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Process and Outcome Research in Child, Adolescent and Parent-Infant Psychotherapy: A Thematic Review

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Process and Outcome Research in Child, Adolescent and Parent-Infant Psychotherapy: A Thematic Review

Foreword

Caroline Lindsey

Consultant Child and Adolescent Psychiatrist; Co-Chair of the External Working Group of the CAMHS module of the Children's NSF

This review of process and outcome research in child, adolescent and parent-infant psychotherapy follows another publication which reviewed effectiveness studies in child and adolescent psychotherapy (Kennedy, 2004). The endeavour reflects the importance now being given by the profession to addressing the issues of researching child and adolescent psychotherapy, despite its many challenges. This is very much to be welcomed and supported.

The choice of the three subject areas is important, including the process of psychoanalytic child psychotherapy, child and adolescent psychotherapy in a clinical setting and parent-infant psychotherapy. They reflect three important types of questions - how does child psychotherapy work; for whom does it work - which children and young people benefit with what kind of problems, and for how long do they need treatment; and how psychotherapy can contribute to

early intervention with parents and infants, to improve sensitivity of parenting and attachment security. The latter has enormous public health implications as well as offering hope of influencing the child's emotional, cognitive and social developmental trajectory before patterns of relating have become set and less susceptible to change.

The complexity of examining the processes of psychotherapy turn on several factors addressed in this review. These include the difficulties inherent in developing the methodological tools for this purpose as well as the struggle involved in conceptualising what it is that needs to be scrutinised. The reader interested in carrying out a study into the process and/or outcome of psychotherapy will find here many measures and assessment tools already available, described within the context of the studies where they have been utilised. This is therefore an exceedingly useful resource for would-be researchers in this field.

The review also encourages the curious psychotherapist to consider the observations to be made and the questions that might be asked of the therapist, the client/patient and parent/carer and referrers about what happens in therapy, how it happens, if it is helpful, the nature of any change and its long-term effects. The review does, therefore, not just answer the question of how research is being carried out now. It hopefully will stimulate a wish to take further the process of examining aspects of psychotherapy, both process and outcome, with increasingly robust and sensitive tools and the recognition of how important this activity is for the future of the profession, its training and funding.

Process and Outcome Research in Child, Adolescent and Parent-Infant Psychotherapy: A Thematic Review

Introduction

This publication follows a previous systematic review (Kennedy, 2004) which focused on effectiveness studies in the field of child and adolescent psychotherapy. The aim of this second review is to look more broadly at other research, not captured in the previous work but nonetheless of relevance to those working psychotherapeutically with children. In order to give some focus to what is a wide area of research, we have set out to limit this review to three distinct areas:

- Researching the process of psychoanalytic child psychotherapy
- Child and adolescent psychotherapy research in a clinical setting
- Parent-infant psychotherapy research

In addition to the three main sections, this publication includes a substantial glossary of many of the measures and assessment tools referred to in each of the sections of the review. We hope this will prove of value to those wishing to explore the field further. Alongside the glossary, each chapter also includes an appendix summarising key research studies discussed in that chapter.

This review does not pretend to be an exhaustive account of all relevant research in the field of child, adolescent and parent-infant psychotherapy. By its very nature, a review of the research literature in a field as wide as this encounters many 'grey' areas that could with some justification be included, but that would result in a loss of focus. Much of the research in the fields of attachment and neuroscience, for example, is of relevance to child and adolescent psychotherapy, but has been reviewed thoroughly elsewhere, and would have taken this review beyond its reasonable boundaries.

Within the fields that have been reviewed, however, we hope to have been fairly comprehensive, and we have tried to highlight key developments in each of the three areas focused on. Our hope is that the review will inform child psychotherapists and others about research of relevance to this field, thus serving as a 'resource' or 'tool kit' to draw on when undertaking research and crucially continuing to ask questions about how and in what way children and their families can best be helped.

Eilis Kennedy and Nick Midgley

Guide for readers

Each section of the Review has two appendices. Appendix A gives more detailed information about selected studies discussed in the main text of that section. Where a study has been included in Appendix A, it is marked with a number in square brackets, e.g. Target and Fonagy (1994) [1].

Where a particular measure or research tool, of particular interest to child psychotherapy researchers, has been referred to in one of the sections, more information can be found about it in the glossary of measures in Appendix B at the end of that section. Where a measure is included in this glossary, it is marked with an asterisk in the main text, e.g. **Child Attachment Interview*. Items in the glossary for each section are included in alphabetical order.

Section One: Researching the process of psychoanalytic child psychotherapy

Process research - the empirical study of what actually takes place in a psychotherapy treatment - is the means by which we explore *why* and *how* change takes place as the consequence of a therapeutic intervention. Such research adds depth and understanding to the question of 'what works for whom?' (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002) and has the potential to help identify the 'active ingredients' or change mechanisms that form the basis for a successful clinical intervention. As such, this approach to research can help develop a more clinically-relevant research programme and, according to a recent review, is 'probably the best short-term and long-term investment for improving clinical practice and patient care' (Kazdin & Nock, 2003, p.1117).

The need for such process research has been consistently emphasised by leading figures in the field of child psychotherapy research (e.g. Russell, 1999; Rutter, 2005). When Alan Kazdin, a prominent international researcher in the field of child psychotherapy, undertook a comprehensive review of psychotherapy research with children and adolescents only a few years ago, he concluded:

> Perhaps the greatest limitation of contemporary therapy research is the paucity of studies that attempt to explain why and how treatment works. Without such research, work is likely to hobble along (2000, p.127).

In his review of over 200 child psychotherapy outcome studies (including psychodynamic, cognitive behavioural and other therapeutic modalities), Kazdin (2000) calculated that less than 3% of these studies examined the treatment process in relation to outcome. But unless an understanding of the psychotherapy process can be incorporated into the investigation of treatment outcome, progress will be limited:

> The goal for therapy research is to understand how treatment leads to change and how various factors relate to change. The goal ought to be approached by emphasising theory that poses the processes (or mechanisms) through which therapy operates [...] Identifying how therapy works, even for one or two forms of therapy, could reveal processes that have generality across many types of therapy (ibid, p.9/10).

Psychoanalytic child psychotherapy is, in this respect, in a potentially strong position when it comes to process-outcome research, because the field has traditionally been very strong at developing theories of therapeutic action and the mechanisms of change. However these mechanisms have been conceptualised by different theorists in ways which do not always map easily onto each other. The traditional psychoanalytic literature often focused on the importance of interpretation and insight in facilitating change, but many alternative explanatory models exist, even within psychoanalysis and psychoanalytic psychotherapy, and there has been an increasing emphasis on factors such as the therapist's capacity to 'contain' projections, to act as an 'auxiliary ego' or provide a 'holding' environment. (For a recent overview of psychoanalytic models of therapeutic change, see Barish, 2004).

From a certain point of view, every clinical paper in the field of child psychotherapy could be described as a piece of research into therapeutic process and the nature of change (Midgley, 2006a). Yet because of the range of theoretical models of therapeutic change found in the psychoanalytic literature - some compatible, others contradictory - Kazdin's words of caution, although addressed to all types of child psychotherapy research, are perhaps especially relevant to psychoanalytic child psychotherapists:

> Conceptualizations often are at such a global level that they defy empirical evaluation [...] The safety of a technique is assured in the short run by hiding behind global interpretations and clinical experience. However, the techniques and their interpretations will wither with changing times and fads if not subjected to and bolstered by empirical findings (2000, p.217)

As Kazdin makes clear, such empirical study is not only of value to researchers examining the underlying mechanisms to explain the outcome of psychotherapy; it is also of value to clinicians who wish to systematically examine the nature of psychoanalytic work with children with the aim of clarifying and improving clinical practice. For this reason, the current review aims to bring together some of the key measures and methods that have been developed in this field, as well as to summarise some of the initial findings that derive from the use of such approaches.

The study of the process of psychotherapy *with adults* has developed rapidly during the last twenty years, but progress in the empirical study of work with children has lagged behind. Llewellyn and Hardy (2001), in a helpful review of process research in adult psychotherapy, distinguish between three types of process research:

- Studies which describe behaviours and processes occurring within therapy sessions (exploratory studies)
- Studies which investigate the links between specific psychotherapy processes and treatment outcome (hypothesis testing)
- Studies which examine the links between specific psychotherapy processes and theories of change (theory development) (2001, p.1)

Within the field of child psychotherapy research, most (but not all) studies that will be reviewed in this chapter fall within the first category of exploratory studies. This is to be expected in a fairly undeveloped area of research, where the priority is on the development of measures and the meaningful description of the clinical process with children. After all, as Shirk and Russell point out, 'to understand how and why therapy works requires specification of what actually transpires in the therapy session' (1996, p.x).

But as these authors also point out, research which focuses only on descriptive accounts of child or therapist behaviours, without being informed by a conceptual model of change processes, are ultimately of limited value, and it is necessary in the long term to move to a more sophisticated level. In the research that will be reviewed below, some studies have tried to test specific hypotheses, such as the work of Traux and Wittmer (1973) or Gorin (1993), in which a specific aspect of the psychotherapy process (such as defence interpretation) is linked to measures of outcome. The findings of these studies are inevitably tentative, and are also vulnerable to criticisms that potentially compounding variables make such correlations of limited clinical relevance. More promising is the emergence of studies with a sound theoretical basis, which attempt to explore psychodynamic models of change in meaningful empirical terms, such as the work (reviewed in more detail below) of Philps (2003), Carlberg (1997),

Moran and Fonagy (1987), Gerber (2004), Russell, Bryant & Estrada (1996), Kassett, Bonanno, & Notarius (2004).

It is hoped that future research will be increasingly informed by a greater integration in theoretical thinking about change processes and will be enhanced by the increasing availability of meaningful measures of child psychotherapy process. Methods developed to study the process of psychoanalysis and psychotherapy with adults may well serve as inspiration for future research on psychoanalytic child psychotherapy, but a review of such literature is beyond the scope of this chapter, and in many ways the process of child psychotherapy is quite distinct from work with adults (Dimon, 1996; Lanyado & Horne, 1999). For these reasons, this chapter aims to summarise the main approaches to the systematic investigation of psychoanalytic child psychotherapy currently available, without substantial reference to comparable developments in the field of psychotherapy research with adults.

[N.B. Useful summaries of recent work on process research in the field of adult psychoanalysis and psychotherapy can be found in Dallos and Vetere (2005), Lepper and Riding (2006), Toukmanian and Rennie (1992), Dahl, Kachele and Thoma (1988), Weiss and Sampson (1988), Ablon and Jones (2005) and Bornstein and Masling (1998)].

Measures of children's behaviour within a clinical setting

The development of measures of child behaviour

If systematic research into the process of child psychotherapy is to be carried out in an on-going way, it is vital that reliable measures of what is going on within sessions are developed. Shirk and Russell (1996) have helpfully reviewed the history of the development of such measures in the wider field of child psychotherapy (both psychodynamic and behavioural), showing how early measures often focused on trying to develop reliable categories for children's in-session behaviours.

While some research studies have focused explicitly on one type of behaviour, most researchers have been keen to develop more broad categorisations of children's activities in the psychotherapy setting, although inevitably some form of selection has to take place. For example, early studies such as that of Landisberg and Synder (1946) and Moustakas, Sigel & Schalock (1956) focused on children's behaviours relevant to the quality of affective expression, since such behaviour was seen as of significance within the model of play therapy that the researchers were investigating. Howe and Silvern (1981) took a different approach, generating potential categories for their **Play Therapy Observational Instrument* by reviewing the theoretical literature (including psychoanalytic approaches) in order to identify four a priori dimensions of children's functioning during play therapy (emotional discomfort; competence in relation to people and things; maladaptive coping strategies; and use of fantasy play). For each of these dimensions, a number of behavioural correlates were identified and coding of video-tapes of play therapy sessions were carried out to try and establish reliability, although success was limited. Nevertheless, the study marks an early attempt to use empirical research not only to develop theoretically-informed measurement tools, but also to intervene in important clinical and theoretical debates. For example, this particular study found that children who were able to talk more about feelings, worries and troublesome events were also more likely to be rated highly for 'emotional discomfort'. The authors argue that this finding may have implications for the debate about the importance of verbalization in the psychotherapy process with young children, although the conclusions they draw, based on such a small sample, are inevitably tentative.

Children's play: An example of theoretically-informed research

The approach taken by Howe and Silvern (1981) suggests the possibility of focusing on child behaviours that are of theoretical significance to a psychoanalytic or psychodynamic perspective. For example, a number of studies (e.g. Neil, 1996) have focused on children's play within a psychodynamic session, on the basis that play itself is considered to be a central feature of psychoanalytic child psychotherapy. Cohen et al. (1987) offers an exploratory study of children's in-session play, which appears to have been the basis for the development of the **Child Psychoanalytic Play Interview* (CPPI, Marans et al., 1991).

One of the advantages of the CPPI, which is a 30-item measure of different themes in young children's play in an analytic session, is that the themes are analytically-informed, and are not just descriptors of thematic content (although this also has disadvantages in terms of the level of inference needed to code, and the subsequent difficulties in terms of inter-rater reliability). The study by Cohen, Marans, Dahl, Marans & Lewis (1987) used a version of the CPPI to focus on one session of play with a single child, 'Sam', examined from a psycholinguistic and psychoanalytic perspective [1]. Analysis of the session of this 5-year old boy revealed the successful orchestration of multiple forces within a play interview, and illustrated the way that the analyst followed emerging themes and feelings.

Such an approach has been taken one step further by Saralea Chazan and her colleagues, with the development of the **Children's Play Therapy Instrument* (CPTI). In a series of papers, Chazan and her colleagues (Kernberg, Chazan & Normandin, 1998) have demonstrated the reliability and validity of this psychodynamically-informed measure of in-session play activity, and demonstrated its use in a number of different clinical contexts to reveal the formal structure and underlying meaning of play activity. In Chazan and Wolf (2002) selected transcripts (beginning, middle and end) of the twice-weekly psychodynamic treatment of a six year old boy with depressive episodes were studied over time, using the CPTI, to examine changes in psychotherapy. Initially presenting as a 'conflicted player', the amount of time spent on play activity gradually increased across the course of treatment, with fewer shifts in and out of play activity. The coding of thirteen different strategies used in playing out the dynamics of conflict showed the variety of coping and defensive strategies used by this child and the way in which they shifted over the course of treatment, towards 'a more fluent flow and elaboration of play activity' (2002, p.101).

Other psychodynamic aspects of children's activity and functioning in the therapy setting

Play activity is not the only specific dimension of a child's behaviour in therapy that is of interest to the psychodynamic researcher. Theoretically-driven, empirical investigation of a child's behaviour in psychoanalytic treatment has a long history, going back at least to the work of the Hampstead Index (Sandler, 1987), as illustrated in the work of Bolland and Sandler (1962), where the intensive psychoanalysis of a three year old boy was 'mapped' across a range of analytically-informed dimensions, including object-relations, indications of super-ego functioning and ego development generally, including the use of defences (e.g. the use of projection, regression, turning passive into active etc.) [2]. Such a study of defensive functioning in the analytic setting seems a theoretically-significant one for child psychotherapy researchers, but while a number of measures of defensive functioning in children have been developed, such as the **Defence Mechanism Inventory* (DMI) - Children's Version (Cramer, 1991) and the

**Comprehensive Assessment of Defence Style* (Laor, Wolmer & Cicchetti, 2001), these measures have not yet been used to assess the quality of children's interactions in the therapeutic setting.

A study by Moran and Fonagy (1987), based on the detailed analysis of a psychoanalyst's weekly reports, was able to establish a reliable system of coding for seven out of ten analytic themes that were identified in weekly reports written by the therapist of a three and a half year psychoanalysis with a diabetic adolescent [3]. This ground-breaking study, which made sophisticated use of time-series analysis, went on to explore interesting links between the emergence of particular analytic themes and independent outcome measures.

Elsewhere, attempts have been made to evaluate a number of specific therapy-based aspects of children's interactions, including modes of object-relating in autistic children (Crosse, 1995; Alvarez & Lee, 2004); responses to therapeutic interpretations (Shirk, 1988) and reactions to the therapist's exploration of emotion (Elling, 2000). Alvarez and Lee's study is of particular value, because it demonstrates in a very powerful way the increase in object-related interactions made by a four year old child with severe autism across the course of a single treatment (see Section 2).

While Alvarez and Lee's study looks at *actual* interactions between a child and therapist, psychoanalytic child psychotherapy is also concerned with the quality of *internal* object relations. A number of measures of the quality of object-relations have now been developed for children, the most well-known probably being the *Narrative Story Stems Assessment* (Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003; see Section 2) and the **Child Attachment Interview* (CAI; Target, Fonagy & Shmueli-Goetz, 2003). Less well known, at least in the UK, are the **Object Relations Inventory* (Blatt, Auerbach, & Aryan, 1998), the **Mutuality of Autonomy Object Relations Scale* (Tuber, 1992) and the **Social Cognition and Object Relations Scale* (Kelly, 2005). While all of these measures offer an important perspective on the internal world of the child, they have so far been used only to analyse projective or interview-data, and have not been used in the direct study of the psychotherapy process.

One study that has attempted to bring such an approach to the empirical study of the therapeutic setting itself is Philps (2003, in press), who explored emotional development in psychoanalytic psychotherapy with looked after children [4]. The study made use of the **Personal Relatedness Profile* (PRP, Hobson, Patrick & Valentine, 1998), a measure originally developed for the study of adults, to look for evidence of children's borderline and depressive modes of thinking across the course of a psychotherapy treatment. In the case of two children seen for on-going treatment while in foster-care, Philps found evidence for a gradual decrease in paranoid-schizoid functioning and an increase in depressive functioning within the sessions themselves. The study went on to develop a form of 'systematic mapping' of the psychotherapy process, which aimed to capture the fine-grained transference and counter-transference processes, as well as levels of interpretation, in a more nuanced way.

The empirical study of transference patterns in child psychotherapy is an area of theoretical importance for psychoanalytic research, given the centrality of this concept in clinical practice. The most widely-used measure of transference patterns in the adult psychotherapy research literature is the **Core Conflictual Relationship Theme* (CCRT; Luborsky & Crits-Cristoph, 1998). This measure has been developed for use with children (Luborsky et al., 1995), although as yet it has not been used in the analysis of actual psychotherapy sessions, nor in any significant study of the child psychotherapy process itself.

Studies of therapist interventions in a clinical setting

As Shirk and Russell's (1996) historical review testifies, attempts to develop reliable measures of therapist interventions in child psychotherapy likewise go back to the post-war work of Landisberg and Snyder (1946) and Moustakas and Schalock (1955), where the emphasis was primarily on verbal interventions seen as theoretically relevant to a client-centred approach (e.g. lead-taking, non-directive responses, directive responses etc.). The client-centred approach to child psychotherapy has also led to a focus on developing scales of items such as empathy, positive regard and genuineness (e.g. Siegel, 1972; Wright, Traux, & Mitchell, 1972; Mook, 1982), although a focus on therapist empathy, warmth and positive regard has also been used to explore analytical and psychodynamic psychotherapy (e.g. Traux, Altmann, Wright, & Mitchell, 1973; Smith-Acuna, Durlak, & Kaspar, 1991 [5]).

Interactions between the therapist and child

Several of the above studies have also attempted to explore *interactions* between child and therapist behaviour, by examining the way that certain items coded on the therapist intervention rating predicted certain responses by children (and vice versa). In one study of particular relevance to a psychodynamic perspective, Traux and Wittmer (1973) explored the way in which the degree of focus on confronting defence mechanisms in group psychotherapy for 'juvenile delinquents' predicted positive therapeutic outcomes, and found that such a focus was productive on several measures of outcome [6].

An extremely sophisticated approach to investigating the interaction between therapist and child was taken by Russell, Bryant, & Estrada (1996) using a confirmatory p-technique to examine therapist discourse in high-quality versus low-quality child psychotherapy sessions [7]. The research team used an adaptation of the *Stuttgart Interactional Coding System* (Czogalik, Hettinger & Bechtinger-Czogalik, 1987), which uses five different perspectives (level of involvement, conversational techniques, conversational regulation, thematic concern and temporal orientation) in order to examine the nature of therapeutic discourse. When sessions were then rated for quality using the **Child Psychotherapy Process Scales* (Estrada & Russell, 1999), the authors found that two factors - 'Responsive Informing' (i.e. responsively attending to the child in the present and using neutral description) and 'Initiatory Questioning' (i.e. acquiring novel information from the child about his or her recent past through questioning) - both achieved an acceptable goodness-of-fit for independently-rated high-quality sessions, with the former being most highly responsible for the distinction between 'good' and 'bad' sessions. (The authors of this study suggest that the use of trainee clinicians may have led to an under-emphasis on more sophisticated therapeutic techniques, such as confrontation and interpretation; while the study of more explicitly psychoanalytically-informed therapists might have discovered different patterns and forms of therapist discourse).

Likewise Zurita (1993) in a study examining the way a child reacted to different forms of therapist intervention in a single case of video-recorded brief psychoanalytic psychotherapy, found that supportive-expressive interventions elicited more emotional reactions, verbalisation of conflict and therapeutic progress from the child than other interventions, although the study failed to find any significant differences between the child's reaction to direct, indirect or therapist-related interventions.

In another study exploring the detailed interaction between child and therapist, the ways in which the therapist may act as a 'developmental object' within the moment-to-moment interactions of a psychotherapy session was examined in some detail by Kassett, Bonanno & Notarius (2004) [8]. Using the model of 'affective scaffolding', a term derived from developmental studies of the parent-child relationship, the authors systematically examined transcripts of psychodynamic play therapy sessions with one child, aged five, to explore the contingency between the therapist's interventions and the child's responses. In this way, three 'contingency rules' were identified (e.g. 'if the child's level of emotional expression decreases, then the therapist will provide more scaffolding as indicated by an increase in her subsequent level of intervention'), and significant associations were found between the child's shift in level of emotional response and the amount of 'scaffolding' provided by the therapist.

Such an approach bears some relation to the work done by researchers working with the Birmingham Trust for Psychoanalytic Psychotherapy, who have used conversational analysis and ethnomethodology to investigate psychodynamic group work in schools (Leuder et al., 2005; in press). This careful study explores how a therapeutic orientation (in this case, Kleinian psychoanalytic psychotherapy) works itself into the particular circumstances of moment-to-moment interactions in the clinical setting, through the detailed analysis of four consecutive sessions of therapy for a group of young children in a school setting. The study identifies a number of strategies or 'devices' on the part of the therapists, especially related to the children's expressions of anxiety and the defences against such anxiety, by means of which the play activities of each child were transformed into emotionally-meaningful communications and shared with the group in therapeutically relevant ways. The use of such devices, however, was not mechanical. The researchers noted that 'the therapists used the stock of descriptions with care, strategically and flexibly and not as fixed recipes' (Leuder et al., in press), and describe in detail work with one particular child to show how this approach allowed the boy to gain more freedom in relation to his anxiety-driven, compulsive behaviour.

Turning points in child psychotherapy

Some particularly interesting research has looked at 'turning points' in child psychotherapy, indicating that this may be a particularly fruitful area of further study. Carlberg (1997), for example, describes the importance of experiences of 'new intersubjectivity' in the process of therapeutic change [9], while Terr et al. (2005) focus on the importance of the therapist-child relationship more generally. In a subsequent study, Andersson, Boethius, Svirsky & Carlberg (2006) used specific cue words to explore emotionally-charged events in therapy which evoked strong feelings in the therapist, and provisional links were made with successful outcome of treatment [10].

While these studies were all based on therapists' own accounts of therapeutic events, the use of video-taped recordings of child psychotherapy sessions has also allowed micro-analysis of moment-by-moment interactions between child and therapist, such as the mutual regulation of affect-states (Harrison, 2003). In this study [11], an extremely detailed examination of a single psychotherapy session, the complex interaction that gradually leads to increased affect regulation is carefully elucidated, in a way that appears to confirm some of the findings about the key mechanisms of change in adult psychoanalysis and psychotherapy identified by the Boston Change Process Study Group (BCPSG, 2002). Such an approach adds another dimension to the study of significant moments in child psychotherapy.

Measures of the overall psychotherapy process

While the above studies have broken down the psychotherapy process in order to focus on specific aspects of either the child or the therapist's actions and behaviours, there is a pressing need for approaches that capture the complete process of a psychotherapeutic encounter in all its complexity.

Prescriptive and descriptive approaches

In the context of outcome studies in which the *integrity* of treatments needs to be established - i.e. to establish that the nature of the treatment being carried out in an outcome study of a particular form of child psychotherapy is within the range of accepted technique for that modality of treatment - there has been an increasing number of attempts to provide prescriptive accounts of what *should* be going on in psychoanalytic child psychotherapy. This has led to the creation of a number of manuals of psychoanalytic child psychotherapy, such as the manual of 'time-limited psychodynamic psychotherapy' described by Muratori et al., (2003), the manual of 'supportive-expressive play psychotherapy' described by Kernberg and Chazan (1991) for their studies of children with conduct disorders, or the manual of child psychoanalysis with latency-age children (Miller, 1993). Such documents tend to be based on reviews of the psychoanalytic literature, or interviews with expert clinicians, an approach which can go some way towards identifying the particular technique of psychoanalytic child psychotherapy; although the clinical implications of their use in psychodynamic research has been hotly debated (Trowell, in press).

An alternative approach is to begin by trying to describe what *actually happens* within a clinical session, and gradually build up a model of the process of psychoanalytic child psychotherapy on that basis. Such an approach can be found, for example, in the Trowell, Rhode, Miles, & Sherwood (2003) study of childhood depression [12], in which a version of grounded theory was used to analyse process notes (and some transcripts of audio-recorded sessions) in order to generate themes emerging from the patient's material as well as the range of therapist techniques used. This led to an identification of recurring themes in the sessions of these depressed young people as well as a set of coding categories for therapists' interventions.

Within the Trowell et al. (2003) study, no attempt was made to develop a formal rating scale based on these coding categories, or to establish the reliability or validity of the patients' recurring themes, although frequency counts of themes in two children's treatments suggested certain shifts in the material over the course of the psychotherapy. Kanter (n.d.), in a pilot study to develop a scale measuring themes that emerged in the psychoanalytic treatment of children with obsessional disorders, found that therapists' weekly summaries of case material did not serve as a good basis for studying the actual technique of treatment, although differences in the therapists' implicit working models and types of interpretation were identified.

The development of measures of the overall child psychotherapy process

The above studies are largely descriptive, and make no attempt to form a standardised, reliable measure of child psychotherapy process. Yet the development of such measures is vital if the

study of the process of child psychotherapy is going to develop in a systematic way. For example, the *Psychotherapy Process Inventory*, developed by Baer et al. (1980) as a tool for examining adult psychotherapy, has been adapted for use with children by Gorin (1993) to examine levels of child participation and directive support offered by therapists in treatment [13].

Approaches such as that of Gorin are limited by the fact that they are adaptations of measures used in adult psychotherapy, although such measures may not necessarily be appropriate for studying work with children. For this reason, Estrada and Russell (1999) have developed a **Child Psychotherapy Process Scale* (CPPS) which, although based on a similar adult scale, was designed specifically for studying therapy with children. In an initial study, this measure was able to identify both child and therapist factors in psychodynamic child psychotherapy, as distinguished from other types of treatment. These factors described both positive and negative aspects of the therapy process, and high and low scores on the CPPS correlated significantly with the structure of in-session discourse between child and therapist.

One example of a measure developed more specifically for psychoanalytic work with children - although still largely unused in a research context - is the **Anna Freud Centre Session Rating Scale for Children and Adolescents* (Fonagy, Philips, Buchan, Target, & Weise, 1993), an extremely comprehensive rating scale aimed at describing the manifest and latent content of the child's play and verbal material, including transference themes, as well as the therapist's style, technique and counter-transference themes.

An adaptation of this measure, the **Young Adults Weekly Rating Scale* (YAWRS), designed for use with an older age-group, is a therapist-completed checklist with three main sections, covering the general characteristics of a week's sessions; manifest and unconscious content of material; and the analyst's judgment of the quality of the week. This measure has been used successfully by Gerber (2004) to describe specific interactions between therapist technique and outcome measures, and was designed to incorporate aspects of psychoanalytic technique with young adults that would be considered of theoretical interest to psychoanalytic clinicians from different schools (Kleinian, Independent, Contemporary Freudian etc.). In this important study, a factor analysis showed distinctions could be made between intensive psychoanalysis and non-intensive psychodynamic psychotherapy technique, and that scores on certain aspects of technique predicted positive outcome for the treatment.

Some of the most promising work in this field involves the development of process rating scales which can be used across different types of psychotherapy, but are of relevance, and meaningful, in psychodynamic terms. For example, Weersing, Weiss & Donenberg (2002) developed a **Therapy Procedures Checklist* (TPC), a measure rated by therapists themselves, which has shown some promise in distinguishing psychodynamic, cognitive and behavioural techniques in child psychotherapy. For example, techniques such as interpreting the child's in-session behaviour, or understanding the effects of early experience were seen to be common in psychodynamic treatment, but uncommon in either cognitive or behavioural treatments; while techniques such as challenging irrational beliefs were found to be common only in cognitive treatments.

The **Child Psychotherapy Q-Sort* (CPQ; Schneider, 2004a, b; Schneider, Pruetzel-Thomas & Midgley, in press) is based on a measure of psychotherapy process that was originally developed in the field of adult psychotherapy research, the Psychotherapy Q-Sort (PQS; Jones, Cumming & Pulos, 1993). The latter has shown great promise as a research tool within adult psychotherapy, and alongside the *Vanderbilt Psychotherapy Process Scale* (VPPS; Suh, Strupp & O'Malley, 1986), is the most widely used process measure in adult psychotherapy research.

Given the initial promise of the measure, its clinical relevance and relative ease of use, it is likely that Schneider's *Child Psychotherapy Q-Sort* could come to be of equal importance for research in the field of child psychotherapy. Early studies have included the establishment of 'prototypes' or constellations of Q-items that represent aspects of therapeutic process and action deemed most relevant to different theoretical models of child psychotherapy, including psychodynamic and cognitive behavioural therapies (Schneider, 2004b), as well as studies that have used the Q-sort to try and identify the characteristics of psychoanalytic child therapy in comparison to cognitive behavioural therapy (Pruetzel-Thomas, 2006) and to trace changes in process across the course of a single treatment of child analysis (Duncan, 2006).

The research by Pruetzel-Thomas (2006) and Duncan (2006) was carried out as part of a larger project, the Child Psychotherapy Process Outcome Study (CPPOS), currently underway at the Anna Freud Centre, London (Midgley, 2006b; Schneider, Pruetzel-Thomas & Midgley, in press). This study plans to use a range of methodological approaches to explore a relatively small number of child psychotherapy cases, in order to investigate the process of psychotherapeutic change from multiple perspectives and in some depth.

In this respect, the CPPOS study has something in common with the Erica Process Outcome Study (EPOS; Carlberg and Odhammar, 2006; Fonagy, 2002), based at the ERICA Foundation in Sweden, which aims to explore change processes in child psychotherapy through the qualitative study of 24 children in psychodynamic treatment. Extensive data from each of these cases has been collected with various instruments, including questionnaires every third month and in some cases taped interviews. In connection with each session the therapists complete a form, the *Feeling Word Checklist*, in order to follow the therapists' counter-transference feelings and to facilitate studying sessions of special interest (see also Metcalf, 2002). Data is being analysed using both qualitative and quantitative methods and a follow-up after three years is planned (Carlberg & Odhammar, 2006).

The patient-therapist relationship in child psychotherapy

The concept of therapeutic alliance

While the above studies explore the nature of the interaction between therapist and child in psychodynamic psychotherapy, process research in the field of adult psychotherapy has increasingly come to emphasise the quality of the patient-therapist relationship *itself* as the fundamental factor in therapeutic change (Goldfried & Davila, 2005). Researchers in this field postulate that a combination of relationship factors and specific techniques are the key mechanisms of change, a hypothesis that receives some support in the field of psychoanalytic child psychotherapy from a follow-up study of former child patients' memories of treatment (Midgley & Target, 2005). This study [14] found that the relationship factor - the experience of being attended to by a sympathetic, non-judgmental listener - was seen as of primary importance to these former patients, although psychodynamic techniques, such as particular interpretations that were felt to help develop self-understanding, were also seen as valuable, at least among those who felt that the therapy had been helpful overall (see also Kresheck, 1996).

The relational factors that are hypothesised to be central to the change-process in psychotherapy are often explored under the umbrella term of 'therapeutic alliance' (Horvath, 2006), a relatively

a theoretical concept that can, however, be fairly reliably measured and has been consistently linked to good outcome in studies of *adult* psychoanalytic psychotherapy (Crits-Christoph, Gibbons, & Hearon, 2006), although in the broader field of child psychotherapy research to date the link has been more modest, but still significant (Shirk & Saiz, 1992; Shirk & Karver, 2003; Green, 2006).

As a number of researchers have noted, the terms 'relationship' and 'therapeutic alliance' are broad ones, which need breaking down further if they are to have any real meaning. Shirk and Russell (1996) suggest seeing the therapeutic relationship as being made up of three components: relationship as support; relationship as alliance; and relationship as technique (p.156), and argue that research needs to be focused independently on each of these aspects of the relationship. 'Therapeutic alliance' has been further broken down in the research literature to incorporate three core aspects: the presence of a personal bond between therapist and patient; an agreement between therapist and patient about the goals of treatment; and an agreement as to the means by which these goals may be achieved (Bordin, 1979).

Empirical studies of the therapeutic alliance in child psychotherapy

In the broader child psychotherapy research literature (not exclusively focused on psychodynamic treatments) studies have explored the concept of the therapeutic alliance from the perspective of therapist, child and the independent observer (e.g. DeVet, Kim, Charlot-Swilley, & Ireys, 2003), and each of these appears to be of significance to the ultimate outcome of treatment. Some studies also include ways of examining the therapist-parent therapeutic alliance (e.g. Hawley & Weisz, 2005), which preliminary studies indicate may be a significant factor in determining whether children drop out prematurely from psychoanalytic psychotherapy (e.g. Navradi & Midgley, 2006 [15]).

