgoing and friendly. He looked for good in others and found it. He was loving with foster-mother and friendly with peers. He was not now persecuted, confused, or depressed, and had good insight into himself; his toleration of mental pain was generally very good. His inner world was surprisingly secure, peopled by a good caring mother 'who likes babies', a good father and parental couple.

There were certainly great internal changes in **Sam** as well as the marked external changes. He was no longer persecuted, was very accessible, and had a real concern for others — even his rejecting mother and new half-siblings. All symptoms present at referral had disappeared and the therapist felt she had achieved much more than she had originally hoped for. He was able to be fostered, long-term – unlikely at the start. The outcome of therapy was marked as 1 and the researchers confirmed this.

The following is a brief account of one of the Contrast Cases.

Steven, aged 10 when referred, after an early history of neglect, was placed in a long-term foster-family when he was eighteen months old. His difficult behaviour made the family hesitate to adopt him like **Zelda**. His index of discontinuity was high, at 17, and the stability of current placement rating was 2.

Three-times-a-week therapy was recommended as **Steven** was insecure, sad, restless, and very anxious. He also stole, told lies, and was verbally abusive at home and school, and argued continually with his foster-mother. The recommendation for intensive therapy could not be carried out but the clinic kept in touch with the family. Two years later, at $12\frac{1}{2}$, **Steven** was very little better. He often seemed like a toddler, was rude, dirty, and continually lost his belongings. He finally entered therapy when he was 13.

DISCUSSION AND CONCLUSIONS

These preliminary findings confirm those of an earlier study (Boston & Szur 1983) that severely deprived children are able, in many cases, to make good use of psychoanalytic psychotherapy. The present results are based on a consecutive series of all cases entering psychotherapy within a specified period, rather than on a

selected group of cases volunteered by therapists, as in the previous study. Furthermore, the use of a questionnaire demonstrates more systematically, and in detail, the kinds of change in personality which have occurred.

Most children showed considerable improvement in their relationships with adults, and often also with peers. This is a crucial area of change if successful placement is to be maintained. Concomitant changes in the inner world, necessary for a more confident prediction of future adjustment, were also judged to have occurred in many cases, though it naturally takes time to achieve such fundamental change. Most of the therapists thought a longer period of therapy would be required for the strengthening of internal parental images to be consolidated. In view of the prevalence of learning difficulties in deprived children, it is encouraging to note that improvement in learning and thinking processes was observed in most cases. Most therapists reported an increased tolerance of mental pain which made the patients more emotionally accessible and less prone to defensive strategies. This is important, considering the painful experiences which many children had undergone, and the 'hard-to-reach' quality often initially observed. Self-esteem seems slow to improve in this group of children, perhaps not surprising in those who have experienced severe rejection and abandonment.

There are too few cases so far to enable a comparison to be made between early-adopted children and those with disrupted backgrounds. There is an impression that the differences between the groups is not as great as we anticipated, and that self-esteem, for example, can be low even among early-adopted children. These observations suggest that being adopted when very young does not necessarily ensure good internal parental figures, as the images persist of the original parents who have not kept the child.

It is early, at this two-year stage, to assess the evidence for our hypothesis that psychotherapy facilitates permanent placement. So far, however, none of the adopted cases has 'disrupted'. Precarious long-term foster-placements were consolidated and three children were able to be long-term fostered. One child had to go to boarding-school, but there were no breakdowns of placement owing to the child's behaviour — only one for external reasons.

We hope to report later on the total group of thirty-five cases from which some within-group comparisons may be possible. These may help to answer questions such as: do younger children do better in psychotherapy than older children? How much difference does frequency of sessions and length of treatment make? Do children with very deprived and discontinuous backgrounds do worse? Is there a relationship between breakdown of placement and progress of treatment? It is also hoped to continue to follow through the cases after therapy has stopped, though already many difficulties about follow-up are becoming apparent.

One advantage of this attempt to make children's responses to psychotherapy more open to scientific inquiry is that although it makes a substantial demand on therapists' time it does not require any departure from their normal clinical practice and does not involve patients directly. In the researchers' view there is, therefore,

a greater likelihood that such a model can be incorporated into ongoing clinical work, and for clinical research to be conducted rather than avoided. Although this project is on adopted and in-care children, this method could be used with any children in psychotherapy, and possibly, in an adapted form, with adults.

