A Retrospective Study of the Outcome of Psychoanalysis and Psychotherapy for Children with and without Chronic Medical Conditions

Maureen Avis Parr

Thesis submitted for the Degree of Doctor of Philosophy of the University of London

1994

University College London
Acknowledgements

I am glad to record my warm appreciation of those who have furthered my interest in, and curiosity about, psychoanalytic concepts. Among those who have inspired and encouraged me to think critically and creatively about such matters or who have enabled me to find the intellectual and emotional space to do so, are Parveen Adams, Liam Hudson, and Gillian Russell. My special thanks to them.

My interest in the effects of physical handicap on children’s development was first aroused by watching the skilled and intelligent interactions between a blind friend and his sighted family. I am grateful to Norman Octon, to Valerie Octon, and to their children for teaching me so much.

This thesis was written under the supervision of Professor Peter Fonagy whose expertise and help I am happy to acknowledge. It is part of a large and ambitious psychotherapy process and outcome project based at the Anna Freud Centre. I am indebted to the entire research team, under the direction of Mary Target, for their hard work and patient attention to detail.

This thesis is dedicated to the memory of
Dr George Moran,
Director of the Anna Freud Centre from 1987

The Project reported on in this thesis is a large-scale piece of research which has benefited from the input of a number of different researchers. The author of this report played a full part in collecting data, making research decisions about the data and discussing the findings and implications of the analysis. Her unique contribution was the analysis and interpretation of findings relating to children with chronic medical conditions. The present author alone was responsible for operationalising the parameters which identified these children, deciding the best way to control for extraneous variables, selecting their matched pairs, and subjecting their outcome scores and other data to statistical analysis. The interpretation of the results of such analyses are hers alone. In addition, the groundwork research reported on in the last chapter, demonstrating how children’s psychoanalytic outcome may be reliably predicted from a simple procedure which takes an overall ‘therapeutic benefit’ score from a number of variables, some expeditious, others inhibitory, but all available to clinicians at the assessment period, is the sole work of the author of this thesis.
ABSTRACT

There is a good deal of evidence that medical and psychiatric conditions co-exist in patients considerably more frequently than would be expected by chance. Although the direction of causality is difficult to determine, there seems little doubt that childhood chronic physical illness or disability may precipitate emotional and behavioural pathology. Little is known about response to psychological treatment of children with severe long-term physical problems and few studies to date have compared the clinical response and outcome of such children with physically healthy control groups. In particular, children's reaction to psychoanalytic intervention has received almost no empirical attention at all.

An extensive outcome study set up at the Anna Freud Centre, London, and reported on in this thesis is, as far as is known, the first large-scale study of child psychoanalysis ever attempted. The Centre is engaged in long-term, intensive psychoanalytic treatment of children and adolescents. Retrospective study of the process and outcome of child analysis, using material from cases spanning 40 years, has uncovered a large quantity of demographic, clinical and therapeutic information.

This thesis presents a brief overview of the psychoanalytic or psychotherapeutic treatment of 769 children and young people between the ages of two and 19 years, looking at a wide range of variables associated with diagnostic profiles, demographic characteristics and parental and family factors and relating these, where possible, to treatment and outcome. More detailed attention has been paid to a subgroup of 81 children with long-term physical disabilities, including chronic handicaps such as visual, motor or auditory impairment, chronic organic illnesses like diabetes and epilepsy, and the chronic psychosomatic syndromes of asthma and eczema. They have been matched with appropriate control subjects to try to ascertain the extent to which the presence of a defined medical condition influences the effectiveness of psychotherapy.

We found that medical conditions alone did not affect response to treatment. The target groups of chronically disordered children showed few differences from related control groups. However, a variety of other factors influencing outcome have been identified.
**Table of Contents**

**Part One  Background and Introduction**

<table>
<thead>
<tr>
<th>CHAPTER ONE</th>
<th>Psychoanalysis and its Epistemological Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>What is Psychoanalysis?</td>
</tr>
<tr>
<td>1.2</td>
<td>Further considerations of psychoanalytic theory</td>
</tr>
<tr>
<td>1.3</td>
<td>The relationship between psychoanalytic theory and therapy</td>
</tr>
<tr>
<td>1.4</td>
<td>Can case studies be used as scientific evidence?</td>
</tr>
<tr>
<td>1.4i</td>
<td>Free association</td>
</tr>
<tr>
<td>1.4ii</td>
<td>Transference</td>
</tr>
<tr>
<td>1.4iii</td>
<td>Implications</td>
</tr>
<tr>
<td>1.4iv</td>
<td>Some disadvantages of the case study</td>
</tr>
<tr>
<td>1.4v</td>
<td>Case studies concluded</td>
</tr>
<tr>
<td>1.5</td>
<td>Scientific criteria</td>
</tr>
<tr>
<td>1.6</td>
<td>Experimental evidence</td>
</tr>
<tr>
<td>1.7</td>
<td>The deterministic substrate of psychoanalytic theory and method</td>
</tr>
<tr>
<td>1.8</td>
<td>Psychoanalytic therapy</td>
</tr>
<tr>
<td>1.9</td>
<td>Therapies compared</td>
</tr>
<tr>
<td>1.10</td>
<td>Two universes</td>
</tr>
<tr>
<td>1.11</td>
<td>Conclusion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER TWO</th>
<th>The Psychoanalysis of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Children in psychiatry and psychoanalysis</td>
</tr>
<tr>
<td>2.2</td>
<td>The first child patient</td>
</tr>
<tr>
<td>2.3</td>
<td>Ego psychology</td>
</tr>
<tr>
<td>2.3i</td>
<td>Ego origin</td>
</tr>
<tr>
<td>2.4</td>
<td>Conclusion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER THREE</th>
<th>Outcome Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Outcome versus process</td>
</tr>
<tr>
<td>3.2</td>
<td>The self-evaluation of psychoanalysis</td>
</tr>
<tr>
<td>3.3</td>
<td>Child psychotherapy outcome research</td>
</tr>
<tr>
<td>3.4</td>
<td>Specific issues in outcome research</td>
</tr>
<tr>
<td>3.4i</td>
<td>Ecological validity</td>
</tr>
<tr>
<td>3.4ii</td>
<td>Treatment length</td>
</tr>
<tr>
<td>3.4iii</td>
<td>Treatment defectors</td>
</tr>
<tr>
<td>3.4iv</td>
<td>Follow-up</td>
</tr>
<tr>
<td>3.4v</td>
<td>Diagnostic profiles</td>
</tr>
<tr>
<td>3.4vi</td>
<td>Maturational effects</td>
</tr>
<tr>
<td>3.4vii</td>
<td>Long-term retrospective studies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER FOUR</th>
<th>Child Psychiatric Epidemiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Introduction</td>
</tr>
<tr>
<td>4.2</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>4.2i</td>
<td>Clinic referrals</td>
</tr>
<tr>
<td>4.3</td>
<td>Major child psychiatric diagnoses</td>
</tr>
<tr>
<td>4.3i</td>
<td>Learning disorders</td>
</tr>
<tr>
<td>4.3ii</td>
<td>Specific reading retardation</td>
</tr>
<tr>
<td>4.3iii</td>
<td>Under-achievement</td>
</tr>
<tr>
<td>4.3iv</td>
<td>Problems in speech and communication</td>
</tr>
<tr>
<td>4.3v</td>
<td>School refusal</td>
</tr>
<tr>
<td>4.3vi</td>
<td>Fears and anxieties</td>
</tr>
<tr>
<td>4.3vii</td>
<td>Enuresis</td>
</tr>
<tr>
<td>4.3viii</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td>4.3ix</td>
<td>Conduct disorders</td>
</tr>
<tr>
<td>4.4</td>
<td>Children at risk</td>
</tr>
<tr>
<td>4.4i</td>
<td>Age</td>
</tr>
<tr>
<td>4.4ii</td>
<td>Sex</td>
</tr>
<tr>
<td>4.4iii</td>
<td>Social class</td>
</tr>
</tbody>
</table>
11.3i Descriptive analysis 344
11.3ii Inferential statistical analysis 345
11.3iii Results 345
11.3iv Summary of findings 366
11.4 Discussion 370
11.4i Early terminators 370
11.4ii Predictors of CGAS change 372
11.4iia Initial factors-matched 372
11.4iib Initial factors-unmatched 378
11.4iic Treatment and termination variables 393