A number of attempts have been made to find ways of measuring the quality of the therapeutic alliance in the broader child psychotherapy research literature, based on the above distinctions. Measures such as the **Therapeutic Alliance Scales for Children* (TASC; Shirk & Saiz, 1992; Kronmüller et al., 2002), the **Child Therapeutic Alliance Scale* (CTAS; Foreman et al., 2000) and the **Therapy Process Observational Coding System - Alliance Scale* (TPOCS-AS; McLeod & Weisz, 2005) have all been shown to have reasonable to good reliability and validity and could potentially be used in studies of the process of psychoanalytic child psychotherapy. In the Heidelberg study of the outcome of long-term psychodynamic psychotherapy for children (see section 2), the TASC was used, alongside a new measure investigating the intensity of therapeutic change, with some success in investigating how particular therapeutic processes related to outcome (Kronmüller, 2006).

It is important to remember, however, that simple correlations between good outcome and a strong therapeutic alliance do not prove that the quality of the therapeutic alliance necessarily *led* to good outcome (Kazdin & Nock, 2003). Without multiple measures at a series of time-points before, during and after treatment, one cannot specify whether the alliance is the critical mechanism of change or merely a side-effect (or even a consequence) of good outcome. Where studies of adult psychotherapy have tried to examine the interaction between alliance and outcome more carefully, the suggestion is that the two factors mutually influence each other (i.e. therapeutic alliance leads to symptom change, and symptom change improves therapeutic alliance). Further work is clearly needed on this potentially important aspect of the child psychotherapy process.

Conclusions

As Michael Rustin has reminded us, psychoanalysis, with its established tradition of clinical case study methods, has for most of its history been a field of 'tacit knowledge', a *craft practice* in which 'intellectual sensibilities, fine-honed and shared with the knowledge-community of the profession' have led to impressive developments in knowledge and understanding, 'but subject to little formal clarification at meta-levels of justification' (Rustin, in press).

Recent developments both within and beyond the profession of child psychotherapy, have led to an increasing challenge to this reliance on 'tacit knowledge', and have led to a demand for other forms of investigation to be brought to bear in exploring the psychoanalytic process. Transcripts of audio- or video-taped psychotherapy sessions have become increasingly important, as have new developments in both quantitative and qualitative forms of analysis. While these new approaches offer opportunities for new discovery and increasing dialogue with the wider research community, they are only of value if they are seen as complementary to more traditional forms of clinical research, rather than as an alternative.

This is not to underestimate the importance of developing more empirical studies of the child psychotherapy process. Little more than fifteen years ago, Marans et al., (1991) could say, quite honestly, that 'unlike research in the area of psychoanalytic psychotherapy with adults […] systematic, reliable methods of assessing what emerges in the consulting room with children have not been developed' (p.1017). As I hope this chapter has demonstrated, significant steps have been taken since those words were written to alter this position, and there is now a considerable body of research that has attempted to empirically investigate the process of psychodynamic child psychotherapy and explore how it may relate to both outcome and to the therapeutic process in other forms of psychotherapy (Karver, Handelsman, Fields, & Bickman, 2005).

Based on this accumulated work, a number of findings are beginning to emerge about the possible 'mechanisms of change' that lead to emotional development in the therapeutic setting and approaches to research are beginning to emerge that capture those more subjective and intuitive features that are so central to psychoanalytic psychotherapy with children. The findings that are emerging in this field may play a considerable role in helping to provide support - as well as refining or questioning - traditional ways in which child psychotherapists have understood the nature of the work they are engaged in.

Yet the study of therapeutic process is still not seen as being as high on the research agenda as more straightforward outcome studies, and the number of process studies is relatively small compared to other types of research. As Llewelyn and Hardy (2001) have noted:

> Process research does not tend to attract the same level of attention or funding as outcome research probably because it does not initially appear to give clear answers about what therapy is the most effective to use with which clients. However, this undoubtedly underestimates the potential that process research has to help therapists to understand what is happening when therapy works well and when it does not [...] Hence it offers a way forward to increase the effectiveness of psychotherapy through analysis of the specifics of therapy and by highlighting individual differences (2001, p.16/17).

Despite the potential benefits of such developments, Francis Kelly - a leading advocate of the use of empirical measures, especially projective testing, in clinical research - rightly reminds us that 'the psychoanalytic psychotherapeutic narrative cannot be captured in its entirety by any psychometric measure, no matter how precise or sophisticated that measure is' (Kelly, in press). As such, all attempts to apply new methodologies to empirically examine the process of child psychotherapy have to be treated with caution, and are of value only in so far as they are recognised as simply one strand within a rich and complex tapestry.

Appendix A. Summary of studies

1)

Title
Analytic discussions with oedipal children

Background/aims
This study, part of an ongoing research project involving play and communication in 4- to 6-year old children, represented an attempt to develop a methodology for investigating children's play in the setting of a play session with a psychoanalytic therapist. The aim was that this method of study could be expanded to address other areas of interest.

Methods
20 children, age 4-6, were engaged in three 45-minute play sessions with child psychoanalysts, which were videotaped and transcribed. Tapes and transcriptions were reviewed from multiple viewpoints, including themes and their variations, the modes of representation etc., and one case was examined in more detail from a psycholinguistic and psychoanalytic perspective.

Findings
Analysis of the sessions of a 5-year old boy, 'Sam', revealed the successful orchestration of multiple forces within a play interview, and illustrated the way that the analyst followed emerging themes and feelings. The study illustrated the rich psycholinguistic capacities of 4- to 6-year old children in the oedipal phase, and the way in which play expressed a number of themes determined by the urgency of what was utmost in the child's mind.

Key reference
Cohen, D. J., Marans, S., Dahl, K., Marans, W., & Lewis, M. (1987). Analytic discussions with oedipal children. *Psychoanalytic Study of the Child, 42*, 59-84.

2)

Title
The Hampstead Psychoanalytic Index

Background/aims
The Hampstead Index (Sandler, 1987) was a long-running research project based at the Hampstead Child Therapy Clinic in London (now the Anna Freud Centre), to develop a systematic 'index' of psychoanalytic case material which could be used to develop understanding of psychoanalytic concepts and clinical practice. The aim of this particular study, beyond the systematic presentation of a single case of psychoanalytic treatment, was to demonstrate how the Hampstead Psychoanalytic Index could be applied to clinical case material, and the potential value of this procedure for research in psychoanalysis.

Methods
'Andy', a two-year old child, was one of fifty children in psychoanalytic treatment whose case material was classified in an 'Index working party'. This involved a construction of a set of common categories and an indexing procedure aimed at retaining the flexibility of a therapist's reports, but which at the same time would provide a comprehensive system of classification. Based on systematic recording of process material, data was classified - using the Index Manuals for guidance - under the following headings: 'General Case Material' (including background and biographical data) and 'Psychoanalytic Material' (including Object Relationships, Instinctual material, Fantasies, Ego - including anxiety and defences, Superego, Symptoms and Treatment Situation and Technique).

Findings
As well as presenting a systematic account of a complete psychoanalytic treatment, a number of aspects of the psychoanalytic process are highlighted, e.g. the child's typical means of communication, reactions to interpretation and interruptions etc. Elsewhere, the Hampstead Index has been used to study specific aspects of the therapeutic setting across a range of cases, e.g. to look at ways of understanding and working with assaultive behaviour in child psychoanalysis (Daldin, 1992).

Key reference
Bolland, J., & Sandler, J. (1962) *The Hampstead Psychoanalytic Index. A study of the psychoanalytic case material of a two-year-old child.* New York: International Universities Press.

Other references
Daldin, H. (1992). Assaultive behavior in the analysis of children. *Psychoanalytic Psychology*, 9 (4), 477-488.

3)

Title
Analytic themes in the psychoanalysis of a child with poorly-controlled diabetes

Background/aims
As part of a larger study into the effectiveness of psychoanalysis for children with poorly controlled diabetes (Moran et al., 1991), this study aimed to develop a reliable rating of analytic themes in the five-times weekly treatment of a diabetic teenager with recurrent diabetic imbalance, and to explore the relationship between psychoanalytic themes and an independent index of the quality of diabetic balance.

Methods
The content of the psychoanalysis, based on a clinical paper written by the treating analyst, was examined in order to extract the major analytic themes. Ten analytic themes were identified and operational definitions created, and these themes were then rated in the 148 weekly reports by three independent raters. Those themes that were found to be reliably coded were then explored in relation to an independent measure of diabetic control, i.e. twice-weekly urine testing, and a time-series analysis was carried out to investigate associations between psychoanalytic themes and the quality of diabetic balance.

Findings
Seven out of the ten analytic themes could be reliably coded by independent raters. Two themes of psychic conflict were found to predict short-term changes in diabetic control. In the long term the verbalization of conflict was strongly associated with improved diabetic control.

Key reference
Moran, G., & Fonagy, P. (1987). Psychoanalysis and diabetic control: a single-case study. *British Journal of Medical Psychology, 60*, 357-372.

4)

Title
The process of child psychotherapy with looked after children

Background/aims
Based on the treatment of three fostered children in psychodynamic psychotherapy, treated by a single child psychotherapist (the researcher), this study aimed to explore the impact of the borderline-type dynamics of certain children in foster-care on 'the subjective environment' of social workers and carers, and illustrate developments in the psychodynamic psychotherapy of these children using a number of innovative methods.

Methods
A qualitative analysis of process notes and interviews with carers and social workers was undertaken, and a representative sample of session notes were then rated using quantitative measures (Personal Relatedness Profile, Hobson, Patrick & Valentine, 1998) to assess borderline and depressive features in the children. Following from this, a systematic mapping of the process of therapy sessions was carried out on these same sessions, focusing on transference, counter-transference and outcome episodes.

Findings
The initial qualitative analysis suggested that an injunction against loving the fostered children was one of the consequences of the borderline-dynamics at play in these children's 'subjective environments', alongside defences of splitting, denial and projective identification. The subsequent study of these children's psychotherapy process notes suggested a freeing of depressive capacities as a result of the therapy, especially related to increased work in the transference in the 2nd year of treatment. The systematic mapping of the process of therapy allowed a more nuanced understanding of the transference-countertransference dynamics.

Key reference
Philps, J. (2003) *Applications of child psychotherapy to work with children in temporary foster care.* Unpublished Psych.D. thesis, University of East London.

Other reference
Philps, J. (in press). Mapping process in child psychotherapy - steps towards drafting a new method for psychoanalytic psychotherapy research. In N. Midgley, J. Anderson, E.Grainger, T. Nesic-Vuckovic & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings.* London: Routledge.

5)

Title
Comparison of child- and therapist-report measures of the psychotherapy process

Background/aims
While a number of measures have now been developed to assess the therapeutic process in child psychotherapy based on objective ratings of video-taped recordings of sessions, there have not been many attempts to find systematic ways to measure the child's (and the therapist's) own perspectives on the therapeutic process. This study aimed to develop such measures and to explore correlations between the child and the therapist's perception of the therapeutic process.

Methods
Two self-report instruments developed in the study of adult psychotherapy were adapted for use in child psychotherapy. For the therapist report (TR), the measure assesses four domains (each with a number of sub-scales): the therapist's affect in the session; the therapist's perception of his or her interpersonal behaviour; the therapist's perception of the child's affect; and the therapist's goals. For the child report (CR), administered immediately after the session by an independent examiner, the same four domains are assessed, but from the child's perspective. The therapeutic process of twenty long-term individual psychotherapy treatments, involving children with a mean age of 8.9 years, were assessed over a three-month period, with therapists and children completing the TR and CR respectively after six specified sessions. The internal consistency of each subscale and the item-whole correlations for each subscale were calculated, and correlations were also explored between the CR and the TR and their subscales.

Findings
Both the CR and the TR yielded internally consistent subscales that appeared to measure dimensions of child and therapist affect and behaviour, but there were no significant correlations between any of the therapist's and the child's subscales when rating the same sessions, suggesting there may be significant differences in the way child and therapist view the therapeutic process.

Key reference
Smith-Acuna, S., Durlak, J., & Kaspar, C. (1991). Development of child psychotherapy process measures. *Journal of Clinical Child Psychology, 20*, 126-131.

6)

Title
The therapist's focus on defence mechanisms

Background/aims
This study aimed to assess the relationship between the therapist confronting clients with their defence mechanisms and therapeutic outcome with 'juvenile delinquents', aged between 14 and 18, based in residential institutions and seen in a psychodynamically-informed, time-limited group psychotherapy.

Methods
All sessions from eight psychotherapy groups, each with ten children, were tape recorded and two samples were taken from each session and rated by two experienced clinicians for the degree of therapist confrontation on defence mechanisms using a 5-point Likert scale. Therapy groups were divided between high and low-levels of therapist focus on defence mechanisms, and analyses of co-variance with a range of outcome measures were calculated.

Findings
In virtually all measures of outcome, those patients who were confronted with analysis of their defence mechanisms showed the greatest therapeutic gain, reaching a level of statistical significance for 13 out of the 20 outcome measures.

Key reference
Traux, C., & Wittmer, J. (1973). The degree of therapist's focus on defence mechanisms and the effect of therapeutic outcome with institutionalized juvenile delinquents. *Journal of Community Psychology, 1*, 201-203.

7)

Title
Therapist discourse in high- and low-quality child therapy sessions

Background/aims
To assess whether measures of different types of therapist discourse could be found in child psychotherapy sessions of high- or low-quality.

Methods
From a sample of 35 child psychotherapy sessions with five different children in individual psychotherapy, all aged between 7 and 9, three of the highest and three of the lowest quality sessions, as identified by the *Loyola Child Psychotherapy Process Scales* (Estrada & Russell, 1999), were selected. Within these selected sessions, all therapist utterances (n=907) were rated using an adapted version of the *Stuttgart Interactional Category System* (SICS), which rates different modes of interaction. The first stage of analysis involved an exploratory principal-components analysis, to assess the underlying interactional factors within the therapists' discourse. The second stage of analysis involved a confirmatory factor analysis, to develop a general measurement model for the structure of therapist participation in high-quality sessions. The final stage of analysis involved assessing the invariance of factor structures across high- and low-quality sessions, using further confirmatory factor analyses.

Findings
Independent raters were able to reliably differentiate high- and low-quality sessions using the CPPS (from .72 to .75). A p-technique analysis of these sessions, rated using an adapted version of the SICS, revealed three factors that seemed to correspond across session types: Responsive Informing, Initiatory Questioning and Positive Regard. The confirmatory p-technique determined that the first two of these factors achieved an acceptable goodness-of-fit for high-quality sessions, but that the third factor (Positive Regard) did not. Statistical tests and effect-size measures revealed replicable and large differences between high- and low-quality sessions for these two factors of therapeutic interaction, with Responsive Informing being most responsible for this difference. The research indicates the important role of structuring that child psychotherapists bring to their work with highly disturbed children, although studies of more explicitly 'psychoanalytic' approaches may suggest different patterns and forms of therapist discourse.

Key reference
Russell, R, Bryant, F., & Estrada, A. (1996). Confirmatory p-technique analyses of therapist discourse: high- versus low-quality child therapy sessions. *Journal of Consulting and Clinical Psychology, 64* (6), 1366-1376.

8)

Title
Affective scaffolding in child psychotherapy

Background/aims
This study reports on the development of a tool for studying one particular aspect of the therapeutic process using the model of 'affective scaffolding'. This model focuses on the relationship between a therapist's interventions and the child's progress in expressing emotions.

Methods
An affective scaffolding framework was applied to the clinical material derived from transcribed therapy sessions of a 5-year-old child referred for psychodynamic play therapy who had suffered severe trauma and multiple losses. Using systematic observational methods, sequences of verbal interactions about emotions were collected and coded, and the contingency between the child's responses and the therapist's interventions across these sequences was analysed. In order to test predictions about affective scaffolding, three 'contingency rules' consistent with the goal of dynamic therapy were operationalised, and a number of hypotheses were tested.

Findings
The results of the study found significant associations between the child's shift in level of emotional response and the amount of scaffolding provided by the therapist, as well as between the therapist's use of the contingency approach and the child's shift in his next level of emotional expression. The results suggested a potential analogy between the therapist-child relationship and the adult-child relationship, especially as a means of promoting the development of emotional regulation. The study shows how a construct widely used within developmental research, i.e. affective scaffolding, could be usefully applied to a clinical setting, with potential theoretical implications for the study of emotional development and therapeutic change.

Key reference
Kassett, J., Bonanno, G., & Notarius, C. (2004). Affective scaffolding: a process measure for psychotherapy with children. *Journal of Infant, Child and Adolescent Psychotherapy, 3* (1), 92-119.

9)

Title
Turning points in child psychotherapy

Background/aims
To increase knowledge about processes of change through an analysis of psychotherapists'-experiences of 'turning points' in child psychotherapy.

Methods
Four consecutive studies were undertaken at the Erica Foundation, Sweden, each focusing on change processes and turning points in child psychotherapy. The first (pilot) study was a qualitative analysis of 'turning point sessions' in five child psychotherapy treatments, via the analysis of process notes, questionnaires and taped interviews with the therapists. A second, more extensive study looked at time-limited changes in 102 therapies via a therapist-completed questionnaire. Two intensive studies followed from this. One was an in-depth analysis of 'negative' and 'positive' turning points in six therapies (using process notes, questionnaires and taped interviews with therapists); the other was a study of 'processes of change' in three therapists (using similar data, plus interviews with the parent counsellor, parents and other significant persons in the child's life).

Findings
Different kinds of turning points can be described. A few were turning points in the sense of sudden, unexpected change that persists. Some were better categorised as 'the process goes on'. It was often possible to reconstruct a process leading up to the change. In the beginning of therapy turning points were connected with the therapeutic alliance, later with conflict and working through. From the analysis of factors seen as underlying change processes, a description of conditions beneficial to change was given. Change was often identified when the therapeutic frame was broken, and something unpredictable or unusual happened. The meeting between two subjects, and the creation of a 'new intersubjectivity', was seen as the nucleus of change.

Key reference
Carlberg, G. (1999). *Turning points in child psychotherapy: Psychotherapists' experiences of change processes.* Stockholm: Pedagogiska institutionen Stockholms universitet. (In Swedish with a summary in English)

Other references
Carlberg, G. (1997). Laughter opens the door: turning points in child psychotherapy. *Journal of Child Psychotherapy, 23* (3), 331-349.

Carlberg, G. (in press). Turning points in child psychotherapy: Exploring psychotherapists' experiences of change processes. In N. Midgley, J. Anderson, E. Grainger, T. Nesic-Vuckovic., & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings.* London: Routledge.

10)

Title
Memories of significant episodes in child psychotherapy

Aims/background
The way in which child psychotherapists recall significant episodes in treatment is a relatively neglected field in therapy process research, yet it relates in significant ways to concepts such as the counter-transference, which are clinically of such importance in psychoanalytic child psychotherapy. A focus on significant episodes also relates to other research on 'turning points' in child psychotherapy (Carlberg, 1997). The focus of this study was on how emotionally balanced therapy episodes are remembered and evaluated by child psychotherapists.

Methods
Drawing on an autobiographical memory approach, 31 child psychotherapists were given four cue words (irritated, ashamed, loving and elated) to elicit specific therapy episodes, and a set of specific questions was then asked about each memory. Two comparison groups (teachers for the disabled and music therapists) were also included, in order to explore whether child psychotherapists differ in their evaluations and degree of specificity of memories of therapy episodes.

Findings
Results showed that all participants were able to retrieve memories of episodes, with negative memories returned to less frequently and positive memories being easier to recall and more vivid. Memories derived from positive cue words were also judged to have had more importance for the outcome of treatment, although memories derived from the cue word 'irritated' were also found to be seen as having a more positive importance for outcome. No clear patterns of differences were found between the different groups.

Key reference
Andersson, G., Boethius, S., Svirsky, L., & Carlberg, G. (2006). Memories of significant episodes in psychotherapy: an autobiographical memory approach. *Psychology and Psychotherapy: Theory, Research and Practice, 79* (2), 229-236.

11)

Title
Moment-to-moment change in psychoanalytic treatment

Background/aims
The aim of this study was to explore the moment-to-moment 'micro-process' by which a seven-year old child in psychoanalytic treatment was able to modify her way of dealing with loss in the analytic relationship. The wider aim was to demonstrate the way that 'transitional episodes', when repeated across the course of a treatment, may play an important role in the process of therapeutic change.

Methods
The moment-to-moment process between two points, A and B, in a single session of a psychoanalytic treatment with a seven year old child was examined to understand how this child moved 'from fear to freedom' in relation to the topic of loss. The material was studied and described in two forms: written transcript of a video-recording (for the verbal material) and narrative description (for the non-verbal material). A detailed review of this data was then made by the analyst/researcher, in her role as participant-observer, following two major steps: firstly, the identification of the major points of change in the session; secondly, an evaluation of the local level interactions between the major change points.

Findings
The detailed study of the one twelve-minute section of a therapy session illustrated how this child moved from being too fearful to confront her feelings about loss to being free to express such feelings, both verbally and non-verbally. A detailed analysis of the process of change from 'fear to freedom' in this brief interaction (itself broken down into nine sub-sections) suggested that patterns of interaction at the local level, involving mutual regulation of affect and intention and symbol formation, constituted the basis for the emergence of higher-level processes of humour and imaginative play. It is suggested that such experiences of 'interactive play', when perceived as small transitional episodes that are repeated many times across the course of a treatment, create a constantly evolving set of 'implicit relational knowings' that may be the basis for therapeutic change, and can be understood as the 'something more' than interpretation that the Boston Change Study Group (2002) have examined in their studies of non-interpretative mechanisms in psychoanalytic therapy..

Key reference
Harrison, A. (2003). Change in psychoanalysis: Getting from A to B. *Journal of the American Psychoanalytic Association, 51* (1), 221-256.

12)

Title
The process of psychotherapy with young people suffering from depression

Background/aims
As part of a larger study into the outcome of time-limited psychodynamic psychotherapy with children suffering from depression (Trowell, Rhode, Miles, & Sherwood, 2003), the researchers attempted to trace connections between quantitative outcome measures and the process of the young people's therapy.

Methods
Preliminary discussions with therapists aimed to elucidate the significant aspects of treatment. Therapists' process recordings from two treatments (every fourth session) were then read in order to generate categories, using a grounded theory approach, related to the patients' material and the types of interventions by therapists. A preliminary comparison was also made between some transcripts based on audio-tapes of the sessions and the therapists' process recordings.

Findings
Preliminary discussions with therapists, each describing their own case, found little overlap between their understandings of significant aspects of the treatment. In respect of using a tape recorder, most therapists expressed concern at the beginning, but found that their own and the child's experience of the tape varied across sessions and across treatments, often appearing to represent a 'third party'. Comparison of process recordings and transcripts of audio-recordings found no major discrepancies, although process notes showed inevitable evidence of editing or compression in respect of non-interpretative interventions, such as clarifications or questions. A list of coding categories emerged both for the children's material and the therapists' interventions, and frequency counts of themes in two children's treatment suggested certain shifts in the material (e.g. in the manifestations of aggression), and a possible link was found between existential anxieties and problems in managing aggression. The most common interventions in these treatments were variations on 'mirroring', especially of the child's feelings, as well as transference interventions. Even transference interpretations tended to involve clarification of feelings towards the therapist, rather than linking the child's relations to the therapist with attitudes towards other figures in their life.

Key reference
Trowell, J., Rhode, M., Miles, G., & Sherwood, I. (2003). Childhood depression: work in progress. *Journal of Child Psychotherapy, 29* (2), 147-170.

13)

Title
Predicting child psychotherapy outcome using process factors

Background/aims

Predictors of child psychotherapy outcome are not well established, and those that have been established (e.g. the age of the child, certain types of disturbance) are based on factors which are extrinsic to the treatment process itself. This study aimed to explore aspects of the therapy process itself which might contribute to the outcome of treatment.

Methods
Thirty-one children and adolescents at five outpatient centres in the US, with an average age of 11, were seen in psychoanalytic or psychodynamic therapy. Clients were rated independently for global change in impairment and improvement in the primary problems that clients had presented at the outset of therapy, and therapists completed the modified version of the Psychotherapy Process Inventory (PPI; Baer et al., 1980). Two of the subscales of the PPI ('therapist directive support' and 'client participation') were explored to see if there were any correlations with therapeutic outcome.

Findings
The study found that client participation in therapy was the strongest predictor of global change in therapy, but no other process factors were significantly correlated with outcome. The study had a number of methodological limitations, however, so the findings could not easily be generalised.

Key reference
Gorin, S. (1993). The prediction of child psychotherapy outcome: factors specific to treatment. *Psychotherapy, 30* (1), 152-158.

14)

Title
Recollections of being in child psychoanalysis

Background/aims
The aim of this study, which was part of a larger follow-up study of child psychoanalysis based on interviews with 27 adults who had been in psychoanalytic treatment at the Anna Freud Centre as children between 1952 and 1980 (Schachter & Target, in press), was to explore the participants' attitudes towards being in child analysis, including their memories of what actually took place, and their feelings about the figure of the analyst.

Methods
As part of a larger study on the long-term follow-up of child analysis, semi-structured interviews exploring 'memories of therapy' were carried out with each of the participants. These interviews were transcribed and analysed using a qualitative method based on Interpretative Phenomenological Analysis (IPA; Smith, Jarman and Osborn, 1999).

Findings
Analysis led to the identification of two main themes: 'Attitudes towards being in therapy', and 'Memories of therapy and the therapist'. The results suggest that many former patients had little conscious understanding of why they had been in treatment as children; although it was predominantly in the group of former adolescent patients that this was felt to be a problem. For those who felt the child analysis had been a positive experience (who tended to have been younger when in treatment), the emphasis was on being attended to by a sympathetic, non-judgmental listener; for those who were more negative about their experience, a sense of the analyst as distant and unresponsive was primary. Overall, the study indicates that former child analytic patients do have memories of certain aspects of their treatment (sometimes very clear ones) and are able to give accounts of their analyses (sometimes very eloquently), which in certain significant ways are different from those accounts normally provided by child psychoanalysts themselves.

Key reference
Midgley, N., & Target, M. (2005). Recollections of being in child psychoanalysis: a qualitative study of a long-term follow-up study. *Psychoanalytic Study of the Child, 60*, 157-177.

Other references
Midgley, N., Target, M., & Smith, J.A. (2006). The outcome of child psychoanalysis from the patient's point of view: a qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Practice, Research, 79*, 257-269.

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Title
Premature termination in child psychoanalysis

Background/aims
Dropping out of psychotherapy among children and adolescents is a significant problem affecting 40-60 percent of the cases receiving outpatient care in general child and adolescent mental health services (Kazdin, 1996), although the range of definitions of 'drop out' and 'premature termination' make comparisons between different studies difficult. Many factors have been investigated as possibly contributing to premature termination, but most of the findings were found to be inconsistent and contradictory throughout the literature.

Methods
This study involved an audit of the files of closed cases at the Anna Freud Centre, London, during the period 1999-2003, followed by an exploratory study of five cases that were terminated prematurely. The case notes of these five cases - especially the assessment and intake material - were explored qualitatively in order to explore possible predictive factors in cases that terminated without agreement from all parties involved (child, carers and therapist).

Findings
The audit confirmed that the rate of dropout from child analysis - when understood to be an ending which is not agreed by all parties, at whatever stage this may be in the treatment - is more than half of all cases. The audit also suggested that there are differences between cases that terminate prematurely or by mutual agreement in relation to gender and average length of therapy, but not in several other respects. The second part of this study, based on a thematic analysis of initial family interviews, discovered a set of themes characteristic of the assessment phase of work with families who were later to withdraw from treatment prematurely. These themes related to the parents' motivations for entering into therapy, their expectations about treatment in terms of its process and outcome, as well as their ability to think about feelings.

Key reference
Navradi, A., & Midgley, N. (2006, October). *An exploratory study of premature termination in child analysis.* Paper presented at the IXth World Congress of Psychosocial Rehabilitation, Athens.

Appendix B. Glossary of Measures

Title
The Anna Freud Centre Session Rating Scale for Children and Adolescents

Background/aims
This measure was designed to provide a rating scale to be used on process reports written by therapists, of specific relevance to child psychoanalysis. It aims to capture both the nature of the child's material and the analyst's interventions.

Description of measure
The Rating Scale is a Likert-style form designed to be filled in by the treating analyst or therapist in reference to a single session. For that reason, it could be seen as a systematic way of capturing aspects of what might usually be included in the therapist's process notes. The scale is extremely comprehensive, with six sections covering 'general characteristics' (which itself has ten sub-sections, each with up to 13 specific items), 'manifest content', 'preconscious themes', 'predominant unconscious dynamic themes', 'therapy style' and 'judgment of the quality of the session'.

Uses/validity
Perhaps because of the sheer size of the Rating Scale, it has not yet been widely used in research studies and its reliability and validity are yet to be established. However, it has been used in a number of preliminary studies, such as Evers (2003), where it was used to explore self and object representations, as manifested in the psychoanalytic treatment of two latency age girls with overanxious disorder, and Rudolphson (2003), where it was used to explore transference themes in the psychoanalytic treatment of two adolescents with depressed mothers. A version of the Scale, the Young Adults Weekly Rating Scale (YAWRS) has also been used as part of the Anna Freud Centre's Young Adults Research Project (Gerber, 2004).

Key references
Fonagy, P., Philips, B., Buchan, E., Target, M., & Weise, K. (1993). *The Anna Freud Centre session rating scale for children and adolescents.* Unpublished manuscript, London: Anna Freud Centre.

Other references
Evers, H. (2003). *Childhood anxiety and the concept of the background of safety. Two retrospective case studies on self and object representations.* Unpublished MSc thesis, Anna Freud Centre / University College London.

Rudolphson, E. (2003). *The internal world and the transference of children with depressed mothers.* Unpublished MSc thesis, Anna Freud Centre / University College London.

Title
The Child Psychoanalytic Play Interview (CPPI)

Background/aims
The CPPI is designed to be a technique for studying the thematic content of children's play (guided by psychoanalytic formulations) in a psychodynamic play session.

Description of measure
Based on a review by experienced psychoanalytic clinicians of video-taped sessions of ten children, aged between 4-6, playing in an unstructured play session, thirty thematic categories of play were identified (e.g. rejection, imitation of adult roles, messing and breaking etc.) and descriptive definitions of these categories were written. These were then coded using a time-based coding approach (one minute) to rate each occurrence of a theme.

Uses/validity
In the initial study, several themes were mentioned by all children (e.g. power), while others were less frequent (e.g. bodily damage). Inter-rater reliability varied considerably depending on the theme, but after a revision of the definitions of the low-score themes, the overall inter-rater reliability improved, although some themes still had poor inter-rater reliability. Despite the small sample size and certain difficulties in establishing inter-rater reliability for certain themes, the CPPI offers a technique for studying the thematic content of children's play which appears to cover most themes generated by children in this age group (4-6) and can achieve a moderate level of agreement between clinically-trained raters.

Key reference
Marans, S., Mayes, L., Cicchetti, D., Dahl, K., Marans, W., & Cohen, D. (1991). The child psychoanalytic play interview. *Journal of the American Psychoanalytic Association, 39*, 1015-1036.

Other reference
Cohen, D.J., Marans, S., Dahl, K., Marans, W., & Lewis, M. (1987). Analytic discussions with oedipal children. *Psychoanalytic Study of the Child, 42*, 59-84.

Title
The Child Psychotherapy Process Scales (CPPS)

Background/aims
The CPPS is a modification of a well-known adult psychotherapy process scale, the *Vanderbilt Psychotherapy Process Scales* (Suh, Strupp & O'Malley,1986), with additional items generated by experienced clinicians. It aims to describe and evaluate the process of child psychotherapy, from a pan-theoretical perspective, in a reliable and valid way.

Description of measure
The CPPS is a 33-item (15 child and 18 therapist) measure using a five-point Likert-type format, designed to be used by objective observers on the basis of videotape or transcripts of child psychotherapy sessions. Items include both positive and negative aspects of child and therapist behaviours and attitudes, selected for their likely impact in facilitating or impeding progress in child psychotherapy, as displayed within whole sessions or segments thereof.

Uses/validity
In an initial study, reliability of the measure was assessed and component analyses were carried out to assess the main child and therapist factors relevant to the therapy process. Principal component analysis revealed three child factors (therapeutic relationship, child therapeutic work and child readiness) and three therapist factors (therapist technical work, therapeutic relationship and technical lapse). The scales are based largely on behavioural/observable expressions of child feelings rather than more intrapsychic experiences and were validated on a relatively small sample of children with a narrow band of disorders, all treated by trainees. Nevertheless, results suggested that the instrument is reliable and can discriminate child therapy processes from sessions differing in judged quality. A number of interesting correlations were discovered between different factors on the scale, e.g. between 'child therapeutic work' and 'therapist technical work', suggesting that the collaboration between the child and therapist on the central tasks of therapy is essential for effective child treatment.

Key reference
Estrada, A., & Russell, R. (1999). The development of the child psychotherapy process scales (CPPS). *Psychotherapy Research, 9* (2), 154-166.

Other reference
Russell, R, Bryant, F., & Estrada, A. (1996). Confirmatory p-technique analyses of therapist discourse: high- versus low-quality child therapy sessions. *Journal of Consulting and Clinical Psychology, 64* (6), 1366-1376.

Title
The Child Psychotherapy Q-Sort (CPQ)

Background/aims
The Child Psychotherapy Q-Sort (CPQ) is an adaptation of the Psychotherapy Q-Sort (PQS) developed by Enrico Jones (2000). The PQS is recognized for its effectiveness in capturing the complexity of psychotherapy process for adults. This new measure provides a language and rating procedure for describing therapist-child interaction in clinically relevant terms in a form suitable for quantitative comparison and analysis.

Methods
The CPQ consists of 100 cards, each with a statement describing a significant feature of child therapy process. Items were culled from an extensive review of child psychotherapy literature, and adaptations of the PQS. Items are pan-theoretical and cover three categories: (a) items describing child's attitudes, behaviour, or experience; (b) items reflecting the therapist's actions and attitudes; and (c) items capturing the nature of the interaction of the dyad, the climate, or atmosphere of the encounter. To allow for greater reliability, a coding manual provides explicit rules governing the level of inference regarding the content domain represented by each item.

