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# Revisiting 'What works for whom?': A qualitative framework for evaluating clinical effectiveness in child psychotherapy

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**Abstract** *This paper describes a framework for evaluating the effectiveness of child psychotherapy used by child psychotherapists in an inner city Child and Adolescent Mental Health Service (CAMHS). The Hopes and Expectations for Treatment Approach (HETA) involves using the assessment for psychotherapy that normally precedes treatment to derive a baseline from which to generate a set of hopes/expectations as regards the effects of the treatment on the part of parents and the psychotherapist, to be revisited one year after the start of the psychotherapy and/or at its completion. The Strength and Difficulties Questionnaire, for parents and schools, was also administered before and after the treatment. The characteristics of the first 30 children referred for psychotherapy over a particular time period are described. Of the first 15 children in this group to complete one year of individual psychotherapy, all showed change or significant change in the areas concerning parents' and therapists' hopes at the end-of-year review, as rated by parents and psychotherapists. A case of a child with conduct disorder is used to describe how the assessment generated a psychoanalytic formulation, how the therapist's understanding was fed back to the parents, and how the parents' and therapist's hopes and expectations were derived and recorded. This case illustrates powerfully the impact of trauma in the parents' backgrounds on the internal world of the child, and how the method provides a useful bridge between parent and child work. Feedback from the psychotherapists, the parents and the referrers using the framework is reviewed, and in conclusion the paper argues for the framework's value in promoting good practice in the treatment and management of complex cases and in enhancing awareness of the nature and scope of the psychotherapy process.*

**Keywords** Evaluation; clinical effectiveness; conduct disorder; Hopes and Expectations Approach (HETA); psychotherapy assessment.

## Introduction

Child psychotherapists are under pressure to demonstrate the clinical effectiveness of child psychotherapy. The challenge is to find ways of doing this that respect the psychoanalytic process and the complexity of our cases and working contexts. In the

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United Kingdom, the contextual complexity includes a rapidly changing National Health Service.

As illustrative of the difficulties, the National Institute for Clinical Excellence (NICE), a body that has an increasingly important role in decision making about treatment choice, uses a notion of a hierarchy of evidence that places the randomised controlled trial (RCT) at the top as a so-called 'gold standard'. In the RCT, carefully matched groups of patients with clearly defined conditions are randomly assigned to a treatment group, a non-treatment group or a group receiving standard care. The degree of recovery in the treatment group is compared with that in the non-treated or standard-care control group. The strength of the method is that it allows one to claim with the greatest certainty possible that any significant changes in the treated group are due to the intervention rather than to extraneous circumstances.

For the child psychotherapy profession as a whole it is clearly necessary that we undertake research of this nature. The *Systematic Review of Psychoanalytic Approaches* (Kennedy, 2004) commissioned by the North Central London Strategic Health Authority usefully collates information on the effectiveness of child psychotherapy treatment using the above criteria, and indicates that some progress has certainly been made in response to the challenge facing the profession. In addition, the NHS itself is now encouraging so-called 'pragmatic' trials which recognise the diversity of referral populations while retaining commitment to the RCT.

However, there are many problems with using the RCT as a research method for child psychotherapy. Apart from the ethical problems of withholding treatment from children who need it, the method requires a level of specificity in selecting and matching numbers of patients that is not feasible in the ordinary family clinic. Furthermore, since the RCT requires a homogeneous sample, usually selection is made on the basis of psychiatric criteria. This would exclude a fair proportion of our cases, who are very troubled children but who do not reach the threshold for a psychiatric diagnosis. On the other hand, selecting a research sample based on context, life circumstances or presenting problems would be likely to include children who diverge significantly in other ways. In addition, co-morbidity and case complexity are becoming defining features in relation to children referred to child and family services, operating at so-called *Tier 3* in the UK context. These children often depend on the support of multiple agencies such as special schools, social services and other medical services. The therapeutic effectiveness of any intervention in these circumstances depends on good liaison and communication to create a developmentally supportive environment around the child. The RCT cannot capture this complexity (Richardson, 2003). Finally, there is also the more fundamental problem of generalising findings from large-scale research studies to the individual case: it is fair to say that the 'purer' the study in traditional scientific terms, the less relevant it becomes for making predictions about individual patients, with the multiple problems and complex family backgrounds that they are likely to bring with them (Hollway, 2001, 2004).

Evaluation frameworks for child and adolescent mental health in general, and child psychotherapy in particular, therefore need to address the question of whether treatments work from a number of different perspectives, recognising, as Midgley

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(2004) suggests, the particular strengths and limitations of both quantitative and qualitative methods. The need to progress on a number of fronts has been recognised by the North Central London Strategic Health Authority, which commissioned a second 'thematic' review of child, adolescent and parent–infant psychotherapy effectiveness, taking account of a broader range of research models, including qualitative methods, suitable for answering different kinds of questions (Kennedy and Midgley, 2007).

Within this diversity, a particularly important set of questions concerns the perspective of the service user or users. In the light of the *National Service Framework for Children* (Department of Health, 2004) child psychotherapists, like other professionals in child mental health services, will need to find constructive ways of involving parents, patients and referrers in the evaluation and outcome monitoring process. However, there are as yet rather few guidelines on how to proceed.

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## An evaluation of clinical effectiveness

This paper presents findings from a qualitative framework used for outcome monitoring under the umbrella of audit. In contrast to the RCT, which uses carefully selected samples, the aim here is to include all comers rather than selecting according to a particular research design or research questions, and to make parents' experience of the child's progress in psychotherapy intrinsic to the evaluation process.

This approach, the Hopes and Expectations for Treatment Approach (HETA), was developed in an inner city London borough characterised by high levels of deprivation and ethnic diversity. It is based on a recognition that the work done with parents is crucial to sustaining child psychotherapy and to ensuring its effectiveness. In the light of the *National Service Framework for Children* (Department of Health, 2004), we are likely to be asked to demonstrate our responsiveness to parents' experiences of treatment. HETA stresses the particular importance of the assessment for psychotherapy which normally precedes the beginning of treatment: in building a preliminary picture of the child's internal world and overall development; in formulating an account of symptomatology in psychodynamic terms; in giving the child the experience of being understood in a way which will reveal his or her availability to respond to the psychotherapeutic method; and in informing a case for what psychotherapy might achieve.

Boston and Lush (1994) have demonstrated the value of assessment and formulation in setting a baseline or starting point for the evaluation of the individual child's progress in psychotherapy in their longitudinal study of the effectiveness of child psychotherapy for looked-after children. In managing the actual practice of psychotherapy, however, a particularly important part of the assessment is the feedback meeting with the parents or carers. Here, the psychotherapist must report on his or her thoughts after assessing the child in a way that connects with the parents' own experience. If parents are to accept it, the proposal for psychotherapeutic treatment must make sense in terms of their anxieties and understanding as well as the psychotherapist's formulation of the problem in psychoanalytic terms. The connection parents make with the child psychotherapist at this time may be crucial in enabling them to sustain commitment to a lengthy and difficult treatment.