An obvious limitation of these results is that they depend mainly on the therapists' own assessments, and therefore can be considered subject to bias. The separating of initial from later assessments and the use of a large number of different categories to describe the children go some way towards making the data available for scientific scrutiny and towards making possible a somewhat more objective, and certainly more discriminative, evaluation of outcome.

The spectrum of personality change observed by the therapists in the course of their work with the patients is not obtainable, by definition, for a non-treatment control group. However, the contrast group does provide some comparison data and an indication of how similar children are likely to fare without psychotherapy. If the study can be continued into long-term follow-up, it is hoped to be able to compare the general outcome data with that already published for children in care, eg Wolkind & Renton (1979), Rutter, Quinton, & Liddle (1983), Triseliotis & Russell (1984), Rowe *et al.* (1984), Mann (1984).

The collection of more systematic data to meet research requirements would entail a greater degree of active participation with the therapists as co-research-workers. Similar routine data collected on all cases seen in a clinic would obviously facilitate research, but even then the kind of qualitative data on individual children required for our baseline on psychotherapy cases cannot be obtained outside the individual psychotherapeutic interview, and is therefore not practical where many children may be seen in a family context only.

The lessons we have learned from this pilot project, and our struggles to find a suitable methodology for evaluating qualitative changes in psychotherapy have led to some thoughts about how to improve the method, particularly with a view to obtaining independent information from different sources. One possibility is that the research cases would be restricted to those seen by therapists who would agree to collect the required data at the specified times. This would probably also require cooperation from parents, social workers, and children if the study is to be continued into follow-up. To reduce therapist variables, cases might be further restricted to those seen by staff or supervised by staff. Children who, after initial assessment, do not proceed to therapy, or who have to wait a year or more, could be offered six-monthly holding interviews so that these could be used as contrast cases. Tightening up the requirements in these suggested ways would be likely to reduce the size of the study-group, but would enable more systematic independent information to be obtained. It would also increase the possibility of a suitable contrast group. Using cases from more than one clinic is a possible way of increasing the size of the study-group as well as providing possibilities for control groups and for reliability studies of the forms.

In a naturalistic research such as this, it may not be possible to achieve methodol-

ogical exactitude without sacrificing the meaningfulness and clinical relevance of the results. We hope to report later on further aspects of the project.

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ACKNOWLEDGEMENTS

We wish to thank the Child & Family Department of the Tavistock Clinic for their continued support, including financial help. We also valued very much the constant support of the Fostering & Adoption Workshop in the Child & Family Department.

Our thanks are due to the following child psychotherapists and child psychiatrists without whom the project could not have taken place: Chriso Andreou, Lorenzo Crespi, Dilys Daws, Sira Dermen, Louise Emanuel, Michelle Hudson, Steven Isaacs, Corinne Kostick, Charlotte Jarvis, Savi Mackenzie Smith, Ann McFadyen, Mando Meleagrou, Sheila Miller, Lynda Miller, Eileen Orford, Ann Parr, Helene Pereira, Susan Reid, Margaret Rustin, Patsy Ryz, Ruth Seglow, Naomi Shavit, Michael Sones, Angelica Trellis-Fishman, Judith Trowell, Louise Weir, and others of the Child & Family and Adolescent Departments of the Tavistock Clinic.

We are also grateful to Shirley Hoxter, our external assessor.

We also wish to thank the following honorary research assistants: Lucia Franco, Jon Kramer, Lisa Loughlin; our in-take secretary, Linda Kaufman; and our secretaries, Jane Rayner and Janice Uphill.

Our thanks are also due to the Child Psychotherapy Trust for their financial support.

We also wish to thank the anonymous referee for *Psychoanalytic Psychotherapy* who made useful suggestions.