Findings
The present version of the CPQ represents the culmination of results from three studies: (a) item and manual development; (b) item coverage and content domain; and (c) item validity across child patients. Each of these studies mutually informed the other, and this upwardly spiralling process resulted in the 100 discrete items. As part of this upwardly spiralling process of item construction and reconstruction, insights from the body of relevant research and wisdom shared by experienced child clinicians served to imbue each item with thought and inquiry both historical and current.

Key reference
Schneider, C. (2004a). *The development of the child psychotherapy Q-set.* Unpublished dissertation, University of California, Berkeley. Dissertation-Abstracts-International:-Section-B:-The-Sciences-and-Engineering, 65 (2-B): 1039.

Other references
Schneider, C. (2004b). *The development and first trial application of the child psychotherapy Q-set.* Published online by the International Psychoanalytical Association: http://www.ipa.org.uk/research/htm/schneider.pdf

Schneider, C., Pruetzel-Thomas, A., & Midgley, N. (in press). Concept and intuition in child psychotherapy research. In N. Midgley, J. Anderson, E.Grainger, T. Nesic-Vuckovic & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings.* London: Routledge.

Title
The Children's Play Therapy Instrument (CPTI)

Background/aims
Play has been widely recognised as a central feature of psychodynamic child psychotherapy and has been considered by many as central to an understanding of the therapeutic action of child psychotherapy. The CPTI aims to be a reliable measure of patterns of play activity within a clinical setting.

Description of measure
The CPTI rates children's behaviour in a therapeutic setting at three different levels. The first level involves a segmentation of the child's activity (non-play, pre-play, play and interruption). The second level involves a dimensional analysis of the play activity itself, firstly at a descriptive level (e.g. category of play activity), then at a structural level (including affective, cognitive, dynamic and developmental components), and finally at an adaptive level (e.g. neurotic, borderline etc.). The third level of analysis involves studying the pattern of a child's activity over time, including the continuity and discontinuity of play narratives.

Uses/validity
Inter-rater consensus (rather than reliability) has been achieved using the CPTI, and the measure has been used to illustrate changes in the patterns of play activity over time in the course of psychodynamic treatment (Chazan & Wolf, 2002). The use of the CPTI in clinical supervision was also found to provide common ground in case discussion and facilitated the supervisory process, and the measure has been adapted for use in other settings, such as the classroom.

Key reference
Kernberg, P., Chazan, S., & Normandin, L. (1997). *The children's play therapy instrument: Manual and scale*. Unpublished manuscript.

Other references
Chazan, S. (1998). The children's play therapy instrument (CPTI): description, development and reliability studies. Journal of Psychotherapy Practice and Research, 7, 196-207.

Chazan, S. (2002). *Profiles of play: Assessing structure and process in play therapy*. London: Jessica Kingsley.

Chazan, S., & Wolf, J. (2002). Using the children's play therapy instrument to measure change in psychotherapy: the conflicted player. *Journal of Infant, Child and Adolescent Psychotherapy, 2* (3), 73-102.

Title
The Child Therapeutic Alliance Scale (CTAS)

Background/aims
The CTAS was developed because the patient's contribution to the therapeutic alliance early in the therapy has, according to Foreman et al. (2000), been one of the few factors in psychotherapy research that has been shown to be predictive of outcome, giving the concept increasing importance in psychotherapy research. However reliable measures in the field of child psychotherapy research have yet to be widely developed.

Description of measure
The CTAS contains eight items, each a 7-point scale measuring the different elements of the patient's contribution to the therapeutic alliance, to be rated by an independent observer of actual psychotherapy sessions, by means of video-recording. Based on the California Psychotherapy Alliance Scales (Gaston & Marmar, 1994), the CTAS was developed to reflect the unique qualities of psychodynamic play therapy with children.

Uses/validity
Items on the CTAS are reportedly easy to learn and rate and acceptable inter-rater reliability could be attained fairly quickly, making this a practicable measure to use. Items were internally consistent, and the scale has been used in an interesting way by Foreman, Gibbins, Grienenberger, & Berry (2000), in a study which aimed to assess whether associations could be found between ratings of the 'plan compatibility' of therapist interventions, based on an independently generated case formulation, and measures of patient progress and therapeutic alliance. The first step involved the development of a case formulation, known as a 'plan formulation', consisting of a series of statements about the patient's therapeutic goals and methods of working in therapy. Using video-tapes of the sessions, independent judges then rated therapist interventions as to whether they were supportive of the patient's plan. Independent measures of patient process and patient outcome were made, using the Progressiveness Scale for Children (PSC) and the Child Therapeutic Alliance Scale (CTAS), and correlations between 'plan compatible' and 'plan incompatible' interventions were calculated. A significant association was found between the plan-compatibility of therapist interventions and changes in patient behaviour following the interventions on some items of the Child Therapeutic Alliance Scale and, to a more modest degree, on the Progressiveness Scale for Children.

Key reference
Foreman, S., Gibbins, J., Grienenberger, J., & Berry, J. (2000). Developing methods to study child psychotherapy using new scales of therapeutic alliance and progressiveness. *Psychotherapy Research, 10* (4), 450-461.

Title
The Comprehensive Assessment of Defence Style (CADS)

Background/Aims
The empirical assessment of defence mechanisms has been an important challenge for psychodynamic researchers, although most attempts to develop reliable measures of defensive mechanisms have focused on adults. The aim of the CADS was to develop a reliable method of assessing defence mechanisms in children and adolescents that would be based on questionnaires rather than projective tests, which can be time consuming and require a greater level of specialist training both for administration and coding.

Description of measure
The CADS questionnaire covers 29 defence mechanisms widely discussed in the psychoanalytic and psychiatric literature, and operationalised each one using two or three behavioural derivatives observable in daily situations (e.g. 'blaming others for one's mistakes' as an example of projection). The 72 items are then rated by parents or carers from 0-3, for the extent to which each item characterises the usual behaviour of the child.

Uses/validity
In a comparison of clinical and non-clinical children, the CADS was able to reliably distinguish between the two groups, with the clinical population using more 'immature' defences and both adolescents and girls using more 'mature' defences that younger children and boys. Although the reliability and validity of the measure are encouraging, this measure has yet to be widely used in the research literature.

Key reference
Laor, N., Wolmer, L., & Cicchetti, D. (2001). The comprehensive assessment of defense style: Measuring defense mechanisms in children and adolescents. *Journal of Nervous and Mental Disease, 189* (6), 360-368.

Title
The Core Conflictual Relationship Theme (CCRT) - Child Version

Background/aims
The Core Conflictual Relationship Theme (CCRT) is one of the most widely used measures in the field of adult psychotherapy process research, partly due to the fact that it aims to assess the central psychoanalytic concept of 'transference' in a clearly operationalised way. The aim of this study was to develop a version of the measure that could be used with children.

Description of measure
Unlike the adult CCRT measure, which has been widely used as a way of measuring the client's 'transference template' in video-recordings of actual therapy sessions, the child version was developed using a videotaped interview with young children (aged 3-5) in a laboratory setting, using the 'Doll Family Story Method'. Children are invited to complete a number of narrative story stems and transcripts of the narratives are analysed using the CCRT scoring method, which focuses on three themes: 'wish' (W), 'relationship-other' (RO) and 'relationship-self' (RS).

Uses/validity
The level of inter-rater reliability for the scoring of the CCRT was 'generally satisfactory' and certain clusters of themes did appear to be pervasive across each child's narratives. An examination of frequency profiles suggested that each child did appear to have certain 'core themes', and that these clusters remained stable from age 3 to age 5. In particular, the 'wishes' appeared to remain more consistent over time than either the 'relationship - other' or 'relationship - self' themes. Although the child version of the CCRT has not been widely used, initial studies suggest that there is some indication that children may develop a pervasive pattern of relationship themes by the age of 3 and that this remains reasonably constant over time. The CCRT could possibly be used as an assessment of 'transference' patterns in child psychotherapy.

Key reference
Luborsky, L., Luborsky, E., Diguer, L., Schmidt, K., Dengler, D., Schaffler, P., Faude, J., Morris, M., Buchsbaum, H., & Emde, R. (1995). Extending the core relationship theme into early childhood. In G. Noam & K. Fischer (Eds.), *Development and vulnerability in close relationships* (pp. 287-308). New Jersey: Lawrence Erlbaum Associates.

Other reference
Luborsky, L., & Crits-Cristoph, P. (1998). *Understanding transference: the CCRT method. 2nd Edition.* Washington DC: American Psychological Association.

Title
Defence Mechanism Inventory (DMI) - Children's Version

Background/aims
Defence mechanisms are one of the most important ideas in classical psychoanalytic theory and the development and use of defence mechanisms in children, and the way these may change in psychoanalytic treatment, is of significant interest to child psychotherapy. This measure was therefore an attempt to adapt the widely-known Defence Mechanism Inventory for use with children.

Description of measure
The DMI (Child Version) makes use of the Thematic Apperception Test, a standard set of dramatic pictures presented to a child, with a request that a story be told about each picture. The stories are then coded using the specially developed Defence Mechanism Manual (Cramer, 1991) in order to assess the use of three types of defence: denial, projection and identification.

Uses/validity
The DMI - Child Version has been used with children of different ages and a reliable coding of the developmental differences in the use of the three defences was established, with denial more common among younger children and identification used more frequently in late adolescence (Cramer, 2002). The findings have been replicated in a later study (Porcerelli, Thomas, Hibbard, & Cogan, 1998), and further studies have demonstrated changes in defence mechanisms as a result of child psychoanalysis (Cramer, 2000); the greater use of defence mechanisms during stressful situations; a correlation between the use of defence mechanisms and lower psychological upset in children after a traumatic incident; and gender differences in the use of defence mechanisms (see Cramer, 2002).

Key reference
Cramer, P. (1991). *The development of defence mechanisms: Theory, research and assessment.* New York: Springer-Verlag.

Other references
Cramer, P. (2000). Changes in defence mechanisms during psychoanalysis and psychotherapy: a case study. In J. Cohen & B. Cohler (Eds.), *The psychoanalytic study of lives over time (pp.309-330).* San Diego: Academic Press.

Cramer, P. (2002). The study of defence mechanisms: Gender implications. In R. Bornstein & J. Masling (Eds.), *The psychodynamics of gender and gender role.* Washington: American Psychological Association.

Title
Mutuality of Autonomy (MOA) Object Relations Scale

Background/aims
There is a long history linking psychological test data with psychodynamic theory, and such tests have become increasingly common in the assessment of progress and outcome in psychoanalytic treatment. Assessment of the nature and quality of internal object relationships is of particular relevance to psychoanalysis, especially in the object-relations tradition. The MOA therefore aims to assess the quality of children's object relations and self-other representations.

Description of measure
The MOA (Tuber, 1992) is a 7-point scale used to rate a child's responses to the Rorschach, with the most adaptive scale point used to rate Rorschach responses that indicate simultaneous awareness of self and other in mutual interaction, and the lowest scale point depicting overwhelming toxic control and destruction of a calamitous nature imposed on a helpless victim.

Uses/validity
Inter-rater reliability of the MOA falls within the 70-90% range, which is very high. It has been used prior to psychodynamic psychotherapy, and key treatment paradigms were found to closely match MOA patterns (Tuber, 1992). The MOA has also been used in a very interesting single case study of one boy seen both in child analysis and at a seventeen year follow up (Tuber, 2000).

Key reference
Tuber, S. (1992). Empirical and clinical assessments of children's object relations and object representations. *Journal of Personality Assessment*, 58, 179-193.

Other reference
Tuber, S. (2000). Projective testing as a post-hoc predictor of change in psychoanalysis: The case of Jim. In J. Cohen & B. Cohler (Eds.), *The psychoanalytic study of lives over time* (pp. 283-308). San Diego: Academic Press.

Title
The Object Relations Inventory (ORI)

Background/Aims
Mental representation of self and other is considered to be a central construct in psychoanalysis for understanding development and functioning, as well as the process of therapeutic change. The nature of such representations can be seen to be related to particular types of psychopathology and particular stages of development. The ORI aims to assess the quality of such mental representations of self and other in a valid and reliable way.

Description of measure
The Object Relations Inventory (ORI; Blatt, Auerbach & Aryan, 1998) is an open-ended interview appropriate for use with adolescents. Participants are asked to describe a number of significant figures in their lives (e.g. mother, father, friend, self, therapist) and after each description, the interviewer asks for an elaboration of each adjective used in describing the figure. To rate the ORI, Diamond, Blatt, Stayner, & Kaslow (1991) developed a Differentiation-Relatedness Scale, which describes ten different levels of self-other representations. This scale assesses two dimensions of self and object representation: the differentiation of self and other; and the establishment of increasingly mature levels of inter-personal relatedness. Such progression can be thought about within psychoanalytic theory as marking a shift from more borderline to neurotic levels of personality organisation; or as representing a shift from the paranoid-schizoid to the depressive position.

Uses/validity
Reliability of the Differentiation-Relatedness Scale has been established and the measure has been used to assess therapeutic progress in the psychoanalytic treatment of seriously disturbed young adults (Blatt, Auerbach & Aryan, 1998) during long-term, intensive inpatient treatment. A single-case study, looking at representations of the therapist, also indicated the importance of working through to a more integrated view of the therapist if therapeutic change is to take place (Blatt et al., 1996).

Key reference
Blatt, S., Auerbach, J., & Aryan, M. (1998). Representational structures and the therapeutic process, in R. Bornstein & J. Masling (Eds.), *Empirical studies of the therapeutic hour (pp. 63-107)*. Washington: American Psychological Association.

Other references
Blatt, S., Stayner, D., Auerbach, J., & Behrends, R. (1996). Change in object and self representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry, 59*, 82-107.

Title
Personal Relatedness Profile (PRP)

Background/aims
There is a widespread scepticism concerning the reliability and validity of psychoanalytic judgments of patient-therapist transactions. The development of the PRP was designed to show how psychoanalytically relevant characteristics of subjects' interpersonal relations - especially paranoid-schizoid and depressive aspects of psychological functioning - could be reliably rated in a clinical setting.

Description of measure
The PRP is a 30-item measure scored using a 5-point Likert-style scale (from 'very uncharacteristic' to 'very characteristic'). The 30 items cover aspects of personal relatedness (e.g. the ability to show genuine, appropriate concern between participants), characteristics of people (e.g. being omnipotent and showing no need of others) and predominant affective states (e.g. feelings of claustrophobia and/or intrusion). An overall score is intended to show the predominance of paranoid-schizoid or depressive functioning.

Uses/validity
The PRP was developed in the context of adult psychoanalysis and, in a small-scale initial study, was found to have reasonable inter-rater reliability among trained clinician-raters, and discriminated clearly between patients with borderline or dysthymic features. The PRP has been used in a single study of child psychotherapy (Philps 2003, in press), where it was used to rate process notes of psychotherapy sessions, and it showed some ability to capture fluctuations in psychological functioning across the course of treatment.

Key reference
Hobson, P., Patrick, M., & Valentine, J. (1998). Objectivity in psychoanalytic judgements. *British Journal of Psychiatry, 173*, 172-177.

Other references
Philps, J. (2003) *Applications of child psychotherapy to work with children in temporary foster care.* Unpublished Psych.D. thesis, University of East London.

Philps, J. (in press). Mapping process in child psychotherapy - steps towards drafting a new method for psychoanalytic psychotherapy research. In N. Midgley, J. Anderson, E.Grainger, T. Nesic-Vuckovic & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings.* London: Routledge.

Title
Play Therapy Observation Instrument (PTOI)

Background/aims
The PTOI was developed in order to provide a reliable instrument to measure children's playroom behaviour, using dimensions of relevance to assessing areas of functioning, diagnosis, therapy process and outcome.

Description of measure
The Play Therapy Observation Instrument is a rating scale describing 31 child behaviours, designed to be coded using video-tapes and transcripts of play therapy sessions.

Uses/validity
Results of the initial study indicated that 13 of the behaviours were scored with a high level of inter-rater reliability. These reliable scores formed three statistically valid and theoretically meaningful subscales: emotional discomfort, use of fantasy play as a coping method; and the quality of the child's interaction with the therapist. Children's scale scores were sufficiently stable within sessions and across two therapy sessions to indicate that they reflected individual differences.

Key reference
Howe, P., & Silvern, L. (1981). Behavioural observation of children during play therapy: preliminary development of a research instrument. *Journal of Personality Development, 45*(2), 168-182.

Title
Social Cognition and Object Relations Scale (SCORS)

Background/Aims
Given the centrality of the concepts of 'internal objects', object relations and object representations to contemporary psychoanalysis, the SCORS has been developed to find a valid way to operationalise these concepts and to assess a child's object-relations capacity and functioning in a reliable and clinically-meaningful way.

Description of measure
The SCORS is a rating scale used to score the Thematic Apperception Test (TAT), and measures four main areas of psychological functioning: cognitive and affective representations of others; quality of affect valence defining relations; capacity for emotional investment in relationships; and capacity for understanding interpersonal motivation with respect to self and other. Each of these domains is scored along a 5-point developmental scale, from most primitive to most mature. In a recent revision of the SCORS, Western (1995) added four more dimensions and re-structured the rating system as a Q-Sort.

Uses/validity
The SCORS has been fairly widely used with both clinical and non-clinical groups and its reliability and validity has been quite firmly established. The measure has been used in the assessment of sexually and physically maltreated children (e.g. Freedenfeld, Ornduff, & Kelsey, 1995; Ornduff, 1997) and borderline adolescents (Westen et al., 1990), and, in a review by Kelly (2005), has been considered to 'offer the child clinician and researcher a tool and a paradigm that is both reliable and valid …. [and] offers the opportunity to look at the child or adolescent's object relations from a variety of cognitive and affective vantage points' (p.622)

Key reference
Westen, D., Lohr, N., Silk, K., Kerber, K., & Goodrich, S. (1985). *Social cognition and object relations scale* (SCORS): Manual for coding TAT data. Ann Arbor: University of Michigan.

Other reference
Kelly, F. (2005). The clinical application of the Social Cognition and Object Relations Scale (SCORS-R) with children and adolescents. In S. Smith & L. Handler (Eds.), *The clinical assessment of children and adolescents: A practitioner's handbook*. Mahwah: NJ, Lawrence Erlbaum Associates Inc.

Title
The Therapeutic Alliance Scales for Children (TASC)

Background/aims
The concept of 'therapeutic alliance' has been found to be of considerable significance in studies of adult psychoanalysis and psychotherapy, but to date there have been few reliable measures for use with children and adolescents, and different studies have conceptualised the 'therapeutic alliance' in different ways. The TASC aims to differentiate between a child's general participation in treatment and a child's affective orientation to the therapeutic relationship, and to develop a reliable scale to measure the latter construct.

Description of measure
Items for the TACS were initially solicited from experienced psychodynamic clinical psychologists and psychiatrists in order to develop two scales of the child's affective orientation to therapy, which were termed 'bond' and 'negativity'. From the initial item pool, eight items referring to either positive or negative orientation to therapy were selected and written in parallel form for the child and the therapist.

Uses/validity
As expected, initial results suggested a negative correlation between the bond and negativity dimensions from both child and therapist perspectives. There was also evidence of a moderated degree of convergence between child and therapist perspectives for the affective quality of the therapeutic relationship. Within each perspective (child and therapist), the scales of affective orientation were significantly related to subscales measuring verbalization and overall participation in therapy, but these results were not obtained across perspectives.

The TACS has been used to assess the quality of the therapeutic alliance for children between 7-12 in inpatient psychiatric treatment and was also used in the impressive Heidelberg Study investigating the outcome of short-term and long-term psychodynamic psychotherapy with children (Kronmüller, 2006).

Key reference
Shirk, S., & Saiz, C. (1992). Clinical, empirical and developmental perspectives on the therapeutic relationship in child psychotherapy, *Development and Psychopathology, 4*, 713-728.

Other references
Kronmüller, K. (2006, November). *Outcome of the Heidelberger Study - Research on working with children and adolescents in long-term psychoanalytic psychotherapy.* Paper presented at the EFPP Conference, Berlin.

Title
The Therapy Procedures Checklist (TPC)

Background/aims
Child therapy effectiveness research has, historically, suffered from poor specification and assessment of the treatment model and procedures under investigation. The Therapy Process Checklist (TPC) was developed to help address this limitation by providing a means of assessing child therapists' etiologic views and technique use in routine clinical practice along psychodynamic, cognitive-behavioural, and behavioural dimensions.

Description of measure
The TPC is a therapist-report measure of the techniques employed when working with child and adolescent clients. The final version of the TPC scales consists of 50 theoretically specific psychotherapeutic techniques: 20 from the psychodynamic, 13 from the cognitive and 17 from the behavioural domain.

Uses/validity
A survey of published child psychotherapy experts demonstrated that TPC items were theoretically specific, and factor analyses of TPC reports from a national sample of child therapists displayed a strong three-factor structure. TPC scales had excellent internal consistency and good test-retest reliability. Patterns of therapist response to the scales were distinct to theoretical orientation, suggesting that the measure may assess meaningful differences between therapists. The findings suggest the TPC may be a psychometrically sound measure and a useful assessment tool in child and adolescent psychotherapy research in the actual clinical setting.

Key reference
Weersing, V., & Weiss, J. (2002). Development of the Therapy Procedures Checklist: A therapist-report measure of technique use in child and adolescent treatment. *Journal of Clinical Child Psychology, 31* (2), 168-180.

Title
The Therapy Process Observational Coding System - Alliance (TPOCS-A)

Background/aims
The concept of 'therapeutic alliance' has been found to be of considerable significance in studies of adult psychoanalysis and psychotherapy, but to date there have been few reliable measures for use with children and adolescents, and different studies have conceptualised the 'therapeutic alliance' in different ways.

Description of measure
The TPOCS-A is a nine-item observational measure, designed to provide a comprehensive coding system capable of objectively describing both child-therapist and parent-therapist alliance. The measure focuses specifically on two alliance dimensions - 'bond' (i.e. the affective aspects of the relationship) and 'task' (i.e. participation in the activities of therapy).

Uses/validity
Both child and parent forms showed acceptable inter-rater reliability and internal consistency, although evidence for convergent validity was mixed. When applied to cases treated for internalising disorders in an outpatient community mental health setting, both forms were associated with outcome: child-therapist alliance during treatment predicted reduced anxiety symptoms at the end of treatment; parent-therapist alliance during treatment predicted reduced internalising, anxiety and depression symptoms at the end of treatment. The findings held up well after confounding variables were controlled, suggesting that both child-therapist and parent-therapist alliance play key (and potentially different) roles in the outcome of treatment as usual.

Key reference
McLeod, B., & Weisz, J. (2005). The Therapy Process Observational Coding System - Alliance scale: Measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology, 73* (2), 323-333.

Title
Young Adult Weekly Rating Scale (YAWRS)

Background/aims
As part of a larger research study looking at the outcome of the psychoanalytic treatments of 25 young adults seen for intensive psychoanalysis (n=14) or psychodynamic psychotherapy (n=11) at the Anna Freud Centre, the Young Adult Weekly Rating Scale (YAWRS) - a measure based on the *Anna Freud Centre Session Rating Scale for Children and Adolescents - was developed as a measure of psychoanalytic process.

Description of measure
The YAWRS is a checklist designed for use by the treating analyst, as a way of recording all themes emerging during a set period of treatment, including: (a) the behaviour of a patient in a session, (b) the manifest content of the patient's report, (c) the affect, transference themes, and defences that are contained in the patient's material, (d) unconscious themes, and (e) the analyst's style of intervention and counter-transferential experience of the patient and session.

Validity/uses
As yet, data on the reliability of this measure - which is clinically-meaningful, although time-consuming to use - have yet to be established. In the Young Adults Study, a factor-analysis of the 1,314 YAWRS questionnaires from the first year of each treatment was carried out in order to explore links between process and outcome. The results of the factor analysis of the YAWRS questionnaires showed that in the 1st year of psychoanalysis higher scores were found on therapist dynamic technique, patient dynamic material and negative patient transference, compared to the psychodynamic psychotherapy group. In the combined group, higher scores in the first year on therapist dynamic technique, patient dynamic material and discussion of contract were predictive of positive outcome. Despite the limitations of a small sample, and the fact that the study of the process of treatment was based entirely on the therapist's report of patient and therapist behaviour, this study has some very interesting findings.

Key reference
Gerber, A. (2004). *Structural and symptomatic change in psychoanalysis and psychodynamic psychotherapy: a quantitative study of process, outcome and attachment.* Unpublished PhD thesis, University College London.

Section Two: Child Psychotherapy Research in a Clinical Setting

The aim of this section is to look at the range of psychoanalytically informed research relevant to particular clinical groups as well as child psychotherapy practice in a clinical setting. It is not intended to exhaustively cover all available research in this field but rather to provide an overview and to focus particularly on insights research may provide for practicing clinicians.

Research on referrals to child psychotherapists working in a multi-disciplinary team

There have been two national audits on the work of child psychotherapists within the NHS which have provided information on the kind of children seen by child psychotherapists (Beedell & Payne, 1987; Rance, 2003). One audit looked at data on over 1,000 children (Rance, 2003) [1] providing important information regarding the demographic details of children seen, diagnostic classification and involvement of other professionals. A more recent audit, by Midgley and Petit (2006), has also explored the ethnicity of children seen by child psychotherapists in CAMHS, and concluded that that the children seen by child psychotherapists are fairly representative of overall CAMHS populations, although with some specific differences in respect of certain ethnic groups.

A study by Kam & Midgley (2006) explored how child and adolescent mental health professionals made decisions regarding whether a young person needed individual child psychotherapy. Using the method of Interpretative Phenomenological Analysis (Smith, Jarman, & Osborn, 1999) they looked in more depth at the reasons for referral from the perspectives of different members of one multidisciplinary team. Three themes emerged from the analysis, indicating that referral-making decisions depend on ideas regarding the modality of therapy, features of the child and family referred (but not reducible to diagnostic categories) and the stage at which therapeutic work with the family has reached at the time of referral. Deciding to refer a child for psychotherapy appeared to be largely based on 'experience and discussion' with other mental health professionals, the decision to refer often made on the basis of the emotional impact the child had on the clinician as much as any specific behaviours or diagnosis. The stage at which the therapeutic work had reached was also an important factor influencing referral with a clear view expressed that individual child psychotherapy should not be a 'first port of call' when a child is in need of therapeutic help. In the first stage family work was seen as the most appropriate form of therapy so that the child's difficulties were looked at in context.

Engaging families and evaluating outcome in a CAMHS setting

A 'contract' (now called the * '*Hopes and Expectations for Treatment Approach*' form) for undertaking psychotherapeutic work has also been developed and evaluated in a CAMHS clinic (Urwin, 2007, in press). The contract is filled out with the family following assessment

for psychotherapy. Parents are invited to describe past and present concerns and also hopes and expectations for treatment. Psychotherapists are also required to indicate their concerns as well as expectations for treatment. Practical details regarding dates and times of therapy and holidays are included in the form and the form has proved a useful means of monitoring change (Correia & Nathanson, 2005; Urwin, 2007, in press).

Research on Child Psychotherapy Training

Some interesting research is beginning to emerge regarding the training of child psychotherapists (Sternberg, 2005). A two year infant observation is part of the training of all child psychotherapists and it is thought that the experience develops particular therapeutic skills and capacities (Horne & Lanyado, 1999). Sternberg set out to examine whether students developed in the ways predicted form the extensive literature on infant observation. Four groups of students who were engaged in carrying out infant observation in several major training institutions were interviewed at the beginning of their observation experience and then again after one year. The transcripts of these interviews were analysed using grounded theory (Glaser & Straus, 1967).

In the follow up interviews there was evidence of various changes as predicted, notably a greater awareness of and sensitivity to the communication of feelings as well as a greater capacity to reflect and think about experience. Developing a sense of 'multiple perspectives' through identification with different family members was also a feature of the experience reported by the groups. In addition most groups spoke of how they had gained knowledge of child development and early non-verbal communication. Certain skills such as attending to and recording observations in great detail weren't generally referred to by the students, though were likely to be evidenced in their regular presentations to seminar groups. Sternberg concludes that while the capacities and skills claimed to be promoted by infant observation do not precisely match those identified as having developed from the pre and post observation interviews there is evidence for substantial changes which are likely to be, at least in part, attributable to the observation experience.

Research with children and young people in different clinical groups

Children who have experienced maltreatment and neglect

This is an area that child psychotherapists have particularly focused on. Some research projects have looked at the efficacy of child psychotherapy for children within the care system (Lush, Boston & Grainger, 1991; Boston & Lush, 1993) or for girls who have experienced sexual abuse (Trowell et al., 2002). In addition there is a substantial body of work looking at the impact of abuse on children's development, compared with children who have not had these experiences. This research has also tracked changes in children's development over time in response to the impact of adoptive placements (Hodges & Steele, 2000; Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003)

Interventions for children who have experienced abuse

The Tavistock study of children in the care system (Lush, Boston & Grainger, 1991; Boston & Lush, 1993) was originally intended as a pilot study to explore how children in this group would respond to individual psychotherapy as well as looking at the accuracy of therapists' predictions regarding outcome. The majority of children in the study [2] had improved by the end of treatment and some of the outcomes assessed were independently rated part by a blind rater. While the lack of randomization limits the conclusions that can be made regarding therapeutic efficacy, interesting information is nonetheless generated regarding the outcome of therapy and therapists' views on this.

The researchers devised two forms, one completed following the initial assessment, the other at the end of treatment. The forms focused on personality and emotional development as well as symptomatic improvement and changes in the child's external situation and relationships. Beneficial effects were found to broadly concur with the therapists' predictions of likely progress in therapy. Not surprisingly, there was a tendency for good progress to be related to more stable current placements and good external support for therapy. As part of this study a more in-depth single case experimental study, was undertaken with a boy age ten, who had been taken into care at the age of nine months, but who was presenting with significant difficulty at the time of referral. He had weekly psychotherapy for three years. A range of standardized measures from multiple perspectives were used showing improvement over the four year follow up period (Lush, Boston, Morgan & Kolvin, 1998).

Trowell et al.'s (2002) intervention study [3] compared the outcomes of treatment for girls (aged 6-14) who had been sexually abused. Focused individual psychodynamic psychotherapy for up to 30 sessions was compared with up to 18 sessions of psycho-educational group psychotherapy. In addition both groups had parent/carer work. The girls were randomised to one or other treatment and the treatments were manualised. The study showed the girls to be presenting with high rates of psychiatric disturbance and there was some amelioration in this for both groups following treatment. Post traumatic stress disorder was most common diagnosis (73%), followed by major depressive disorder (57%) and separation anxiety disorder (58%). Individual psychoanalytic psychotherapy appears to had a preferential impact on the PTSD scale dimensions of re-experience of traumatic event and persistent avoidance of stimuli (Orvaschel, 1989) compared to group treatment. Generalised anxiety disorder proved the most liable to remit while depressive disorder and separation anxiety disorder were less likely to remit, although two thirds of those with depressive disorder and half those with separation anxiety disorder no longer had this disorder one year on.

The numbers in this study were smaller than the study authors had initially planned, 35 received individual and 36 group therapy, and the level of abuse the girls experienced high (e.g. over 30% had been exposed to multiple perpetrators), this combined with the fact that two active treatments of a good standard were being compared (ethical approval was declined for a no treatment control group) makes it unsurprising that it was difficult to establish clearer differences in outcome between the two groups. Indeed the authors quote Kazdin as stating that alternative models of active therapy tend to be equally effective (Kazdin, 2000b).

The follow up period of this study was two years but despite the efforts of the research team a proportion were lost to follow up mainly due to reluctance to complete standardized assessment interviews.

The impact of abuse on children's psychological development

Another substantial body of work undertaken by Jill Hodges, Miriam Steele and colleagues explores the impact of maltreatment and neglect on children's development. The **Story Stem Assessment Profile* (formerly known as the 'Little Pig' stems) was specifically devised to explore the inner representational world of children (age 4-8) who have been subjected to maltreatment or neglect (Hodges, 1990). *The Story Stem Assessment Profile* battery was developed from the **MacCarthur Story Stem Battery* but five additional stems are introduced to look at issues around maltreatment (Hodges, Hill, Steele & Henderson, 2004).

Hodges and colleagues have looked at the effects of abuse on children's representations as well as changes in these representations following adoptive placement (Hodges, Steele, Hillman, Henderson & Kaniuk, 2003). Informed by Bowlby's metaphor of 'internal working models' of attachment, it is hypothesized that children's representations are built up over time in response to expectable interactions with others and the narrative method aims to elicit 'generic representations of child-parent relationships, because these are, arguably, the most likely to affect later relationships' (Hodges & Steele, 2000). The child's play narrative is viewed as an indicator not so much of reality but of how 'the child reflects upon reality' (Hodges & Steele, 2000). The story stem assessments are videotaped, transcribed and rated for the presence or absence of thirty two themes, each theme is rated on a three point scale (Hodges, Hillman, Steele, & Henderson, 2004) and those trained in the method achieve good levels of reliability.

As part of a research project (Hodges & Steele, 2000) four groups of children's narrative assessments were compared i.e. children who have been removed from abusive settings some time earlier and placed in permanent adoptive families (the Coram group), a group of children removed from families in which they have been abused and placed in foster or residential care (the clinical group) and two comparison groups comprising of relatively disadvantaged children (matched comparison group) and a group of predominantly middle class first born children from the London Parent Child Project (LPCP group). Differences in narrative themes were found between the groups, for instance themes of realistic or pleasurable domestic life were found most in the LPCP children and least in the 'clinical group'. The clinical group more often depicted themes such as: a child being injured or dead; adults as unaware of children's needs or distress; lack of acknowledgement of distress; shifts in a character from being 'bad' to 'good' or vice versa.