CHAPTER TWELVE Conclusion
12.1 Summary of main findings 399
12.1i Factors exerting influence on outcome 399
12.2 A preliminary investigation to test the prognostic ability of variables identified retrospectively as having good or poor influence on outcome 405
12.2i Introduction 405
12.2ii Method 405
12.2ia Samples 405
12.2ib Procedure 406
12.2ic Results 406
12.2id Discussion and Conclusion 406
12.3 Associations between target and control groups 407
12.4 Discussion of issues and questions raised earlier 408
12.4i Methodological concerns 408
12.4ii Criteria offering evidence for therapeutic efficacy 410
12.4iii The disadvantages of the individual case study 410
12.4iv Is child psychoanalysis beneficial to the patient? 413
12.4v Is depth analysis the best possible intervention? Can shorter and/or less intensive régimes be as effective? 414
12.4vi Can current analytic processes be improved? 415
12.4vii How do physically ill children respond to psychoanalytic treatment? 416
12.5 Discussion of possible limitations of the current investigation 416
12.5i Treatment integrity 416
12.5ii Controls 418
12.5iii Retrospective evidence 418
12.5iv Matched variables 420
12.5v Sample 420
12.5vi Long-term studies 421
12.5vii Follow-up 421
12.5viii Research instruments 423
12.6 Conclusions and suggestions for further research 426

References 430

Appendices
Appendix A 446
Appendix B 465
Appendix C1 466
Appendix C2 471
Appendix C3 472
Appendix C4 473
Appendix C5 474
Appendix C6 475
Appendix D 476
Appendix E 477
Appendix F 478
Appendix G 480
Appendix H 481
Appendix J 482
Appendix K 484
Appendix L 485