Our study aims to use not only psychotherapist but also parent experiences of the assessment to provide a baseline against which to evaluate the child's relative progress and the direction taken by psychotherapy over the first year.

The first of the two following sections describes the methods used to ascertain the nature of the population referred for child psychotherapy in the present study, and the procedures used in assessment and evaluation. An example of an assessment of a particular case illustrates what the psychotherapy assessment established, how findings were conveyed to the parents and how hopes and expectations for treatment were derived and recorded.

Findings, presented in the second section, include: first, a survey of all children and adolescents referred for psychotherapy over a six-month period; second, an evaluation of the progress of the first 15 cases to complete one year of psychotherapy; and third, a description of the psychotherapy of the child mentioned above, in order to illustrate how the evaluation framework can capture the relation between the psychotherapy process and change in the child observed by parents and psychotherapist, and may enhance the relation between child psychotherapy and the work with parents proceeding in parallel.

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## Methodology

### *Referral information*

The evaluation method used aims to provide a thorough account of the population of children and young people referred to the service for psychotherapy, and to involve the referrers in the evaluation process. As found by Kam and Midgley (2006) in their audit of psychotherapy referrals to another inner-city CAMHS, within our service the vast majority of referrals for psychotherapy are internal, made by colleagues in the multidisciplinary team.

Linda Dawson has designed a psychotherapy referral form to collect relevant information (see Appendix 1). This records the name and profession of the referrer, the child's age and ethnicity, the length of time that the child has been involved in work in the service already, any psychiatric involvement, the referrer's reasons for requesting psychotherapy at this point and what he or she hopes it will achieve. This helps to prompt the referrer to think about why psychotherapy might be the treatment of choice, and provides some baseline information about the referrer's expectations, for the evaluation at the end of treatment. The form also asks referrers about their continuing involvement, to establish what they can provide in terms of work with the parents. Involvement with social services, education and other agencies will also be noted.

### *Standardised measures*

Following the psychotherapy referral, and assuming the psychotherapist is satisfied that psychotherapy is likely to be a viable option, the child's parents and school complete a Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). This questionnaire is one of the instruments used in the evaluation package developed by the CAMHS

Outcome Research Consortium (CORC), a multidisciplinary consortium aiming to address the demand for routine clinical effectiveness monitoring in CAMHS in the NHS. This package is being used by CAMHS in a number of areas and is likely to be introduced more widely across the UK. The HETA framework for evaluating child psychotherapy effectiveness is designed so that it may be run alongside and be compatible with CORC. Findings from the use of the SDQ will be presented in a later paper.

### *Psychotherapy assessment*

HETA aims to build on and enhance rather than supplant the assessment method normally used by child psychotherapists. Although individual psychotherapists may differ, it is usual to see the child individually for two or three assessment sessions, and to follow this with a feedback meeting with the parents. During the series of assessment sessions the psychotherapist will develop some kind of psychoanalytic formulation explaining what might underlie the child's difficulties and why psychotherapy might be helpful. At this point it is helpful if the psychotherapist writes a preliminary version of the formulation for the file.

As noted previously, at the feedback meeting with the parents the psychotherapist aims to make a bridge with the parents, and to explain his or her understanding of how the child's problems might have arisen in terms that 'gel' with their experience of the child. If the psychotherapist recommends psychotherapy for the child, the case must be made in terms that the parents can appreciate. An illustration of how the formulation may be fed back to parents is given later.

If it is agreed that psychotherapy is to begin, the referrer, the parents and the psychotherapist have a further meeting to complete the Hopes and Expectations for Treatment Record Form (see Appendix 2). This form is in three parts.

Part 1 records in a relatively simple way the parents' main concerns, any changes occurring during the assessments and the psychotherapist's impressions of the child, such as presenting personality, obvious strengths and difficulties and how he or she approached the sessions.

Part 2, headed 'What has been agreed', records the commitment made to psychotherapy in terms of intensity and length of treatment. For example, this may be for once-weekly psychotherapy for one year in the first instance, with the added explanation that child psychotherapy usually goes on for longer. Times of sessions and the frequency of meetings between the parents and family worker are included, and a start date is set.

Part 3 records hopes and expectations, and is in three sections. Section 1 records the parents' hopes for the treatment, in terms of three areas where they would hope to see changes in the course of the year. Importantly, this is not a wish list. Since it follows the feedback meeting, the parents' expectations should incorporate their understanding of the feedback given by the psychotherapist. Section 2 records three areas in which the psychotherapist would anticipate seeing changes within the psychotherapy sessions during the course of the year. These hopes and expectations are based on the psychotherapist's formulation and should include anticipated areas of difficulty and resistance. Section 3 records three areas where, given the understanding derived from

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the assessment and the rationale for psychotherapy formulated, the psychotherapist believes that changes observable at home or at school could be anticipated.

Illustrative examples of what change might look like are required for each item in each section. For example, parents with concerns about how their son expressed aggression would consider it progress if he could be more patient with his younger brother by the end of the year, which would be exemplified if he would let him have a go on his PlayStation sometimes.

## *Review and evaluation*

Once psychotherapy has started, the child psychotherapist normally meets with the parents, with or without the parent worker, for a review every term. The anticipated developments referred to in the HETA record contribute to the background of this discussion, but the form itself is not brought into the meeting, as focusing parents' attention at this time on a desired end point might get in the way of thinking about relative progress or difficulties in the present.

At the review at the end of the second term of psychotherapy, a decision may have to be made about whether the psychotherapy will end at the end of the year or continue into a further year. If it is to end, the child will normally be told before the holiday, giving a term to work on ending.

At the end of the third term, or the first year of treatment, the child's progress is reviewed with the parents and parent worker in the light of the HETA record. Achievements, disappointments and the unexpected are noted. A simple scoring scheme used to facilitate an evaluation of the degree of progress is described in the 'Findings' section below. The SDQ follow-up questionnaires are administered. If psychotherapy is to continue for a further year, which is likely in most cases, the HETA record is modified in the light of what has changed or what has been learned, and the psychotherapist's reformulation. Modifications are introduced to the HETA record each year, and use of the SDQ is continued.

At the end of the treatment, information is obtained from the parents regarding their perceptions of change in the child, using the HETA record, and they are asked about their experience of their child's psychotherapy.

These steps are summarised in Figure 1 on the next page.

The case of Nicky, below, illustrates an assessment, a feedback meeting and how the HETA record is completed.

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## *An illustrative case: Nicky*

### *Referral*

Nicky was referred at the age of eight after two previous periods of work in the clinic for a combination of problems including soiling, aggressive and unmanageable behaviour, stealing, lighting fires, a tendency to confuse fantasy and reality and telling lies. He fought with his older brother, and had no friends. At the time of referral he was waiting for a place at the local special school for children with behaviour problems; he

1) The referral for child psychotherapy form is completed by the family worker.

2) The Strength and Difficulties Questionnaire is given to the parents and the child's school.