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Appendix I

INDEX OF DISCONTINUITY OF PAST CARE

Number of moves	3 points for each move up to and including 3 years old
	2 points for each move 3 - 6 years old
	1 point for each move 7+ years old
Strangeness of move	(to be added to each move)
	3 points for institution or group care
	2 points for strangers (family)
	1 point for known family
Adverse factors	(additional points:)
	for physical or sexual abuse, or other severe traumas (can be any number of these)

Appendix II

INDEX OF STABILITY OF CURRENT PLACEMENT (at referral, exploration stage)

on 5-point scale:

1	stable - no moves likely
2	probably stable - moves unlikely
3	doubtful
4	likely to be further moves
5	almost certainly further moves

Appendix III

Form 2 (revised November 1988)

ADOPTION/FOSTERING/IN-CARE RESEARCH
PSYCHOTHERAPY FOR THE CHILD

The purpose of this form is to obtain some baseline data about the child at the beginning of psychotherapy which could be compared with data obtained at later stages in therapy or at follow-up. Please feel free to use your own formulations or to make comments if you feel the suggested categories are inadequate. Please fill in as much as possible when assessment is completed.

Name of child_____ CC_____
Date of birth_____ Person filling in form for initial assessment
School (present)_____ _____
_____ Team (if any) _____
Has there been a school report? Yes__No__ Has there been a psychological assessment?
Who was referrer?_____ Yes__ No__
If yes, name of psychologist _____
Date of starting therapy (if started)____ Number of sessions weekly _____
Individual _____ Group _____

If child is being recommended for therapy, is concurrent help being offered to:

natural parents _____ how often? _____ by whom? _____
adoptive parents _____ how often? _____ by whom? _____
foster parents _____ how often? _____ by whom? _____
house parents _____ how often? _____ by whom? _____
social worker _____ how often? _____ by whom? _____
network _____ how often? _____ by whom? _____
school _____ how often? _____ by whom? _____
other _____ how often? _____ by whom? _____

Personality and problem as seen initially by referrer:

Personality and problem as seen initially by family or home:

Is the child currently living with:

natural parents _____
adoptive parents _____
foster parents _____
long-term _____
short-term _____
children's home _____
boarding school _____
other (specify) _____

Has there been any change of home placement during the assessment/exploration period?
Yes _____ No _____ If yes, specify:

From your initial contact with _____ can you say anything about his/her manner of communication:

Please tick any of the following categories which apply:

Communicates adequately by words, drawing or play, as appropriate to age _____
Difficulty with communication - non-verbal or countertransference feelings mainly relied on _____
Communicates mainly by action or massive projection _____
Was reluctant to communicate _____
Likely to be able to make use of interpretation _____
Likely to respond to setting _____
Some capacity for change _____
Good motivation _____
Resistant _____
Rigid defences _____
Suspicion and mistrust predominate _____
Management problems likely, such as:

Please add any others you feel are important:

From your present knowledge of the child, can you comment on any of the following:
(Please leave blank if you feel items cannot be assessed at this stage)

	Observed by Yourself	Reported by others (specify who)
Behaviour		
Relationships		
- with parents: natural		
adoptive		
foster		
house		
- with other adults		
- with siblings		
- with peers		
Use of abilities		
Symptoms		
Delinquent trends		
General personality		
Other		

Surmised current personality organisation. Please comment on any of the following areas which seem relevant, brifly giving evidence where possible.

	Comments
DEGREE OF PERSECUTION	
CONFUSION	
DEPRESSION	
CONCERN FOR OTHERS	
SPLITTING PROCESSES	
INTEGRATION	
EMOTIONAL ACCESSIBILITY	
ANXIETY	
DEFENSIVE STRUCTURES	
TOLERATION OF MENTAL PAIN	
MATURITY	
PERCEPTION OF SELF	
FEELINGS OF SECURITY	
FEELINGS OF CONTAINMENT	
BALANCE OF INTROJECTIVE/ PROJECTIVE PROCESSES	
DEPTH OF RELATIONSHIPS	
CAPACITY TO THINK	
CAPACITY TO LEARN	
CAPACITY TO PLAY (if age appropriate)	
CAPACITY TO SYMBOLISE	
ACCESS TO IMAGINATION/ PHANTASY	
STRUCTURE OF INNER WORLD	

How would you see the balance of internal and external factors (ie temperamental, constitutional versus traumatic, family, etc.)?
If there is a team formulation which is different from, or not covered by, above, please state:

Reason(s) for recommendation for psychotherapy, and what it is hoped to achieve

Number of sessions per week desirable _____
practical _____
External support required for psychotherapy to be viable:

Criteria which would need to be met for a judgment of improvement to be made:
External: (in terms of behaviour, relationships, symptoms, use of ability, etc.)