7
List of Tables

Table 5.1 Child hospitalisations
Table 7.1 Diagnostic parental interviews for the total sample
Table 7.2 Diagnostic child interviews for the total sample
Table 7.3 Numbers and percentages of children assigned to one of Anna Freud’s Diagnostic categories for the total sample
Table 7.4 Frequency of specific diagnoses between internal and external raters for 139 child cases
Table 7.5 Frequency of specific diagnoses between internal external raters for 43 adult cases
Table 7.6 Chronically Disabled children
Table 7.7 Breakdown of final list of Chronically Disabled subset
Table 7.8 Chronically Ill children
Table 7.9 Breakdown of final list of Chronically Ill subset
Table 7.10 Breakdown of final list of Chronically Somatic subset
Table 7.11 Mean age of Target and Control groups
Table 7.12 Social class of Target and Control groups
Table 7.13 Year of coming into treatment for Medical and Control children
Table 7.14 Initial number of sessions for Target and Control groups
Table 7.15 Primary diagnostic category at assessment for Target and Control groups
Table 7.16 Number of siblings for Target and Control children
Table 8.1 Sex distribution for Non-Medical sample
Table 8.2 Age group for Non-Medical sample
Table 8.3 IQ for Non-Medical sample
Table 8.4 Medical history for Non-Medical sample
Table 8.5 Hospitalisations for Non-Medical sample
Table 8.6 Social class distribution for Non-Medical sample
Table 8.7 Primary caretaker for Non-Medical sample
Table 8.8 Family status for Non-Medical sample
Table 8.9a Separations for Non-Medical sample
Table 8.9b Total parental separations occurring at any age for Non-Medical sample
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9c</td>
<td>Total parental deaths occurring at any age for Non-Medical sample</td>
<td>209</td>
</tr>
<tr>
<td>8.10</td>
<td>Type of maternal employment for Non-Medical sample</td>
<td>210</td>
</tr>
<tr>
<td>8.11</td>
<td>Number of sibs for Non-Medical sample</td>
<td>210</td>
</tr>
<tr>
<td>8.12</td>
<td>Referral source for Non-Medical sample</td>
<td>212</td>
</tr>
<tr>
<td>8.13</td>
<td>Child's past diagnostic status for Non-Medical sample</td>
<td>212</td>
</tr>
<tr>
<td>8.14</td>
<td>Child's current diagnostic status for Non-Medical sample</td>
<td>212</td>
</tr>
<tr>
<td>8.15</td>
<td>Diagnostic category at assessment for Non-Medical sample</td>
<td>214</td>
</tr>
<tr>
<td>8.16</td>
<td>CGAS at assessment for Non-Medical sample</td>
<td>214</td>
</tr>
<tr>
<td>8.17</td>
<td>Parental GAF group for Non-Medical sample</td>
<td>216</td>
</tr>
<tr>
<td>8.18</td>
<td>Parental past diagnostic status for Non-Medical sample</td>
<td>216</td>
</tr>
<tr>
<td>8.19</td>
<td>Parental current diagnostic status for Non-Medical sample</td>
<td>216</td>
</tr>
<tr>
<td>8.20</td>
<td>Parental illness status for Non-Medical sample</td>
<td>218</td>
</tr>
<tr>
<td>8.21</td>
<td>Initial and maximum weekly number of sessions for Non-Medical sample</td>
<td>218</td>
</tr>
<tr>
<td>8.22</td>
<td>Length of treatment for Non-Medical sample</td>
<td>218</td>
</tr>
<tr>
<td>8.23</td>
<td>Reason for termination for Non-Medical sample</td>
<td>221</td>
</tr>
<tr>
<td>8.24</td>
<td>Child's psychiatric status at termination for Non-Medical sample</td>
<td>221</td>
</tr>
<tr>
<td>8.25</td>
<td>CGAS at termination for Non-Medical sample</td>
<td>221</td>
</tr>
<tr>
<td>8.26</td>
<td>CGAS change for Non-Medical sample</td>
<td>222</td>
</tr>
<tr>
<td>9.1</td>
<td>Gender distribution for Medical samples</td>
<td>227</td>
</tr>
<tr>
<td>9.2</td>
<td>Gender and psychosomatic condition for Somatic sample</td>
<td>227</td>
</tr>
<tr>
<td>9.3</td>
<td>Age group at start of treatment for Medical samples</td>
<td>227</td>
</tr>
<tr>
<td>9.4</td>
<td>IQ levels for Medical samples</td>
<td>228</td>
</tr>
<tr>
<td>9.5</td>
<td>Type of learning difficulty for Medical samples</td>
<td>228</td>
</tr>
<tr>
<td>9.6</td>
<td>Social class for Medical samples</td>
<td>230</td>
</tr>
<tr>
<td>9.7</td>
<td>Primary caretaker for Medical samples</td>
<td>230</td>
</tr>
<tr>
<td>9.8</td>
<td>Family status for Medical samples</td>
<td>230</td>
</tr>
<tr>
<td>9.9</td>
<td>Parental divorce/separation statistics by sample</td>
<td>232</td>
</tr>
<tr>
<td>9.10</td>
<td>Major losses for Medical samples</td>
<td>232</td>
</tr>
<tr>
<td>9.11</td>
<td>Type of maternal employment for Medical samples</td>
<td>232</td>
</tr>
</tbody>
</table>
Table 9.12 Referral source for Medical samples
Table 9.13 Child’s past diagnostic status for Medical samples
Table 9.14 Child diagnostic status at assessment for Medical samples
Table 9.15 Principal diagnostic category at assessment for Medical samples
Table 9.16 Principal and additional diagnostic categories at assessment for Medical samples
Table 9.17 CGAS by decile at start of treatment for Medical samples
Table 9.18 Anna Freud diagnostic category for Medical samples
Table 9.19 Father’s GAF scores for Medical samples
Table 9.20 Mother’s GAF scores for Medical samples
Table 9.21 Past parental diagnoses for Medical samples
Table 9.22 Present parental diagnoses for Medical samples
Table 9.23 Summary of mother’s psychiatric symptoms and treatments
Table 9.24 Summary of presence of father’s psychiatric symptoms
Table 9.25 Detailed symptom/treatment breakdown for parents of Disabled children
Table 9.26 Detailed symptom/treatment breakdown for parents of Ill children
Table 9.27 Detailed symptom/treatment breakdown for parents of Somatic children
Table 9.28 Mother’s physical illness for Medical samples
Table 9.29 Father’s physical illness for Medical samples
Table 9.30 Summary of length of treatment for Medical samples
Table 9.31 Reason for termination for Medical samples
Table 9.32 Child psychiatric status at termination for Medical samples
Table 9.33 Principal termination diagnostic category for Medical samples
Table 9.34 CGAS change for Medical samples
Table 9.35 Termination CGAS score for Medical samples
Table 10.1 Percentage of children presenting various types of learning difficulty for Medical Target and Medical Control groups
Table 10.2 Medical history for Medical Target and Medical Control groups
Table 10.3 Parental loss/separation for Medical Target and Medical Control groups
Table 10.4 Major losses for Medical Target and Medical Control groups 294
Table 10.5 Maternal employment for Medical Target and Medical Control groups 296
Table 10.6 Referral source for Medical Target and Medical Control groups 296
Table 10.7 Principal diagnostic category for Medical Target and Medical Control groups 298
Table 10.8 Principal and additional diagnostic categories for Medical Target and Medical Control groups 299
Table 10.9 Child diagnostic status at assessment for Medical Target and Medical Control groups 299
Table 10.10 Child past diagnostic status for Medical Target and Medical Control groups 300
Table 10.11 Anna Freud diagnostic category for Medical Target and Medical Control groups 300
Table 10.12 CGAS at start for Medical Target and Medical Control groups 302
Table 10.13 Mother’s GAF scores for Medical Target and Medical Control groups 304
Table 10.14 Father’s GAF scores for Medical Target and Medical Control groups 305
Table 10.15 Past parental diagnoses for Medical Target and Medical Control groups 306
Table 10.16 Present parental diagnoses for Medical Target and Medical Control groups 307
Table 10.17 Detailed symptom/treatment breakdown for parents of Disabled Target and Disabled Control children 310
Table 10.18 Detailed symptom/treatment breakdown for parents of III Target and III Control children 311
Table 10.19 Detailed symptom/treatment breakdown for parents of Somatic Target and Somatic Control children 312
Table 10.20 Detailed symptom/treatment breakdown for parents of All Medical Target and All Medical Control children 313
Table 10.21 Parental physical illness for Medical Target and Medical Control groups 315
Table 10.22 Type of therapist for Medical Target and Medical Control groups 315
Table 10.23 Summary of length of treatment for Medical Target and Medical Control groups 315
Table 10.24 Extended table of length of treatment for Medical Target and Medical Control groups 316
Table 10.25 Reason for termination for Medical Target and Medical Control groups 316
Table 10.26  Child psychiatric status at termination for Medical Target and Medical Control groups