The Thomas Coram Adoption Project (Hodges et al., 2003) looks at changes in children's behaviour and adjustment in relation to numerous variables, including the adoptive parents' attachment organization and the child's maltreatment history over the first two years of placement. This group of 'late placed' maltreated adopted children is compared with children adopted 'early' in infancy. When comparing narrative assessments of the children it was noted that late placed children were much more likely than the infancy adopted group to try to avoid the story task but after the first year of adoptive placement this had decreased markedly. The late-placed group showed significantly higher levels of catastrophic fantasy and bizarre-atypical responses compared with the infancy group and this was largely maintained after a year in placement. The late placed group also showed more extreme aggression which did not decrease. Compared to the infancy placed children the late placed children were less likely to show adults helping children and being affectionate and more likely to show adults as aggressive, rejecting and unaware of their needs. At one year changes could be identified in relation to parents helping children although there was little change in terms of parents being represented as affectionate or aggressive. Some small changes were also noted in the child's self representation and tendency towards 'magical/omnipotent responses' a year following adoption. Hodges and colleagues conclusion is that changes in the children's representations over time indicate

'not erosion but competition: not so much that earlier, negative internal working models fade away, but rather that alternative, competing ones get developed and may even become dominant' (Hodges & Steele, 2000). The job of adopters could be seen as the 'active disconfirmation of existing negative models and building up of competing ones' (Hodges & Steele, 2000).

Other interesting findings from the Thomas Coram Adoption Project include the influence of the adoptive parents attachment style on children's story stem responses [4] (Steele, 2006; Steele, Hodges, Kaniuk, Hillman & Henderson, 2003). As early as three months into an adoptive placement, themes of 'aggressiveness' in the children's story stems were significantly more likely to appear in the story completions of children adopted by mothers classified as 'insecure' on the Adult Attachment Interview as opposed to those classified as 'secure'. Significant differences in themes were also identified in the children's story completions in mothers classified as unresolved with respect to past trauma. The findings suggest that unresolved mourning in a parent may exacerbate the emotional worries of a recently adopted child. Overall there was a tendency for the children adopted by mothers in this category to appear less able to use an organised strategy to deal with conflict depicted in the story. The researchers note that it is surprising, given the adverse early histories of the children that so soon after being placed in a new environment the influence upon the child of the adopter's state of mind with regard to attachment can be discerned.

The experiences of children in foster care

Further work includes research on the experience of siblings in foster care (Hindle, 2000) and applications of child psychotherapy to work with children in temporary foster care (Philps, 2003). Hindle's case based study, centered on ways of examining the nature and significance of sibling relationships for children unable to live with their families of origin, and where decisions about permanency of placement were being considered. Semi-structured interviews were used to gather data from the child's social worker, fostering support worker and foster parent. In addition a psychotherapeutic assessment was undertaken of the sibling pair and the siblings on their own. All joint sessions were videotaped as was the first individual session for each child in whom the *Story Stem Assessment Profile* was undertaken. In keeping with usual practice process recordings were also made. At baseline the CBCL (Achenbach & Edelbrock, 1993) and a sibling questionnaire (Furman, 1990) were completed by the foster parent. Grounded theory (Glaser & Strauss, 1967) was used to analyse qualitative data. The analysis of all this data enabled in-depth assessments of the children and formed the basis for recommendations to Social Services. It was concluded that anxieties within the professional network often prevented the children's perspective being fully considered and an assessment model for considering the sibling dimension in informing decision making in child care cases was proposed.

Philps's study also identified un-helpful dynamics in the wider system surrounding children in temporary foster care placement (Philps, 2003). She developed a working hypothesis with regard to the nature of these processes in the childcare system, through looking in depth at two case studies of children in therapy and in foster care. It was noted that within the social work and foster care environment, injunctions appeared against loving the fostered children, or allowing them to maintain affectional bonds with their birth family for fear of harming them or the foster families in some way and this appeared to lead to a potentially confusing and distancing compartmentalization of identities for the children. This hypothesis was tested further in relation to a third single case study and themes identified in systemic interviews by an independent researcher (Fausset, 1996) appeared to support it. In addition the children's therapeutic developments were evaluated using variety of measures (see section one).

Disruptive Behaviour Disorders

Anderson looked at children presenting to CAMHS with risk taking and dangerous behaviour and using grounded theory methodology (Glaser & Strauss, 1967) identified three situations in which such behaviour occurs, which she describes as: 'no haven'; 'illusory haven'; 'perilous haven' (Anderson, 2001, 2004) [5]. All three situations appeared to be damaging to the child and each category is described as being associated with a different clinical prognosis. The category of 'no-haven' she describes as being characterized by a 'predominance of hostile feelings between parent and child', whereas in the category of 'illusory-haven' there appears to be an affectionate relationship between parent and child but the child seems to be 'neither thought about emotionally' nor 'held in the parent's mind'. A 'perilous-haven' configuration seems to occur when 'the parent has markedly split feelings about the child but has some awareness of these ambivalent feelings'. Different strategies in treating each of these three groups are identified with the ultimate aim of creating a 'safe-haven' for the child which offers security, emotional responsiveness and developmental opportunities.

The large Anna Freud Centre retrospective study (n=763) looked at differences in outcome according to diagnostic category (Fonagy & Target, 1996). In general children with a diagnosis of disruptive disorder were harder to treat, particularly if the diagnosis was of conduct disorder rather than oppositional defiant disorder [6] (Fonagy & Target, 1994) and in comparison those diagnosed with emotional disorders did better ($p<0.0001$). Children with disruptive disorders were difficult to maintain in treatment and more liable to drop out. Prognosis improved for younger children and those in intensive treatment. Indeed when those children treated intensively for three years were compared, the differences in outcome between those diagnosed with disruptive disorder and those diagnosed with emotional disorder were no longer significant (Fonagy & Target, 1994). Diagnostic variables that predicted improvement in the disruptive disorders group included: the presence of an anxiety disorder, absence of co-morbidity and school reported problems. The retrospective nature of these studies limit the conclusions that can be drawn.

A small (n=26) German study (Winkelmann et al., 2005) compared children with behavioural disorders treated with psychodynamic short-term psychotherapy (PSTP) with a waiting list control. 31% of the children in the treatment group showed clinically significant improvement compared with 8% of those in the control group.

Personality Disorder

An interesting study (Gerber, 2004; Fonagy, Gerber, Higgitt & Bateman, 2002) looks at the efficacy of psychoanalytic psychotherapy as a treatment for young adults with depression, anxiety and personality disorders (mainly cluster B i.e. narcissistic and borderline). This quasi-experimental study [7] looked at 25 young adults (aged 18-24) sequentially assigned to psychoanalysis (n=14) or psychodynamic psychotherapy (n=11). The process of psychotherapy was reported using a novel 899 item questionnaire, the *Young Adult Weekly Rating Scale* (see section one). Patients were assessed by an independent psychiatrist at intake, termination and at eighteen month intervals after intake and termination with the Adult Attachment Interview (Main & Goldwyn, 1998) and a range of other symptomatic and diagnostic measures. Over the course of treatment (6 months to 8 years long), 12 of 19 (with adequate data) patients improved symptomatically on an aggregate measure. Ten of the 12 improvers were in the psychoanalysis group, suggesting that this is a more effective treatment in this population.

Fascinatingly with respect to the Adult Attachment Interview (AAI) the results showed a high proportion of secure classifications at initial assessment (54%) and in successful treatments a move towards a preoccupied-entangled attachment pattern which began to resolve by termination. Such changes have not been reported before and challenge the assumption that attachment security is a proxy for therapeutic improvement. Gerber quotes Lichtenberg (2003): *'For therapists, the dialectic between coherence and incoherence is complex. A move from coherence toward a degree of incoherence may signal the opening up of exploration of an area of affectively loaded struggle. Alternatively a move from incoherence to coherence can signify positive change as noted by Muscetta et al., (1999). However, premature restoration of coherence can indicate shutting off the opportunity to explore, while too great a loss of coherence may be the beginning of a period of disorganization'* (Lichtenberg, 2003, p.202). Gerber proposes that in patients with severe character pathology who at first appear to be secure, the transition to a preoccupied-entangled state may be necessary (but not sufficient) for their successful treatment. At or beyond termination of the treatment, a transition back to a secure classification might be expected as evidence of their structural change. Gerber is careful to point out that this was a quasi-randomised study with a small sample size and that many potential confounding variables (such as fewer Axis II subjects in the psychoanalysis group) may explain the results. Further research using the AAI at similar time points during the course of therapy is recommended in a larger sample.

With regard to personality dysfunction in children a study [8] by Weise and Turber (2004) notes that while narcissistic pathology is a major focus in the adult psychiatric literature, particularly among psychoanalytic clinicians, narcissistic pathology in children has received less attention. They set out to look at correlations between the clinical assessment of narcissistic personality disorder in children and adolescents and underlying self and object relationships. Support for the clinical literature, which describes these children as lacking in empathy or struggling with self esteem regulation and in poor control of their impulses or aggression was found. Additionally, a tendency to have a vulnerable sense of identity and to be preoccupied with seeking out and developing relationships with others was noted to differentiate these children from peers with similar behavioural and diagnostic profiles. One unexpected finding in the opposite direction to that predicted was that the narcissistic group showed a significantly higher investment in relationships than the control group. This was considered to possibly reflect a wish to seek out relationships which provide confirming and admiring responses.

Suicide and Self-harm

A study by Wright and colleagues looked at attachment in suicidal adolescents and explored the phenomenology of different presentations of suicidality from a psychodynamic as well as attachment theory perspective (Wright, Briggs & Behringer, 2005). Thirty five adolescents participated in the study. Twenty five of these were either receiving an assessment for psychotherapy or in weekly psychotherapy. These participants were classed, by a blind rater looking at the case notes, as being either High Suicidal Risk (HSR) or Low Suicidal Risk (LSR). A control group was recruited from local schools. The adolescents were assessed using the Adolescent Separation Anxiety Test (ASAT; Scott Brown & Wright, 2003) and two self-report forms, the Inventory of Interpersonal Problems (Barkman, Hardy & Startup, 1996) and the Youth Self-Report (Achenbach, 1991). It was found that the 'HSR' adolescents included a majority of adolescents whose narratives were enmeshed/preoccupied and no secure narratives.

In contrast the 'LSR' group was more evenly spread across the three main attachment narrative patterns and the control sample was over-represented within the secure category. It was also

noted that the High Risk group often spontaneously made references to suicide or mental disturbance when filling out the Youth Self Report form. The characteristics of the young person's attachment pattern guided how they communicated their suicidality. The narratives of the pre-occupied-insecure group were characterized by being trapped within a great sense of worry, having high degrees of incoherence and communicating anxiety to others. In contrast those classified as insecure/dismissing downplayed their suicidal feelings so that there was a risk that clinicians might underestimate the level of risk.

An as yet unpublished study by Briggs and colleagues develops these themes further by looking at risks and protective factors in the 'internal worlds' of female adolescents at risk of suicide (Briggs, Grayson & McLean, manuscript in preparation).They set out to look beyond the broad attachment categories to focus in more detail on the adolescent's state of mind and patterns of relatedness with respect to suicide. A consecutive sample of twenty female adolescents (scoring 3 and above on a rating scale for suicide; Pfeffer et al., 1993) and referred to an outpatient psychotherapy service were selected for inclusion in the study. Three psychoanalytic psychotherapists judged the states of mind, emotions and object relatedness of the subjects by looking at detailed process notes of assessment sessions. These assessors were also given some basic background information about the young person but were otherwise blind to the rest of the study. The psychotherapists were asked to assign ratings to a Suicide Fantasy Scale, which aims to operationalise key concepts about suicidality from a psychoanalytic perspective (Briggs, Keeley, & McAulife, 2001). The inter-rater reliability of the raters in completing this task was assessed with some factors on the scale rated more reliably than others. The researchers plan to undertake further research in order to develop and refine the scale for use as a clinical assessment instrument.

An interesting research proposal (Anderson, 2005) sets out to look at what psychoanalytic thinking and clinical assessments can contribute to the understanding of suicidal behaviour in young people. It is planned to set up a research group of child psychotherapists who will assess young people following a suicide attempt and make detailed observations and process notes which would subsequently be gathered up by the research team and analysed using grounded theory methodology. It is hoped by using this approach to contribute to the risk assessment of these young people by generating an explanatory theory linked to clinical assessment.

Emotional Disorders

The large Anna Freud Centre study (Fonagy & Target, 1996) identified that when children were grouped according to diagnostic category, in general those children diagnosed with emotional disorders did better ($p<0.0001$). Children with emotional disorder proved amenable to psychoanalytic treatment with the vast majority showing a favorable response (Target & Fonagy, 1994a). Children within this category designated as being 'severely disturbed' were substantially more likely to improve if in intensive treatment (78.7% vs. 26.1%).

These findings indicating a better response for emotional or 'internalising' problems are reflected in other studies. A community based audit by Baruch, Fearon & Gerber, 1995, of psychoanalytic treatment for adolescents and young adults presenting with multiple severe difficulties (median no of ICD-10 diagnosis 3, median score for psychosocial stress`4, severe) showed that 'internalising' problems were more responsive to treatment. 'Externalising problems were more difficult to treat although the likelihood of improvement increased if the externalising problems were associated with internalising/emotional problems or if the individual was in more frequent treatment.

An Italian quasi-randomized trial (Muratori et al., 2002) of structured focused psychodynamic psychotherapy (11 sessions) for children (age 6-11 years) with emotional disorders showed that internalising problems were particularly responsive to treatment although externalizing problems also improved. The outcome was better for those children with 'pure' emotional disorders (ICD-10) as opposed to 'mixed' emotional disorders (ICD-10).

A follow up of this study [9], with a larger sample size revealed interesting findings (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003). While both the experimental treatment group and the control improved on measures of global functioning (assessed by the C-GAS; Shaffer et al., 1983) in the first six months only the experimental group showed evidence of a shift to a non-clinical range maintained at two year follow-up (the authors hypothesise that the initial therapeutic improvement might be attributable to the assessment that the control group also received). On the other outcome measure used, the CBCL (Achenbach & Edelbrock, 1993) the authors note evidence of the 'sleeper' effect. No differences between the groups were noted in the first six months but at two year follow up significant changes, including a move into the 'non-clinical' range for internalizing and total problems scales, were noted in the group that received psychodynamic psychotherapy. While internalizing problems improved so did externalizing problems (ES 0.61 and 0.59, respectively). The improvement in externalizing problems had not been expected. The authors speculate that the level of clinical disturbance in this sample (largely comprised of 'intact' Italian families of 'middle' socioeconomic status with lower than average mean scores on the CBCL) was such that a short term focused treatment was able to effect change.

A randomized trial in an Indian school setting (Sinha & Kapur, 1999) selected young people who were identified as having emotional problems on the General Health Questionnaire and who scored high on the internalizing scale and low on the externalizing scale of the Youth Self Report. Significant improvements were seen with treatment (ten sessions of Psychodynamic Orientated Supportive Therapy) in this sample which had high levels of internalizing problems. A high percentage (>90%) showed clinically significant improvements in almost all areas of functioning. There was a significant improvement in internalizing problems, adjustment and interpersonal confidence.

Depression

A multi-centre randomized trial [10] by Trowell et al., focuses on childhood and early adolescent depression (ages 10-14 years) and compares focused individual psychodynamic therapy, FIPP (with parallel parent work) and systems integrative family therapy, SIFT (Trowell et al., 2007). The trial was undertaken in London, Athens and Helsinki. The researchers planed the study on the basis of preliminary evidence that psychodynamic psychotherapy might be an effective treatment for depressed children and young adolescents (Wrate, 1995; Trowell, Kolvin, Weeramanthri, Berelowitz & Leitch, 1998) as well as the awareness of the importance of family and contextual factors in the aetiology of depression (Tsiantis et al., 2005). In comparing the two treatments it was hypothesized that individual therapy (FIPP) and family therapy (SIFT) would lead to different responses and outcomes in the participants. Seventy one children were recruited. All of those included met the criteria for major depressive disorder (MDD) and/or dysthymia and were assessed using the Kiddie-SADS (Kaufman et al., 1997) and the Child Depression Inventory (Kovacs, 1981). Treatment was conducted over a nine month period and consisted of eight to fourteen 90 minute sessions of Family Therapy (mean=11) or sixteen to thirty 50 minute sessions of Individual Therapy (mean=24.7) plus individual parent sessions (one per two sessions of child's therapy) by a separate case worker. There

were between 4 and 6 individual therapists and 4 and 6 family therapists in each of the three centres.

Assessment took place prior to treatment, at the end of therapy and at six months follow up. The mean age of the participants was 12 years and almost two thirds (62%) were male. Just under half (44%) had a history of maternal psychiatric illness.

At the end of treatment significant reductions in disorder rates were seen for both groups (Trowell et al., 2007). A total of 74.3% of cases were no longer clinically depressed following Individual Psychotherapy and 75.7% of cases were no longer clinically depressed following Family Therapy. There was also an overall reduction in co-morbid conditions across the study. The changes in both treatment groups were persistent and there was ongoing improvement. At follow up six months after treatment had ended, 100% of cases in the Individual Therapy group, and 81% of cases in the Family Therapy group were no longer clinically depressed.

Individual therapy was found to have been effective in cases of Major Depressive Disorder, Dysthymia and 'double depression'. There were no relapses in the six months following treatment end and in addition all cases of depression had resolved at follow up, suggestive of a 'sleeper effect' (i.e. an ongoing response to therapy following completion).

In the family therapy group there were also no relapses in the six months following treatment end and there was further improvement over the follow up period. While response rates appear to have been 20% greater in the Individual Therapy group compared to Family Therapy at follow up this was influenced by the inclusion of four cases lost to follow up in the Family Therapy group, who were all considered in the analysis as unsuccessfully treated cases.

While the final outcome appears to have been similar, a different pattern of response to treatment was noted in the two groups. Family work appeared to have highly effective initial impact whereas the response to individual work was slower but more sustained. On the Moods and Feelings questionnaire for example (Angold, Costello, Pickles, Winder, & Silver, 1987) the family therapy group had a lower score at end of therapy despite having had a higher score than individual therapy at baseline. These differences had disappeared at follow up. By follow up many of the family therapy trajectories seemed to have plateaued, while the individual group trajectories suggested the possibility of further improvement.

The results of the study suggest that both individual therapy and family therapy may be more effective in the treatment of depression in this age group than other forms of treatment (Trowel et al., 2007).

A small study by Horn et al., (2005) in Heidelberg looked at the efficacy of psychodynamic short-term psychotherapy (PSTP) for the treatment of depression in children and adolescents compared with a waiting-list control. Twenty children and adolescents fulfilling the diagnosis of major depression or dysthymia were included in the research. The treatment group received 25 sessions of psychodynamic psychotherapy. In contrast to the treatment group, where 20% of the children showed clinically significant and reliable improvement, no subject in the waiting-list control group met this criterion.

Anxiety

Another small study (n=26) by the Heidelberg group compared psychodynamic short term psychotherapy (PTSP) with a waiting list control (Kronmüller et al., 2005). Whereas 62% of the patients in the treatment group showed clinically significant and reliable improvement at the end of therapy, this was the case for only 8% of the subjects in the waiting list condition.

Children with a Physical illness

Moran and colleagues undertook a series of studies looking at psychoanalytic psychotherapy as a means of helping young people with poorly controlled diabetes (Moran & Fonagy, 1987; Moran, Fonagy, Kurtz, Bolton, & Brook, 1991; Fonagy & Moran, 1990).

A well designed quasi randomized study, [11] compared children with unstable insulin dependent diabetes who received psychoanalytic psychotherapy 3 to 5 times a week for a mean period of 15 weeks with a group of children who had unstable diabetes and who were in receipt of routine psychological input but did not receive individual psychotherapy over this period. The two groups were comparable on most demographic and clinical variables. There were three children in the experimental group with growth failure (height velocity below third centile) and 73% of the experimental group and 63% of the control group had a psychiatric disorder.

At the end of treatment a significant improvement in diabetic control was noted in the experimental group compared to control. This improvement was maintained at one year follow up. All but one subject in the experimental group showed a reduction in glycosylated haemoglobin (a reduction in glycosylated haemoglobin represents good diabetic control) over the course of treatment whereas only four out of eleven in the control group showed an improvement. At one year follow up nine of the experimental group patients remained below their preadmission average HbA1c levels (glycosylated haemoglobin) whereas three of those in the comparison group did so. Clinically relevant was the reduction of HbA1c levels to within the 'acceptable' range for diabetes in six of the experimental group whereas none of the comparison group showed such an improvement. Four out of the experimental group and eight out of the comparison group were readmitted in the year after discharge (Moran et al., 1991).

What makes this study particularly interesting is the researchers stated scepticism about the capacity of conventional psychological outcome measures to capture the kind of change they were looking for, so for this reason the primary outcome measures selected were physical and related to mainly to the children's diabetic control. As part of this study three children with diabetes and growth retardation [12] were studied, using a single case experimental design methodology, in all three cases there were gains in height over the predicted height following psychotherapeutic treatment (Fonagy & Moran, 1990).

Another study explored the psychological impact of liver transplantation on children's inner worlds (Gritti et al., 2001). Children who had received a liver transplant had a psychoanalytically orientated assessment which included one 50 minute play and free drawing session as well as cognitive and other testing such as the **Children's Apperception Test* (CAT). The children's parents were also interviewed. Eighteen out of 21 pediatric transplant recipients who were approached for the study agreed to participate. The patients were compared with an age and gender matched control group. The mean age of the children was 6.8 years (range 4.4 years to 10.8 years).

Most patients (94.4%) and controls (88.8%) used the opportunity to draw in the 50 minute assessment. Although the interviewer made no explicit mention of the transplant, eleven children (61.1%) used drawings as a medium to represent this experience. Only three of the children specifically mentioned transplantation and many appeared reluctant to talk further about it if it was introduced as a topic on the basis of the session material.

The Children's Apperception Test (Bellak, 1968) stories were revealing. In 83.3% of patients vs. 38.8% of controls a traumatic experience was described, typically, a 'hero' in danger of his life, threatened by enemies or natural events (fire, water). This 'hero' invariably survived, often in a in a magical way or as the consequence of the intervention of a powerful figure. Fear of death and abandonment by parents were recurrent themes in the patients' stories compared with controls. Strikingly the need to receive parental care was expressed by the 'heroes' in most of the cases (94.4%) but not the controls (5.5%). Overall the use of defenses (such as splitting, denial and undoing) to avoid anxiety prevailed. The IQ of the patients was normal although lower than that of the controls. Parental interviews revealed that many parents didn't talk openly to their child about the transplant mainly because they felt there child was too young to understand.

The researchers viewed that this lack of communication between the parent and child about the transplant may have meant that the child's experience became a 'family secret' and hence possibly more traumatic for the child. It was noted that many of the psychological difficulties appeared to be related as much to the impact of chronic liver disease as to the impact of transplantation itself. The researchers conclude that the psychoanalytic assessment method was helpful in studying children's internal representations of their experiences, including pre-verbal experience and that further research of this kind would assist in informing services about psychological support for children and their families.

Anorexia Nervosa

Two studies have looked at the effectiveness of psychodynamic psychotherapeutic treatment for Anorexia Nervosa

One Randomized Controlled Trial [13] (Robin et al., 1999; Robin, Siegel, & Moye, 1995) compared Behavioural Family Systems Therapy (BFST) with Ego Orientated Individual Therapy (EOIT) for children aged twelve to nineteen. The researchers who conducted the study, had developed the BFST approach. The background of the EOIT therapists is not entirely clear, although efforts seem to have been made to ensure fidelity to this psycho-dynamically derived model of treatment. The sample was in part recruited rather than entirely clinically referred which may have resulted in a less impaired sample. Both treatments were shown to be effective in the treatment of Anorexia. The BFST group showed faster change on some weight measures but more cases in the BFST group required hospitalization. In both groups there were improvements in measures of observed family conflict, illustrating, the authors conclude, that family therapy is not necessary in order to bring about a change in parent child interactions (in the EOIT group the adolescents were seen individually and the parents in parallel).

Another study (Vilsvik & Vaglum, 1989) looked at the long-term follow up in a group of adolescents who had received individual psychodynamic therapy for Anorexia (parents and young people were seen for about an hour a week over a period of eleven months on average). The follow up period ranged from one to nine years (mean four years). While the authors acknowledge that in an uncontrolled study it isn't possible to attribute positive outcomes to

the treatment received they note that most of the young people had a good outcome. All were physically well at follow up and 60% were doing well in terms of their 'interpersonal situation'. The authors note that younger age and stable family background may have contributed to the positive outcome.

Autism

An ongoing research study, [14] is assessing the impact of psychoanalytic child psychotherapy for children with autism and their families (Reid, Alvarez & Lee, 2001). The researchers have developed a specialized psychotherapeutic technique that takes into account the particular developmental difficulties of this group of children (Alvarez & Reid, 1999). One component of this approach is to endeavor to work with the intact 'non-autistic' parts of the child's personality and to appreciate the individual differences and personal motivation of the children. Close attention is also paid to the impact on families of living with a child with such a profound level of disability. The researchers predict that children and families receiving an extended psychotherapeutic assessment (over 6-12 months) will show developmental change of a nature and degree significantly different from a control group who do not receive such input. The study is ongoing but preliminary results appear to support this hypothesis.

A single-case study by Alvarez and Lee (2004) aimed to identify early forms of interpersonal relatedness in a 4 year old child with autism and to examine changes in this over a three year period while the child was in psychotherapy. The child was severely autistic, scoring 38.0 on the Childhood Autism Rating Scale (CARS; Schopler, Reichler & Rennedr, 1986) and his mother was interviewed using the Autism Diagnostic Interview (ADI-R; Lord, Storoschuk, Rutter, & Pickles, 1993) which confirmed and detailed further the child's impairment in the areas of reciprocal social interaction, communication and repetitive, stereotyped behaviors. The child received psychotherapy three times a week over 42 months and all of these sessions were videotaped. Ratings were made from videotapes twice yearly for the three years of treatment. The first 5 minutes and the middle ten minutes of each videotaped session were selected and the total 15 minutes divided into forty-five, twenty second clips. Twenty seconds was considered sufficient time to gauge the components of early relatedness under investigation. A rating scale was designed to capture signs of early relatedness. Five codings were made for each time point and included (1) Frequency and duration of looks to another person (2) General mood state (3) Emotional engagement (4) Degree of interest in the other person (5) Triadic episodes (a triadic episode implies the child 'understands' that the other person holds in mind an attitude towards the shared item i.e. person-person-object, forms of relating that serve to integrate a common world between two individuals). A proportion of the clips were rated by a blind rater and the inter-rater reliability was high.

Over the course of treatment the clinical observations demonstrated an improvement in the child's capacity to engage in more developed forms of dyadic relating. In addition there was a reduction in the child's level of excitement and agitation, an increased capacity to maintain attention and evidence of an emerging 'personality'. The formal ratings demonstrated not just that components of dyadic relatedness could be reliably measured but that these forms changed over time e.g. the number and quality of looks to the clinician improved; emotional expressiveness shifted from being predominantly neutral at baseline to predominantly expressive in the following two years and emotional engagement with the clinician also increased. There was however no conclusive evidence for change in the level of triadic relating. Episodes of joint attention were recorded from the start and these increased up to and including year two from baseline but then decreased again to just above baseline in year three. It is concluded that while the study

shows that early forms of social relating do develop, the study also underlines the importance of a carefully calibrated analyses of the components and sub-components of social relatedness

An ongoing study by Rhode and colleagues looks at the impact of therapeutic infant observation on children identified as having difficulties as assessed by the Checklist for Autism in Toddlers or CHAT (Baron-Cohen et al., 1996; Rhode, in press).

The systematic use of therapeutic infant observation was pioneered by Houzel (1999) and has been offered as an intervention to babies considered to be displaying early signs of social and communication difficulties. It is proposed that three main qualities of the observer contribute to the therapeutic effect of a participant infant observation. The first is the observer's perceptual receptivity (i.e. attention to details and sequences of behaviour), secondly her emotional receptivity and finally and possibly most importantly, the observer's unconscious receptivity, that is the observer's 'openness to communications at the deepest level, beyond what can be achieved through an effort of will' (Rhode, in press).

A pilot study has been undertaken looking at the facilitatory effects of infant observation on toddlers identified at an early stage as having communication difficulties. Families are contacted through workers in primary care who have concerns about the child's capacity to communicate or who have been alerted by the parents regarding such concerns. If families consent to participate a research worker visits the home to administer various baseline assessments. These include the Checklist for Autism in Toddlers or CHAT (Baron-Cohen et al., 1996). The sensitivity of the CHAT is low (it picks up only 27% of children found to have Autism at the age of 3 ½) however it produces few false positives, making it a useful screening instrument for Autism. It is valid between 16 and 20 months. The child's attachment status in a separation reunion task is also assessed. In addition demographic details and information about the mother's health, her experience of pregnancy and the child's early development is gathered. The short form of the Parent Development Interview (Slade et al., 2003, see section three) is also completed. Once the baseline information has been collected the intervention starts, comprising weekly visits by a participant observer and fortnightly visits from a parent worker. At the end of the year the Parent Development Interview is again administered as is a general health questionnaire and the separation-reunion task. At the age of three an independent psychiatric interview is arranged if one has not already been put in place by statutory services.

So far only three children have been offered the programme. Preliminary findings show one child who was rated as high risk on the CHAT, assessed as having no signs of autism when seen by an independent psychiatrist at age 3 ½. Another child was offered the intervention at 12 months, so was too young for the CHAT but he appeared to make progress. These very preliminary findings have encouraged the researchers to proceed further with the pilot and recruit 6 more children assessed as being 'high risk' on the CHAT. It is hoped that the specificity of the CHAT in predicting Autism will enable the researchers to ascertain on the basis of this pilot whether there is a case for evaluating the intervention further in a randomized controlled trial

Obsessive Compulsive Disorder

A small Israeli study, showed improvements in young people with OCD treated with psychotherapy who had previously failed to comply with behavioural treatment (Apter, Bernhout, & Tyano, 1984). The small study size and non randomized design, limits the conclusions that can be drawn.

Children with learning difficulties

A study [15] by Heinicke & Ramsay Klee (1986) looked at boys aged 7-10 years referred with reading retardation and associated emotional disturbance. The children were given psychoanalytic psychotherapy over a period of two years. All of the children improved with treatment but those seen more frequently (four times a week for one or two years) improved most, particularly with regard to self esteem, flexible adaptation, capacity for forming and maintaining relationships, frustration tolerance and ability to work. A smaller pilot study by the same group had similar findings (Heinicke, 1965). One non-controlled study focuses on a small sample of very young children (mean age 3yrs and 8months) with developmental delay, oppositional defiant disorder or in some cases pervasive developmental disorder and showed gains in I.Q level following psychoanalytically based treatments (Zelman, Samuels, & Abrams, 1985).

Mixed Diagnoses

A number of studies have focused on children presenting in middle childhood with a range of difficulties rather than belonging to a particular diagnostic category.

One randomized trial (Smyrios & Kirby, 1993) [16] looked at children age 5-7 years with 'disturbances of emotion specific to childhood' (WHO, 1978) who had sought assistance from the Child & Family centre where the study was based. Quite stringent exclusion criteria were applied (i.e. exclusion of single parent families, those with a history of mental illness, children with a previous history) suggesting that the families involved in the study were a less disadvantaged group. This study randomized participants to three groups of psycho-analytically informed family and individual treatment of different lengths (time limited, time unlimited and a minimal contact control). All three groups did well on a variety of outcome measures at four year follow up, although the group seen least did rather better. The researchers speculate that the four session 'minimal contact control' group may have proved most effective because the families own capacities for coping and resilience had been harnessed.

A further study [17] by Szapocznik et al. (1989), looked at Hispanic boys age 6-12 years presenting with a range of diagnoses (e.g. 32% ODD, 30% anxiety disorder, 16% conduct disorder). The participants in this study were recruited through a media campaign and school counselors rather than being clinically referred. The inclusion criteria were quite stringent (those not living in a two parent family were excluded as were families with a history of mental health care or those who had not been living in the US for more than 3 years). This study compared structural family therapy with individual psychodynamic child psychotherapy and a 'recreational' control.

Attrition was greatest in the control group (43%) and greater in the family therapy group as compared to the individual therapy (16% vs. 4 %). Both family therapy and individual psychodynamic therapy were similar in reducing behavioural and emotional problems on a variety of outcome measures, including family systems and individual psychodynamic rating scales. These improvements were maintained at one year follow up. On measures of family functioning the control group stayed the same, the family therapy group improved but those receiving individual psychodynamic psychotherapy showed a deterioration at one year follow up. This finding may possibly be biased as an intention to treat analysis was not carried out despite variable drop outs in the three groups and, but is also likely to be attributable to the fact that the individual psychodynamic child therapy was undertaken in the absence

of any parallel parent work, contrary to usual practice. The study underlines the importance of working with the wider family system in conjunction with individual work with the child.

Two German studies (Petrie & Thieme, 1978; Winkelmann et al., 2000) involved naturalistic follow up of children and adolescents with a range of difficulties referred to clinics specializing in psychoanalytic psychotherapy. One of these studies (Winkelmann et al., 2000) noted that improvement in the period after treatment seldom occurred if difficulties were not resolved in the therapy itself but improvements seen during therapy continued after therapy.

Outcomes over the long-term

The Anna Freud Centre long-term follow up study

The Anna Freud Centre long-term follow up study [18] looks at outcomes of child psychotherapy from childhood into adulthood (Schachter 2004; Shachter & Target, in press; Target & Fonagy, 2002). This study was designed to provide a life-span perspective on a group of children with childhood disorders and specifically to examine whether gains in treatment in childhood are maintained into adulthood and help to 'forestall some of the negative risk factors associated with early psychiatric disturbance' (Champion, Goodall & Rutter, 1995). This study compared children who had received treatment at the Anna Freud Centre as children (between 1952 and 1991) with the siblings of those who received treatment. Initially it had been planned to have another comparison group of children referred with apparently similar psychopathology who didn't receive treatment, but largely for ethical reasons it proved impossible to trace and contact such a group.