Internal: what kind of psychodynamic change would you hope to achieve?

Anticipated progress of therapy (assuming adequate external support and continuity)
Please assess on the following 5-point scale. Tick only one. If not sure, add query.

_____ 1. Considerable progress in personality development
(Note: This should denote a definite change in personality organisation, as well as improvement in symptoms and major problems. This might include cases where some symptoms persist, but there is really a marked general improvement.)

_____ 2. Some progress in personality development
(Note: Some progress in the direction of category 1, but where there is still Some way to go - some problems may be remaining but general improvement less marked than category 1.)

_____ 3. A little progress
(Note: This might include relief of acute anxieties or symptoms or beginnings of personality change, even though anxieties or symptoms persist.)

_____ 4. Doubtful progress
(Note: Uncertain whether the child will be able to make much use of treatment.)

_____ 5. Poor expectations
(Note: Little change expected.)

Any other comments

On how many interviews is this assessment based _____
State whether child seen alone
with family
with siblings

Signed _____
Date _____

Thank you for filling in this form.

Appendix IV

Form 3 (Progress/Termination Report)
2nd revision

ADOPTION/FOSTERING/IN-CARE RESEARCH
PSYCHOTHERAPY FOR THE CHILD

Name of child_____ Name of therapist _____
Date of birth_____ CC _____
School (present)_____ _____
_____ Team (if any) _____
Any contact with school by Clinic? Yes__No__
Date of starting therapy _____ Individual ___ or Group ___
Date of finishing therapy (if finished) no. in group ___
_____ siblings _____
No. of sessions weekly _____ unrelated _____
Attendance (Please tick as appropriate)

A1 Very good ___ (NOTE: This would imply always attends, except for the odd cancellation for illness etc. or a specific period of absence for known reasons in otherwise regular attendance)

A2 Reasonable __ (NOTE: Some cancellations and/or periods missed but on the whole sufficient attendance for therapeutic process to be viable)

A3 Poor ___ (NOTE: Cancellations sufficiently frequent or prolonged or attendance erratic enough for therapeutic process to be impeded.)

A4 Very poor ___ (NOTE: More absence than presence)

IF PARTICULAR DIFFICULTIES, EXPLAIN BRIEFLY

Has there been any psychological assessment? Yes___ No___
If so, date(s) _____

External support for therapy (Please tick)
(NOTE: This would include not only whether the child is brought or helped to come, but the psychological backing for therapy)

Comments

S1 Very good ___
S2 Adequate ___
S3 Dubious ___
S4 Poor ___
S5 Absent ___

Has child's therapist had contact with natural parents _____ how often? _____
adoptive parents _____ how often? _____
foster parents _____ how often? _____
house parents _____ how often? _____
social worker _____ how often? _____
network _____ how often? _____
school _____ how often? _____
other _____ how often? _____

Consultation/help provided for supporters, excluding above contacts and routine meetings. (Please tick as appropriate).

			BY SELF	COLLEAGUE	REGULARLY (specify how often)	OCCASIONALLY
P	Parents	natural ___ adoptive ___ foster ___ house ___	_____	_____	_____	_____
SW	Social Worker		_____	_____	_____	_____
N	Network		_____	_____	_____	_____
S	School		_____	_____	_____	_____
O	Other		_____	_____	_____	_____
	Not appropriate		_____	_____	_____	_____

[Suggest code regular, occas., no]

Do you consider such work with _____ has been useful in:-

a) Maintaining the child in therapy? _____
b) Facilitating satisfactory adjustment in placement? _____
c) Helping parents or clients personally? _____
d) Or that the work was not found to be useful or helpful? _____
e) Or did not manage to engage client(s)? _____

If more than one supporter has been worked with, please repeat above as appropriate, enlisting help of relevant colleague if necessary.