Table 10.27  Summary of termination diagnoses for Medical Target and Medical Control groups

Table 10.28  Summary of termination diagnoses, including non-diagnosable cases, for Medical Target and Medical Control groups

Table 10.29a  Expanded principal termination diagnostic category for Medical Target and Medical Control groups

Table 10.29b  Expanded principal and additional termination diagnoses for Medical Target and Medical Control groups

Table 10.29c  Primary termination diagnoses, including non-diagnosable cases, for Medical Target and Medical Control groups

Table 10.30  Termination CGAS score for Medical Target and Medical Control groups

Table 10.31  CGAS change for Medical Target and Medical Control groups

Table 11.1  Breakdown of the 20 best and 22 worst CGAS change scores

Table 11.2  CGAS change predictors for early terminators in Medical Target and Medical Control children

Table 11.3  CGAS change predictors for Medical Target and Medical Control children who came out of treatment within 6 months

Table 11.4  CGAS change predictors for all Medical Target and Medical Control children

Table 11.5  CGAS change predictors for Medical Target and Medical Control children completing a minimum of 6 months' treatment

Table 11.6  Mean CGAS change for Medical and Control groups compared with the subgroup from these samples whose mothers had been hospitalised

Table 11.7  CGAS change predictors for all Medical Target children

Table 11.8  CGAS change predictors for all Disabled children

Table 11.9  CGAS change predictors for all Somatic children

Table 11.10  CGAS change predictors for all III children

Table 11.11  Matched initial factors affecting outcome, by sample

Table 11.12  Unmatched initial factors affecting outcome, by sample

Table 11.13  Treatment and termination variables affecting outcome, by sample

Table 11.14  Correlation of marital problems with other variables for a number of samples

Table 11.15  Correlation of Father's GAF with selected child variables and comparison with Mother's GAF correlation
Background and Introduction
Chapter One

Psychoanalysis and its Epistemological Background
1.1 What is Psychoanalysis?

Psychoanalysis is a multi-faceted approach to psychological understanding. It is, first and foremost, a theory (or rather, a vast collection of theories) describing a) the course of normal child development in psycho-sexual terms and explaining deviations from this norm as fixations at, or regressions to, earlier phases of sexual organisation. These vicissitudes of development are dispositions to phantasy and, as such, are the origins of later neuroses, psychoses and perversions. Neurotic responses, the predominant focus of psychoanalytic theory, are assumed to be determined and maintained by the deployment of a whole battery of psychic defences which enable unacceptable (sexual and aggressive) ideas and wishes to be kept from conscious awareness, thus reducing manifest anxiety. The theoretical compass of psychoanalysis also incorporates b) the functions and causes of dream-work, c) the underlying motivations, meanings and objectives of parapraxes (faulty actions supposedly due to unconscious conflict of wishes), d) explanatory description of the aetiology and maintenance of internal relationships between mental structures and the neurotic symptoms which form in the interstices of these structures and e) a framework for explaining the therapeutic action of psychoanalysis.

Secondly, psychoanalysis is a therapy, freeing the neurotic from the power of his repressed instincts and enlarging the area of his life over which he has conscious control and, allied to this, it is a technique, facilitating access to human mental contents by observing and analysing ideas overtly expressed in behaviours such as dreams, slips of the tongue and bungled actions, jokes, symptoms and free associative connections.

In the beginning, the theory, therapy and technique of Freudian psychoanalysis were expanded and modified only in line with their creator's own developing ideas and experience. But such purity could not be sustained for long; the new ideas and their implications excited independently-minded thinkers and clinicians and, often against the background of the founder's disapproval, psychoanalysis branched out. There are three generally accepted uses of the word ‘psychoanalysis’ today (Farrell 1981). The wide use
includes not only relatively unadulterated Sigmund Freudianism, but also the theoretical and therapeutic contributions of a horde of both respected and less esteemed progeny, some obedient to their ancestor, others rebellious, including Anna Freud, Melanie Klein, Jacques Lacan, Erich Fromm, the schools of ego psychology, object relations and the socio-cultural concepts of neo-Freudianism, and a whole host of other developments including existential psychoanalysis, feminist psychoanalysis and Marxist psychoanalysis.

The narrow use of the term is reserved for the psychoanalysis of classical persuasion, and the restricted use describes Freud's own contribution.¹

A major difficulty in determining in which sense the term has been used and should be understood is that psychoanalysts generally assume that they can use the word to refer to the particular branch of analysis which they practise without making explicit their allegiance. Such 'intellectual imperialism' (Edelson 1988) overspills into the research arena where adherents of one branch of analysis are often not prepared either to formulate hypotheses in the terms of rival frames of reference, nor to look objectively at their own assumptions. The actual clinical phenomena and symptomatology seen in the consulting room are relatively independent of theoretical conjecture, but the meanings attached to presented material are various.

All three uses of the term ‘psychoanalysis’ will be used in this study, though the narrow and restricted uses of the term predominate. It is hoped that context will make clear in which sense the term is being used.

¹ The psychoanalytic psychotherapy evaluated in this research study lies right on the boundary between the wide and narrow usages. The theoretical and technical contributions of Anna Freud, at whose Centre all children in this study were treated, remained relatively faithful to her father's original insights; some modifications were, nonetheless, inevitable in the expansion of psychoanalysis to the treatment of children. Results and conclusions cannot be assumed to be applicable to other ('wide') methods of psychoanalytically-informed treatment in other centres.
1.2 Further Considerations of Psychoanalytic Theory

The plurality of psychoanalytic theory by no means exhausts its complexity. Each strand can be conceptualised on a number of levels. This has implications, to be discussed later, for the extent to which the theory can be considered to adhere to the canons of scientific respectability - that is, whether it is testable and potentially falsifiable.