3) Assessment takes place as follows:
    a. child psychotherapist meets the parents
    b. three sessions with the child
    c. feedback meeting with the parents and referrer, using this as the basis for deriving the hopes and expectations for treatment.

4) At another appointment, the Hopes and Expectations for Treatment Record form is completed. The length of the therapy is agreed, for example, for 'one year in the first instance' or 'a minimum of a year, and usually longer'.

5) The child psychotherapist meets with the child's parents with/without parent worker on a termly basis.

6) At the end of the second term, the child's progress is reviewed with the parents, psychotherapist and family worker. If a decision is made to end the psychotherapy, the child is normally told at the end of the term before the holiday, giving a term to work on ending.

7) At the end of the third term, the child's progress is reviewed and scored with the parents in light of the Hopes and Expectations for Treatment Record, noting achievements, disappointments and the unexpected. SDQ follow-up questionnaires are given to the parents and the school.

8) If the therapy is to continue, the expectations and hopes in the HETA record are modified in the light of what has changed or what has been learned and the psychotherapist's reformulation. Changes in practical arrangements, for example the times and numbers of sessions, are also recorded.

9) The HETA record is modified each year in the light of new developments or information.

10) SDQ follow-up questionnaires are administered to the school and the parents annually.

*Figure 1* Procedures for assessment, and for completing and reviewing the HETA record.

had a Statement of Special Educational Needs for behaviour problems and learning difficulties. A psychiatrist assessed him for ADHD, found that he did not have ADHD and rather reluctantly gave a diagnosis of conduct disorder. The psychiatrist noted Nicky's low self-esteem and suspected that emotional factors lay behind many of his difficulties. Nicky is quite good at football but at the time of referral would often spoil his team's chances by getting sent off for fighting.

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On the referral form, the referrer recorded that she hoped that psychotherapy would help Nicky feel better about himself, and that this would improve family relationships and help him make good use of his place at the special school, available the following term. A significant family factor is that Nicky's father injured his back very severely in a car accident when Nicky was five years old, shortly before the first referral. He had not been able to work since at his job as a lorry driver. He is involved in looking after both boys.

*Assessment sessions*

As is my usual practice, Nicky's parents attended for the first part of the first assessment session. A slight boy, squeezed shyly between his parents, Nicky reached for the toy tiger on the table as his father began to speak, then withdrew when his mother joined in with a long list of problems, taking himself off to the back of the room with a ball. The parents' tone softened as they explained that one of the problems was that Nicky was not as able as his elder brother and that he minded about this. Nicky returned to the table and was very attentive when I asked about early history. Both parents agreed that Nicky did not seem to have difficulties at nursery school, though it had been hard to toilet-train him.

Once he was on his own with me, it was not hard to engage Nicky, after I understood that he needed help to bring himself forward. He told me his brother always took things from him. Almost despairing, he explained that his brother was better at things than he was because he was 10. He always would be better than him, because when he was 10 his brother would be 12. However, he was encouraged by the idea that when he was 10 he could be better at things than he is now. Using big animals and little animals, he told me that he was afraid of his father and of the toilet. He thought that something would come out of the toilet and bite him.

For the second appointment, Nicky arrived in a new football shirt, plainly for me to admire. He told me that he had had a 'terrific' week at school. This turned out to be true. However, he also began a detailed account of his football matches, how he had got lots of cups, and that there was one 'THIS big!' (Nicky stretched his arms out). He was going to be playing matches in Manchester, Liverpool, Tottenham, Spain, Brazil, etc., etc. Despite the grandiosity, the exaggeration was touching in its naivety. Eventually I commented that Nicky felt that coming to see me was very special. 'Yes,' he said, with genuine seriousness. I gently distracted him from playing football in the room and suggested he drew a picture. He said that he was no good at drawing but would have a go.

Using a pink wax crayon, he sketched a semi-circle, and added other marks. He then took a black felt-tipped pen and drew a solid semi-circle so that it virtually covered the pink one. He told me this was a 'black moon'. The contrast between these two shapes was shocking. I was reminded of Freud's (1917) phrase about the 'shadow of the object that falls upon the ego' in *Mourning and Melancholia*. He added a yellow wax crayon 'sun', a blue round shape with green marks, 'the earth', and other shapes, obviously planets. He told me he had been learning about planets at school, and about the Romans, and about different places and about things in the past.

At this point Nicky picked up the pick-up lorry and the van and explained that the van had broken down. I said that Nicky's father used to work as a driver, didn't he?

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'Yes,' he said immediately, 'until he got the sack. He got the sack because he wasn't well. He should have rung in and told them he wasn't well. He didn't turn up so he got the sack. He should have rung in. I was ringing in on my mobile, "Hello, my Dad can't get in," but I was too late. He got the sack.' 'What *kind* of not well?' I asked. Nicky said, 'Too much down the pub. It was his heart. He was being sick and it went into his heart.' Rather furtively, Nicky looked round the back of the dolls' house, then went to set up a line of bricks.

A little later I asked Nicky how using the toilet was going. He said that the poohs were getting better. The trouble now was wees! If he had a drink he has to go to the toilet and doesn't get there in time and has an accident. I said I was thinking about his Dad. He had an accident, didn't he? 'It wasn't my fault!' Nicky squealed, 'It wasn't my fault that he lost his job!' I said that it was not Nicky's fault, but he might have *thought* it was. 'I get you,' Nicky said. He seemed relieved by this insight.

At the third and final assessment session, Nicky was subdued. I noted that this was the last of our three sessions, and then I would meet with his Mum and Dad. Nicky started throwing bricks, picking off the cars one by one. Later he made two towers of bricks with conical tops. He had to knock the tops off without knocking the rest down. I wondered who it was that he would be knocking down, a mother, a father or a brother? 'A brother,' he said instantly. I said it would be difficult to knock down the son without knocking down the mother as well. I thought he was trying to knock out the baby he felt was blocking the way to the mother. 'No,' he said immediately. 'It's the other way round!' and successfully skimmed the top off a tower. 'The mother is no problem. I'm not trying to get to her. She can stay where she is!'

At this point I formulated the idea of a rather alarming maternal object, and that Nicky was looking to be reunited rather than split off from his baby self. Nicky complained that his brother would not play with him. He came over and made a telephone call on one of my two toy phones. 'Tell Cathy I'm coming up to see Nicky later on today!' Receiving the message, I said, 'Nicky? Oh good!' Nicky blushed. He then telephoned his father, making it clear he needed to speak to him, not me. 'Yeah? Yeah. Alright then. See you later.' I said that he was checking that it was OK with his Dad to come and see me, like he might want to check it out with my husband or some person like that. 'Yes,' he said, and smiled and agreed he would like to come again for more work.

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### *Formulation*

During the assessment the referrer saw Nicky's parents for one appointment. In that time Nicky's mother told her that Nicky had cried a lot as a baby and that she herself had been very depressed. Both parents felt that Nicky himself was at times depressed.