Any other comments

Who was the referrer? _____

Has there been any recent contact with referrer? (Please tick)

Yes ___ (if so, date _____)
No ___
Not appropriate ____ (ie self-referral, referrer no longer involved)

Has the referrer an opinion on the current state of the child? (Please tick)

R1 Improved _____
R2 Same _____
R3 Worse _____
R4 Don't know _____
Not appropriate _____ (self-referral, or referrer left or no longer involved)

How do current family/home now see the child?

Don't know _____
If known, please summarise briefly:

NP Is the child currently living with - natural parent(s)? ____
AP - adoptive parent(s)? ____
LF - long-term foster parent(s)? ____
SF - short-term foster parent(s)? ____
CH - children's home ____
BS - boarding school ____
Oth. - other (specify) ____

Have there been any changes of home placement since the child started therapy?

No _____
Yes _____ If yes, how many? ____ Please give dates_____
_____

If yes, please give reasons for any moves:

Do you consider these moves to have been related to the therapy in any way?
If yes, please specify_____

Response to psychotherapy

(By response, is meant capacity to use the opportunity, irrespective of rate of progress or severity of disturbance.)

In general, do you consider the child's response to therapy has been:

VG very good? _____
A adequate? _____
D dubious? _____
P poor? _____
I Not possible to work with _____

Please tick any of the following categories which apply:

Communicated adquately by words, drawing or play, as appropriate to age _____
Difficulty with communication - non-verbal or countertransference feelings only have to be relied on _____
Reluctant to communicate _____
Is able to make use of interpretation _____
Responds to setting _____
Some capacity for change _____
Good motivation _____
Resistant _____
Rigid defences _____
Suspicion and mistrust persist

Management problems
- aggressive, violent _____
- truanting from sessions ___
- shutting out _____
- other _____

Please add any others you feel are important:

Esternal changes observed in the child since starting treatment:

	Observed by Yourself	Reported by others (specify who)
Behaviour		
Relationships		
- with parents: natural		
adoptive		
foster		
house		
- with other adults		
- with siblings		
- with peers		
Use of abilities		
Symptoms		
Delinquent trends		
General personality		
Other		

Current personality organisation and attitudes from your experience in therapy. Please comment on any of the following areas which seem relevant, brifly giving evidence where possible.

	Comments
DEGREE OF PERSECUTION	
CONFUSION	
DEPRESSION	
CONCERN FOR OTHERS	
SPLITTING PROCESSES	
INTEGRATION	
EMOTIONAL ACCESSIBILITY	
ANXIETY	
DEFENSIVE STRUCTURES	
TOLERATION OF MENTAL PAIN	
MATURITY	
PERCEPTION OF SELF	
FEELINGS OF SECURITY	
FEELINGS OF CONTAINMENT	
BALANCE OF INTROJECTIVE/ PROJECTIVE PROCESSES	
DEPTH OF RELATIONSHIPS	
CAPACITY TO THINK	
CAPACITY TO LEARN	
CAPACITY TO PLAY (if age appropriate)	
CAPACITY TO SYMBOLISE	
ACCESS TO IMAGINATION/ PHANTASY	
STRUCTURE OF INNER WORLD	

How would you see the balance of internal and external factors (ie temperamental, constitutional versus traumatic, family, etc.)?
General comments on any personality changes (if not already covered):

Progress of therapy
Please give a considered view based on child's material, after discussion with Case Consultant or supervisor as appropriate. Tick only one. If not sure, add query.

_____ 1. Considerable progress in personality development
(Note: This should denote a definite change in personality organisation, as well as improvement in symptoms and major problems. This might include cases where some symptoms persist, but there is really a marked general improvement.)

_____ 2. Some progress in personality development
(Note: Some progress in the direction of category 1, but where there is still Some way to go - some problems may be remaining but general improvement less marked than category 1.)

_____ 3. A little progress
(Note: This might include relief of acute anxieties or symptoms or beginnings of personality change, even though anxieties or symptoms persist.)