The simplest division of analytic theory is into metapsychological and clinical concepts. It is possible, in principle, to make empirical statements using clinical or low level language (Farrell 1981). For example, the statement 'Men with homosexual inclinations not overtly acted upon, tend to display paranoid character traits' is a testable proposition. The metaphysical (high level) statement, referring to abstractions like the unconscious or sexuality (not simply, for Freud, a matter of biological drive discharge but carrying an additional psychoanalytic responsibility for the formation of individual differences) or repression, offers a coherent account, a biographical narrative, that may well be plausible but which relies on concepts of mental processes that are difficult, if not impossible, to operationalise.

High level and low level statements can be further subdivided, as Rapaport and Gill (1959) have done, imposing a four-fold hierarchical structure onto psychoanalytic theory. Between the Metaphysical Propositions with their untestable dynamic, economic, structural, genetic and adaptive assumptions, and the Empirical Propositions with their precise hypothetical assertions, Rapaport and Gill place General and Specific Psychoanalytic Propositions. The former explains psychic structural formation in the paranoid-homosexual in terms of, for example, repression, denial, projection and other defence mechanisms; the latter states that the repression of sexual wishes plays a role in determining symptomatology and personality.

This multiplicity of theories, and levels at which they can be understood, makes for confusion in any discussion of psychoanalysis. Freud himself often made the kind of error that Gilbert Ryle was later to call a 'category mistake' (Ryle 1949). That is, he would talk about the metapsychological aspects of...
his theory as though they were statements belonging higher up the empirical hierarchy. The demands of logic are violated when physical metaphors like 'gaining access' to the unconscious, 'lifting' repressions, 'filling in' gaps in memory are used to talk about mental concepts. Can we really 'make conscious what is unconscious'? (Freud 1917). We mistake a mental process for a physical action when we talk about unconscious conflict, and contradict ourselves when we talk about unconscious intentions. Indeed, Stuart Hampshire asserts that 'Intention is the one concept that ought to be preserved free from any taint of the less-than-conscious. Its function, across the whole range of its applications, is to mark that kind of knowledge of what one is doing, and of what one is inclined to do, that is fully conscious and explicit' (in Dilman 1988).

Not all philosophers agree with this (eg Moore 1988, Dilman 1988) and, of course, this problem, far from being exclusive to psychoanalysis, is common to many branches of the human and clinical sciences. We talk carelessly about 'placebo effects' (can a placebo have an effect?) and use 'IQ' and 'intelligence' as though they were interchangeable and synonymous (and as though we knew what they meant). Even physics reifies intangible concepts like electrons. It is not Freud's illogicality per se that is the problem but his conflation of distinct concepts. Nor would we need to concern ourselves with the minutiae of philosophical debate were it not that this underlines the difficulties in deciding which psychoanalytic propositions are testable and how they might be evaluated. This is the great dilemma for metapsychology.

1.3 The relationship between psychoanalytic theory and therapy
Freud claimed that both major strands of psychoanalysis, firstly the theory and, secondly, the combination of therapy and techniques, were indissolubly intertwined and had been from the inception: 'There has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results'. The theory was formulated, tested and
modified, and its efficacy asserted, almost entirely from clinical evidence which, itself, was assimilated into the evolving theory. Mental phenomena, in Freud's view, had dual explanations, the causal and the functional; he was interested both in how they had arisen and in how they were maintained. To mount a full-scale investigation into their aetiology and sustenance required access to patients and their mental depths. So, although theory and therapy might have been of equal importance to Freud this owed very little to humanitarian desires to alleviate suffering, and a great deal to intellectual curiosity. 'We do analysis for two reasons,' he said: 'to understand the unconscious and to make a living' (Frosh 1987). What he called, rather disparagingly, 'therapeutic zeal' (op cit) was to be avoided because it interfered with the proper conduct of an analysis, the primary goal of which was not cure but knowledge. According to Stephen Frosh, the early psychoanalysts found therapy a nuisance, because it required the 'watering down of analytic severities in the face of the pragmatics of everyday life.' The theoretical hunt for the unconscious could not be pursued to the kill because of the dangers of patient attrition and other confounding variables like falling in love with the doctor².

Freud became adept at making a virtue of necessity and turning the irritations of treating recalcitrant patients into the theoretical fascinations of transference and resistance. This sleight-of-hand has provided fuel for the argumentative fires of Marxist thinkers like Herbert Marcuse (and the feminists who latched on to the Marxist coat-tails) who have violently criticised psychoanalysis for playing false to its original insights. The theory, they say, has a radical vision for change but the therapy is simply a compromise with the forces of oppression (capitalists with the means of production at their disposal or patriarchal authority with the desire to keep women and the weak in positions of subjugation). Freud, though not much concerned with the disenfranchised or with the rights of women, would have

² There are many references in Freud's published work to therapeutic success being subordinate to theoretical development, e.g. Freud 1909b; Freud 1925a; and the editors' note in Freud and Breuer 1893. Even the rare protestation to the contrary that 'the scientific results of psychoanalysis are at present only a by-product of its therapeutic aims' is immediately followed by the statement that 'it is often just in those cases where treatment fails that most discoveries are made' (1909a.)
agreed with this analysis of therapy, but would have been a great deal more pessimistic about the possibilities of it ever being able to produce any change that might be construed as radical. And this was why therapeutic process continued to fascinate him a good deal more than outcome did. His view was that patients needed to adapt to their pain and unhappiness; it was unlikely that their distress would be removed altogether or even substantially alleviated. Freud aimed only to 'transform hysterical misery into common unhappiness' (Freud and Breuer 1893). There were no final solutions to despair because everything, treatments and 'cures' included, could themselves be analysed into an infinite regress.

Does this co-reliance of theory and therapy mean that the refutation of one would necessarily herald the downfall of the other? Or that the validation of one requires blind acceptance of the other? Surely not. Even if psychoanalytic therapy is successful in achieving whatever it sets out to do, that doesn't mean that its underlying assumptions are correct. There may be a variety of reasons why the therapy is effective that have nothing to do with, or may even be in opposition to, Freudian theoretical assertions. Conversely, therapeutic failure may simply mean that correct theoretical tenets are not being applied, or are not able to be applied, to their best advantage. Yet the mistake made by so many psychoanalytic commentators, adherents and detractors alike, is to conflate the two main strands of psychoanalysis and to assume that what goes for one goes for both. Freud, though often guilty of propagating confusion himself, explained his medical colleagues' objections to the fledgling psychoanalysis as based upon their having 'unjustifiably transferred what is a characteristic of the technique on to the theory itself. It is the therapeutic technique alone that is purely psychological; the theory does not by any means fail to point out that neuroses have an organic basis' (Freud 1905b).