Given the 'black moon' material, this was not surprising. My psychoanalytic formulation found Nicky a likeable boy whose problems with behaviour and reality testing were, I thought, probably consequent on a relationship with a depressed primary object, with whom he was partly identified, and which 'collapsed' on him, unable to tolerate his ordinary developmental aggression. The subsequent Oedipal development and move to identify with his father was itself affected by the trauma of his father's

physical and possibly emotional collapse, at an age when omnipotent thinking was at its height, leaving Nicky terribly confused about what causes what. That is, phantasy was unchecked by external reality. The result was a reduced capacity for symbol formation in favour of rather concrete forms of symptomatology and acting out. The major defence, splitting off his difficulties through an omnipotent reversal and 'dumping' his difficulties, was concretely expressed through soiling.

Nicky's responsiveness to exploratory interpretation was encouraging, and suggested that psychotherapy could be effective in bringing about some developmental realignment, through addressing primarily the deficit in the object rather than attempting, for example, to challenge the omnipotence and grandiosity head-on. My hypothesis was that a strengthened and more dependable object relation achieved through the dependability of the psychotherapeutic setting would itself reduce impulsivity and contribute to improvements in symbolic functioning and ego development.

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*Feedback meeting*

At the feedback meeting we learned that Nicky had shown much improved behaviour and attentiveness at school during the period of the assessment, although soiling remained a problem. The parents therefore felt positive about the assessment experience. The task was to feed back some of the thinking expressed in the formulation in a way that would connect with their experience of Nicky.

I stressed Nicky's communicativeness and how some of Nicky's difficulties could be because in some ways emotionally he was like a younger child. His parents understood the fears about the toilet, as their older boy had been through a phase of thinking that monsters might come out of there. I said that I thought that Nicky would have been sensitive to his mother's depressed state, and that, given his wish to be a super-hero, he may have imagined he caused his father's accident with his own thoughts. I thought he was confused about how powerful his angry feelings could be. The parents agreed to once-weekly psychotherapy, and we arranged another appointment to complete the HETA record form, giving examples of what hoped-for improvements would look like.

*Completing the HETA record form*

Completing Section 1, about their own hopes and expectations, the parents hoped that, over the course of the year:

1. Nicky would calm down a bit and be less driven by his feelings.
   How would you tell? Nicky would be less impulsive, and be more able to think ahead.
2. Nicky would come to show a different attitude.
   How would you tell? Nicky would be less aggressive, and polite and loving more of the time.
3. Nicky would show improvements in concentration and motivation.
   How would you tell? Nicky would want to stick at things, work or play, for longer periods without giving up.

For my part, in Section 2, on my own hopes and expectations for change in the sessions, based on my experience in the assessment and my psychoanalytic formulation, I hoped that, over the course of the year:

1. Nicky would become more aware of his feelings so he could think about them and not just act them out.
   How would you tell? Nicky would come to talk more about his feelings when he was playing. I would expect him to use toys, cars, animals and people a bit more, playing football in the room a bit less!
2. Nicky's difficulties about separation and separateness would become apparent in his therapy.
   How would you tell? Nicky might have difficulties coming into or leaving sessions sometimes, and he might be particularly thrown by holiday breaks from the therapy. I warned the parents that there might be times when he would not want to come.
3. I hoped that I would understand more about Nicky's big imagination.
   How would you tell? I thought I would get the opportunity to observe, and Nicky might himself observe, how, if things went a little bit wrong for him, he made them MORE wrong. I hoped that this awareness would help him find ways of getting back on track.

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Outside the sessions, at home and at school, I hoped that:

1. Nicky would be more cheerful and optimistic.
   How would you tell? Nicky's parents would be able to tell the parent worker about events that Nicky had obviously enjoyed.
2. There would be improvements in Nicky's relationships with other children.
   How would you tell? Nicky's parents would see Nicky making more effort to develop skills like taking turns.
3. Nicky would learn more positive ways of getting attention.
   How would you tell? Nicky might let his parents know about good things that he had done in school, showing them that he was proud of his achievements.

The parent worker arranged to continue to meet the parents every fortnight, to work on managing behaviour at home in the light of these hopes and expectations. We were able to start Nicky's psychotherapy after the summer holiday. His progress will be described after illustrating general characteristics of the sample.

## Findings

### *Characteristics of referrals for psychotherapy*

In all, 30 children were referred for psychotherapy to the three clinics in the service over a six-month period. The referral forms indicated a striking diversity in presenting symptoms as well as complex family factors. Ages ranged from three to 17 years, with

children of eight being most highly represented. As one might anticipate, more boys than girls were referred until adolescence. A range of ethnicities was represented. Of particular note is the fact that more Bangladeshi children were beginning to be referred for child psychotherapy treatment, although this proportion is below that of Bangladeshi children in the local population (see Figure 2).

Like Nicky, the majority of the referred children had been known to other workers for at least a year, many more than two years, and had been seen by several professionals. Kam and Midgley (2006) reported similar findings. Sometimes, a long period of time before psychotherapy begins may reflect psychotherapy being seen as a 'treatment of last resort' for difficult cases. However, more positively, a sustained period of work before psychotherapy begins, supporting parenting skills and reducing the tendency to scapegoat the child, may be a valuable or necessary prerequisite before families are ready for the commitment to psychotherapy.

Referrals came from all disciplines in the service. For this group of 30, the predominant referrers were child and adolescent psychiatrists, as indicated in Figure 3. The low numbers of referrals from psychologists and family therapists reflects staff vacancies at the time.

Roughly half of the referred children had, like Nicky, received a psychiatric diagnosis. There were four children with autistic spectrum disorder or Aspergers syndrome. Notably, the referrers of these children were not requesting the psychotherapist to cure autism, but rather sought changes that might improve the quality of life for the child and family: for example, to help a child gain some self-understanding to enable him or her to cope with secondary school transfer; to help reduce the frequency of tantrums; or to help a child be less sad and become more confident about putting feelings into words.

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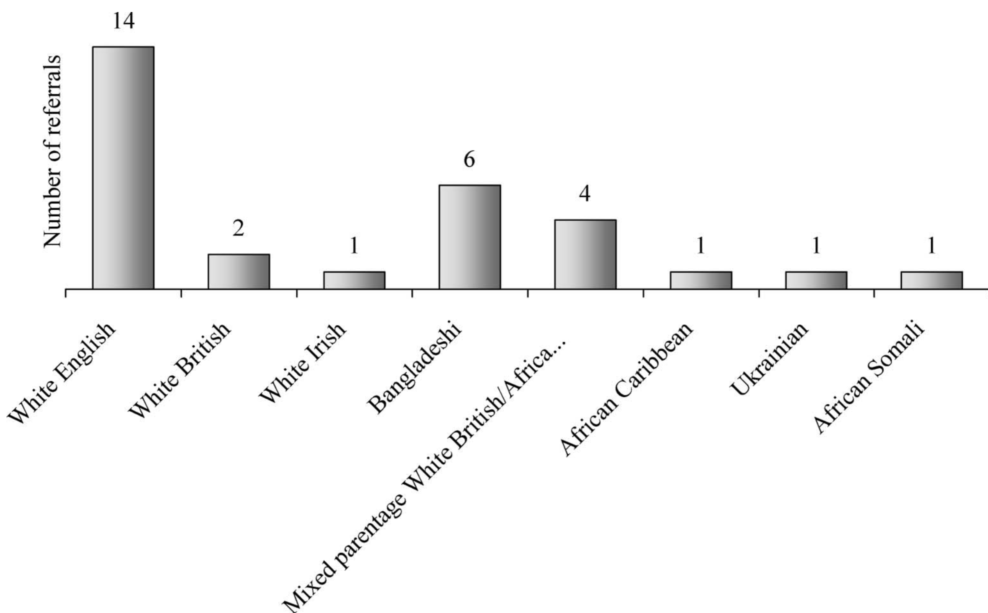


*Figure 2* Ethnicity of referred children.