_____ 4. Doubtful progress
(Note: Uncertain whether the child will be able to make much use of treatment.)

_____ 5. Poor expectations
(Note: Little change.)

_____ 6. Worse. Please state in which respects:

If you have an opinion on the reason for the deterioration, please give it briefly:

To what extent do any symptoms present at referral persist?

Do you feel you have achieved what you hoped to achieve for this patient? ie have your criteria for improvement been met?
external _____
internal _____
Any other comments:

How many times has the child been seen individually when this rating was made?____
(If the child is being seen in a group only, use the number of times the child has attended the group.)
Are any processed records of sessions available? Yes _____
No _____
If yes, please give dates (unless regularly written up in detail)

Has the case been supervised?
If so, by whom? _____

IF THERAPY IS CONTINUING, PLEASE OMIT REMAINING QUESTIONS, SIGN, DATE, AND RETURN FORM.
IF CHILD HAS STOPPED THERAPY, PLEASE GIVE REASONS:

Mutually agreed	___	Reason:
Terminated by therapist	___	Reason:
Terminated by child	___	Reason (if known):
by parents	___	Reason given:
by Social Services	___	Reason given:

Have any arrangements been made for follow-up with the child? (please tick)

FO	None	___
FA	Available if required	___
FOP	Occasional - initiated by patient	___
FOT	- initiated by therapist	___
FR	Regular - specify:	

Have any arrangements been made for follow-up

FP	with parents	___
FRef	with referrer	___
FSS	with Social Services	___
FSch	with school	___
FOthr	with other - specify:	

If not, would follow-up

be possible	___	with? _____
inadvisable	___	
impossible	___	
don't know	___	

Is a termination summary/report available?

yes	___
no	___
in preparation	___

SIGNED _____ DATE _____ PROFESSION _____

Thank you for filling in this form and for helping with the research.

PLEASE RETURN TO DOLLY LUSH

Appendix V

THERAPISTS' PREDICTIONS OF OUTCOME IN PSYCHOTHERAPY CASES
(first twenty cases)

NAME	SEX	AGE	WHERE LIV-ING	STAB PLACE.	INDEX DISCON	NO. OF SES's WEEKLY	LENGTH THERAPY IN MONTHS	APPROX. NO. OF SES's	PRED. OF OUT-COME	THER. VIEW OF OUT-COME	RES. VIEW OF OUT-COME
ROBERT	M	12	AP	1	5	1	25 stopped by child	80	2(?)	5	5
LOIS	F	18	AP	1	16	1	7 stopped by child	22	2	2	2-3
SALLY	F	15	AP	1	6	1	9 stopped by child	25	2	2	2-3
ARTHUR	M	7	AP	1	22	1-2	26 cont.	110	2	2	2
ANGELA	F	9	AP	1	6	1	22 stopped mutual	75	1	1-2	1
MARY	F	16	AP	1	21+	2	22 stopped by child	76	2	2	2-3
JOHN	M	16	AP	1	7	1	27 stopped by child	100	2	2-3	2-3
DORA	F	14	LF	2	22	1	18 stopped mutual	40	2	2	2
THELMA	F	15	LF	3	11	1	15 stopped by child	35	1(?)	2	2-3
MATHEW	M	17	LF	1	19	1	26 cont.	90	1(?)	2-3	2
SYLVIA	F	7	LF	3	6	3-1	13 stopped by s.s.	87	2-4	3-4	3
JULIAN	M	9	LF	3	9	1	14 stopped by ext. circs.	30	2-4	4	4
ZELDA	F	7	LF	2	25	3	32 stopped by child	330	1-2	1-2	1-2
SAM	M	2	SF	5	12	3-1	31 cont.	150	not known	1	1
SANDRA	F	6	SF	4	28	2-3	25 cont.	205	2-3	2	2
HILDA	F	12	CH	5	26	1	17 stopped by child	40	2	4	3-4
KATH	F	11	CH	5	29	1	39 cont.	140	2-4	1-2	2
JAMES	M	9	CH	2	21	1-2	18 stopped by child	100	2	1	1-2
EDNA	F	11	CH	5	16	3	26 cont.	300	3	2	2
DEREK	M	16	Hostel	5	?50	1	9 stopped by child	20	4-5	4	4