In all, 34 former patients and 11 siblings of former patients participated in the study. These subjects were interviewed in depth and completed a range of outcome measures. Those that had received treatment in childhood were found to be functioning well and reported low levels of adversity, relatively few severe life events and good health with minimal use of medical services. They displayed adequate personality functioning across a range of domains and a low rate of personality disorders. The participants' level of functioning as adults was significantly related to attachment security, with secure attachment being associated with better coping and functioning. A key finding of the study was that the best predictor of adult outcome was a child's overall level of functioning as identified using the **Hampstead Child Adaptation Measure* (HCAM score; Schneider, 2000) before receiving treatment. The number of co-morbid diagnoses at the end of treatment also appeared to be linked to a long-term adverse outcome. A secure adult attachment status was common to those who moved from poor functioning as children to high functioning as adults

Interestingly while adversity in childhood was greater in the treated siblings, the untreated siblings were found to experience more negative life events in adulthood. In relation to personality functioning, the entire sample appeared to be doing well in the work domain and in the area of intimate relationships those children successfully treated in childhood appeared to be doing better than their untreated siblings. Possible adverse effects of treatment were highlighted in relation to attachment security where it was noted that if the immediate outcome of treatment was good the treated children did as well as their siblings in adulthood but if the treatment had been unsuccessful their attachment style was predominantly preoccupied/entangled. Those in the sample who did not receive psychoanalytic treatment were predominantly dismissing in their attachment style. Treated subjects demonstrated a balanced and accurate memory of their childhood experiences, however in contrast to their siblings their memories tended to be more painful. This study also found that there was relatively

high agreement between the adult recall of events and the childhood case note recordings.

The researchers point out that the small, unrepresentative size of this sample means that the findings can only be tentative. However the study is unique in terms of the length of follow up and the development of an interview protocol for the long term assessment of psychoanalytic treatment

Outcomes from childhood into adulthood from the perspective of the patient

As part of the Anna Freud long-term follow up study the outcome of child psychoanalysis was also looked at from the perspective of the patient (Midgley, 2003; Midgley, Target & Smith, 2006). This study explores the memories of adults who were in analysis as children and looks at what meaning the participants have given to the experience of therapy in the context of their later lives - not only how they understood what therapy was about, but also how they feel it has effected their lives both as children and adults. All adults who were referred as children to the Anna Freud Centre between 1952 and 1980 were invited to take part the follow up study. Of those whose whereabouts were established 42% agreed to be interviewed. A total of 27 adults in this group had received intensive (i.e. four or five times per week) child analysis and this group was selected to be interviewed in depth. The average age of the participants was 36 and five had been under 6 at the time of childhood referral, sixteen had been between 6 and 12, with six referred in adolescence. The mean time in treatment was two years and nine months. This study used the 'memories of therapy' semi-structured interview, developed specifically for the project. Interpretative phenomenological analysis was found to be particularly helpful in analyzing the data because of its focus on a detailed exploration of the participants' view of the topic under investigation (Smith et al., 1999).

A large number of the participants found it difficult to state with certainty whether the therapy had helped them or not because of the problem of knowing how things might have turned out if they hadn't received treatment. One person described this vividly by stating 'And if it did help me, I'm very grateful but-how do I establish that, because unless there was another clone of me, sitting next to me that didn't come….'

Two thirds of those who took part were able to describe some aspect of the experience of child psychoanalysis that they felt to be helpful at the time. Some were more confident about the positive impact than others. Several of the participants described how being able to talk and 'unburden' themselves was helpful. One described how the treatment provided a 'sort of canvas' to 'express myself in a way that I wouldn't necessarily have been able to talk to anyone else about these problems.' Some noted how the therapist's attention made them feel more confident. Talking appeared to enable some to see things differently.

Nine participants (mainly men), went beyond describing how the therapy helped them to see things differently to describing how it enabled them to deal with things differently as children and in particular how it helped in managing feeling states, especially stress and anxiety. One participant noted how 'even if the problems didn't go away I was certainly able to deal with them in a much more constructive manner and I didn't allow these worries to affect me.'

The ability to cope with feelings better was associated, for six of the interviewees, with a feeling that they developed 'the tools for self-analysis'. One interviewee recalled how his therapist once said to him 'the point of this, the point of the treatment, is for you to be able to do what you're doing without me, on your own.' While this ability was mostly seen as

helpful one participant talked of feeling that it might have made him 'a bit more likely to be introspective…to analyse a bit too much' and that he thought 'it can put too much emphasis on the individual to solve the problem.' Others also questioned the potentially negative impact of the therapy.

Interestingly, the majority of negative comments were made by women rather than men and they were all latency age or older at the time of being referred for therapy. Such comments included feelings that the therapy was 'pointless' and had made no difference or that it had set them apart from others, as one observed 'the last thing I wanted was to feel different'. In some this sense of being different created or exacerbated a sense that they were somehow 'damaged'. Two of the participants described feeling that there was 'something wrong' with them and for one this had confirmed her anxieties about being 'mad'.

While most of the participants struggled with how to evaluate the impact of psychotherapy on their lives, the majority (two thirds) did feel that the therapy had been helpful to them. The emphasis placed by many on the importance of the experience of being listened and understood by the therapist appears to echo the importance that children in family therapy research place on 'being heard'. There is support too for the idea that the therapy enabled the children to 'see' things differently and in this way enhanced resilience and coping.

Conclusions

The richness and diversity of the research presented here challenges the assertion that there is a dearth of 'evidence' in this field. Many of the findings provoke further questions for researchers and clinicians alike. How for instance, do we understand the finding that a shift from secure to insecure attachment is associated with improvement in the treatment of young adults with personality and affective disorders? Benefits are noted to accrue from longer more frequent treatments in many studies yet one randomized trial comparing treatments of different lengths found the briefest intervention to be most effective at four year follow up, what are the implications of this? Indeed brief interventions appear to be effective for certain groups, but depending on the diagnosis or type of difficulty, differences in outcome are associated with the frequency and length of treatment. How can the length and intensity of treatment be tailored to the presenting problem?

Particular treatments appear to work in different ways: family therapy appears to have a highly effective initial impact on childhood depression; the effect of individual child psychotherapy appears to be slower yet possibly more sustained. What determines these different patterns of response? Individual psychotherapy for the child in the absence of work with the parents or family seems to lead to poor outcomes for the family, whereas parent work undertaken in conjunction with individual work has been shown to have an impact on family functioning. What then is the best combination of treatments and in what order for any given clinical situation? An ongoing response to treatment or 'sleeper effect' is noted in several studies, what is the mechanism by which this occurs? Professionals within the multidisciplinary child mental health team base their clinical judgments on considerations broader than that of diagnostic groupings. How can this be taken into account in research?

The complexity of the process of change is highlighted by looking at the subtleties of shifts in previously maltreated children's representations of family life in response to adoptive placements. The interplay between parental states of mind and the child's representations is apparent as early as three months following the placement. Can further research similarly capture these kinds of processes?

Perhaps some of the most interesting questions are asked by former patients themselves. For any given individual how can the impact of a therapeutic intervention be fully assessed? As well as the many benefits thought to be attributable to psychotherapeutic treatment what are the possible adverse effects? How commonly do children in treatment feel that they are damaged in some way, that there is something wrong with them? Or as one child ventured is there 'too much emphasis on the individual to solve the problem'? These studies may therefore stimulate future research as well as developing clinical thinking.

Further research of sufficient quality to answer such questions will be dependent on research funding. With regard to effectiveness research where the randomized trial is one of the most powerful methodological tools, Chalmers cautions: *'It is unclear what the future holds for randomized controlled trials that address issues of no interest to industry but are of great importance to patients and practitioners. It cannot be assumed that the things that get studied in trials, or the way that they are studied, necessarily reflect the priorities of patients and health professionals'* (Chalmers, Rounding & Lock, 2003).

At the same time while outcome studies are informative about the potential for beneficial or adverse outcomes over time and with particular groups of patients, for the practicing clinician, retaining a focus on the process and short term goals of psychotherapeutic treatment and not just the expected 'end result' is of central importance. Gerber quotes Anna Freud *'it is very much like driving somewhere. Your aim is to arrive, and if instead of looking at the road, you think how nice it will be when you arrive, you will probably have an accident'* (Sandler, Kennedy & Tyson, 1980, p.251; Gerber, 2004)

Appendix A. Summary of studies

1)

Title
Report on the survey of ACP members about the Outcome Study. Part II: Summary of therapist activity and child data

Background/aims
The survey aimed to collect information about therapist activity and child data.

Methods
A questionnaire survey of members of the Association of Child Psychotherapists.

Findings
213 child psychotherapists responded to this survey providing anonymous data on 1,025 children seen in long term therapy. The majority (89%) of respondents were working in a variety of NHS settings. The kind of information described in the survey was as follows:
Age of children: 5.2% 0-4, 47.4% 5-11, 47.2% >12
Gender: Boys 55.7% Girls 43.9%
Family: 56% living with two parents (9% adopted), 17.6% single parent, 23.2% residential, foster or other carers
School: 74.2% mainstream education, 10.9% special school, and 6.1% college
Other professionals dealing with child: 63.2% had other agencies involved, 37% Social Services, 25.9% Educational Psychologist, 14.5% Paediatrics
Previous assessments or treatments: Psychiatry 21.9%, Clinical Psychology 10.3%, Paediatrician 4.1%
Symptoms/Diagnosis: 26.6% formal psychiatric diagnosis, of which 28.8% Autistic Spectrum Disorders, 15.3% ADHD, 13.5% Depression

Key reference
Rance, S. (2003). Report on the survey of ACP members about the Outcome Study. Part II: Summary of therapist activity and child data. *Bulletin of the Association of Child Psychotherapists, 133*, 25-32.

Other references
Beedell, C., & Payne, S. (1987). *Making the case for child psychotherapy: A survey of the membership and activity of the Association of Child Psychotherapists.* Unpublished manuscript. Commissioned by the Association of Child Psychotherapists.

Kam, S. (2004). *Who is referred for child psychotherapy and why?* Unpublished master's thesis, University College London.

2)

Title
Evaluation of psychoanalytic psychotherapy with children: therapists' assessments and predictions

Background/aims
(1) To test the hypothesis that severely deprived children can benefit from psychotherapy and that their adjustment in family placements might be facilitated.
(2) To devise a suitable methodology for evaluating psychoanalytic psychotherapy. To develop ways of making public therapists aims for their particular patients.

Methods
A non randomised controlled pilot study. The participants in the study were adopted and 'in care' children age 2-18, referred to the Tavistock Clinic over a three year period who received psychotherapy. There were thirty one participants in the intervention group and a small comparison group of seven. Most of the children (19 out of 31) were offered once weekly psychotherapy with the remainder being offered twice or three times a week psychotherapy. Parent/carer work was undertaken in parallel. Thirteen stopped well before the two year stage and twelve of this group were in once weekly treatment. There were twenty three different therapists. Half the final sample was under ten years.

Outcomes were assessed at baseline and included the Index of Discontinuity of Past Care, which took into account number of previous moves, history of abusive care, murder of parent etc. as well as the stability of the current placement. This was rated on a 5 Point scale. A Therapist's Questionnaire (form 2) was completed after assessment. Clinical judgments were recorded, noting aims for therapy and criteria for improvement. Anticipated progress was rated. At follow up the therapist's questionnaire (form 3) was completed. This records actual progress and change. External reports on progress (from school, carers etc.), were also gathered. An independent clinical rating, by 'blind' clinician rater, a senior child psychotherapist from outside the clinic was also undertaken.

Findings
Therapists' ratings at the end of treatment (form 3) were: improved 26 rated 1, 2 or 3 (some degree of improvement) of whom 23 were rated 1or 2 (definite or considerable improvement). Four were rated as making doubtful progress. One child was rated as having made no change. No children were rated as worse. Observations: a trend was noted for more frequent and longer therapy to be more effective. There was also a tendency for good progress to be related to more stable current placements and good external support for therapy. Therapists' predictions of outcomes were also looked at. Therapists predicted outcome well. In twenty three out of thirty one cases the predictions were the same. In five cases the children did worse than expected and five cases did better. In the comparison group that was recommended for psychotherapy but did not receive it, none in this group improved. At baseline the psychotherapy group and those not referred for psychotherapy did not differ substantially in terms of background and current placement. At baseline the comparison group was similar on most measures apart from stability of current placement, which was slightly less stable. External reports obtained corroborated the improvements seen by therapists. An independent rater confirmed the findings of the therapists. The therapists criteria for improvement was often exacting, specifying internal as well as external change. Of note the child who appeared to be 'most damaged' in the study but was also the youngest (2years) did very well.

Key reference

Lush, D., Boston, M., & Grainger, E. (1991). Evaluation of psychoanalytic psychotherapy with children: therapists' assessments and predictions. *Psychoanalytic Psychotherapy, 5* (3), 191-234.

Other reference

Boston, M., & Lush, D. (1994). Further considerations of methodology for evaluating psychoanalytic psychotherapy with children: reflections in light of research experience. *Journal of Child Psychotherapy, 20* (5), 205-229.

3)

Title
Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change

Background/aims
To compare psychoanalytic psychotherapy with group psychotherapy as a treatment for girls who have been sexually abused.

Methods
A multi-centre randomised controlled trial. 71 participants were randomly assigned to (1) focused individual psychotherapy (30 sessions) or (2) psycho-educational group therapy (up to 18 sessions), led by co-therapists. After random allocation of the abused girls to the two interventions the carers were then assigned to a carers groups or individual support. It was not possible to maintain the randomisation procedure for the carer intervention (foster carers were excluded from groups).

Participants were symptomatic sexually abused girls (6-14years), mean age, 10 years. Forty nine of the girls were in the family home, 22 girls were looked after and accommodated. Diagnostic categories: PTSD (73%); Major Depressive Disorder (57%); Generalised Anxiety Disorder (37%); Separation Anxiety Disorder (58%). Study participants appeared to be more seriously abused than in other studies (e.g. over 30% had been exposed to multiple perpetrators). Outcomes: (1) The Schedule for Affective Disorders and Schizophrenia (Kiddie-SADS) (2) Global impairment of functioning assessed using the K-GAS based on the Children's Global Assessment Scale (C-GAS) (3) Post-traumatic stress disorder -assessed using Orvaschel's PTSD scale. Outcomes were assessed at: (1) Baseline prior to therapy (2) One year after the start of therapy (3) At two year follow up.

Findings
It was considered unethical to have a no treatment control group (the ethics committees in two hospitals refused to endorse a no treatment group). The two comparison treatments were expected a priori to be effective but in different ways. The individual therapy appears to have had more of an impact on the PTSD dimensions of re-experience of traumatic events and persistent avoidance of stimuli. Comparison of therapy groups on K-GAS and three PTSD Dimensions: on K-GAS the between group effect sizes never achieved 0.5 (used as the criterion of medium effect). The same was true of the PTSD dimension of 'persistent symptoms of increased arousal'. On the PTSD dimensions of re-experience of traumatic event and persistent avoidance of stimuli the mean change scores of individual therapy as compared to group therapy were associated with effect sizes of 0.5 or greater.

Key reference
Trowell, J., Kolvin, I., Weeramanthri, T., Sadowski, H., Berelowitz, M., Glasser, D., & Leitch, I. (2002). Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry, 180*, 234-247.

Other reference
Trowell, J., Berelowitz, M., & Kolvin, I. (1995). Design and methodological issues in setting up a psychotherapy outcome study with girls who have been sexually abused. In M. Aveline & D. Shapiro (Eds.), *Research foundations for psychotherapy practice* (pp. 247-262). Chichester: John Wiley & Sons.

4)

Title
Attachment representations and adoption: associations between maternal states of mind and emotion narratives in previously maltreated children

Background/aims
To examine the observed links between representations of attachment among adoptive mothers obtained immediately prior to placement of a late-adopted child and the emotion narratives provided by these children within three months of the placement.

Methods
A sample of 43 mothers who had 61 children placed with them. The children ranged in age from 4 to 8 years with a mean of 6 years. The children had all suffered from serious adversity including neglect, physical abuse and sexual abuse. Five children were placed with single adopters and the rest with a married couple. The mothers were assessed using the Adult Attachment Interview (AAI) prior to placement of the child and children were assessed within three months of the placement using the *Story Stem Assessment Profile*.

Findings
Of the total sample of 43 mothers, 31 (71%) were classified as autonomous-secure, 10 (23%) were classified as insecure dismissing and 2 (5%) were classified as insecure-preoccupied. Of the 43 interviews 9 (21%) were classified as unresolved with respect to past loss or trauma. Themes of 'aggressiveness' in the children's story stems were significantly more likely to appear in the story completions of children adopted by 'insecure' mothers as opposed to 'secure' ones. Significant differences in themes were identified in the children's story completions in mothers classified as unresolved with respect to past trauma. The findings suggest that unresolved mourning in a parent may exacerbate the emotional worries of a recently adopted child. Overall there was a tendency for the children adopted by mothers in this category to appear less able to use an organised strategy to deal with conflict depicted in the story. The researchers note that it is surprising, given the adverse early histories of the children that within three months of being placed in a new environment the influence upon the child of the adopter's state of mind with regard to attachment can be discerned.

Key reference
Steele, M., Hodges, J., Kaniuk, J., Hillman, S., & Henderson, K. (2003). Attachment representations and adoption: associations between maternal states of mind and emotion narratives in previously maltreated children. *Journal of Child Psychotherapy, 29* (2), 187-205.

Other references
Steele, M. (2006). The 'added value' of attachment theory and research for clinical work in adoption and foster care. In J. Kendrick, C. Lindsey & L. Tollemarche (Eds.), *Creating new families: therapeutic approaches to fostering adoption and kinship care*. London: Karnac Books.

Hodges, J., Steele, M., Hillman, S., Henderson, K., & Kaniuk, J. (2003). Changes in attachment representations over the first year of adoptive placement: narratives of maltreated children. *Clinical Child Psychology and Psychiatry, 8* (3), 351-368.

5)

Title
Risk-taking, dangerous behaviour in childhood

Background/aims
This study was undertaken by a child psychotherapist working in a CAMHS setting. The aim of study was to understand risk taking behaviour using psychoanalytic thinking and comparing material from a number of cases across a wide age range (grouped bands). The study looked at twelve children, all of whom engaged in risk taking behaviour that was often accompanied by self-harming/aggression.

Methods
A qualitative analysis of the clinical data gathered was undertaken using grounded theory (Glaser & Strauss, 1967).

Findings
Three different situations were identified in which risk taking, dangerous behaviour occurred and these were named (a) no-haven (b) illusory haven (c) perilous-haven. All three appear to be un-safe for the child. Each 'haven' seems to have a different clinical prognosis. 'No-haven' is characterized by a predominance of hostile feelings between parent and child. In the 'illusory-haven' configuration there appears to be an affectionate relationship between parent and child but the child is neither thought about emotionally not held in the parents mind. A 'perilous-haven' occurs where the parent has markedly split feelings about the child but has some awareness of these ambivalent feelings. Different strategies in treating each of these three groups are identified with the ultimate aim of creating a 'safe-haven' for the child, which offers security, emotional responsiveness and developmental opportunities.

Key reference
Anderson, J. (2001) *Risk-taking, dangerous behaviour in childhood*, Thesis, University of East London.

Other reference
Anderson, J. (2004). Risk-taking, dangerous behaviour in childhood: child protection and clinical strategies. *Journal of Social Work Practice*, 18 (1), 19-32.

6)

Title
The efficacy of psychoanalysis for children with disruptive disorders

Background/aims
A study based on the Anna Freud Centre retrospective case note study. The aim of this study was to compare outcomes for children with disruptive behaviour and emotional disorder. The study has substantial limitations because of it's retrospective, case note design.

Methods
A retrospective controlled trial. Outcomes for 135 children with a DSM-IIIR diagnosis of disruptive disorder were compared with 135 matched children with a DSM-IIIR diagnosis of emotional disorder. Match included gender, age, socio-economic status, CGAS and frequency of sessions. The control sample was selected from 368 cases treated for emotional disorders. The primary outcome measures were 'caseness' and clinically significant change in adaptation level.

Findings
One third of the sample with conduct disorder and 53% of the sample with emotional disorder were no longer diagnosable post treatment. 46% of the conduct disordered sample and 73% of the emotional disordered sample showed clinically reliable improvements. The treatment was more effective for younger children rather than adolescents and more effective for children with a diagnosis of Oppositional Defiant Disorder rather than Conduct Disorder. 31% of children terminated treatment early within one year. Of those disruptive children who remained in treatment 69% were no longer diagnosable on termination. More than 2/3's of those who dropped out of within the first year were in non-intensive treatment. 40% of those in non-intensive dropped out compared with 25% of those in intensive. The differences in outcome between the two groups are reduced when those receiving non-intensive treatment are excluded.

Key reference
Fonagy, P., & Target, M. (1994). The efficacy of psychoanalysis for children with disruptive disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 33* (1), 45-55.

Other reference
Fonagy, P., & Target, M. (1996). Predictors of outcome in child psychoanalysis: a retrospective study of 793 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association, 44* (1), 27-77.

7)

Title
Structural and symptomatic change in psychoanalysis and psychodynamic psychotherapy. A quantitative study of process, outcome and attachment

Background/aims
A quasi-experimental study exploring psychotherapeutic process and outcome in 25 young adults sequentially assigned to psychoanalysis (n=14) or psychodynamic psychotherapy (n=11)

Methods
A quasi-experimental study with sequential assignment to psychoanalysis (n=14) or psychodynamic psychotherapy (n=11). Participants were 25 young adults ranging in age from 18 years to 24 years. All patients had at least one Axis II diagnosis with narcissistic and borderline personality the most common. All patients had at least one Axis I diagnosis (mostly mood disorders). No patient had a diagnosis of psychosis and less than half were on psychotropic medication. About 20% had a previous history of hospitalization. A significant proportion had a history of violent episodes/self harm. Patients were assessed by an independent psychiatrist at intake, termination and 18 month intervals after intake and termination with the Adult Attachment Interview (AAI) and a range of symptomatic and diagnostic measures including structured interviews such as the SADS-L and SCIDII. Treatment continued in an open ended way with average treatment length 3.5 years.

Findings
Over the course of treatment (6 months to 8 years long), 12 of 19 patients (with adequate data) improved symptomatically on an aggregate measure. Ten of 12 improvers were in the psychoanalysis group, suggesting that this is the most effective treatment in this population. On the AAI the results show a high proportion of secure classifications at initial assessment and in successful treatment a movement towards a preoccupied-entangled attachment pattern which began to resolve by termination.

Key reference
Gerber, A. (2004). *Structural and symptomatic change in psychoanalysis and psychodynamic psychotherapy: a quantitative study of process, outcome and attachment.* Unpublished PhD thesis, University College London.

Other reference
Fonagy, P., Gerber, A., Higgitt, A., & Bateman, A. (2002). Anna Freud Centre studies 4: The comparison of intensive (5 times weekly), and non-intensive (once weekly), treatment of young adults (AFC4) In P. Fonagy (Ed.), *An open door review of outcome studies in psychoanalysis* (2nd Edition), (pp. 96-97). London: International Psychoanalytical Association.

8)

Title
The self and object representations of narcissistically disturbed children. An empirical investigation

Background/aims
While a major focus of adult psychiatric literature particularly among psychoanalytic clinicians narcissistic pathology in children has received less attention. This study set out to demonstrate a correlation between the clinical assessment of narcissistic personality disorder in children and adolescents and underlying self and object relationships.

Methods
The study looked at 32 elementary school age children who had been referred for an outpatient psychological assessment. Of the total 32 children, 16 were found to meet DSM-IV behavioural criteria for narcissistic personality disorder. (N=32 16-M 16-F). The social cognition and object relations scale for the *Thematic Apperception Test* (Westen et al., 1995; Westen et al., 1985) was used to compare the object representations of the two groups of referred latency-aged children. Raters who were blind to age, gender and diagnostic category of the participants coded all of the TAT responses (see glossary). Coders were given typed stories organized in a random manner. In one group of children narcissistic issues were thought to be primary. It was predicted that the narcissistic children would (a) depict fewer relationships, of poorer quality (b) exhibit a lower investment in values and moral standards (c) demonstrate difficulty with the experience and management of aggressive impulses (d) manifest unstable self-esteem (e) experience problems with the development of a stable identity

Findings
Support for the clinical literature which describes these children as lacking in empathy or struggling with self esteem regulation and in poor control of their impulses or aggression was found. Additionally, a tendency to have a vulnerable sense of identity and to be preoccupied with seeking out and developing relationships with others was found to differentiate these children from peers with similar behavioural and diagnostic profiles. Essentially three of the five hypothesis were borne out in the expected direction: (a) a lower investment in values and moral standards; (b) more difficulty in managing aggressive impulses; (c) less stable self esteem (as shown by having a less realistic range of positive and negative feelings about themselves).

One unexpected finding in the opposite direction to that predicted was that the narcissistic group showed a significantly higher investment in relationships than the control group. This may reflect an 'object hunger' i.e. a wish to seek out relationships which provide confirming and admiring responses. The authors note a hesitation in diagnosing characterlogical disorders in children and comment that many of these children are only treated for their Axis 1 disorders and any underlying personality difficulties are not specifically addressed. There is as yet no agreed definition of a narcissistic disorder in childhood. The authors comment on the limitations of a small sample size. In addition data was collected by several examiners. The need for further studies to explore or possibly validate the above findings is highlighted. It is noted that projective tests such as this may be a helpful adjunct to the assessment of children with narcissistic vulnerabilities and modes of relating as well as assisting in devising a treatment plan best suited to their needs.

Key references

Weise, K., & Tuber, S (2004). The self and object representations of narcissistically disturbed children. An empirical investigation. *Psychoanalytic Psychology, 21* (2), 244-258.

Other references

Westen, D., Lohr, N., Silk, K., Kerber, K., & Goodrich, S. (1985a). Social cognition and object relations scale (SCORS): *Manual for coding TAT data.* Ann Arbor: University of Michigan.

Westen, D. (1995). *Social Cognition and Object Relations Scale: Q-sort for projective stories (SCORS-Q).* Unpublished manuscript, Department of Psychiatry, The Cambridge hospital and Harvard Medical School.

9)

Title
A two year follow-up of psychodynamic psychotherapy for internalizing disorders in children

Background/aims
A follow up of a previous pilot study (Muratori et al., 2002)

Methods
A quasi-randomised controlled study. Allocation to treatment or comparison group was based on therapist vacancy. The sample size was projected on the basis of the previous pilot study. N=58 (30 of the patients were included previously in the pilot study). A sample size of 58 was calculated on the basis of this pilot study in order to achieve a statistical power of 85%. Participants met DSM criteria for anxiety or depressive disorder and were aged between 6.3-10.9yrs, (mean age 8.8 yrs, S.D. 1.3). Inclusion criteria: (a) DSM-IV diagnosis of depressive or anxiety disorder; (b) Symptoms and difficulties lasting at least a year and circumscribed to a single or several areas but not to all social areas; (c) A C-GAS under 70 The primary outcome measures were: diagnosis as assessed by the K-SADS; the CBCL; the C-GAS.

Findings
From the end of treatment to follow up only the experimental group improved significantly on all three scales of the CBCL. The Effect Size was 0.72. On the CBCL Total Problems and Internalising Scales, both groups moved to the borderline range at end of treatment but a further improvement to the non-clinical range was noted in the experimental group only. Early (at 6 months) improvement in both groups on the C-GAS was identified but only the experimental group made a shift to the non-clinical range that was maintained at two year follow up. The Effect Size for the C-GAS was 0.73. At follow up only the mean of the experimental group had moved to the functional range. On the CBCL no group differences emerged in the first six months whereas at two year follow up only the experimental group improved significantly. The study authors hypothesize that the positive changes in the comparison group (in global functioning) may result from the assessment process. On the CBCL there appears to be some evidence of the 'sleeper effect'. Authors note the 'non linear' nature of treatment outcomes. Lower service use was identified in the experimental group.

Key reference
Muratori, F., Picchi, L., Bruni, G., Patarnello, M., & Romagnoli, G. (2003). A two-year follow-up of psychodynamic psychotherapy for internalizing disorders in children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42* (3), 331-339.

Other reference
Muratori, F., Picchi, L., Casella, C., Tancredi, R., Milone, A., & Patarnello, M.G. (2002). Efficacy of brief dynamic psychotherapy for children with emotional disorders. *Psychotherapy and Psychosomatics, 71* (1), 28-38.

10)

Title
Childhood depression: a place for psychotherapy. An outcome study comparing Individual Psychodynamic Psychotherapy and Family Therapy.

Background/aims
Although considered clinically effective there is little systematic research confirming the use of Individual Psychodynamic or Family Therapy as treatments children and young adolescents. This clinical trial assessed the effectiveness of these two forms of psychotherapy in treating moderate to severe depression in this age group.

Methods
A randomised controlled trial with 72 patients aged 9-15 years. The patients were randomly allocated to either Individual Therapy (Focused Individual Psychodynamic Psychotherapy) or Family Therapy (Systems Integrative Family Therapy). The trial was conducted in London, Athens and Helsinki. All participants were referred into the study from community child mental health services. 24 cases entered therapy in each country. Treatment was conducted over a nine-month period and consisted of eight to fourteen 90 minute sessions of Family Therapy or sixteen to thirty fifty minute sessions of Individual Therapy plus individual parent sessions (one per 2 sessions of child's psychotherapy). Treatment manuals were used to ensure comparability across all three centres, supplemented by cross-centre training. Assessment took place at baseline, end of therapy and six months after the end of therapy. An extensive battery of instruments was administered at each time point including a demography interview, The Kiddie-SADS, The Childhood Depression Inventory, The Moods and Feelings Questionnaire and The Children's Global Assessment Scale (C-GAS).

Findings
The mean age of the participants was 12 years and almost two thirds (62%) were male. Just under half (44%) had a history of maternal psychiatric illness and 15% had a history of depression in their extended family. A significant reduction in disorder rates were seen for both Individual Therapy and Family Therapy. 74.3% of cases were no longer clinically depressed following Individual therapy and 75.7% of cases were no longer clinically depressed following Family Therapy. This included cases of Dysthymia and 'Double Depression' (co-existing Major Depressive Disorder and Dysthymia). There was also an overall reduction in co-morbid conditions across the study. The changes in both treatment groups were persistent and there was ongoing improvement. At follow up six months after treatment had ended, 100% of cases in the individual therapy group and 81% of cases in the Family Therapy group were no longer clinically depressed. (Four cases who had been lost to follow up in the family therapy group were considered as unsuccessfully treated in the analysis). With regard to the Moods and Feelings Questionnaire the Family Therapy group had a lower score at the end of therapy, despite having had a higher score than the Individual Therapy group at baseline. The Family therapy group appears to have made greater improvement, in some respects, by the end of therapy, compared the Individual Therapy group. These differences though had disappeared by follow up. By follow up many of the Family Therapy trajectories appear to have plateaued, while the individual therapy trajectories suggested the possibility of further improvement to follow.

Key reference
Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson K., Barnes, J., & Tsiantis, J. (2007). Childhood depression: a place for psychotherapy. An outcome study comparing individual Psychodynamic Psychotherapy and Family Therapy. *European Child and Adolescent Psychiatry, 16.*

11)

Title
Adolescents with Insulin Dependent 'Brittle Diabetes': A controlled study of psychoanalytic psychotherapeutic treatment

Background/aims
The aim of this study was to examine the efficacy of psychoanalytic child psychotherapy for adolescents with 'brittle' or poorly controlled insulin dependent diabetes.

Methods
A quasi randomised controlled study. N= 22.
Patients were consecutive admissions to one of three wards over a three year period. Assignment to groups was based on the family's area of residence which determined to which of the wards the child was admitted. All those in the experimental group were on the same ward. The existing routine treatment was by national standards of the highest quality. Researchers note that ethical and practical constraints imposed by the gravity of the children's illness prevented them from making truly random assignments.
Inclusion criteria: Age, 6-18 years. IDDM of at least two years duration and a diagnosis of 'brittle diabetes' according to specific criteria.
Psychoanalytic psychotherapy 3-5 times/week for a mean period of 15 weeks (range 5-28 wks) and parent work was compared with inpatient medical intervention (in 5 of 11 cases routine medical management included the involvement of a psychologist or psychiatrist).
Outcomes: Baseline assessments: IQ, child psychiatric assessment, psychological assessment.
Diabetic control as assessed by the following:
(1) The M value (a measure of diabetic control).
(2) The glycosylated hemoglobin concentration (HbA1c) this reflects average blood glucose levels over the preceding 4 weeks.
The number of readmissions to hospital up to one year after discharge (the treatment group were encouraged to seek admission for reasons of psychological distress).
Psychological outcome measures were not used. The authors were sceptical about the relevance of available outcome measures and were concerned about contamination of outcome measures by the treatment process. Physical measures were selected as preferable indicators of structural change. Assessments were undertaken at end of treatment and at one year follow up.

Findings
The two groups were comparable on most demographic and clinical variables. There were three children in the experimental group with growth failure (height velocity below third centile). 73% of the experimental group and 63% of the control had a psychiatric disorder. A significant improvement was noted in diabetic control in the experimental group compared to control. This was maintained at one year follow up. All but one subject in the experimental group showed a reduction in HbA1c over the course of treatment whereas only 4 out of 11 in the control group showed an improvement. At one year follow up 9 of experimental group patients remained below their preadmission average HbA1c levels whereas only 3 of those in the comparison group did so. Clinically relevant was the reduction of HbA1c levels to within the 'acceptable' range for diabetes in 6 of the experimental group whereas none of the comparison group showed such an improvement. M values were not available for all patients but an improvement was noted in the treated group. Four out of the experimental group and 8 out of the comparison group were readmitted in the year after discharge. Significant differences in outcome were noted despite the small numbers.

References

Moran, G.S., Fonagy, P., Kurtz, A., Bolton, A.M., & Brook, C. (1991). A controlled study of the psychoanalytic treatment of brittle diabetes. *Journal of the American Academy of Child & Adolescent Psychiatry, 30* (6), 926-935.

Other reference

Moran, G., & Fonagy, P. (1987). Psychoanalysis and diabetic control: a single-case study. *British Journal of Medical Psychology, 60*, 357-372.

12)

Title
Studies of the efficacy of child psychoanalysis

Background/aims
Three participants in the controlled study of psychoanalytic psychotherapy for poorly controlled diabetes who also had growth retardation were examined to see if the psychoanalytic psychotherapy had an impact on growth retardation as well as diabetic control.

Methods
A single case experimental design (cases also participants in the controlled trial). Participants were 6-18 year olds with uncontrolled diabetes and significant growth retardation (all below the third percentile in height). N=3. Three indicators were used:
(a) Height standard deviation scores for chronological age.
(b) Height velocity standard deviation scores for chronological age.
(c) Predicted adult height from height and bone age before and 6 months after treatment

Findings
The first patient (male) was in treatment between the ages of 8 and 9 1/2. During treatment there was a marked improvement in height velocity scores. This was maintained over the follow up period. His predicted adult height before treatment was 8cm less than at follow up age 10. The second patient (female) age 13 1/2 experienced a marked increase in height velocity during treatment. Her predicted adult height increased by 5 cms. The third patient (male) age 12 1/2, predicted adult height increased by over 10cms. Catch up growth in all patients was associated with improved diabetic control.