Separating the theoretical from the therapeutic in the Freudian body of knowledge is not easily done. However, it seems that Freud did regard therapeutic outcome as different from therapeutic technique which was the means of confirming theoretical assumptions. As far as is possible, we
should try to honour this division when evaluating the significance and legitimacy of psychoanalysis. The passage of time has, perhaps unfortunately, made a separation more tenable than it was in the early days of psychoanalysis - therapists seldom, alas, concern themselves with evaluating *anything*, theory or therapy, and psychoanalytic detractors seem only too ready to jettison the whole psychoanalytic package on the grounds that if one part of the enterprise is flawed it must all be thrown out. Methodological considerations make artificial division in any case, and, *pro tempore*, we shall adopt the 'two-cultures' model of contemporary analyst George Pollock who suggests 'the possibility of two separate but parallel paths, each existing in relative independence but eventually converging' (Pollock 1986).

The debate about the relative merits of psychoanalysis has tended to pivot around the question of whether or not it conforms to scientific criteria. And it is precisely here that the relationship between the theory and therapy may diverge most. Freud believed not only that the theory was scientific but that his promoted methodology of clinical case study was sufficiently rigorous to lend all the empirical support necessary to the theory. Therapeutic effects (as we have seen) were not particularly important to him. Being unsure whether they were even obtainable, he was prepared to sacrifice the therapy to the advancement of the theory.

His belief in the scientific status of his theoretical work rested on his commitment to a biological (even, perhaps, eventually, a chemical or physical) explanation of human behaviour and motivation, based on the transmission, inhibition, excitation and equilibration of energy. But it is not a desired allegiance with the biological and physical sciences that makes work scientific (or not) but the *methods* employed. Freud's discovery of the origins of, motives for, and processes of, mental life were made predominantly through observation, hypothesis-formation and theory-generation. He made use of hypothetico-deductive inductivism, reasoning from the particular to the general, asserting the widespread validity of his propositions from individual analytic cases. It is this reliance on single case studies, allied with
the traditional psychoanalytic refusal to expose the interactions within the
treatment room to outside scrutiny, that has caused the furore surrounding
psychoanalysis' claim to scientific status.

The dismissive attitude of psychoanalysts to controlled experimental testing
of statements, this insistence that the theory is clinically verifiable, tested
out 'on the couch' and that alternative approaches to confirmation are not
merely unnecessary but entirely inappropriate has been severely attacked
over the past four decades by a veritable army of psychoanalytic detractors
led by the redoubtable Hans Eysenck. 'What is wrong with psychoanalysis?'
he demanded in a 1953 essay. 'The answer ... is simple: Psychoanalysis is
unscientific'. Eschewing the clinical evidence with which Freud defended his
position, Eysenck believes that psychoanalysis is, in principle, experimentally
(as opposed to clinically) testable using traditional empirical methods. In
practice, however, this is not possible because Freudian theories are too
vague, general and over-inclusive; they are 'not straightforward statements
of hypotheses from which testable deductions can be made'. Psychoanalysis,
in this view, is inherently empirically indeterminate because it is not possible
to make definite predictions of the [if x then y] kind. Only potentialities and
dispositions can be stated. This allows critics like Eysenck to argue that,
because falsification by negative instances does not invalidate the theory,
the theory is, ipso facto, unscientific.

Freud himself saw no value in putting his theories to the empirical test. His
reaction in 1934 on hearing of an attempt to study repression experimentally
was to send the psychologist involved (Saul Rosenzweig) a postcard which
read, 'I cannot put much value on these confirmations because the wealth of
reliable observations on which these assertions rest make them independent
of experimental verifications. Still, it can do no harm'. The last, rather
patronising, sentence indicates that he was not hostile to empirical research
per se as some critics have claimed. He simply could not see the point of it.
Freud's biographer, Ernest Jones, wrote, 'When he got hold of a simple but
significant fact he would feel, and know, that it was an expression of
something general or universal, and the idea of collecting statistics on the
matter was quite alien to him' (quoted in Rubenstein 1983). He believed in John Stuart Mill's 'principle of the uniformity of nature' (op cit) that states that 'the universe, as far as is known to us, is so constituted that whatever is true in any one case, is true in all cases of a certain description.' For Freud this was a fundamental postulate. If something had occurred in one case of hysteria or obsessional neurosis, or in one child analysis, it had to be present in all similar cases. Thus, theories were supported or disconfirmed only in the consulting-room.

1.4 Can case studies be used as scientific evidence?
It needs clearly stating from the outset that there is an issue to be debated - case studies are not necessarily the best way of testing an hypothesis but, equally, neither are they intrinsically outside the pale of scientific credibility. The psychiatrist and analyst Marshall Edelson argues strongly that 'the case study does not necessarily imply deviation from canons of scientific method and reasoning' (Edelson 1988). Research conventionally concerns itself with isolating the causal mechanisms which give rise to certain observable effects. There is nothing to debar mental states from being considered as such agents of causality. To conjecture underlying, unconscious mechanisms as the motives for visible behavioural effects certainly poses problems but is not forbidden.

Edelson notes three important arguments that Freud used, either explicitly or implicitly, to justify the use of clinical causal inference. These remain current items of contention. The first of these is analogy, which begins the debate by appealing to familiar, non-contentious issues and then compares these to similarities in other, non-familiar, even mysterious, processes. Freud frequently appeals to the common-sense of his readers, gradually moving
them from already accepted tenets of human life and behaviour to the novel\(^3\).

Without analogy it would be difficult for any of the sciences to progress. Wittgenstein's insight that 'The limits of my language mean the limits of my world' implies that we can only conceive of the unfamiliar in terms of what is already known. Kekulé's dream of the snake biting its own tail provided him with a suitable, and hitherto non-existent, framework for understanding the structure of the benzene molecule.