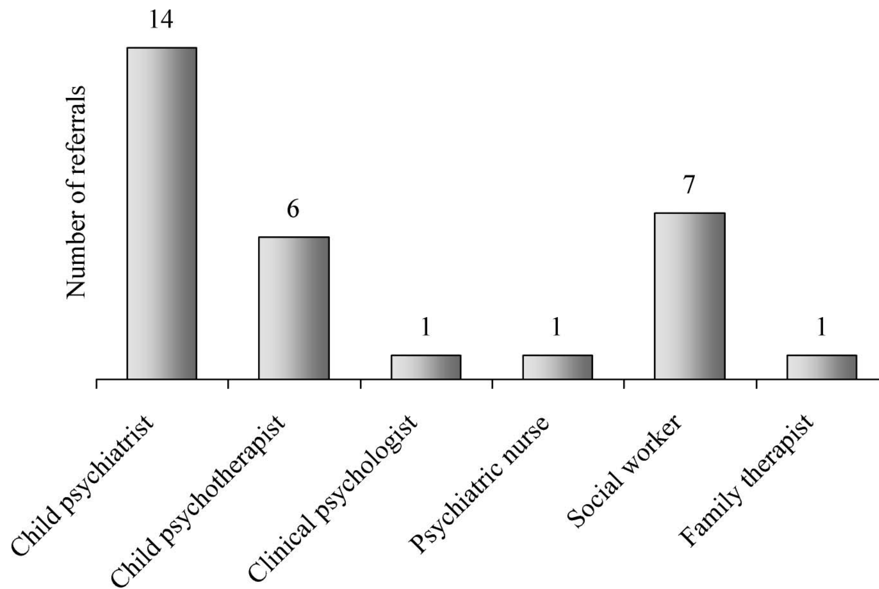


*Figure 3* Agencies referring the children.

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Other diagnoses included ADHD, conduct disorder, post traumatic stress disorder and depression. Four of the children were looked-after children or were living under a care order with relatives. This is fewer than the number of looked-after children normally referred to this particular CAMHS in any given six-month period.

Six child psychotherapists carried out the psychotherapy assessments of this group of children or adolescents. A referral for psychotherapy does not always lead to a psychotherapy assessment, of course, let alone the decision to undertake individual psychotherapy. Of the 30 children referred, 18 months later six children had not been taken on for psychotherapy for practical reasons or because the assessment revealed other factors that needed to be dealt with first. In contrast, two children did not start psychotherapy because of the degree of progress made in the assessment. A further child was seen for short-term individual work and referred on to group work afterwards. This left 21 children for whom long-term psychotherapy was recommended and accepted by the parents or carers.

In general, parents described and acknowledged positive changes in their children during the psychotherapeutic assessment. This may itself be prognostic of the child's capacity to respond to psychotherapeutic treatment. Although most cases had been engaged in family work for some time, the psychotherapy assessments also brought to the surface important life history information not revealed in previous work, or that had been forgotten or had gone unrecorded.

## *Impact of starting psychotherapy and clinical effectiveness*

How can we establish that changes are occurring in the psychotherapy? A simple indication can be obtained by scoring the predictions/expectations made by the

psychotherapists and parents against what is reported in the termly reviews and at the end of the year and/or the treatment. As noted previously, the Hopes and Expectations for Treatment Record Form includes three sections: Section 1 records the parents' expectations; Section 2 records the psychotherapist's expectations for the psychotherapy sessions; and Section 3 records the psychotherapist's expectations for change in the 'outside world' – the home and the school. Each section records three items, with examples required in each case. Using a simple three-point scale to score each item, recording 'no change' as 0, 'some change' as 1 and 'significant change' as 2, the maximum score at each review would be 18.

Of the 21 children who entered psychotherapy, as described above, 15 have been in psychotherapy long enough for there to have been two termly reviews (the second described here as the six-month review in Table I), and to have completed one year of psychotherapy. At the six-month review, the psychotherapists scored the degree to which they thought that each of their three expectations for the psychotherapy process and for the child's behaviour at home and at school had been met. This was repeated in the one-year review, after discussion of the child's progress with the parents and in their presence.

As shown in Table I, it is striking that, even at the six-month review, scores indicated improvements in the children as regards meeting the psychotherapists' expectations of the psychotherapy process and of changes at home and at school. A score of 0 would have indicated no change, but all the children were judged to have shown some change or significant change. By the end of the first year, and relative to

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*Table I* Child psychotherapists' HETA scores at six and 12 months

| Case | CPT re: therapy | | CPT re: home/school | |
|---|---|---|---|---|
| | 6 months | 12 months | 6 months | 12 months |
| 1 | 5 | 5 | 6 | 6 |
| 2 | 3 | 6 | 3 | 4 |
| 3 | 4 | 5 | 3 | 4 |
| 4 | 4 | 5 | 4 | 3 |
| 5 | 3 | 5 | 4 | 5 |
| 6 | 5 | 5 | 4 | 4 |
| 7 | 3 | 5 | 4 | 4 |
| 8 | 5 | 5 | 4 | 5 |
| 9 | 3 | 5 | 4 | 5 |
| 10 | 3 | 5 | 3 | 5 |
| 11 | 3 | 4 | 3 | 4 |
| 12 | 3 | 5 | 5 | 4 |
| 13 | 3 | 3 | 3 | 3 |
| 14 | 2 | 4 | 2 | 4 |
| 15 | 2 | 4 | 2 | 2 |
| Mean | 3.40 | 4.73 | 3.60 | 4.13 |
| Wilcoxon signed ranks test | $z = -3.025$ $p$ (two-tailed) 0.002 | | $z = -1.999$ $p$ (two-tailed) 0.046 | |

the six-month review, the increase in these scores was statistically significant. This finding implies that the psychotherapists' formulations and the value of the psychotherapy are being borne out.

What about the parents' views? At the end-of-year review of therapy, the parents also scored the degree to which their hopes and expectations had been realised, using the same three-point scale. The parents' average score was 4.36 (ranging from 3 to 6), as shown in Table II. In fact, their scores were comparable to the psychotherapists' assessments of change in the child at home and at school, indicating high agreement between the two.