Key reference
Fonagy, P., & Moran, G.S. (1990). Studies of the efficacy of child psychoanalysis. *Journal of Consulting & Clinical Psychology*, 58 (6), 684-695.

Other reference
Moran, G., & Fonagy, P. (1987). Psychoanalysis and diabetic control: a single-case study. *British Journal of Medical Psychology*, 60, 357-372.

13)

Title
A controlled comparison of family versus individual psychotherapy for adolescents with anorexia nervosa

Background/aims
To compare individual and family psychotherapy as a treatment for adolescents with anorexia nervosa.

Methods
A small Randomised Controlled Trial with 37 participants. Participants were randomly allocated to BFST (Behavioural Family Systems Therapy) or EOIT (Ego Oriented Individual Therapy. In BFST the family were seen conjointly and parents were placed in control of the adolescents eating. Distorted beliefs were targeted through cognitive restructuring and strategic/behavioural interventions were used to change family interactions. In EOIT the adolescent was seen individually, with an emphasis on building ego strength and uncovering the dynamics blocking eating. Parents were seen collaterally. The therapy duration was on average 15.9 months. Therapists were given a range of 12-18 months per case rather than a fixed treatment period. BFST families met weekly for approx 72 minutes. EOIT therapists met weekly with adolescents for 45 mins and fortnightly with parents for 54 mins. All sessions were audio-taped. A range of physical and psychological outcome measures were used. Physical outcomes included: Body Mass Index ; target weight; resumption of menstruation. Psychological outcomes included: Eating Attitudes Test (self-report and parental report); Ego Functioning (scales from the eating disorders inventory); Depressive Affect (Beck Depression Inventory; Internalizing behaviour Problem Score from the Youth Self report); Parental CBCL; Family Conflict as assessed using the Parent Adolescent Relationship Questionnaire (PARQ). Outcomes were assessed at baseline, post-treatment and one year.

Findings
Physical outcomes:
BMI (mean): the BFST group improved more and more rapidly. Menstruation: at post treatment significantly more in BFST group were menstruating but not at one year. Regards Target Weight and BMI percentile criteria, both groups did well (two thirds of girls reached target weight at one year follow up).
Psychological outcomes:
Eating Attitudes: improved for both (no significant differences). Depressive Affect: both groups improved. Ego Functioning: few changes in both groups. Family Relations: eating related family conflict improved in both groups. More BFST than EOIT cases required hospitalization.
It is concluded that both treatments are effective for adolescents with Anorexia. BFST produced faster change on some weight measures. The researchers note with interest the similar reduction in family eating related conflict despite the EOIT group not attending a conjoint family meeting and conclude that family therapy is not necessary in order to bring about a change in parent child interactions.

Key reference
Robin, A., Siegel, P., Moye, A., Gilroy, M., Dennis, A.B., & Sikand, A. (1999). A controlled comparison of family versus individual psychotherapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry, 38* (12), 1482-1489.

Other reference
Robin, A., Siegel, T., & Moye, A. (1995). Family versus individual therapy for anorexia: Impact on family conflict. *International Journal of Eating Disorders, 17* (4), 313-322.

14)

Title
The Tavistock Autism Workshop Approach

Background/aims
A non-randomised controlled study comparing extended therapeutic assessments of children with autism and their families with the outcomes for children who have not received such input. The study is ongoing.

Methods
A non randomized controlled study. A clinically referred experimental sample is compared with a matched control group (although selected from a different clinic). The prediction being tested is that the nature and degree of development will be significantly different in the treatment group compared to the control group. An extended therapeutic assessment with the family, over a period of 6-12 months is offered prior to consideration of more specific input e.g. individual child psychotherapy and this is compared with standard treatment for autism, without any psychotherapy input. The children included in the study are all male, referred to the autism team at the Tavistock and under 5 years of age. The control group is drawn from a clinic outside London for whom psychotherapy is not currently available. The children in the control group are matched for age, sex, severity of autism and developmental level.

Baseline (pre-psychotherapeutic assessment): a home visit by a research psychologist who video-tapes a play-based session (capturing what the child typically does at home, the capacity to explore toys and engage in joint play with parent); interviews with the parents to complete the Autism Diagnostic Interview (ADI-R: Lord, Rutter, & Le Couteur, 1994) and the Vineland Adaptive Behaviour Scales (VABS: Sparrow, Balla, & Cicchetti, 1984). The research psychologist also completes the Childhood Autism Rating Scale (CARS: Schopler, Reichler, & Renner, 1986). All sessions are videotaped and detailed process notes made after each session. Parents are requested to keep a diary of their observations and thoughts. After treatment the research psychologist returns to the family and re-administers the pre-treatment measures.

Findings
Twelve families reported as being recruited so far. Three families withdrew from the extended assessment and were not available for follow-up. Seven families have undergone the extended psychotherapeutic assessment. There are preliminary findings on seven families. Six children have improved in a manner consistent with the predictions of the research team.

Key reference
Reid, S., Alvarez, A., & Lee, A. (2001). The Tavistock autism workshop approach: Assessment, treatment and research. In J. Richer., & S. Coates (Eds.), *Autism-the search for coherence* (pp. 182-192). London: Jessica Kingsley.

15)

Title
Outcome of child psychotherapy as a function of frequency of session

Background/aims
To look at the outcome of Child Psychotherapy as a function of the frequency of session. Differences noted in outcome between the groups in spite of small sample size.

Methods
A non randomized comparative study. N=12 (3x n=4). No information is given on how the samples were selected. There appears to have been non random allocation to groups, although an attempt was made to match groups according to key demographic variables. Participants were boys age 7-10 years referred for reading retardation associated with emotional disturbance The study compares psychoanalytic child psychotherapy at different frequencies i.e. once/week or four times/week for two years or once/week for the first year followed by four times/week for the second year. All mothers were seen once weekly. Outcomes were assessed at baseline, end of treatment and follow up. Outcomes included: interviews with parents, teachers, child; I.Q; Reading Ability; The **Diagnostic Profile* (Freud 1965).

Findings
At one year follow up the impact of treatment frequency on rate of improvement of reading was assessed. Those seen once/week improved most initially but in the year after the end of treatment those seen four times/week (either for one or two years) did significantly better in terms of the rate of improvement in their reading ability. With regard to personality functioning those seen more frequently showed at the end of treatment and at one year follow up, more improvement in effective adaptation and adequate self esteem, frustration tolerance and ability to work, capacity for forming and maintaining relationships and flexible adaptation. The results suggest that the outcome of psychoanalytic psychotherapy may be affected by the frequency of treatment. Of note some of the most striking findings were not evident until follow-up.

Key references
Heinicke, C.M., & Ramsay-Klee. D.M. (1986). Outcome of child psychotherapy as a function of frequency of session. *Journal of the American Academy of Child & Adolescent Psychiatry, 25* (2), 247-253.

Other reference
Heinicke, C.M. (1965). Frequency of psychotherapeutic session as a factor affecting the child's developmental status. *Psychoanalytic Study of the Child, 20*, 42-98.

16)

Title
Long term comparison of brief versus unlimited psychodynamic treatments with children and their parents

Background/aims
The purpose of the study was to compare the long term-effectiveness of time-limited and time-unlimited psychodynamically based therapies, with a minimal contact group as a control. The treatments were provided to children diagnosed as having psychological problems.

Methods
A randomised controlled trial. N=30, 25 (male) 5 (female). Inclusion criteria: diagnosis of 'Disturbance of emotions specific to childhood' (WHO, 1978); age 5-9years; assessed by an independent child psychiatrist as needing treatment. Exclusion criteria: single parent family; parental mental illness/drug abuse; history of learning difficulty, psychosis or previous therapy. Random assignment to:
(1) Time limited (12 sessions) psycho-dynamically orientated treatment
(2) Time unlimited psycho-dynamically orientated treatment
(3) Minimal contact control (4 sessions)
The therapy was conducted by four therapists. One therapist worked with the child and the other with the parents. The minimal contact group received on average two assessment interviews, a feedback session and a follow up interview 12 weeks after the feedback session. It had a similar initial format to other therapies. Goals were presented to the family that would have been worked on had there been time and the families were advised to work independently. Outcomes were assessed using: Goal Attainment Scales (the child therapists and parent therapists agreed 3 goals for each family with at least one goal that related directly to the child); the Target Complaint Scales, each parent independently listed in order of severity up to 3 problems that had led them to seek assistance rated on 5 point scale; the Van der Veen Family Concept Inventory, each parent independently describes his or her perception of the family as a functional unit; the Bristol Social Adjustment Scale. Outcomes were assessed at baseline and at four year follow up.

Findings
The time unlimited group received significantly longer therapy than the time limited group. On the Target Complaints Scales the minimal contact group had significantly improved ratings compared to the time unlimited group. On the Van der Veen Family Concept Inventory, analysis of changes from pre-treatment to 4 year follow up indicated a significant improvement for the minimal contact control group. Scores for the time limited and time unlimited groups did not change significantly over time. On the Goal Attainment Scale, there was a significant improvement for all three groups at post treatment and at 4 year follow up. In conclusion all groups improved but the positive results for the minimal contact control group were surprising.

Key reference
Smyrnios, K. X., & Kirby, R. J. (1993). Long term comparison of brief versus unlimited psychodynamic treatments with children and their parents. *Journal of Consulting & Clinical Psychology, 61* (6), 1030-1027.

17)

Title
Structural family versus psychodynamic child therapy for problematic Hispanic boys

Background/aims
To compare structural family therapy and individual psychodynamic child therapy.

Methods
A randomized controlled trial. Random assignment to Structural Family Therapy (SFT) or Individual Psycho-dynamic Child Therapy (IPCT) or a recreational control group. N=88. The sample was recruited for the purposes of research rather than clinically referred. Researchers are open about their allegiance to family therapy however efforts were made to ensure fidelity to both treatment interventions. Despite this, the individual child psychotherapy treatment was unusually undertaken in the absence of any parent work. Treatment duration was a minimum of 12 and a maximum of 24 hours. Both treatments were manualised.
Inclusion Criteria: Hispanic boys; age 6-12 years; two parent family who had lived in US for> 3 yrs; no history of mental retardation, mental health care, suicidal ideation or psychoactive medication disorder. Outcome measures: Behavioural and self report measures: revised Child Behaviour Checklist; Revised Behaviour Problem Checklist; Child Depression Inventory; Children's Manifest Anxiety Scale; Psycho-dynamic Child Rating Scale; Structural Family Systems Ratings. Outcomes administered pre and post treatment and at one year follow up.

Findings
Mean age of the boys was 9 years and 2 months. Diagnosis (DSM-III): 32%ODD; 30% anxiety disorder; 16% conduct disorder; 12% adjustment; 10% other.
Attrition rates from baseline: 43% (13/30) in control group; 16% (5/31) in SFT; 4% (1/27) in IPCT. Sixty nine completed therapy but 11 did not return for follow up (3 in SFT, 5 in IPCT and 3 in the control group). N=69 at post treatment. N=58 at one year follow up. The control group was significantly less effective in retaining cases than the two treatment conditions. Family therapy and psychodynamic therapy were similar in reducing behavioral and emotional problems based on parent and self-reports and psychodynamic ratings of child functioning. These improvements were maintained at one year follow up. On the family functioning measure an improvement is noted in the family therapy group at follow up. The control group remained the same. The individual psychodynamic psychotherapy group showed deterioration at one year follow up however the individual therapy with the child was unusually undertaken without any conjoint parent or family work.

Key reference
Szapocznik, J., Murray, E., Scopetta, M., Hervis, O., Rio, A., Cohen, R., Rivas-Vazquez, A., Posada, V., & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology, 57*(5), 571-578.

Other references
Szapocznik, J., Hervis, O., Rio, A., Faraci, A.M., Foote, F., & Kurtines, W. (1986). *Structural family systems ratings: A manual.* Miami: University of Miami School of Medicine.

Szapocznik, J., Rio, A., Richardson, R., Alonso, M., & Murray, F. (1986). *Manual for the psychodynamic child ratings.* Miami: University of Miami School of Medicine.

18)

Title
The adult outcome of child psychoanalysis: a long-term follow up study

Background/aims
The aim of this study was to explore the long term outcomes of those who had received treatment as children at the Anna Freud Centre.

Methods
The study was designed to enable comparison between four comparison groups. First the study aimed to compare subjects who had received intensive psychoanalytic treatment in childhood (4-5 sessions per week) with those who had received non-intensive treatment (1-3 sessions per week). This comparison had to be abandoned because of difficulties in tracing and contacting treated subjects. Of the 34 treated subjects who participated in the study, the majority (26 out of 34) had received intensive treatment in childhood. Similarly it had been planned to compare the children who received treatment with an untreated control group referred at the same time as the treated subjects, however for ethical reasons it didn't prove possible to trace such a group. A comparison was undertaken with 16 untreated siblings of those who had received treatment in childhood. As part of the study a comprehensive multi-level adult assessment interview protocol was developed. This included the AAI, psychiatric measures (SADS-L and SCID-II) and assessments of adult personality functioning. Five of the assessment measures were incorporated into the Adult Functioning Index (AFI) yielding a single overall score based on both psychiatric and psychosocial functioning.

Findings
Of the 400 former patients who met criteria for inclusion in the study nearly 50% could not be traced. Of those whose whereabouts were established 42% agreed to full interviews and 10% to complete established questionnaires. Of the 60 subjects who agreed to be interviewed 34 subjects actually participated in the study. The majority of subjects appeared to be functioning well and few had personality disorders. Adversity in childhood was greater in the treated siblings but the untreated siblings experienced more negative life events in adulthood. With regard to personality functioning in the work domain, all of sample was doing well. In the domain of intimate relationships those successfully treated in childhood were doing better than untreated siblings. With regard to attachment security if the immediate outcome was good those treated as children did as well as their siblings in adulthood. Those who were unsuccessfully treated had predominantly preoccupied/entangled attachment styles. Those who were untreated were predominantly dismissing in their attachment style. The child's global functioning level pre treatment as assessed by the HCAM was the best childhood predictor of adult outcome. The number of diagnoses at termination of treatment was also a significant predictor of adult outcome. While children assessed as poorly functioning on the HCAM at the time of referral were most likely to end up as poorly functioning adults this was not the case for approximately a third of the sample (n=11) who despite a poor prognosis turned out to be well functioning adults. Common to all individuals with low functioning in childhood (assessment HCAM < 70) who grew up to be high functioning adults was a secure adult attachment status. All of those who seemed to transcend a poor prognosis in childhood based on their pre-treatment levels of global functioning were securely attached in adulthood. This suggests that attachment security may be an important mediator in altering the long-term outcome of childhood disturbance. The researchers point out that the small sample size and lack of statistical power means that these findings should be treated with caution.

Key reference

Schachter, A. (2004). *The adult outcome of child psychoanalysis: A long-term follow-up study.* Unpublished PhD thesis, University College London.

Other references

Schachter, A., & Target, M. (in press). The history and current status of outcome research at the Anna Freud Centre. In N. Midgley, J. Anderson, E.Grainger, T. Nesic-Vuckovic & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings.* London: Routledge.

Target, M., & Fonagy, P. (2002). Anna Freud Centre studies 3: The long-term follow-up of child analytic treatments (AFC3). In P. Fonagy (Ed.), *An open door review of outcome studies in psychoanalysis* (2nd Ed), (pp. 141-146). London: International Psychoanalytic Association.

Appendix B. Glossary of Measures

Title
The Children's Apperception Test

Background/aims
A projective personality test for children age three to ten years. It's development was influenced by the Thematic Apperception Test.

Description of measure
The child is presented with a series of pictures and asked to describe the situations and make up stories about the people or animals in the pictures. Administering the CAT requires training. Children age seven to ten years may find the animal drawings too childish and may respond better to the CAT-H (Children's Apperception Test-Human) a version of the CAT in which human beings replace animals in the pictures. The test normally takes 20-30 minutes.

Uses/validity
The pictures are designed to encourage children to tell stories related to competition, illness, injury, family life and school situations. When analyzing a child's story the administrator is advised to consider: the protagonist of the story; the primary needs of the protagonist; the relationship of the protagonist to his or her personal environment. Also drawn out by the pictures are the child's anxieties, fears and psychological defences. The scoring of the Children's Apperception Test is not based on objective, standardised scales.It must be scored by a trained test administrator. The scorer's interpretation should take into account the story's primary theme; the story's hero or heroine; the needs or drives of the hero or heroine; the main conflicts in the story; the anxieties and defenses expressed in the story; the function of the child's superego; and integration of the child's ego.

Key references
Bellak, L. (1968). The children's apperception test: its use in developmental assessments of normal children. *Journal of Projective Techniques and Personality Assessment, 32* (5), 425-7.

Other references
Lis, A., Mazzeschi, C., Salcuni, S., & Zennaro, A. (2005). The children's apperception test evaluation form: initial data. *Psychological Reports, 96*, (3Pt1), 755-68.

McCoy, D. (2005). *The ultimate guide to personality tests.* Ingelwood, CA: Champion Press.

Title
Hopes and Expectations for Treatment Approach (HETA)

Background/aims
Therapists, children and their carers often begin psychotherapy with implicit ideas about what they hope will come from a psychotherapeutic treatment. The HETA is a primarily clinical tool, which aims to formalise an approach to identifying hopes and expectations of treatment. Such a tool can then be used to revisit hopes and expectations at certain points in treatment, as a way of assessing progress, for either clinical or research purposes.

Description of measure
The HETA Form is in two parts. The first section looks at the carer's concerns about the child and the child psychotherapist's initial impressions of the child, following assessment, and includes information about what has been agreed in terms of treatment. The second section focuses on hopes and expectations for change - in therapy, at school or at home - from the perspective of both therapist and carer.

Uses/validity
While developed primarily as a clinical tool, the HETA can also be used as a research tool, e.g. by introducing a rating to assess to what degree the hopes and expectations have been achieved after a certain period of treatment.

Key reference
Urwin, C. (2006). *Hopes and expectations for treatment form: Child psychotherapy*. Unpublished manuscript, Tavistock Centre.

Other references
Urwin, C. (in press). A qualitative framework for evaluating effectiveness in child psychotherapy. In N. Midgley, J. Anderson, E. Grainger, T. Nesic-Vuckovic & C. Urwin (Eds.), *Child psychotherapy and research: new approaches, emerging findings*. London: Routledge.

Urwin, C. (in press). Revisiting 'What works for whom': a qualitative method for evaluating clinical effectiveness in child psychotherapy. *Journal of Child Psychotherapy*.

Title
Hampstead Child Adaptation Measure (HCAM)

Background/aims
The HCAM was developed at the Anna Freud Centre, London as an attempt to allow clinicians to explore the child's development, pro-social functioning and areas of impairment in a systematic way. The background to this thinking was the psychoanalytic approach of Anna Freud, in particular the Diagnostic Profile (A. Freud, 1965).

Description of measure
The HCAM is a semi-structured interview to be used with a child's parents or carers, covering 15 aspects of the child's adaptation, including relationships (within and outside the family), ability to work, learn and play; to cope with stress and anxiety, levels of confidence and self-esteem, frustration tolerance, general mood and variability of mood, sense of moral responsibility, psychosomatic vulnerability, self-care and sexual development.

Uses/validity
A comprehensive coding scheme, with a highly detailed rating manual, has been developed and preliminary investigations of the HCAM's psychometric properties have been good. The HCAM rating scale was used as part of the Anna Freud Centre's Retrospective Study (Target and Fonagy, 1994; Fonagy and Target, 1994) and was shown to be a clinically-significant measure of overall functioning.

Key reference
Schneider, T. (2000). *Measuring adaptation in middle childhood: the development of the Hampstead Child Adaptation Measure*. Unpublished PhD thesis, University College London.

Title
The Provisional Diagnostic Profile

Background/aims
Anna Freud and her co-workers at the Hampstead Child Therapy Clinic (now the Anna Freud Centre) hoped to develop a comprehensive model of assessment which would go beyond symptoms to look at the structure of the child's personality against a background of normal development.

Description of measure
Based on data collected from unstructured analytic sessions with children, psychological testing and interviews with a child's parents or carers, the Diagnostic Profile aims to offer a comprehensive metapsychological assessment of a child which goes beyond descriptive diagnosis based purely on symptoms. The Profile describes a child's developmental history, important environmental influences, drive, ego (including defences) and superego functioning, affective states, central intrapsychic conflicts and general personality characteristics, leading to an overall (provisional) developmental diagnosis.

Uses/validity
The Diagnostic Profile has been used primarily as a clinical tool, and hence has not been subjected to tests of validity and reliability in a research setting, which would be a considerable challenge. A number of modified versions of the Diagnostic Profile have been developed for the assessment of babies (W.E. Freud, 1971), adolescents (Laufer, 1965) and adults (A. Freud et al., 1965), as well as for certain specific clinical populations, such as children suffering from psychosis (Thomas, 1966). A modified Diagnostic Profile, based on more contemporary psychoanalytic models of development, has recently been developed (Davids et al., 2001). The only use to date of the Diagnostic Profile in a more systematic research study was Heinicke's (1965) study of the comparative outcome of intensive and non-intensive psychotherapy.

Key reference
Freud, A. (1965). *Normality and pathology in childhood: Assessments of development.* London: Karnac, reprinted in1989.

Other references
Davids, J., Green, V., Joyce, A., & McLean, D. (2001). *The provisional diagnostic profile, revised version.* Unpublished manuscript. London: The Anna Freud Centre.

Freud, A., Nagera, H., & Freud, W.E. (1965). Metapsychological assessment of the adult personality: the adult profile. *Psychoanalytic Study of the Child, 20*, 9-41.

Heinicke, C. (1965). Frequency of psychotherapeutic session as a factor affecting the child's developmental status. *Psychoanalytic Study of the Child. 20*: 42-98

Laufer, M. (1965). Assessment of adolescent disturbances: the application of Anna Freud's diagnostic profile. *Psychoanalytic Study of the Child. 20*: 99-123

Title
The MacArthur Story Stem Battery (MSSB)

Background/aims
The basic framework developed out of a collaboration between Bretherton in the mid 1980's who had developed the Attachment Story Completion Task (ASCT) and Emde and colleagues in Denver in 1990 from which the MacArthur Story Stem Battery developed.

Description of measure
This comprises of 11 stories and was originally an amalgamation of five story stems developed primarily by Inge Bretherton who was interested in attachment and six story stems devised by Robert Emde who had an interest in children's moral development. The child is presented with a set of figures, including a child of the same gender as the interviewee. Story stems build up a brief scenario which ends on an emotional highpoint with the instruction to the child to 'show me and tell me what happens next'. The child then takes control of the figures and the narrative. A number of factors are thought to impact on the child's strategy of representation within the story.

Uses/validity
The MSSB is used with children age 3 to 8 years inclusive. A core scoring system has been developed by the MacArthur group but various researchers (Jonathan Hill, Zahn-Waxler, Inge Bretherton) have developed their own rating systems depending on their own areas of interest. The core scoring system looks at content themes, performance features and aggregated themes. In general well adapted children narrate stories that are flexible and context specific whereas maladapted children's stories tend to be over-generalized, repetitive and context invariant. The MSSB has been used in a number of intervention studies to assess outcome. The inter-rater reliability is good (Oppenheim, Emde & Warren, 1997). A computerized version has been developed (Minnis et al., 2006).

Key Reference
Bretherton, I., Oppenheim, D., Buchsbaum, H., Emde, R., & the MacArthur Narrative Group. (1990). *MacArthur story stem battery.* Unpublished manual, Madison: Waisman Center, University of Wisconsin.

Other References
Oppenheim, D., Emde, R., & Warren, S. (1997) Children's narrative representations of their mothers: their development and association with child and mother adaptation. *Child Development, 68* (1), 127-138

Minnis, H., Milward, R., Sinclair, C., Kennedy, E., Greig, A., Towlson, K., Read, W., & Hill, J. (2006). The computerized MacArthur Story Stem Battery-a pilot study of a novel medium for assessing children's representations of relationships. *International Journal of Methods in Psychiatric Research, 15* (4), 207-214.

Title
The Manchester Child Attachment Story Task (MCAST)

Background/aims
This aims to evaluate the child's mental state with respect to attachment representation. Developed by Green and colleagues in Manchester (Green et al., 2000).

Description of measure
It comprises of a series of four story stems, each stem relating to a specific attachment stressor. The child is shown a dolls house and is asked to choose a doll character to represent themselves and another to represent the primary caregiver. The MCAST differs from other Narrative Story Stems, in focusing on a single dyad rather than a larger family, emphasising the child's attachment with the doll figures and inducing a higher degree of emotional arousal in the child in order to activate attachment related thoughts and behaviours. Structured prompts are offered as the child is completing the vignettes and specific probes are offered for mentalising/metacognition. The coding system produces a full categorical attachment classification. It also produces continuous scores for security, meta-cognition, mentalising, disorganisation and narrative coherence.

Uses/validity
The MCAST is easy to administer, although coding and analysis of responses requires more specialised training. It requires video-recording. A computerized version of the MCAST has been developed (CMCAST). Overall agreement between the MCAST and the Separation Anxiety Test has been found (Goldwyn et al., 2000).

Key reference
Green, J., Stanley, C., Smith, V., & Goldwyn, R. (2000) A new method of evaluating attachment representations in young school age children: the Manchester Child Attachment Story Task. *Attachment and Human Development 2*, 1, 48-78

Other reference
Goldwyn, R., Stanley, C., Smith, V. & Green, J. (2000) The Manchester Child Attachment Story Task: relationship with parental AAI, SAT and child behaviour. *Attachment and Human Development, 2*, 71-84

Title
The Story Stem Assessment Profile (formerly known as the 'Little Pig' Story Stem Assessment)

Background/aims
This was developed by Hodges (1990) and was specifically designed for the assessment of abused children.

Description of Measure
The battery consists of 13 stems, eight from the MSSB and five specifically designed for the assessment of abused children. Animal figures are used in two of the stories. The MSSB standard doll family is used (this includes a child of the same sex as the interviewee, a younger sibling, a mother and a father). The child is asked to name the children but not to use their own or siblings' names. Administration takes about an hour and the method is similar to MSSB i.e. the interviewer narrates briefly the beginning of the story and invites the child to 'show me and tell me what happens next'. Each interview is videotaped and the recordings are transcribed to give both the verbal and non-verbal narrative responses. The rating system gives a three point rating to the presence or absence of about 40 themes or characteristics. This includes representations of the parents, representations of the children, indicators of defence and avoidance of anxiety and indicators of disorganisation. A manual details criteria and gives examples of each (Hodges et al., 2004). Ratings on individual themes can be used for detailed clinical assessment and also to generate global constructs such as attachment security, insecurity, positive and negative representations of adults and children, defensive avoidance and disorganisation.

Uses/validity
It is used with children age 4 to 8 years. It is clinically very useful, especially with maltreated children due to it's indirect, non-threatening style. The inter-rater reliabilities for those trained in the rating system average 87% (Hodges et al., 2003). Good discrimination is demonstrated between children who have and have not been maltreated. Among the maltreated group it has been shown to discriminate between more and less severe levels of abuse.

Key reference
Hodges, J. (1990). *Rating manual for the 'Little Pig' story stem assessment.* Unpublished manuscript, London: The Anna Freud Centre.

Other reference
Hodges, J., Hillman, S., Steele, M., & Henderson, K. (2004). *Story stem assessment profile rating manual.* Unpublished manuscript, London: The Anna Freud Centre.

Title
The Thematic Apperception Test

Background/aims
A projective personality test designed in Harvard in the 1930's by Christina Morgan and Henry Murray.

Description of measure
It is used mainly in adults and consists of 31 pictures that depict a variety of social and interpersonal situations. The subject is asked to tell a story about each picture to the examiner. Westen and colleagues developed a social cognition object relations scale (SCORS) to help in soring the TAT and Cramer (2002) has developed a standardized TAT procedure and scale that measures different defense mechanisms (Defense Mechanisms Manual). Three defense mechanisms are assessed, Denial, Projection and Identification.

Uses/validity
The original purpose of the TAT was to reveal the underlying dynamics of the subject's personality, such as internal conflicts, dominant drives and interests, motives etc. It is criticized for it's lack of standardized method of administration as well as lack of norms for interpretation.

Key reference
Westen, D., Lohr, N., Silk, K., Kerber, K., & Goodrich, S. (1985b). *Object relations and social cognition TAT scoring manual.* Ann Arbor: University of Michigan Press.

Other references
Westen, D., Lohr, N., Silk, K., Kerber, K., & Goodrich, S. (1985a). *Social cognition and object relations scale (SCORS): Manual for coding TAT data.* Ann Arbor: University of Michigan.

Cramer, P. (2002a). *Defense mechanism manual.* Unpublished manuscript. Williamstown: Williams College.

Section Three: Parent-Infant Psychotherapy and Research

A growing research emphasis on the importance of very early experiences for later psychosocial functioning has led to a wealth of studies looking at infancy and interventions which promote positive development from the very start of life. In line with Winnicott's idea that 'there is no such thing as a baby...A baby cannot exist alone but is essentially part of a relationship' (Winnicott, 1964, p. 88), therapists, theorists and researchers have directed much of their focus on the parent-infant relationship for understanding and strengthening outcomes for the developing infant.

This section is focused on *psychodynamically informed* clinical interventions and their outcomes, and on the evaluation tools used with parents and infants. It should be noted that discussion of psychoanalytic methods and research with this population is often linked with ideas deriving from attachment theory and it is within the realm of infancy and early experiences that distinctions between the two bodies of thought become blurred. Attachment theory has forged strong links between theory and empirical research and has therefore been pivotal in the study of parent-infant relationships. Many contemporary theorists and clinicians working with parents and young infants from a psychodynamic perspective draw upon ideas and methods borne out of attachment theory. For example, many psychoanalytic therapies will have as one of their aims an improvement in the infant's security of attachment. Moreover, clinical effectiveness is often measured with classic empirical methods developed from an attachment perspective.

Although the infant's mental health is the main goal of all interventions with parents and infants, the psychodynamic approach often emphasises the role of the intergenerational transmission of psychopathology. The explanation of such transmissions draws upon several theories, including ideas from psychoanalysis and attachment theory (Fonagy, 2001).

In the first part of this section we give a brief summary of some of the main psychodynamic approaches to working clinically with parents and infants. Where outcomes of such interventions are available, these are discussed. The second part of this section will outline and review the main measures and methods used in research and evaluation in this field, with a particular focus on measures of the quality of parent-infant relationships.

Psychodynamically informed interventions with infants and parents

A vast number of different interventions for infants in the context of the relationship with their caregiver have evolved over the last few decades, stemming from multiple disciplines and therapeutic backgrounds. Many of these innovative programs aim to intervene directly at the behavioural level, changing parenting patterns and promoting sensitive caregiving strategies which will in turn have positive effects on the infant. Others, and particularly the psychodynamically informed approaches, aim to challenge and alter the

representational world of both parent and infant. The idea is that the underlying unconscious processes which impinge upon the relationship need to be addressed in order to effectively promote positive parenting practices and development for the infant. Some other approaches integrate ideas from several disciplines. A few interventions which have at least some psychodynamic components and their reported outcomes are discussed below. For a more detailed discussion about contemporary psychotherapeutic approaches for parents and infants, see Barrows (2003).

Psychotherapeutic approaches which have been evaluated

Infant-Parent Psychotherapy

Psychoanalytic *Infant-Parent Psychotherapy* has become a cornerstone approach to clinical work with parents and infants. The method, as described by Fraiberg and Lieberman (Fraiberg, 1980; Lieberman, Weston & Pawl, 1991; Lieberman & Pawl, 1993) involves both parent and infant in the therapeutic sessions and the main focus is on the relationship between them. Selma Freiberg's landmark work on how past experiences of the parent play out in their relationship with their infant in the form of 'ghosts in the nursery' (Fraiberg, Adelson & Shapiro, 1987) has had a large impact on psychoanalytic psychotherapies for parents and infants. These 'ghosts' are often understood as projections, typically stemming from the parent's own childhood, which are attributed to the child, and these projections result in distorted perceptions and behaviours in the current relationship. The aim of infant-parent psychotherapy is to intervene and target mutually constructed meanings within the relationship, and to uncover the unconscious processes and conflicts that impact on parental behaviours and attributions towards the infant. Fraiberg addressed the ghosts through containment and interpretation and provided 'education' to the parents about infant development. Lieberman and colleagues have extended this method and incorporated attachment concepts.

A study by Lieberman, Weston & Pawl (1991) investigated outcomes of infant-parent psychotherapy for anxiously attached mother-infant dyads in a low SES population [1]. Infant attachment at 12 months was assessed using the Strange Situation procedure (Ainsworth, Blehar, Waters & Wall, 1978). Dyads where the infant was classified as anxiously attached were randomly allocated to infant-parent psychotherapy or a control group, and a group of securely attached dyads formed a second control group. The intervention lasted for 12 months and outcomes were assessed at the end of this period. They found that intervention infants showed less avoidance, resistance and anger toward the mother. The intervention dyads showed higher levels of goal-corrected partnership, and intervention mothers were more interactive and empathic than those in the anxious control group. Also, there were no differences in outcomes between the securely attached control group and the intervention group.

However, this intervention did not demonstrate a significant improvement in secure base behaviour, as measured by the attachment Q-sort, compared to the control group. The authors explain that this may have been because the improvements seen in the behavioural measures had not yet been consolidated enough to be internalised and reflected in attachment security. Longer term follow-up studies are required to understand the sustainability of treatment effects and demonstrate whether such consolidation in the relationship does occur. This study also investigated how the therapeutic process related to outcomes. Maternal involvement in the

therapeutic process, as reported by the intervener, was measured by the Level of Therapeutic Process Scale (Greenspan & Wielder, 1987). This score was significantly related to adaptive scores for both mother and child, indicating that greater levels of engagement by the parent in the therapeutic process resulted in better outcomes.