The second method used by Freud to shore-up his individual cases, was \textit{consilience of inductions}. One inference is nothing more than an idiosyncratic interpretation but it can be immeasurably strengthened through a large number of single examples that all converge on the same explanation. The protest (Edelson 1988) that \textit{each} inference might share the same weakness (thus, it is the \textit{faulty interpretation} that is repeated, not the confirmation of a particular conclusion) might be partially answered by the consilience of different types of information. 'It is gratifying to be able to report,' wrote Freud, talking about infantile sexuality, 'that direct observation has fully confirmed the conclusions arrived at by psychoanalysis - which is incidentally good evidence of the trustworthiness of that method of research' (1905a). Subsequent psychological research on experimenter effects and similar artifacts of the experimental situation has shown up the flaws inherent in theory-laden observation, a point that will be returned to later, but, in \textit{principle}, direct observation, if suitable safeguards are adhered to (double-blind procedures, control groups, random allocation of subjects etc) could certainly be used to confirm or refute theoretical hypotheses.

\(^3\) Psychoanalysis has often been criticised for trying to disguise ordinary, common-sense understandings of the world with a cloak of esoteric language and for thus deceiving its followers into thinking that they have privileged insights into the world. A psychoanalytic explanation is often only an extension of a common-sense explanation in which desires or motives are advanced as the cause of an action (Hopkins 1988). 'For much of ordinary life it is quite unnecessary to bother ourselves about psychoanalysis or any of the other psychodynamic psychologies that are on sale in the market place. The path of wisdom - for most of us most of the time - is to forget about them' (Farrell 1981). Nevertheless, the central place of conflict in psychoanalytic theory suggests that there is a great deal that is counter-intuitive in its explanations - the notions that even traumatic dreams may be wish fulfilments, for example.

24
Thirdly, Freudian evidence also rests on what Edelson calls *inference to the most likely cause*. This is based on Harré's distinction between *generative* and *successionist* conceptions of causality (Edelson 1988). For scientific criteria to be respected it is not required that causal mechanisms demonstrate an immutable (successionist) regularity in their effects. A cause can be relevant for the occurrence of a subsequent effect without being sufficient reason for the event to occur (or, indeed, without even, in some instances, being necessary). Human science must root itself in the biological world rather than the wholly physical and must align itself with postulated medical causes like viruses, which have a certain predicted (generative) effect and make this effect *more likely* to occur in some persons in some defined circumstances but *not certain* to occur every time or in every person. Individual differences and individual similarities have to be considered together. Freud distinguished between *essential causes* (for example, unconscious conflict and repressed sexuality) which, in his view, were universal and unavoidable, part of *la condition humaine*; *instigating causes*, such as regression and frustration, which affect different people to different degrees at different times, and which are an interaction between the individual and the environment; *favouring circumstances*, such as illness or exhaustion, which strengthen the possibility of effect of an instigating cause and *dispositions or propensities* (fixations, constitutional differences) that supply the individuality that makes certain types of people more likely to suffer certain effects (Edelson 1988).

What are the objections to clinical data being used as evidence for theoretical suppositions? Adolf Grünbaum's philosophical critique of the foundations of psychoanalysis is a cogent argument against the validity of material gathered in this way (Grünbaum 1984). His central objection is that clinical data cannot, by their very nature, be 'clean' but are inevitably and irretrievably contaminated in various ways by the therapeutic encounter in which they are engendered. (It should be noted that Grünbaum is not here debating therapeutic *efficacy* which is another issue altogether.) The main agent of flawed data is the power of suggestion which biases the patient's material in favour of his therapist's theory-laden interpretations ('anticipatory ideas'),
acting as a self-fulfilling prophecy and thus seeming, to the unwary, to unfailingly support the very theory it has set out to test.

The notion of self-validating theories is not new. Ten years before Grünbaum's book was published, the psychoanalyst Judd Marmor pointed out that 'patients of each school (of psychoanalysis) seem to bring out precisely the kind of phenomenological data which confirm the theories and interpretations of their analysts. ... Freudians elicit material about the Oedipus complex and castration anxiety, Jungians about archetypes, Rankians about separation anxiety, Adlerians about masculine strivings and feelings of inferiority, Horneyites about idealised images and Sullivanians about disturbed interpersonal relationships'.

Material is selectively responded to and interpreted according to the therapist's preconceived ideas as Edelson recognises: 'One psychoanalyst will hear as "anal efforts to control" what another understands as "compensatory strivings to overcome a sense of inferiority"' (Edelson 1988). Much analytic debate has centred round the difficulty in avoiding 'theory-congruent insights' (Cohen and Laudan 1983). All observations, as Popper pointed out, are 'theory-laden' but psychoanalytic data is so vastly over-determined that tendentious matching of the evidence to the theory is very easy to achieve. A good scientific test, according to von Eckardt 'must be a statement that can reliably be determined to be true or false using methods that do not themselves presuppose that the hypothesis in question is true.' Most clinical data violate this.

1.4.1 Free Association

Freud was, of course, entirely cognisant of the phenomenon of therapeutic suggestion. His first clinical work with hysterical patients used hypnotic techniques which depended heavily on the suggestibility of the patient, and it was his dissatisfaction with hypnosis as a method of therapy which led him to discover and refine free association as a technique for gaining access to repressed and unconscious ideas.
But is free association any less susceptible to contamination by suggestion? Freud's answer to this, according to Grünbaum who dubs it the 'tally argument', was that the patient can overcome his resistances and successfully deal with his conflicts only if the analytic interpretations he is given 'tally with what is real in him'. Furthermore (and this is one reason why analyses are long drawn-out affairs), the testing of 'anticipatory ideas' takes place over time. In the course of the successful treatment interpretations that are incorrect drop out, leaving only those which 'tally'. In fact, Freud almost seems to be saying that any 'suggestion' present in the clinical situation operates from the patient to the analyst as the latter must modify and refine his interpretations depending on the patient's response. The analyst's rôle is simply to put into words for his patient what the latter already knows to be true, though perhaps not on a conscious level of awareness. 'The doctor ... as a rule ... can only tell his patient what the latter's reason can tell him. But it is not the same to know a thing in one's mind and to hear it from someone outside' (Freud 1916). In practice, however, this criterion of acceptance is very weak as psychoanalysts have a variety of ploys for not conceding to their patients' doubts and rejections of analytic interpretations. The analyst Fenichel has been quoted as saying that 'A patient's yes is usually accepted as a confirmation ... under certain circumstances, a no is not regarded as a refutation' (Fenichel 1945). This annoying tendency to want to have its cake and eat it is one of the attributes of psychoanalysis that least endears it to its critics.