From parents' comments and observations of their child at the six-month review meeting, estimated scores were assigned retrospectively to obtain some sense of the parents' views of the degree of change. Although an estimate, it is interesting that the magnitude of difference between these estimated scores and the 12-month scores is comparable to that in the psychotherapists' ratings (see Figure 4).

The range of scores shown in Table II varies from 2 to 6 – the lowest-scoring young person being a refugee teenager living in hostel accommodation for whom no parent scores were available. Of course, low scores do not mean that the psychotherapy is not working. For example, this young person developed considerably in the second year of treatment. Sometimes external circumstances intervene. For example, Case 13 suggests no development in the last six months in treatment. However, this must be set against the child anticipating the end of treatment because of a disruption to the foster placement.

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*Table II* HETA scores: comparison between parents' and CPTs' scores at 12-month review

| Case | Parent | CPT (home/school) |
|---|---|---|
| 1 | 5 | 6 |
| 2 | 4 | 4 |
| 3 | 4 | 4 |
| 4 | 5 | 3 |
| 5 | 4 | 5 |
| 6 | 5 | 4 |
| 7 | 3 | 4 |
| 8 | 4 | 5 |
| 9 | 5 | 5 |
| 10 | 4 | 5 |
| 11 | 6 | 4 |
| 12 | 5 | 4 |
| 13 | 3 | 3 |
| 14 | 4 | 4 |
| 15 | – | (2) |
| Mean | 4.36 | 4.29 |
| Mann-Whitney U | $U = 92.5$<br>$z = -0.272$<br>$p = 0.804$ | |

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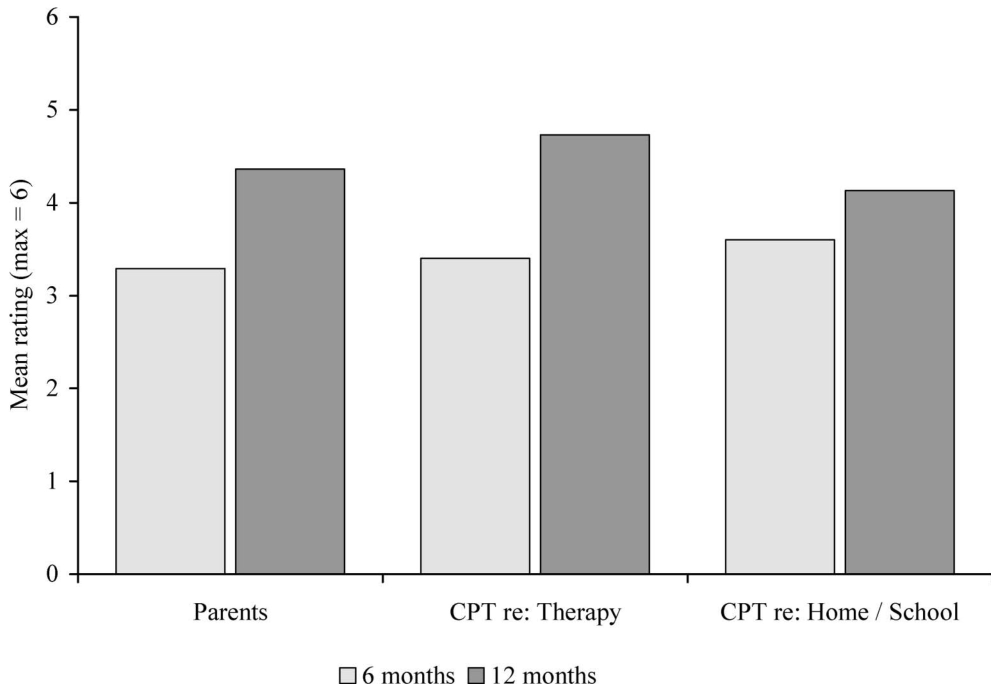


*Figure 4* Relative changes in mean HETA scores between six and 12 months (including estimated scores at six months for parents).

For some children the start of the psychotherapy exposed complexities not demonstrated in the assessment, such as drug use in the family. The initiation of psychotherapy also in many cases revealed greater distress in the parents than was previously recognised. This poses considerable challenge for work with parents. However, this work can be particularly rewarding, as developments in the child can lead to a deepening of the work with the parents, and vice versa. Here there are advantages to having an evaluation model in which parent work and child work are linked.

These processes are illustrated by the work with Nicky; traumatic antecedents of his behaviour difficulties became clear.

## *Nicky's psychotherapy*

Despite the optimism we all felt about the psychotherapy, Nicky's development in psychotherapy began with an alarming period for the parents. The holiday before the sessions started produced a small upsurge in fire setting. In the new term, the date for his move to special school was put back, changed and put back again, prompting aggressive and unmanageable behaviour. Nicky felt rejected by the new school and his current (female) teacher. He was also suspicious of the psychotherapy. After all, if it was any good, he would not have to go!

Nevertheless, Nicky enjoyed coming. A large part of the early sessions were taken up with Nicky and I making and receiving telephone calls and writing letters to family

members, notably excluding the mother. He seemed to be working out something fundamental about communication, and how to contact someone in their absence. He was keen to play games with the fire engine and other vehicles, including a police car and a toy plane. As he approached his school move, the mother and her children were mercilessly blown up in the dolls' house by the plane leaking petrol. The police car, however, was so fierce and punishing that it seemed nothing could be done but to blow this up too, along with the fire engine, destroyed in the crash. I was struck by the badness of the mother and the police car, suggesting a totally unmodulated, savage superego. Nicky inevitably identified with this to escape its ferocity, illustrating the dynamic underlying Nicky's tendency, when things went wrong, to make them even worse, which was captured in the last item on Section 2 of the HETA record. I asked my colleague working with the parents to warn them to expect more fires when Nicky had to move school, in response to the separation.

Despite the difficulties, Nicky was appreciative of interpretive work, and the underlying archaeology steadily became clearer. This came to a head around Guy Fawkes' Day. Nicky talked about remembering a fire he lit when he was very young. He began a drawing of what happened on 'the day when the moon went black'. I wondered if I was going to hear about sexual abuse, a possibility consistent with soiling and fire-raising. However, the thought that began forming in my mind was that we were dealing with abusive experiences in the parental generation.