The Parent-Infant Project (PIP) Approach

A related approach, known as *Parent-Infant Psychotherapy*, has been developed by the Parent-Infant Project (PIP) team at the Anna Freud Centre in London (Baradon et al., 2005). Once again, this method entails work with the parent(s) and infant together, and the relationship between them is the primary focus. It aims to interrupt negative intergenerational patterns and to facilitate positive attachment behaviours between the parent and infant. A variety of measures, such as actions, play and verbalization, are used by the therapist to create meaning for all participants in the sessions.

During the sessions the therapist sits with the parent/s and the baby on the floor so as to facilitate the interaction at the baby's level and developmentally appropriate toys are provided. It is in this aspect that the PIP model differs from that of Lieberman and colleagues which does not prescribe that all parties sit on the floor. By providing the baby with physical access to the parent, the focus lies more powerfully on the infant directly. Of prime importance is the infant's own capacity for attachment, and how impingements from the parent's own internal world might affect the bonding process. Thus, the infant is granted more opportunity, through his exploration, spontaneous play, expression of need and own relational behaviours and experiences, to become an agent of change in the therapeutic sessions. Consequently, the individual infant is as important in the sessions as the parent's representations of him or her.

A preliminary outcome study of the Parent-Infant Project approach used at the Anna Freud Centre has been carried out (Fonagy, Sadie & Allison, 2002). In general, families were positive about the therapeutic experience. Results showed that only 10-15% of parents had significant concerns about their children following the parent-infant psychotherapy, and less than 5% had experienced a worsening. At referral, families had infants that averaged seven points below the norm in terms of mental and motor functioning measured on the Bayley Scales of Infant Development (Bayley, 1969). By six months after the start of treatment, they were equivalent to the age average. This improvement was sustained and slightly improved at the one-year follow-up.

A randomised controlled trial comparing PIP with individual counselling is currently underway. This study will evaluate and compare treatment effects in terms of maternal mental health, child development and social-emotional functioning, the quality of the parent-infant interactions and child attachment security.

Brief psychodynamic mother-infant psychotherapy

A brief intervention for infants and parents has been described by Cramer (1995). Once again, this approach, known as brief psychodynamic mother-infant psychotherapy, draws upon the ideas of Fraiberg in that it aims to uncover the unconscious conflict that the mother brings to her perceptions of and interaction with her infant. Both parent and infant are seen together by the therapist on a weekly basis. Methodologically and theoretically, this approach is similar to that of infant-parent psychotherapy described above. The obvious difference

between the two approaches is in the intensity and length of intervention. Lieberman and colleagues (1991) reported the outcomes of a 12 month intervention, whilst this approach typically involves between 1 and 12 sessions on a weekly basis (Robert-Tissot et al., 1996). Such an approach has been a key feature of the 'Tavistock Under-Fives' model, within which brief infant-parent work has been a core feature (e.g. Hopkins, 1992; Miller, 1992; Barrows, 1999; Pozzi, 1999; Acquarone, 2004).

A study by Robert-Tissot and colleagues (1996) compared brief psychodynamic mother-infant psychotherapy with Interaction Guidance (IG) [2]. IG is another approach of working with parents and infants and their relationship which aims to intervene on a behavioural level by making use of video-recordings of the interaction which are replayed to the parent (for a detailed description, see McDonough, 1995). Unlike the psychodynamic approach, IG does not involve explicit reference to the parent's past history. Participants were recruited from a Child Guidance Clinic where infants were referred for sleeping, feeding and behavioural difficulties. Assessments were carried out before the intervention, one week after the end of treatment, and six months later. Results showed that both interventions were effective in reducing symptoms in the infant, improving the quality of interactions between mother and infant, increasing maternal self esteem and reducing negative affects. There was little difference in outcomes of the two different approaches. Treatment benefits were sustained at the 6-month follow-up.

This study suggests that both behavioural and psychoanalytic approaches might have benefits for the parent, the child, and the relationship between them. Given the short-term nature of these approaches, it appears that changes can be effected quickly and that longer-term work might not always be necessary. Of course, research exploring this idea would be helpful for therapists to find the most cost-effective way of working with this population.

Watch, Wait and Wonder

A relatively different approach from those described above is known as Watch, Wait and Wonder (WWW; Muir, 1992), which emphasises the role of the infant as the 'initiator' in the sessions. A psychodynamic model is used, but WWW targets both the behavioural and representational levels. During the first half of each session, the parent is asked to be on the floor with the baby, to observe the infant's activity, to interact only when the infant initiates joint activity. The aim is for the parent to develop 'an observational reflective stance', and through this potentially gain more understanding of the infant's inner world. At the same time, the infant has the opportunity to negotiate his relationship with his parent and can start to master his environment.

During the second half of the session, the parent discusses with the therapist her experiences of the infant-led play. This allows her to examine her infant's internal world and also her own internal working models of herself in relation to her baby. A therapeutic alliance is fostered between parent and therapist, but unlike other psychodynamic parent-infant psychotherapies, the transference in their relationship is not a point of focus. The ultimate aim and focus is on the infant in relation to the parent.

A study by Cohen and colleagues (1999) compared the outcomes of WWW and psychodynamic mother-infant psychotherapy, such as the approach developed by Fraiberg and colleagues. Both treatments consisted of weekly sessions lasting on average five months. At the end of treatment, mothers who received the WWW intervention had higher levels of parenting satisfaction and competence and lower levels of depression than those in the mother-infant

psychotherapy group. In addition, infants in the WWW group showed a greater increase in emotional regulation and cognitive development, and a greater shift toward more organised or secure attachment strategies than those in the PPT group. Interestingly, there was no difference between the two groups in terms of maternal sensitivity and responsiveness.

A further follow up six months after the end of treatment (Cohen et al., 2002) showed that benefits observed at the end of treatment were maintained or improved in both groups, and also that attachment security, maternal depression and infant cognitive development and emotion regulation improved in the PPT group to the equivalent level as those in the WWW group [3]. These results indicate that both interventions appear to be equally effective, but that improvements can be effected more rapidly when the WWW model is used.

The Solihull Approach

The Solihull Approach is a brief (five sessions or less) intervention for preschool children with sleeping, eating, toileting, or behavioural disturbances (Douglas, 1999). The intervention forms part of a comprehensive learning resource for practitioners, mainly primary care professionals such as health visitors, working with such children. The approach is integrative and is informed by psychoanalytic, developmental and behavioural concepts. More specifically, the ideas of containment (psychoanalytic), reciprocity (developmental), and behaviour management (behaviourism) are drawn upon. The model was developed by child psychotherapists using the Tavistock model of intervention for Under 5's.

A small-scale evaluation of the Solihull Approach showed a significant decrease in the level of presenting difficulty and parental anxiety over an average of three sessions (Douglas & Brennan, 2004). However, these results should be interpreted with caution as there were no control conditions and the sample size of thirteen families was very small. A further pilot evaluation of the Solihull Approach, when compared to standard Health Visiting practice, has found a statistically significant decrease in distress, stress levels and parental perception of child difficulty for the children in the Solihull Approach group (Milford, Kleve, Lea & Greenwood,, 2006). In addition, qualitative studies of the impact of the Solihull Approach on both mothers (Maunders, Douglas & Giles, in press) and health visiting practice (Whitehead & Douglas, 2005) have been reported. In the latter study, semi-structured interviews were carried out with four health visitors and a thematic analysis of their responses was conducted. Results showed that the approach had led to changes in the health visitors' practice, made them feel more positive about their work, impacted referrals and improved their partnerships with other professionals. However, health visitors expressed a need for additional support and more consistency in the approach.

Approaches derived from research

Just as clinical interventions should be evaluated for outcomes, the outcomes of research studies should also inform clinical intervention. For example, the evaluation of the impact of interventions on clinical practice, such as the study of the Solihull Approach mentioned above, can and should be used to audit and change the intervention strategy so that best practice is always adhered to. A further psychoanalytic approach is described below as it has evolved from outcomes of more empirical research methods and demonstrates how these can inform new clinical approaches.

Psychoanalytically informed video feedback

A model of intervention which draws upon psychoanalytic methods as well as knowledge from microanalytic methods in infant research has become increasingly recognised (e.g. Beebe, 2003; 2006). This relatively innovative approach makes use of knowledge from decades of infant research into the second by second processes of parent-infant interaction. Microanalytic studies of face-to-face interactions have usually focused on contingencies (or influences) of one partner's behaviour on the other, particularly in terms of affect, arousal, attention and timing. Behaviours, such as gaze, facial expression, vocalisation, distress and self-soothing, maternal touch, and infant engagement with a stranger are observed and analysed on a micro-level, usually second by second or frame by frame. This wealth of research has shown how certain interactive patterns are linked with outcomes for the child and it is these outcomes that inform the intervention.

The intervention, as described by Beebe (2003; 2006) usually consists of between two and four lab visits, where parent/s and infant as well as a stranger and the infant are videotaped in face-to-face interaction. Video feedback sessions follow, where the therapist uses makes use of both psychoanalytic techniques and knowledge of microanalysis of parent-infant interaction to work with the parent. Thus, this method departs from the traditional psychoanalytic techniques as knowledge and findings from research are fed back to the parent during the sessions.

Despite the strong research influence on the development of this technique, more research beyond clinical case studies is needed to show whether the outcomes following intervention are as expected. Recent research by Amanda Jones (2005, 2006), however, has moved some way towards building an empirical foundation for an understanding of what the key change processes in such therapeutic interventions might be, and this is likely to form a good basis for further studies to investigate clinical outcome.

Summary

The approaches described above are not inclusive of all psychodynamically informed interventions that have been developed and that are currently being used. Instead, they serve to illustrate some of the main themes and methods that underlie almost all such models. The studies of clinical outcomes that we have discussed indicate that such approaches can be effective in alleviating maternal and infant mental health and developmental problems and in improving the quality of relationship between parent and infant. However, compared with other fields of therapeutic intervention, clinical effectiveness studies of parent-infant interventions are relatively sparse.

The focus will now turn to some of the tools and methods that have been used in outcome and theoretical studies of parent-infant relationships from a psychoanalytic perspective.

Evaluating the parent-infant relationship: Measures and methods

As the clinical focus on early intervention during infancy and the relationship between parent and infant is becoming more widely recognised, so too is the need for methods and measures of observing and analysing parent-infant interactions. The aim of this section is to describe and evaluate some of the more widely used instruments for the assessment of parent-infant relationships.

The need for such measures is threefold. Firstly, systematic methods for assessing the nature and quality of the parent-infant relationship can form the basis for understanding the intrapsychic and external precursors and outcomes of particular behavioural patterns within the relationship. Different methods and methodologies differ in the degree to which they emphasise internal and unconscious drivers of interactive behaviours, and their subsequent effect on psychological outcomes.

The second use for such measures is in the evaluation of therapeutic outcomes. The selection of the appropriate measure to capture the aims of the intervention is crucial, and can be difficult. Many standardised measures are only available as unpublished manuscripts and information about the content and theoretical background is often difficult to find. This problem is confounded by the sheer number of different methods and measures currently being used.

Finally, several instruments for analysing parent-infant interactions can be seen as clinical tools that serve to inform practitioners about detecting risk factors and sources of conflict within the relationship. The use of well-validated, standardised instruments can complement normal clinical observation in that they are grounded in empirical evidence of the particular behaviours that have been shown to be important in terms of clinical outcomes.

The selection of measures upon which we focus has been based on the apparent widespread use of them in the current literature, and their level of appropriateness for those coming from a psychodynamic perspective.

I. RATING THE QUALITY OF PARENT-INFANT INTERACTIONS

All of the measures described in this section involve qualitative ratings of the interaction rather than time-series or sequence analyses. Although microanalytical measures have provided extremely useful methods for many studies, they are very time-consuming and impractical in most research and clinical assessment settings. The focus here therefore, is on the overall quality rather than quantitatively identifiable components of the interaction.

Broad Global Measures

Some measures of parent-infant interaction draw upon a multitude of theoretical and clinical ideas and place an emphasis on a very broad number of behavioural and affective aspects of the relationship. Such measures include the Parent-Child Early Relational Assessment and the Coding Interactive Behavior rating systems.

Parent-Child Early Relational Assessment

**The Parent-Child Early Relational Assessment* (ERA; Clark, 1985) is one of the most widely used tools for assessing the affective and behavioural characteristics of interactions between parents and infants. It has been used in more than two-hundred projects internationally (Clark, 1999). The content of the instrument was informed by a number of different fields including psychodynamic, self-psychology, attachment, developmental, and soviet cognitive-linguistic theories, empirical studies and clinical observations (Clark, 1999). The instrument was initially developed for use with a clinical population to describe interaction patterns and inform intervention strategies (Musick, Clark & Cohler, 1981). It has since been refined to be applied as a clinical and outcome assessment tool that can be used with a broad range of clinical and normative populations.

Five minute segments of four different contexts of interaction between the parent and infant (feeding, structured task, free play, and separation-reunion) are observed and videotaped. It is worth pointing out that it is possible to select only one or a couple of contexts that might be most relevant for the purposes of the user. Each context elicits different behaviours and affective states which are of importance to the relationship between parent and the developing infant. Segments are rated on 65 (29 parent, 28 child, and 8 dyadic) behavioural and affective variables on 5-point Likert scales with behavioural anchors. The instrument is designed to pick up on both positive and negative behaviours and affective states. For example, parents are rated on positive variables such as sensitivity and responsiveness to infant cues, and negative variables such as intrusiveness and angry/hostile tone of voice. The infant is rated on variables such as mood, emotional lability, social initiative and responsiveness. The dyadic variables examine factors such as reciprocity, enjoyment, and tension in the interaction.

A second stage of the ERA can be useful in some instances. The video is replayed to the parent in interview. Parents watch segments of the video and are asked about factors such as their relationship with their child, how they interpret the child's behaviour, who the child reminds them of, and their own sense of competence, enjoyment and difficulty in the interaction (Clark, 1993). This additional source of information is particularly useful when using the ERA as a clinical tool to aid in the intervention process and assess for areas of need.

Clinical experience and substantial training are required to reliably use the ERA, especially when it is being used as a research tool (Clark, 1993). Due to the comprehensiveness of the measure, the actual scoring of the interactions can be complex and time-consuming (Crowell & Fleischmann, 1993). It usually takes about one hour to rate one segment.

The broad range of theories and observations upon which it is based makes this measure a good instrument for evaluating a wide range of interactional characteristics. The focus is on both negative and positive behaviours. However, training to use the measure and coding interaction using it can be time-consuming and costly.

Other broad global measures

The ERA is in some ways an exemplar of many measures of this type, which bring together a very broad range of parent, infant and dyadic behaviours as well as theoretical underpinnings. For example, the *Coding Interactive Behavior* system (CIB; Feldman, 1998) is another very similar global scale used for rating interactions between adults and children aged between 2 and 36 months. The CIB coding system is a global measure that looks at parent, child and dyadic affective states and interactive styles. There is some overlap in the codes between these two measures but, with only 42 codes, the CIB is not quite as comprehensive but is less cumbersome to use than the ERA.

Two related coding systems for evaluating the overall quality of interaction between parents and infants, the *Nursing Child Assessment Teaching Scale (NCATS)* and the N*ursing Child Assessment Feeding Scale (NCAFS*; Barnard, 1978; Sumner & Spietz, 1995) are extremely widely used. The teaching and feeding scales were developed for use by nurses and other health professionals and have become probably the most widely used instruments for the assessment of parent-child relationships in the health sector. A list of behavioural items (73 items on the teaching scale, and 76 items on the feeding scale) are rated as 0 if the behaviour does not occur or 1 if it does. Examples of items are: 'Caregiver describes perceptual qualities of the task materials to the child' (teaching scale), and 'Child demonstrates satiation at the end of feeding'(feeding scale). Scores are summed and can give an overall quality of interaction total, a measure of the degree of contingent responses, as well as totals on six subscales: parent's sensitivity to cues, parent's response to child's distress, parent's social-emotional growth fostering, parent's cognitive growth fostering, child's clarity of cues, and child's responsiveness to caregiver.

A major problem with the simple yes/no binary coding system is that the frequency and intensity of particular behaviours are not measured so there is no distinction between subtle and more extreme versions of the same behaviour. In fact, one study (Johnson & Lobo, 2001) found that the NCATS scores did not differ for mothers with and without HIV infection, despite the fact that the mothers with a diagnosis of HIV had more symptoms of depression. Another study showed the NCATS to be related to maternal education and knowledge, but not depression and self-efficacy (Gross, Conrad, Fog, Willis & Garvey, 1993). Therefore it is unlikely that these measures are suitable for studies where mental health issues and affect quality are of importance, and particularly when a psychodynamic approach is taken. These measures are not psychoanalytic or appropriate as an evaluation of psychodynamically informed interventions. However, we have included them in this review as the widespread use of these coding systems means that they might be considered by researchers and clinicians searching the literature for well accepted and psychometrically sound instruments.

Maternal Sensitivity and attachment-based measures

As previously mentioned, attachment theory has strongly influenced research and outcome measurement with parents and infants. As a result, a number of measures which draw upon ideas of attachment security and maternal behaviour linked with secure and insecure attachments have evolved.

Ainsworth's Maternal Sensitivity Scale

Mary Ainsworth and colleagues were one of the first groups to devise standardised rating scales of the quality of interaction between parents and infants. Their work was based on intensive home observations of interaction between parents and infants during the first year of the children's lives (Ainsworth, Bell & Stayton, 1974, 1978). They found that maternal sensitivity, the mother's accuracy in perceiving and interpreting her infant's cues and her ability to react in a timely and appropriate manner, was crucial for the positive development of infant attachment. The concept can be seen as covering four distinct components of maternal behaviour: attention to infant cues, the correct interpretation of those cues, the prompt response to the cues, and the appropriateness of the responses. Rating on the **Maternal Sensitivity Scale* is on a simple 9-point global scale of maternal sensitivity.

The sensitivity scale was developed and originally used in the context of lengthy home visits and observations of the family. However, no guidance on the optimal setting in which to observe and record interactions was provided and it has subsequently been applied to contexts of

variable lengths, recording procedures, and interaction tasks such as free play, feeding and teaching tasks (Pianta, Scroufe & Egeland, 1989; Isabella, 1993; Fineman, Beckwith, Howard & Espinosa,1997; Lohaus, Keller, Ball, Elben & Voelker, 2001, 2004).

The measure is, on the surface, simple. However, good knowledge of development and behaviour is required for any observer to make accurate judgements. For example, the appropriateness of maternal responses to infant cues is not always a simple compliance with the infant's wishes. There is a need for a 'sensitive' mother to balance the infant's immediate wishes with what is likely to make him feel more secure, comfortable and competent in the long-run. These compromises change with the age of the infant and the observer needs to be able to assess that this balance is being kept and is appropriate for the baby's stage of development. Also, the observer needs to make a judgement about the underlying internal processes of mother and infant which guide their behaviour. They need to ask questions such as: what does the baby really want, and are the mother's perceptions of the infant's cues distorted?

Although it is generally acknowledged that a great deal of experience and training is needed to reliably assess maternal sensitivity, Ainsworth and colleagues never formalised the training procedure. For this reason, there has been no control of the adequacy of all raters to accurately assess maternal sensitivity. Even though inter-rater reliability is usually established *within* studies, the construct of maternal sensitivity may very well differ between the many laboratories and settings in which it has been used, jeopardising the overall construct validity of the measure. The lack of detailed behavioural descriptors in the original rating scale only serves to exacerbate this problem.

Although some studies have found maternal sensitivity to be predictive of infant attachment (Ainsworth et al., 1971, 1974), these findings have not been consistently replicated (Isabella, Belsky & von Eye, 1989). In a study by Isabella (1993) sensitive responsivity was measured when infants were aged one, four and nine months. They found that security of attachment measured at 12 months was predicted only by the one month and four month measures of maternal sensitivity, not at nine months. The temporal stability of maternal sensitivity has been shown to be moderate to poor (Isabella, 1993; Lohaus, Keller, Ball, Elben & Voelker, 2004).

A study by Lohaus and colleagues (2004) investigated the four dimensions of maternal sensitivity: perception, interpretation, promptness of response and appropriateness of response, and found these to be highly correlated, indicating the unidimensional nature of the rating scale. This study found that maternal sensitivity was not predictive of developmental outcomes in the child later on, but concurrent validity between maternal sensitivity and child crying and security of attachment was found.

The maternal sensitivity scale was one of the first attempts at drawing out a single score of parent-infant interaction behaviour that is meaningfully linked with child outcomes. Although the measure is simple to apply and interpret, this simplicity also underlies its shortcomings. The first major problem is that very few behavioural indicators of sensitivity are provided as guidelines to rating, which undermines the overall validity and reliability of the measure. Secondly, the context and length of observation are not specified; the authors did very lengthy home observations, which are not practical in most current research settings (Meins, 1999; Biringen, Robinson & Emde, 2000). The result is that a large number of researchers have been using their own interpretations of what sensitivity actually is, and have used multiple contexts to elicit those behaviours that they deem relevant. Other better operationalised measures have evolved from the original ideas of maternal sensitivity and two of these are described below.

Emotional Availability Scales

The **Emotional Availability Scales* (EA; Biringen, Robinson & Emde, 1993; 2000; Biringen, 2000) is a method of assessing dyadic interaction for the emotional availability of the parent to child and child to the parent. It draws mainly upon the ideas of attachment theory and imbeds these concepts within the framework of emotional availability. Emotional availability refers to a person's ability to express their emotions and to perceive and respond to the emotional needs and goals of another (Emde, 1980). The ideas of maternal sensitivity developed by Ainsworth and her colleagues (1974) are used and expanded upon so that the focus incorporates more emotional and relational dimensions and is operationalised by more behavioural descriptors. It is a global measure of overall interactional style in each partner and requires clinical judgement and an awareness of contextual factors.

Two versions of the EA scales are available for different ages of the child: The Infancy to Early Childhood Version for infants aged 0 to 4 years and the Middle Childhood Version for school-age children from 5 years old up. The scales are comprised of four parental dimensions (sensitivity, structuring, non-intrusiveness and non-hostility) and two infant dimensions (responsiveness and involvement) of emotional availability.

The recommended method of data collection for coding the EA scales is to video-record at least 20 minutes of interaction, although it has been used for shorter time periods. The scales have been used to code interactions in various contexts, from unstructured home observations to day care settings, to stressful laboratory tasks such as the still face paradigm. Coding is relatively simple as each of the six dimensions is coded on Likert type scales. The extent of the Likert scale is different for the dimensions, each being on a 9-, 7-, or 5-point scale.

Extensive training is required to reach reliability on the EA scales. A great advantage to this instrument is that training can be done via distance learning tapes and consultation and/or follow-up workshops. This makes it one of the more cost-effective measures to train on, especially for those not based in the US where most of these measures have been developed.

The EA is a recently popular and theoretically grounded measure of parent-infant interaction. It has taken the concept of maternal sensitivity and grounded it in a far more concrete framework, adapted it for use in research settings which require shorter observation times, and added theoretically important emotional components of behaviour to the traditional indicators of the maternal sensitivity construct. Once trained, the instrument is succinct and easy to use and interpret.

CARE-Index

The **Child Adult Relationship Index* (CARE-Index; Crittenden, 2001) is another instrument that is strongly influenced by attachment theory and the concept of maternal sensitivity. Patricia Crittenden extended the theory of attachment and developed what is called a dynamic-maturational model (DMM). This theory outlines the self-protective strategies that evolve within attachment relationships and extend throughout the lifespan (Crittenden, 2005). Essentially, the model adds to Ainsworth's theory of attachment to include compulsive and coercive organised strategies that an infant might use. These more extreme patterns of behaviour are seen in more high risk populations, often with maltreating or psychiatrically ill parents. The CARE-Index takes into account these more extreme organised attachment strategies, how they evolve within and contribute to the parent-infant relationship. It can be used for the assessment of interaction between caregivers and infants aged from birth to about three years old. It was developed as a research coding instrument, but may also be applicable to clinical and assessment settings. It has become a widely used research tool for the assessment of parent and infant interactions.

The CARE-Index is used to code video-recorded interactions of parent and infant playing together as they usually would for three to five minutes. They are provided with toys and can choose to use them or not. As the procedure is robust to the context in which it is carried out, videos can be taken in the home, laboratory or in a clinic setting (Crittenden, 2001). The coding system is comprised of seven scales: three parent descriptors (sensitive, controlling, unresponsive) and four infant descriptors (cooperative, difficult, compulsive and passive), each one having two points allocated, giving a total scale score of 14 for the parent and child each. The facial and vocal expression, position and body contact, expression of affection, turn-taking, control, and choice of activity are all coded for both parent and infant on the seven scales.

Once trained to reliability, the CARE-Index is relatively quick and easy to use (15 to 20 minutes to code one interaction). It allows for flexibility in the context of the interaction, and only requires very short interactions to be recorded. It has been shown to be psychometrically robust, and is particularly good at discriminating between good and problematic relationships. It has been developed with high-risk population in mind and is thus sensitive to the precedents of later psychopathological outcomes.

Measures of maternal behaviour linked with disorganisation

The following measures take a step on from the global rating systems to focus more specifically on anomalous maternal behaviours which have been found to be linked with disorganised attachment. They are therefore focused on psychopathology as opposed to overall quality.

FR Coding System

The **Frightened/Frightening coding system* (Main & Hesse, 1992) has emerged from the increasing recognition and interest in the disorganised attachment classification of infants (Main & Solomon, 1986) and the correlates associated with it. Disorganised attachment has, unlike the secure and two insecure attachment strategies originally defined by Ainsworth and colleagues (1978), been found to be strongly predictive of later psychopathology (Hesse & Main, 1999), and is thus of enormous clinical importance. Given that the disorganised attachment strategy appears to be independent of temperamental or constitutional elements related to the child (Schuengel, Van Ijzendoorn & Bakermans-Kranenburg, 1999), attention has been drawn to how this might emerge out of contextual and environmental influences, such as the parent-child relationship.

Main & Hesse (1990) put forward the idea that there is a second generation effect whereby past trauma or loss experienced by the parent, when unresolved, leads to particular anomalous behaviours toward the infant that places the infant in a paradoxical attachment position, then leading to disorganisation. The basic premise is that the unresolved loss or trauma experienced by the parent emerges at times as an alteration of normal consciousness, resulting in behaviours that can be either frightening to the child, or that indicate that the parent is frightened. As the attachment figure is normally the source of comfort for the child during times of heightened arousal, the parent becomes at the same time the source of fear and the source of regulation of that fear and it is within this double bind system that the child is not able to form an organised attachment strategy. These frightening or frightened behaviours (termed FR behaviours) form the basis of this coding system. The coding system is comprised of six subcategories (Hesse & Main, 1999). The first three are seen as the primary form of FR behaviour as they are directly experienced by the infant as frightening (Main & Hesse, 2006). They are:

1. Frightening/ Threatening behaviour: e.g. looming or assuming attack postures toward the infant.
2. Frightened behaviour: e.g. pulling or backing away from the infant, frightened facial expressions.
3. Dissociated behaviour: e.g. stilling, freezing, sudden changes in voice, sudden changes in mood or state.

The next three subcategories are deemed to be secondary as they are not seen as overtly frightening to the infant. However, such behaviours have often been observed in parents of disorganised infants, and they are indirectly frightening for the child as they usually involve shifts in consciousness in the parent. These are:

4. Timid/deferential (role reverting) behaviour: e.g. submissive to infant, treating child as attachment figure.
5. Sexualised behaviour: e.g. sexualised or romantic caressing, extended kissing.
6. Disorganised/disoriented behaviours: e.g. contradictory signals such as approaching infant with head averted, limpness of movement, sudden changes of affect.

Coding has been applied to free play, caregiving and structured interactions in the home and laboratory. The length of observations has varied between 30 minutes and four hours (Main & Hesse, 2006). The level of FR behaviour is scored by instance on a 9-point rating scale. The entire segment is given an overall rating based on the highest score of all instances in that segment. Scores above 5 are classified as FR, those below 5 are not, and a score of 5 is borderline.

The FR coding system has provided a refreshingly different approach to the assessment of parent-infant interactions. One study has shown that FR behaviour does not correlate with maternal sensitivity but does predict infant attachment patterns (True, Pisani & Oumar, 2001). This provides some evidence that FR behaviour is both different to the more general measures of 'good mothering' and in some ways more enlightening. However, as it is focused on parental loss or trauma and the link with infant disorganisation, there is a strong focus on the psychopathological aspects of interaction with very little attention to the positive, resilience-forming functions within the relationship.

Atypical Maternal Behavior Instrument for Assessment and Classification

The **Atypical Maternal Behavior Instrument for Assessment and Classification* (AMBIANCE; Bronfman, Parsons & Lyons-Ruth, 1999) is theoretically and functionally related to Main & Hesse's FR coding system described above. It was developed around the same time as the FR coding system and the early system was called the FR+. The focus remains on maternal behaviours that are theoretically and empirically linked with disorganised attachment in infancy, later social difficulties and psychopathology, and the intergenerational transmission of attachment difficulties. However, the work of Lyons-Ruth and colleagues builds on from the idea of frightened/frightening maternal behaviours and posits that there is a broader range of behavioural correlates that can also link with infant disorganisation. The AMBIANCE includes all of the FR behaviours on the Main and Hesse coding system as well as additional behaviours relating to two further hypotheses about the precedents of disorganisation (Lyons-Ruth, Bronfman & Atwood, 1999; Lyons-Ruth, 2001).

Firstly, it is proposed that parents may display contradictory or competing caregiving strategies, in the same way that the disorganised behaviours of the infant are often contradictory in nature. These behaviours are termed affective communication errors and can be seen as incongruent physical and verbal behaviours, missed cues, or inappropriate responses to infant cues. Secondly,

they posited that it is not only overtly frightening behaviours that are of importance, but also the parent's overall ability to regulate infant arousal under stressful conditions, the breakdown of which can be seen as a 'failure to repair' for the infant. Thus, parental withdrawal or role-reversing behaviours would also serve to inhibit the parent from being able to adequately regulate and respond to the infant's fearful arousal and attachment behaviours.

The AMBIANCE coding system is comprised of five subscales:

1. *Affective communication errors*: includes contradictory behaviours to the infant and non-responses, inappropriate or mismatched responses to infant cues. For example, smiles while using a stern voice ignores infant's cue for distance.
2. *Role-confusion*: including role-reversing and/or sexualised behaviours toward the infant. For example, asks infant's permission to do something, kisses infant in a sexualised manner.
3. *Disorganised/ disoriented behaviours*: including fearful, confused and disoriented behaviours. For example, exhibits a 'haunted' or frightened voice, wanders aimlessly around the room.
4. *Negative-intrusive behaviour*: includes frightening verbal and physical behaviours. For example, pulls infant by the wrist, mocks infant, withholds toy from infant.
5. *Withdrawal*: behaviours and verbalisations which create a distance between parent and infant. For example, squats behind infant to play, interacts silently with infant.

Coding requires a count of the number of affective communication errors on each dimension during the interaction, assigning an overall score of the level of disruption on a scale of 1 to 7, and a classification of disrupted versus not disrupted (an overall score of 5 or more is classified as disrupted). The cases classified as disrupted are also assigned a subtype of either intrusive/self referential or withdrawing, depending on their main behavioural strategies seen in the interaction. These two subtypes have been theoretically and empirically linked with different outcomes for the infant, although still within the disorganised framework (Lyons-Ruth, 2001; Lyons-Ruth et al., 1999).

The AMBIANCE was originally developed from and used with observations of maternal behaviour with their 18-month old infants on the Strange Situation (Ainsworth, 1978), a laboratory procedure entailing episodes of separations and reunions which is designed to heighten and elicit attachment behaviours in the infant. It is an interesting measure that is grounded within a strong theoretical and empirical framework. The measure draws together the seminal ideas introduced by Main and Hesse of how maternal state of mind, particularly in relation to unresolved trauma, links in with behaviour towards the child, and subsequent child attachment patterns and psychopathology, and widens the lens through which we analyse the parent-child interactions. It could be said that the additional dimensions of the AMBIANCE which are not part of the FR model are an attempt to bring back to the fore the classic ideas of maternal sensitivity (Madigan, Moran & Pederson, 2006). For example, when coding for affective communication errors, a very common code is the parent missing the infant's cue. Parental withdrawal behaviours also are often classic signs of insensitivity. However, this is not a measure of maternal sensitivity in that it is focussed on the pathological. Positive reparation behaviours might be taken into account to a certain extent when deciding upon overall level of disruption, but these are not part of the coding system itself.

Given the strong theoretical and empirically demonstrated ties between AMBIANCE codes and infant and maternal psychopathology, this measure is appropriate for clinical and research use in clinically referred and at-risk populations and as an outcome measure for interventions which focus directly on the parent-child relationship.

Diagnostic/ Screening measures

Some instruments have been developed with the specific aim of diagnosis and clinical intervention in mind.

Parent-Infant Relationship Global Assessment Scale

The Parent-Infant Relationship global assessment scale (PIRGAS; Zero to Three, 1994) was developed by a task force of clinicians as an additional component to the clinical assessment and diagnosis of relationship disorders on the Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-3; Zero to Three). It is completed after a thorough clinical evaluation of the infant's problems and is a global assessment of the quality of relationship between parent or caregiver and child. Three components of the relationship are assessed: behavioural quality of the interaction, affective tone, and psychological involvement. One global score on a 90-point scale is given and score definitions range from grossly impaired (10) to well adapted (90). The PIRGAS can be used with children from birth to five years of age.

As primarily a diagnostic tool rather than an evaluation measure, there is not a great deal of information about the psychometric properties of the PIRGAS. Some evidence of concurrent validity comes from one study which demonstrated an association between PIRGAS ratings and maternal psychopathology, the duration of regulatory problems in the infants, the number of affected domains, and cumulative risk scores (von Hofacker & Papousek, 1998). Also, PIRGAS scores are able to discriminate between infants referred for attachment disorders and those referred for other reasons (Boris et al., 1998). Aoki and colleagues (2002) examined the predictive validity of the PIRGAS and found that PIRGAS scores when the infant was 20 months predicted internalising symptoms in the child as well as mother-child interactions in a problem-solving paradigm at 24 months. As with diagnostic procedures in general, a great deal of clinical experience is required to reliably rate parent-infant dyads on the PIRGAS.

The Parent-Infant Relational Assessment Tool

An instrument, the Parent-Infant Relational Assessment Tool (PIRAT; Broughton, 2005), has been developed by psychoanalytic parent-infant psychotherapists at the Anna Freud Centre in London. The aim of the PIRAT is to provide a tool that can be used by health professionals in various settings (home, clinic or consulting room) to assist in their assessment of risk and appropriate intervention strategies. The measure is comprised of six infant to parent variables (infant's seeking of contact, responsiveness to contact, responsiveness to stranger, ability to communicate needs, ability to be comforted and quality of contact) and six parent to infant variables (parent's initiation of physical contact, parent's initiation of emotional contact, parent's playfulness in relation to infant, pleasure in parenting, hostility and blame, and quality of contact). Each is rated on a three-point scale.

Research into the reliability and validity of the measure is currently underway. Although it is essentially a clinical assessment tool that can be rated from observations or video interactions, it holds the potential to be used as an evaluation and outcome measure. As the theoretical background is heavily grounded in psychoanalytic thinking about the parent-infant relationship, it may be a suitable measure of psychoanalytically-informed intervention. However, further research is needed to determine whether it is sensitive to change and to assess its reliability and validity in various populations.

Overview of interaction measures

The measures discussed here differ in the extent to which they break the interaction down into its various components. Some measures, such as the AMBIANCE and FR coding system are very specific in the behaviours they aim to explore. The selection of behavioural components of relevance is clinically and theoretically informed. These measures in particular have evolved out of a psychodynamic approach to parent-infant relationships. They are based on assumptions about the unconscious processes underlying particular behaviours, and the subsequent impact of them on the infant's internal working model.

Other measures such as the ERA and the CIB encompass a far broader range of behavioural components of the relationship. These include physical, vocal, affective and intersubjective behaviours. Although such measures are inclusive in their approach, it might be said that factors that appear significantly important to the observer get lost within the plethora of so many other variables and by then subtotalling the components as though each were of equal significance. For example, a mother's hostility towards her infant may stand out to the observer as clinically very worrisome. However, if that same mother was also responsive, resourceful, and physically affectionate, among other things, the single high score on the hostility variable will be diluted in its apparent level of importance. On the other hand, the richness of data from such measures can be useful for understanding the most basic components of the interaction and how these relate to each other.

In comparison, the EA scales and CARE-Index have only a small number of variables that are rated. By having fewer but broader variables, the observer is given somewhat more flexibility to reflect in the overall score the meaning and relevance of what might have been brief events or more subtle behaviours. Hence, the overall quality and 'feel' of the interaction is retained. This may be seen as akin to the move from a strongly quantitative approach to a more qualitative analysis. On the other hand, ratings on only a small number of generalised scales might also leave the rater feeling that the complexity of the relationship is lost in a single score. One relatively new approach to dealing with these issues is the use of infant observation as a research tool.

Infant Observation as a research tool

Direct infant observation has formed an integral part of psychoanalytic training and practice since it first emerged from the culture of the Tavistock Clinic in London almost sixty years ago. It involves, in its prescribed form, the regular observation of infants and their mothers or primary caregivers within a natural - usually home - setting with observations and subsequent reflections then recorded. Although the infant is the direct focus of attention, all of the infants' behaviours, affects and responses throughout the observation are recorded in relation to the carer's conscious and unconscious stimuli. Thus, infant observation can give insight into naturalistic parent-infant interaction.

While infant observation has existed alongside psychoanalytic practice and importantly, training (Sternberg, 2005), it's potential as a powerful research tool has only recently begun to be emphasised. With the rapid development of means of investigating infant development and the parent-infant relationship (Rustin, 2006), what can infant observation bring to this fast growing research area?

There is little published literature thus far that explores the role of infant observation in research, and little discussion regarding the methods that might be applied. However, Rustin (2006)

proposes five main emerging research agendas where infant observation is becoming recognised: studies of the development of the infant psyche, containment and its disorders, therapeutic infant observation, infant observation in medical settings and cross-cultural studies [4].

Issues of generalisability and consistency across observers and observations place much of infant observation research in the qualitative tradition - it has its place in exploring psychoanalytic hypotheses, or more recently, in generating new hypotheses, but formal methods of data analysis have not usually been applied. Briggs (1997) however broke out of this tradition and demonstrated how grounded theory analysis could be applied to infant observation and produce quantifiable results. By rating categories and sub-categories of observed behaviours and interactions he produced a viable way of making cross-case comparisons (Rhode, 2004). This differs from standardised rating scales in that the approach is 'bottom-up', exploring interactions as and how they occur without any imposed structure. Other research currently under way, such as the cross-cultural study of *Changing Identity in Becoming a Mother* (Urwin, 2006); have begun to integrate the infant observation method with other forms of data collection and analysis in very promising ways.

II. OTHER WIDELY USED MEASURES IN PARENT-INFANT RESEARCH

Measures of maternal attachment and representation

Investigation into the mental representation of attachment and attachment-related behaviour has persisted since Bowlby introduced the concept, and first gained research recognition with the creation of the Strange Situation and its coding system (Ainsworth et al, 1978) to categorise infant attachment. Six years later, the Adult Attachment Interview (AAI), along with its own coding system (George, Kaplan & Main, 1985), was developed to classify adult attachments with past and current attachment figures (Turton, McGauley, Marin-Avellan & Hughes, 2001). Later, interview schedules that tap into parental representations of the attachment relationship with their own children have evolved.

The Adult Attachment Interview

The AAI was developed to capture a person's experience of attachment with their parents (or other attachment figures). The semi-structured interview, composed of twenty questions, is designed to evoke the individual's memories and interpretations of events in their past relating to their attachment figure. This discourse is then coded to elicit the unconscious representations underlying the interviewee's relation of such events, and relate this to their attachment status.

The interview itself can take 60-90 minutes, but the complex coding can take somewhat longer. Two coding systems have been developed to interpret the AAI - the original Main & Goldwyn coding system (Main & Goldwyn, 1998) which was developed alongside their creation of the interview, and the later reflective functioning coding system developed by Fonagy & Target which is described in more detail below (Fonagy, Steele, Steele & Target, 1997). Both coding systems require extensive training to reach reliability.

The AAI has been used extensively in attachment research, and has been widely validated as a measure of attachment relationships. Its clinical utility in parent-infant psychotherapy has also been recognised (Steele & Baradon, 2004). It was however, originally developed for a middle-class, non-clinical group, and its extensive use within psychopathology and forensic populations entails some limitations. The trauma of past events, or current psychiatric complications that might be associated with high-risk populations, can make interviewing

and coding very challenging and these issues are discussed further in detail in Turton et al. (2001).

Maternal Representations

While the AAI valuably explores an individual's recollection and interpretation of past relationships and relates these to attachment classifications, other research has focused on the 'maternal state of mind' in specific conditions (e.g. Reid, 2003, who describes the inner world of the mother following the birth of a child born 'in the shadow of death' [5]), or parents' perceptions of their own infants and children when there are difficulties in the early relationship (e.g. Balbernie, 2003[6]). A number of tools have evolved to explore current representations of a parent's relationship with his or her child in the present, two of which will be described here.

The Working Model of the Child Interview (WMCI)

The Working Model of the Child Interview (WMCI, Zeanah, Benoit, Hirshberg, Barton & Regan, 1994) is a structured interview which enables classification of parental perceptions of their child and their relationship with them. It was developed for research purposes, but like the AAI, has also been used in clinical settings (Zeanah & Benoit, 1995). The interview transcription can be rated on eight five-point rating scales: richness of perceptions, openness to change, intensity of involvement, coherence, caregiving sensitivity, acceptance, infant difficulty, and fear for infant safety. Some of these scales are derived from the AAI coding system. From these ratings, parents can be classified as balanced, disengaged or distorted. In addition, the affective tone of the parent's responses can also be rated on measures of joy, anxiety, pride, anger, guilt, indifference, disappointed, and other emotions expressed.

Studies have shown that classifications on the WMCI are stable over time (Benoit, Parker & Zeanah, 1997), related to infant attachment security (Benoit et al., 1997; Zeanah et al., 1994), and discriminate between high and low-risk populations (Benoit, Zeanah, Parker, Nicholson & Coolbear, 1997).

The Parent Development Interview (PDI)

The PDI is a semi-structured clinical interview designed to elicit parents' representations of their child, their experiences of their relationship, and perceptions of themselves as parents. Unlike the AAI, the PDI is evoking current experiences and recent memories, and thus can be seen to be a more 'online' measure of present internal working models and reflective functioning capacity. As such, it can be used as an important tool in exploring the parent-infant relationship and the parent's mental representations of the relationship's different facets.

Reflective Functioning

Both the AAI and the PDI can be coded in terms of the interviewee's level of Reflective Functioning (Fonagy et al., 1997). Reflective functioning refers to an individual's ability to understand one's own and another's behaviour in terms of the mental states which underlie that behaviour, and an ability to understand the intersubjective nature of mental states. With reference to the parent-infant relationship, high levels of reflective functioning in the parent are essential for the parent to be able to attribute appropriate thoughts and emotions to their child, and to successfully hold the child in mind (Slade, in press).

Infant Outcome Measurement

Although the focus of this chapter is on the parent-infant relationship, as mentioned previously

one of the ultimate goals in any therapy which also involves the baby is a successful outcome in the infant's mental health, attachment behaviour, and developmental trajectory. Thus, important and widely used tools in the evaluation of these outcomes, even if they are not specific to a psychodynamic approach, will be briefly touched upon here.

The Strange Situation

An extremely well accepted method for assessing an infant's attachment to a parent or caregiver is **Ainsworth's Strange Situation Procedure* (SSP; Ainsworth, Blehar, Waters & Wall, 1978). The twenty minute procedure involves observing a 12-18 month old infant's reaction to a series of separations and reunions with his or her parent, and the presence of a stranger coming in and out of the room.

The protocol is as follows:

1. Parent and infant are introduced to the room which has age-appropriate toys laid out.
2. Parent and infant are left alone and the infant is allowed to explore.
3. Stranger enters, talks with parent, and then interacts with infant. Parent leaves quietly.
4. First separation episode: The stranger will attempt to comfort infant if distressed.
5. First reunion episode: Parent enters and stranger leaves. Parent greets and comforts infant, then leaves again.
6. Second separation episode: Infant is alone.
7. Stranger enters and attempts to comfort infant if distressed.
8. Second reunion episode: Parent enters, greets infant, and picks up infant; stranger leaves inconspicuously.

Two aspects of the infant's behaviour are observed - their reactions to separation and reunion, and their level of exploration throughout the procedure. The original coding system allowed for categorisation of infants on one of three categories: secure, insecure-avoidant, and insecure ambivalent. Further categories and descriptions have been developed later on by Main & Solomon (1986), who introduced the concept of disorganised attachment, and Crittenden, who expanded the categories to include compulsive and obsessive strategies (Crittenden, 1995).

An alternative measure to the Strange Situation is the *Attachment Q Sort* (AQS; Waters & Deane, 1985), which can be carried out by a trained observer after several hours of observation of the parent and child. The observer has about 100 statements, each describing a specific behavioural characteristic, which are ranked from 'most descriptive of the child' to 'least descriptive of the child.' These are then compared with the profile of a 'prototypically secure' infant which is provided by attachment experts, and a score for attachment security can be computed. The benefits of this methodology are that it can be used with older children (up to 48 months rather than 18 months), and it is not as intrusive or stressful as the SSP.

Bayley Scales of Infant Development

The Bayley Scales of Infant Development (Bayley, 1969) are a comprehensive set of measurements for infants aged 1 month to 42 months. Accounting for prematurity, infants work through a selection of age appropriate motor and mental tasks, aimed at stretching the infant to the limit of their capabilities but also allowing them to achieve successes. Delivery of the tasks can take up to an hour, depending on the performance and motivation of the infant. Their ability on each of these scales allows a calibrated percentile ranking and developmental age marker to be assigned in terms of motor and mental development. In addition, an observational scale based on the practitioner's ratings of the infant's behaviours,

interactions and responses, produces a calibrated score for behavioural development. These three scores can then be monitored across time to chart the developmental progress of the infant, possibly in relation to an intervention. The administration and coding of the Bayley Scales must be taught by an experienced practitioner.

Summary

The selection of the appropriate instrument for research relating to parent-infant relationships depends on a number of factors. Most importantly, the measure should fit with the purpose for its use and should tap into those constructs which the user wishes to explore. If it is to be used as a measure of outcomes of clinical intervention, the measure should also match with the target population and aims of the intervention. For example, if the intervention aims to modify intergenerational patterns of psychopathology, tools such as the AMBIANCE and FR coding systems would tap into important and relevant behaviours. On the other hand, if the aim is to develop and foster more positive care-giving in the general sense, perhaps other measures such as the EA scales would be more appropriate and informative.

Furthermore, the decision is inevitably influenced by the resources available in terms of costs of training and the time taken to become reliable. Most measures require costly training, usually based in the U.S.A., and it can sometimes take up to a year or more to achieve reliability.

With the wealth of instruments now available, from diverse theoretical bases, clinicians and researchers alike have the tools at their fingertips to continue to add to our understanding of every nuance of the parent-infant interaction.

Appendix A. Summary of studies

1)

Title
Preventive Intervention and Outcome with Anxiously Attached Dyads

Background/aims
The aim of this study was to determine whether parent-infant psychotherapy could improve the quality of the relationship between anxiously attached dyads. Evidence suggests that attachment patterns remain stable from twelve months of age, unless intervention can significantly change in the mother's pattern of representations and interactions. It was hypothesized that parent-infant psychotherapy, with its emphasis on the parent-infant relationship and addressing maternal sensitivity, empathy, etc. might be able to initiate this change.

Methods
One hundred dyads (infants aged 12 months at start of study) were taken from a population deemed to be at high risk for anxious attachments (high levels of poverty and low SES). Dyads were assessed for attachment classification using the Strange Situation, with anxiously attached dyads assigned to either an intervention or control group, and those dyads that were securely attached formed a second control group. Intervention in the form of parent-infant psychotherapy within the home was on a weekly basis for one year. Outcome was based on a number of constructs of parent behaviour, aggression, reciprocity and dyadic interaction observed in a 1 3/4 hour video-taped laboratory session.

Findings
The anxiously attached dyads assigned to the intervention and control groups differed significantly at follow-up; with intervention mothers having higher scores in initiation and empathic responsiveness and intervention toddlers a reduction in angry behaviours. Significant differences between the anxiously attached control group and the intervention group were also recorded post-treatment in proximity avoidance and contact resistance. There were no significant group differences in any of the outcome measures between the securely attached controls and the intervention group, indicating that the two groups were comparable post-treatment. There was however no significant shift in the Q-sort scores - the measure of internalised attachment security - for the intervention group. Thus it appears that the parent-infant psychotherapy was successful in enhancing many aspects of the parent-infant interaction, but that these changes were not yet consolidated sufficiently in the one year to modify attachment classification.

Key reference
Lieberman, A., Weston, D., & Pawl, J. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62* (1), 199-209.

2)

Title
Outcome Evaluation in Brief Mother-Infant Psychotherapies: Report on 75 cases

Background/aims
The aim of this study was to investigate the effectiveness of two forms of brief parent-infant psychotherapy; Psychodynamic Therapy with its emphasis essentially on maternal representations, and Interaction Guidance Therapy with its emphasis on the parent-infant interaction. It was of interest whether both forms of brief intervention were as effective as each other and in what domains, and whether their outcome effects were long-lasting.

Method
75 dyads (children under 30 months), all of whom had been referred to the clinic for a range of behavioural or interactional disorders, were assigned to either of the two intervention groups. Both interventions were provided on a weekly basis in a clinic setting with the average number of sessions being six. Outcome measures included a symptoms checklist for a range of disturbances, maternal representations collected in interview setting, and aspects of parent-infant interaction from a series of videotaped episodes.

Findings
Significant post-treatment symptom relief was found in a range of areas including feeding and sleeping, and although both treatments were effective in symptom reduction, they differed in those for which they were particularly effective. In both treatments, all measures of interaction improved significantly post-treatment and continued to improve once treatment had ceased. Mothers were found to be more sensitive (higher scores following Interaction Guidance Therapy) and children less unresponsive. Mothers' representations also improved across both treatments, in particular self-esteem (higher following Psychodynamic Therapy) and affect. All changes in symptoms, interaction and representation were maintained across a six-month follow-up. Discussion explores the significant role for brief mother-infant psychotherapies and where their potential limitations might lie.

Key reference
Robert-Tissot, C., Cramer, B., Stern, D., Rusconi Serpa, S., Bachmann, J., Palacio-Espasa, F., Knauer, D., De Muralt, M., Berney, C., & Mendiguren, G. (1996). Outcome evaluation in brief mother-infant psychotherapies: Report on 75 cases. *Infant Mental Health Journal, 17*(2), 97-114.

3)

Title
Six-month follow-up of two mother-infant psychotherapies: convergence of therapeutic outcomes

Background/aims
The aim of the study was to investigate parent, infant and dyadic outcomes six months after dyads had received one of two forms of mother-infant psychotherapy, and compare these to outcomes immediately following completion of their therapy. The two forms of mother-infant psychotherapy were Watch, Wait and Wonder (WWW) - where the infant is seen as a patient in their own right and an important 'initiator' in the sessions - and a more generic psychodynamic psychotherapy (PPT) - where the infant is still involved, but the primary focus is on working with the mother.

Methods
58 dyads from the 67 that participated in the original study were available to be included in this follow-up analysis. The same battery of assessments that were completed immediately post treatment were repeated at this follow-up stage and consisted of a range of parent, infant and dyadic measures. These included scales of maternal perception of parenting, maternal depression, infant development and interaction and attachment scores.

Findings
As predicted, the improved outcomes in both groups recorded immediately following treatment had persisted and both groups had also continued to improve. Although post treatment improvement was greater for those dyads who participated in WWW, at this follow-up stage the PPT dyads also showed such improvements suggesting that PPT is an effective modality of change, but that this change takes place over a wider time scale. Mothers in the WWW group however, persisted in having lower parenting stress in general and greater comfort in dealing with infant behaviours. Continued improvement in both groups was found on the mother-infant interaction scale, specifically with regards to increased dyadic reciprocity and decreased maternal intrusiveness. Only one third of infants moved to a more secure attachment classification, with no significant difference between groups at six-month follow-up, and although further analysis will explore this in more depth, in view of Bowlby's (1979) emphasis on attachment's resistance to change such short-term intervention might not be expected to elicit greater shifts in classifications. Both treatments appear to have effective and long-lasting results and discussion explores the routes that might explain the differing time scales for outcomes.

Key reference
Cohen, N.J., Lojkasek, M., Muir, E., Muir, R., & Parker, C.A. (2002). Six month follow-up of two mother-infant psychotherapists: Convergence of therapeutic outcomes. *Infant Mental Health Journal, 23* (4), 361-380.

4)

Title
Infant observation research: What have we learned so far?

Background/aims
Psychoanalytic infant observation has for decades been an essential part of psychoanalytic training and practice. Its merits as a research tool are only just beginning to be realised. The paper explores published literature in the field of infant observation as a research tool, considering what it has leant so far to psychoanalytic understanding and where it might lead in the future.

Methods
Compares and contrasts the contribution of clinical and observational methods in psychoanalytic understanding both in terms of ontology and epistemology. The paper discusses methodological issues potentially associated with infant observation as a valid research tool, and goes on to detail the agendas emerging in infant observation research.

Findings
The paper argues that infant observation has much to lend to psychoanalytic research. It notes the need for more published literature in the field, particularly calling for discussions around methodology, and identifies five of the most important research agendas emerging from the field:

- The integration of the infant psyche
- The study of containment
- Therapeutic infant observation
- Medical-based infant observation (e.g. neo-natal care)
- Cross-cultural studies in infant observation.

The paper effectively explores the role of this unique historical tool in today's fast growing research forum. It is a useful summary of what has gone before in terms of infant observation research, but also what is pertinent now in order that it finds a place in current research literature.

Key reference
Rustin, M. (2006). Infant Observation Research: What have we learned so far? International *Journal of Infant Observation, 9* (1), 35-52.

5)

Title
The inner world of the mother and her new baby born in the shadow of death

Background/aims
This piece of research aimed to explore maternal states of mind following the loss of an infant or small child and the birth of the next baby; in particular, how the nature of the mother's inner world might have influenced the mourning process and the way this might be expressed in the relationship with the new baby as well as in the transference.

Methods
Three mothers were seen for psychoanalytic psychotherapy on a weekly basis in a perinatal service in order to explore the impact of the loss of a young child prior to the birth of a new baby and the impact of this on the new mother-infant relationship and the therapeutic process. Process recordings of the sessions were then analysed using a method similar to Grounded Theory (Strauss & Corbin, 1990) and the predominant themes in each case were coded and written up in a case-study format, leading to a cross-case comparison.

Findings
Four common themes were found across the three cases: the loss of the baby; the therapeutic relationship; mourning; and the next baby. The presentation of a single case study reveals the way in which these themes were played out in the case of one particular mother.

Key reference
Reid, M. (2003). Clinical research: the inner world of the mother and her new baby - born in the shadow of death. *Journal of Child Psychotherapy, 29* (2), 207-226.

6)

Title
Mothers' descriptions of their infants

Background/aims
This piece of research aimed to compare and contrast the way in which different caregivers described their infants and the relationship between the pair of them, with a particular focus on the presence or absence of references to mental states.

Methods
Transcripts of interviews centred on perceptions of their infants with five mothers who had all been seen for infant-parent psychotherapy in a clinical setting were examined using a qualitative, narrative approach from two perspectives: 1) to discover how internal world references had been applied within descriptions of themselves and of their child; and 2) how each mother's ideas about her infant were put in the wider context of the caregiving relationship. Contextual information from the process notes of the infant-parent psychotherapy was also drawn upon.

Findings
Narrative analysis of the interview transcripts led to the emergence of seven themes. These were used to provide narrative structures in order to quantify how many times each of these occurred in reference to the child's and the parent's internal and external worlds. This allowed comparisons between the different proportions of time within a particular narrative allocated to each theme by each parent. Case studies of individual mother-infant dyads are presented and compared, and the variation in the number of references to the infant's internal world is linked to the concept of 'reflective functioning' (Fonagy & Target, 1997). Findings suggest that clinical risk is associated with a decrease in references to the internal world of either mother or infant in the mother's interview, and indicate that the analysis of parental discourse in terms of capacity for reflective functioning could be a useful diagnostic tool.

Key reference
Balbernie, R. (2003). The roominess of language: mothers' descriptions of their infants and a discourse analysis approach to reflective function. *Journal of Child Psychotherapy, 29* (3), 393-413.

Appendix B. Glossary of Measures

Title
Ainsworth's Maternal Sensitivity Scale

Background/aims
Ainsworth and colleagues studied maternal behaviours that are facilitative of secure base behaviour and attachment security in infants. Of the different facets of maternal behaviours they found maternal sensitivity to be the most global assessment of relational behaviours and the best predictor of infant attachment security. Maternal sensitivity is a mother's accuracy in perceiving and interpreting her infant's cues and her ability to react in a timely and appropriate manner.

Description of measure
The work was based on intensive home observations of interaction between parents and infants during the first year of the children's lives. A simple rating scale of maternal sensitivity was developed for use with parents of infants aged 9 to 12 months. Rating is on a 9-point scale of maternal sensitivity, with five anchor points of highly insensitive (1), insensitive (3), inconsistently sensitive (5), sensitive (7), and highly sensitive (9).

Uses/validity
This measure was found to be significantly related to the attachment security of the infants. However, the lack of very detailed behavioural descriptors and the fact that no formal training procedure was established has meant that this rating scale has been used in many different ways by different groups. However, the sensitivity scales have formed a basis for several other measures which have been better operationalised, and these have become far more widely used in recent studies.

Key reference
Ainsworth, M.D.S., Bell, S.M., & Stayton, D.J. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M.P.M. Richards (Ed.), *The integration of a child into a social world* (pp. 97-119). London: Cambridge University Press.

Other references
Lohaus, A., Keller, H., Ball, J., Elben, C., & Voelker, S. (2001). Maternal sensitivity: Components and relations to warmth and contingency. *Parenting: Science and Practice, 1* (4), 267-284.

Lohaus, A., Keller, H., Ball, J., Elben, C., & Voelker, S. (2004). Maternal sensitivity in interactions with three- and 12-month old infants: Stability, structural composition and developmental consequences. *Infant and Child Development, 13*, 235-252.

• For a critique of the rating scale:
Meins, E. (1999). Sensitivity, security and internal working models: Bridging the transmission gap. *Attachment & Human Development, 1* (3), 325-342.

Title
The Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE)

Background/aims
An observational measure to assess the degree of anomalous maternal behaviours towards infants which are linked with disorganised attachment in infancy.

Description of measure
The AMBIANCE coding entails looking for disrupted maternal behaviours on five dimensions: affective communication errors, role/boundary confusion, disorganised/disoriented behaviours, negative/intrusive behaviour, and withdrawal. Behaviours on each of the dimensions are coded, and an overall score of the level of disruption on a 7-point scale is given. A binary code of disrupted or not disrupted is also given.

Uses/validity
The original coding system rates maternal behaviour during the Strange Situation, but it has also been used in free play and other interaction settings. It has also been used for coding interactions where the infant is as young as four-months old, or as old as seven years. It has been shown to be significantly related to disorganised attachment in infants and could be significantly predicted by maternal unresolved classifications on the AAI. Concurrent validity has also been established with level of maternal reflective functioning. It has been shown to be stable over time. Sensitivity to treatment change has been demonstrated in one study of parents and their infants with feeding problems but more studies are needed to better determine the instrument's sensitivity to treatment effects.

Key reference
Bronfman, E., Parsons, E., & Lyons-Ruth, K. (1999). *Atypical Maternal Behaviour instrument for assessment and classification.* Harvard Medical School, Unpublished manual.

Other references
Lyons-Ruth, K. (2001). The two-person construction of defences: Disorganised attachment strategies, unintergrated mental states, and hostile/helpless relational processes. *Newsletter of the Division of Psychoanalytic Psychology of the American Psychological Association.*

Lyons-Ruth, K., Bronfman, E., & Atwood, G. (1999). A relational diathesis model of hostile-helpless states of mind: Expressions in mother-infant interaction. In J. Solomon & C. George (Eds.), *Attachment Disorganization* (pp. 33-70). New York: Guilford Press.

Lyons-Ruth, K., Bronfman, E., & Parsons, E. (1999). Maternal frightened, frightening, or atypical behaviour and disorganised infant attachment patterns. *Monographs of the Society for the Research in Child Development*, 64, 67-96.

Title
Child Adult Relationship Index (CARE-Index)

Background/ aims
The CARE-Index is a rating scale of parent and child interaction which draws on the ideas of maternal sensitivity and attachment behaviours. It is based on the dynamic maturational model of attachment which expands on the self-protective strategies that evolve in the attachment relationship.

Description of measure
The scale is comprised of three parent descriptors (sensitive, controlling, unresponsive) and four infant descriptors (cooperative, difficult, compulsive and passive), each one having two points allocated, giving a total scale score of 14 for the parent and child each. Interactions of free play lasting between three and five minutes are rated.

Uses/validity
The CARE-Index can be used for parents and infants aged from 0 to 3 years. Sensitivity to change has been demonstrated in several treatment outcome studies. It is able to discriminate between mothers with and without psychiatric disorder, and between irritable and non-irritable infants and the subsequent link with maternal depression. Discriminant validity has also been demonstrated between groups of mothers of different risk status. In one study, the CARE-Index was used to show a link between classifications on the AAI and maternal sensitivity, but not between maternal sensitivity and infant classification. However, other studies have shown a link between maternal sensitivity on the CARE-Index and infant attachment classification.

Key reference
Crittenden, P. M. (2001). *CARE-Index: Coding Manual.* Miami, FL. Unpublished manuscript.

Other references
Crittenden, P. M. (1985). Maltreated infants: Vulnerability and resilience. *Journal of Child Psychology and Psychiatry, 26*, 85-96.

Crittenden, P. M., & Bonvillian, J. D. (1984). The effect of maternal risk status on maternal sensitivity to infant cues. *American Journal of Orthopsychiatry, 54*, 250-262.

Title
Emotional Availability Scales (EAS)

Background/aims
The Emotional Availability Scales is a global rating system for assessing dyadic interactions. It measures the emotional availability of the parent to child and child to the parent. It draws mainly upon the ideas of attachment theory and maternal sensitivity and imbeds these concepts within the framework of emotional availability.

Description of measure
Two versions are available: The Infancy to Early Childhood Version for infants aged 0 to 4 years and the Middle Childhood Version for school-age children from 5 years old up. The scales are comprised of four parental dimensions (sensitivity, structuring, non-intrusiveness and non-hostility) and two infant dimensions (responsiveness and involvement) of emotional availability. The recommended method of data collection is to video-record at least 20 minutes of interaction, although it has been used for shorter time periods. Each of the six dimensions is coded on 9-, 7-, or 5-point scale Likert type scales.

Uses/validity
The EA scales appear to demonstrate robust links with infant attachment classifications, with high levels of sensitivity correlating with secure attachment classifications and early secure attachments predicting greater emotional availability over time. Concurrent validity has also been established between EA ratings and maternal attachment classifications on the Adult Attachment Interview. The stability of the measure appears to be good. After training, inter-rater reliability is generally quite high. Training to reliably use the EA Scales can by done using the manual and distance training tapes, making it easier and less costly than other similar measures. Consultation and workshops are also provided by the author.

Key reference
Biringen, Z., Robinson, J.L., & Emde, R.N. (1993). *Emotional Availability Scales*. Denver, USA: University of Colorado, Health Science Center. Unpublished manuscript.

Other references
Biringen, Z., Robinson, J.L., & Emde, R.N. (2000). Emotional Availability Scales, 3rd edition. *Attachment and Human Development, 2*, 256-270.

Biringen, Z. (2000). 'Emotional availability: Conceptualizations and research findings'. *American Journal of Orthopsychiatry, 70*, 104-114.

Title
Parent-Child Early Relational Assessment (ERA)

Background/ aims
A widely used coding system for rating interactions between parents and infants. The earliest version was developed for use with a clinical population to describe interaction patterns and inform intervention strategies. This later refined version can be applied as a clinical and outcome assessment tool that can be used with a broad range of clinical and normative populations. The measure is informed by a number of different fields including psychodynamic, self-psychology, attachment, developmental, and soviet cognitive-linguistic theories, empirical studies and clinical observations.

Description of measure
Five minute video-recorded interactions of feeding, structured task, free play, and separation-reunion are observed and rated on 65 (29 parent, 28 child, and 8 dyadic) behavioural and affective variables on 5-point Likert scales.

Uses/validity
Later studies using the ERA have produced verification of the psychometric properties. For example, the discriminant validity of the ERA has been established through a number of studies comparing different populations, such as drug-using parents versus non-drug using controls, parents of non-organic failure to thrive children compared to parents of children with adequate growth, and mothers with psychiatric diagnoses versus those without. Sensitivity to change following therapeutic intervention has been demonstrated in several studies. The concurrent validity of ERA subscales have also been demonstrated with significant relationships to a number of constructs such as, among others, infant attachment and internal working models. The ERA is a comprehensive measure but may be in some ways too comprehensive as meaningful affects and behaviours might be diluted amongst others that might not be clinically as important. Training is provided by the author and can be costly.

Key reference
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Other references
Clark, R. (1993). *Interactions of psychiatrically ill and well mothers and their young children: Quality of maternal care and child competence.* Evanston, IL: North Western University. PhD dissertation.

Title
Frightened/Frightening (FR) Coding System

Background/aims
The FR coding system examines parental behaviours towards an infant which are thought to be linked with unresolved loss or trauma in the parent's own past and current and later psychopathology and attachment difficulties for the infant. It is stems from psychoanalytic and attachment ideas.

Description of measure
The coding system is comprised of six subcategories: frightening/threatening behaviour, frightened behaviour, dissociated behaviour, timid/deferential behaviour, sexualised behaviour, and disorganised/disoriented behaviours. The level of FR behaviour is scored by instance on a 9-point rating scale. The entire segment is given an overall rating based on the highest score of all instances in that segment. Scores above 5 are classified as FR, those below 5 are not, and a score of 5 is borderline.

Uses/validity
This coding system has been applied to free play, caregiving and structured interactions in the home and laboratory. Studies have consistently shown that maternal FR behaviours are predictive of infant disorganisation, particularly the dissociative and threatening subscales. The relationship between maternal unresolved attachment status on the Adult Attachment Interview and FR behaviour has also been established. One study (True et al., 2001) also measured maternal sensitivity on Ainsworth's rating scale and found that this was not significantly correlated with maternal FR behaviour. In addition, FR behaviour was a better predictor than maternal sensitivity of infant attachment classification, although the contribution of both measures to explain the variance was very small.

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Title
Ainsworth's Strange Situation Procedure (SSP)

Background/ aims
Ainsworth and her colleagues carried out in-depth observations of families and developed the Strange Situation procedure as a method for determining the quality of attachment between infants and their parents.

Description of measure
The SSP is a widely used laboratory procedure for categorising 12-18 month old infant's attachment strategy to his/her caregiver. It involves a series of separations and reunions between parent and infant, and the presence of a stranger to the infant in a standardised format.

Uses/validity
The infant's behaviour is observed in terms of: separation anxiety, willingness to explore, stranger anxiety and reunion behaviour. In the original study, infants could be classified into three groups: Secure (66%), avoidant insecure (22%), and resistant insecure (12%). Later work by Main and Solomon (1986) defined a fourth group of infants who could be classified as 'disorganized'. These children show inconsistent and confused behaviour, often characterized by behaviours such as stilling, freezing and rocking. Crittenden has also added to the original Strange Situation classification system by proposing that infants may use coercive and compulsive attachment strategies.

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Ainsworth, M.D.S., Bell, S. M., & Stayton, D.J. (1971). Individual differences in strange situation behavior of one-year-olds. In H.R.Schaffer (Ed.), *The origins of human social relations* (pp.17-57). New York: Academic Press.

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Ainsworth, M.D.S., Bell, S.M., & Stayton, D.J. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In Richards, M.P.M. (Ed.), *The integration of a child into a social world* (pp.97-119). London: Cambridge University Press.

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All images of children used in this publication are portrayed by models and are for illustrative purpose only.