Unusually, Nicky's mother brought him for the next session on her own. At their meeting she told my colleague that she hated it when the children's father got angry with the children because it reminded her of her own father and his cruel treatment of her. He would regularly beat her and had burned her lower body with boiling water. In the meantime, in Nicky's session:

> Nicky continued his drawing of 'the day the moon went black', less a drawing perhaps than a reconstruction. He set the paper on the desk and surrounded it with the two telephones and wild animals from his box, a tiger, polar bear and crocodile. I was instructed to write a letter. Nicky stuck a piece of sellotape across his picture, put glue on top of this and then put yellow felt tip on top of the glue. 'First it was white and then it was yellow,' I said. Nicky picked up what I had written and wrote a shortened version of this in telegraphese. I thought of a two- to three-year-old learning to talk. I said that I was thinking about how when he was a baby, what was first white, the milk from the mummy, goes inside him and helps to make him grow, and what is left over comes out yellow, as wee. 'Hm-mm', he said, 'Yes, that's right.' He began adding green to make grass. This did not stick. The crocodile at his elbow bit the telephone wire. Manically he broke away from the table, but then instructed me to write another letter. I wrote, 'Nicky is frightened of the angry Mummy. This is like a crocodile.' I did not think that he could read this but he drew a circle around 'angry', asked what the message read and seemed impressed. He picked up the toy plane, making it fly, saying this was his Dad. I said he went with his Dad to get away from the Mummy when she was angry. Nicky said that this was right. He then made the plane land in territory full of wild animals. I commented on how frightening it would be landing in a place

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like this, with loads of dangerous wild animals. Perhaps these were the other babies. He would be very worried if he felt that there was not enough milk and he thought it was going to be up to him to make more. Nicky returned to his picture, adding some red marks to the paper. This was blood, from the teeth, the biting. He put sellotape over the top of it. This was 'to keep the blood in'. He then played a game in which he joined up the school bus with the other cars, linking them all together. He told me that they had heard that he would be starting his new school before Christmas, and he had met his new head teacher called Philip.

This linking in Nicky's play reflected how he had been able to take in what I had said and to integrate some of his aggression. From that time there was a considerable softening in the way that Nicky's relationship with his mother was expressed in Nicky's play, and in general the savagery of the policeman/superego became less marked. There was also more evidence of Nicky owning feelings and emotional states, as was illustrated the following week when I gave Nicky the Christmas holiday dates.

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Gloomily Nicky looked at the calendar chart I had made. He pointed to the last square on the bottom of the page, and said, 'That's the day I get selected,' meaning, to play for England. However, we both knew of the fragility of this defence. Nicky started to kick the ball around. I suggested that he did not want to think about the calendar because he did not like the feelings it gave him and that he was angry with me for bringing this news. 'Nah,' he said, but then added, 'The thing is, I feel kind of *embarrassed*. Tomorrow we are not going to win our football match,' naming a local junior team. 'We're going to lose, and we haven't lost all season.' I said I wondered if what he felt about getting this calendar and missing two sessions was more like being *embarrassed* because it was about losing something. Nicky said that was it. He spent time firing missiles at two cups but eventually said that he would finish his drawing.

Nicky drew some squares on the picture, with small daubs of glue in the middle, that were like the squares of his calendar with circles inside representing his sessions. He made lines with his ruler, at angles to each other. Overall, the impression was of a wig-wam, breast and/or fire. 'There,' he said, 'It's finished now. It's called the "Death Triangle". This is where the oil went, that made the fire.' I asked how the fire got started. Nicky said that it started because someone took some keys. He took a car from his box and muttered about his brother. 'It's called the "Death Triangle" *and* the "Fire of Death".'

I commented on how the feeling of having to move out for the holiday was like having to deal with a triangle, and being excluded. Nicky was well aware that all the locked cupboards in the room contained other children's boxes. Unconvincingly, he said he did not care about other children coming in because he would beat them up. I asked Nicky if there had been any fires lately. With touching honesty he told me that there had been. He had taken in matches and tried to light a fire in the sink at school. It went whoosh! Nicky's eyes gleamed with an alarming quality of sexual excitement, aggression and something more ordinarily boyish and wondering. I asked why a fire in the sink? Nicky did not know, and ran his fingers

> around the taps of my sink. The room felt absolutely scorching. I was acutely aware of his mother's recent disclosure. Nicky left to go to the toilet.

There are three sides to a triangle, of course, and the one that was missing at this point was the father. In describing psychotherapeutic work with children who soil, Barrows (1996) has proposed that an unresolved Oedipal situation is a significant factor in these cases. Important facts about Nicky's father's past came to light in the next two weeks.

The move to the new school went considerably better than Nicky and his parents had expected. I was due to see his parents for a review appointment. Mysteriously, though, they did not turn up. At his next session:

> Nicky was very subdued. He was finding it difficult to do history at school. He was supposed to know about kings and queens, and about what happened in England in 1500. 'How am I supposed to know? I wasn't even alive then!' I asked him how anyone could know. He said he thought their parents might tell them. And *their* parents might tell them, or their grandparents. His grandfather was about 100. Then very sadly, and completely convincingly, he told me that his grandfather had died at the beginning of the week. This of course explained the parents missing the appointment.

My colleague established in her next meeting with the parents that the parents had forgotten the appointment. There had in fact been no recent deaths in the family. But Nicky's paternal grandfather died when Nicky's father was nine years old, Nicky's current age. Nicky's grandmother married again several years later. Nicky's father felt his relationship with his own father was a good one, as was his relationship with his stepfather. They did not know if Nicky knew of his natural grandfather's death.

The missed review appointment was held in the following term. Nicky's parents described a child who they felt was calmer, much happier and able to be part of the family. Nicky did not shout at them or answer back or have tantrums as he used to, because he seemed to understand and accept more what was wanted. He was more thoughtful about other people and asked more questions. Nicky was coming home from school with merits for good behaviour and was pleased to tell his parents this. He was doing his homework and sticking at it. The two brothers would now play together for limited periods. From being a boy with no friends, Nicky had made new friends in the neighbourhood and was trusted out. Soiling remained a problem area. It had appeared to be under control towards the end of the previous term, but to come apart again during the holidays. It had improved again by half term.

At the end of the first year, although soiling remained a problem, recurring especially with separations and times of stress in the family, Nicky's developments were being sustained, with a total HETA score of 14. The family were keen to make a commitment to a further year of psychotherapy. During this year I saw more resistance coming from Nicky, more anger in the sessions and more of what his parents called 'attitude', but interestingly improvements in the soiling were reported during the course of the year. The psychotherapy was continued for one further term to support a successful transfer to mainstream secondary school.

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## *Discussion*

Nicky's development through psychotherapy would not have been predicted by outcome research evidence, which on the whole does not give an optimistic picture for psychotherapy in cases of conduct disorder (Fonagy *et al.*, 2002). This case is also a good example of a point Margaret Rustin (2000) has made – that many children referred for psychotherapy nowadays must deal with the impact of internalising the consequences of difficulties their parents have experienced, as well as their own problems. This is one reason why the link between the child work and the parent work is so important.

A recent review by Elliot *et al.* (1999) outlines basic principles of good qualitative research:

> [Qualitative research aims to] understand and represent the experiences and actions of people as they encounter, engage, and live through situations. In qualitative research, the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied. Qualitative researchers accept that it is impossible to set aside one's own perspective totally (and do not claim to). Nevertheless, they believe that their self reflective attempts to 'bracket' existing theory and their own values allow them to understand and represent their informants' experiences and actions more adequately than would otherwise be possible.
>
> (Elliot *et al.*, 1999: 216)

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They go on to define specific criteria. These include: owning one's own perspective – that is, making clear the personal, intellectual and professional allegiances of the investigators; the grounding of emerging hypotheses in examples; provision of credibility checks, such as triangulation; and coherence. 'Through these processes, the results of several different forms of data and of analysis are drawn together into a net of meaning that has structural strength' (Leuzinger-Bohleber and Target, 2002: 5).

The work I have described is not research; I have described an evaluation framework introduced under audit as part of routine monitoring. Nevertheless, I think that it is clear that we have followed many of these guiding principles. It is therefore possible that, with further development – including, for example, working with transcripts of assessment sessions and/or the feedback meetings – the framework could be used in research comparing different groups, in exploring processes of change or in illuminating psychodynamic aspects of different psychopathologies, as well as in research concerned more specifically with outcomes of psychotherapy intervention.

As part of the audit process, modifications are still being developed. For example, adaptations are required with adolescents; parents and the adolescent are both present in the feedback meeting. It may be inappropriate to give feedback on the adolescent's interaction with the therapist. Here Section 2, outlining the psychotherapist's hopes and expectations for treatment, is completed separately, involving the young person only in a general way. For looked-after children, the HETA record is filled in with the foster carers at a meeting ideally including the child's social worker.

Many of the 15 children's psychotherapies are still ongoing. It is therefore too soon to ask parents to comment on their experiences of their involvement with psychotherapy and the approach. However, it has been possible to ask the psychotherapists and the referrers.

For psychotherapists, a major anxiety about this approach must be that establishing expectations renders the therapeutic process too goal-orientated, cutting across the prerequisite to foster a therapeutic stance freed from pressure of 'memory and desire', in the sense described by Bion (1970). It is partly to counteract this that we advocate keeping the HETA record in the filing cabinet rather than reviewing it frequently, and not scoring it with parents until the end of the first year. Another concern might be that, rather than telling us anything new, the method merely reveals what we know already from experience and good clinical practice. This may be true, but the point is to find a way of communicating it to others. Correia and Nathanson (2005) used the HETA record and found it valuable in enhancing the psychotherapeutic process and as a learning experience. A major benefit for the psychotherapist is that the framework encourages one to be more rigorous in thinking about 'Why psychotherapy?' and to develop more precise and richer formulations. Insofar as these can be checked against emerging material and modified in the light of experience, it is an aid to thinking about psychotherapeutic and developmental processes. Furthermore, something powerful and interesting happens when experience with individual cases can be observed as re-occurring across members of a group.

As far as referrers are concerned, feedback from colleagues in the multidisciplinary team has been positive, in general stressing the value of bringing together the psychotherapy and the parent work. The referral form, for example:

> is very useful because it makes me ask why I want the (psychotherapy) service now, and what realistically I hope it could achieve; it helps me think about how to orient the family to the commitment to psychotherapy, and to prepare for a change of gear in my work with the parents.

Of the HETA record, one referrer commented:

> I think parents like it because it makes what could be mysterious and subject to all kinds of fantasies more accessible.... It puts a framework around the work – we have a sense that we are all, parents and therapists, in this together. The parents feel that the psychotherapist is taking on board *their* concerns.... It introduces a level of participation into the treatment process that other disciplines would do well to emulate.

Time will tell whether we can continue to maintain these positive developments.

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## Appendix 1

## PSYCHOTHERAPY REFERRAL FORM

**Name of child/young person:**

**Clinic number:**

**Dob/Age:**

**Date of Referral to Clinic:**

**Ethnicity:**

**Referrer for Psychotherapy:**

**Psychiatric involvement/diagnosis if applicable:**

**What has been the duration and frequency of your contact with the child/adolescent and his/her family?**

**What has led you to consider psychotherapy for this child/adolescent at this point?**

**What would you hope that psychotherapy would achieve?**

**How would you know if this was achieved?**

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**What would be your continued involvement with this family and how often could you see the parent(s)?**

**Signed: Designation: Date:**

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## Appendix 2

## Hopes and Expectations for Child Psychotherapy Treatment Form (HETA)

Name of Child:
Date of Birth:
Age:
Psychotherapist:
Family Worker:

(Psychotherapist) has seen (Child) for a psychotherapy assessment at the request of (Parent worker/referrer). (Psychotherapist) has seen (Child) for three assessment sessions. You have met with (Parent Worker) and (Psychotherapist) for one/two feedback meetings.

**Part 1**
To Be Completed By Parent(s) or Carers:

Before the assessment your main concerns about (Child) were: Please give examples.

1.

2.

3.

To Be Completed By Child Psychotherapist:

After meeting (Child) for three assessment sessions (Psychotherapist's) main thoughts about (Child) were: Please give examples.

1.

2.

3.

*Please record below any developments in the child or new information that became apparent during the course of the assessment.*

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**Part 2**
**What Has Been Agreed**

To be completed by parents, child psychotherapist and family worker:
After meeting with (Psychotherapist) and (Parent worker) for one/two feedback sessions, you have agreed:

a) (Child) will come for (one) session a week on at for one year in the first instance.
b) (Parent worker) will meet with you, without (Child), about (twice a month) to work on things at home.
c) (Psychotherapist) will meet with you, without (Child), once a term to talk about how things are going.

(Psychotherapist) has explained that it is very important that (Child) attends his/her sessions regularly. (Psychotherapist) will take annual leave from time to time, generally in school holiday times. (Psychotherapist) has agreed that s/he will let (Parent worker) and yourself know in advance of these breaks in order to prepare (Child) for the interruption to therapy.

You have agreed to avoid disruptions to (Child's) therapy wherever possible, and to bear the therapy in mind when planning holiday breaks yourselves.
If it is known in advance at any time that (Child) will miss a session, you have agreed to let (Family worker) know so that the gap can be worked on in the therapy.

## Part 3
## Hopes and Expectations from Treatment

*Section 1*
To Be Completed by Parent(s) or Carer:

Over the course of the year you would like to see the following changes in (Child):

1.

a) How would you tell? Give examples.

2.

b) How would you tell? Give examples.

3.

c) How would you tell? Give examples

*Section 2*
To Be Completed By the Child Psychotherapist:

Over the course of the year (Psychotherapist) would hope to see/anticipate the following changes in (Child) in the sessions:

1.

a) How would you tell? Give examples.

2.

b) How would you tell? Give examples.

3.

c) How would you tell? Give examples.

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*Section 3*
To be Completed By the Child Psychotherapist

Over the course of the year (Psychotherapist) would hope to see/anticipate the following changes in (Child) at home and at school.

1.

a) How would you tell? Give examples.

2.

b) How would you tell? Give examples.

3.

c) How would you tell? Give examples.

This information will be used to evaluate (Child's) development at the termly meetings between parent(s) or carers, family worker and child psychotherapist.

Thank you for completing this hopes and expectations form.

**Signed:** (Child Psychotherapist)

**Date**:

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