Frank Cioffi believes, however, that Grünbaum has overestimated the power of the tally argument and the confidence that Freud invested in it (Cioffi 1988). Even in the early days, patients knew his theories and were likely to select material and accept interpretations based on pre-conceived expectations. When the 'Rat Man' was asked by Freud why he had chosen to begin his consultation with a detailed account of his sexual experience he replied

---

4 Freud supported this manoeuvre as necessary when dealing with patients who defended against the truth of psychoanalytic interpretations. 'According to psychoanalytic theory, I told [the 'Rat Man'] every fear corresponded to a former wish which was now repressed; we were therefore obliged to believe the exact contrary of what he had asserted' (Freud 1909a). See, for further examples, Freud 1905b (several references); Freud 1911; Freud 1906, and Freud 1925b.
that that was what he knew about Freud's theories (Freud 1909a). Instead, Cioffi suggests, Freud appealed to direct observation in the transference to confirm his interpretations.

1.4.ii Transference

The phenomenon of transference (another factor influencing the length of treatment) complicates the therapeutic situation immeasurably. It is a distortion of relationship which operates in both directions but more particularly from patient to analyst. The emotions which have coloured the patient's former relationships, especially the very early ones, are assumed to be displaced 'unrealistically' onto the analyst. These can be pointed out, interpreted and 'worked through' to give the patient an insight into his patterns of relating. Within the transference, analytic interpretations may at first be 'resisted' or, alternatively, accepted without reference to their validity. At the beginning of his psychoanalytic career Freud viewed transference as an occupational hazard but by the time he was marshalling the 'tally' argument he had seen that it could be valuable to the analytic process as a manifest sign of the patient's inner world. In fact, according to Freud, 'The emergence of the transference ... has always seemed to me the most irrefragable proof that the source of the driving forces of neurosis lies in sexual life.' This argument has never received anything approaching the degree of attention that it merits, for if it had, investigations in this field would leave no other conclusion open. As far as I am concerned, this argument has remained the decisive one, over and above the more specific findings of analytic work' (Freud 1914).

The original psychoneurosis is replaced by a transference neurosis as the patient acts out his unconscious ideas, wishes and beliefs in his relationship to the analyst. 'Finally every conflict has to be worked out in the sphere of transference'. The transference is correctly interpreted by the analyst and the patient gains insight and is able to give up his maladaptive behaviours. The

---

5 'It is the sexual function that I look upon as the foundation of ... the psychoneuroses in general' (Freud 1905b). Sexuality, for Freud, was the sine qua non of mental life; transference merely confirms this.
gaining of insight was, and still is, considered to be the hallmark of a successful treatment.

Regardless of the relative merits of the 'tally' argument or the transference phenomenon in best allowing Freud to assert the usefulness of case study material as a reliable and valid tool for supporting or disconfirming the theory, the important and essential fact is Freud's belief that psychoanalysis was unique in providing the conditions and depth analysis which enabled insight to be gained. Furthermore, insight was the only cure for neurosis. Grünbaum calls this 'Freud's Master Proposition' or the 'Necessary Condition Thesis'.

1.4.iii Implications
There are several implications which follow from the above. Firstly, if psychoanalysis is indeed peerless, as Freud is suggesting, then there is no apparent need for clinical or experimental tests. It stands on its own merits. Needless to say, this is not a strong argument; even Freud's first flush of enthusiasm had to be modified over the years to take account of unmistakable and impossible-to-ignore spontaneous remissions and the unfortunate tendency for even a successfully-analysed neurosis to recur. Still, perhaps it was enough (for Freud if not for his critics) to be able to claim that it was 'primum inter pares'.

Secondly, the patient's response to interpretation, once his defences have been dealt with, is trustworthy. It is unclear why we should accept this proposition. Can a patient (or, for that matter, an analyst) ever be sufficiently free of hidden motivation to ensure adequate recognition of correct interpretation? After all, it was Freud himself who drew our attention to the subversive workings of the unconscious. Nowadays we have additional evidence from cognitive and social psychology which gives even greater reason to be sceptical about the unreliability of introspection. Nisbett and Wilson have demonstrated that subjects are often undependable informants on the effects of stimuli on their own behaviour (Nisbett and Wilson 1977). The conclusion across much similar research is that we have little or no direct introspective access to higher order cognitive processes.
These results were not available to Freud and, had they been, he might have dismissed them as too experimental to have any bearing on the arcane process of psychoanalysis which, successfully conducted, places the analysand in a privileged position of self-knowledge. Besides, the 'anticipatory ideas' only have to tally with what is psychically 'real'; the transference only has to match conjectured characteristics of the patient's former relationships. As we shall see, this does not necessarily correspond to external truth. But research on placebo effects deals precisely with the patient's individual version of events and shows them to be vulnerable to suggestion and other artifacts of an interpersonal situation. Moreover, if neurosis can make a later reappearance, how are we to judge at the termination of the first treatment whether the patient is in possession of a genuine insight which will permanently alter his way of being in the world?

Thirdly, the assumption that a cure relies on correct interpretation is something of a circular, self-reinforcing argument. If the interpretation is on the mark, the patient gains insight and, being insightful, he recognises the interpretation to be correct. In any case, insight is not enough. There are plenty of people who have received an insight that they are Napoleon or the Son of God. Closer to home, an early psychoanalytic insight that neurosis was the result of childhood sexual seduction was later disowned by Freud. So insight is certainly not sufficient. In many cases it doesn't even seem to be necessary; behaviour therapy, for instance, seems to be able to produce change without it. Even if we allowed the importance of insight, the actual intellectual content of it seems irrelevant. A Jungian or Kleinian 'insight' doesn't seem to be markedly inferior in its effects to a Freudian 'insight'.

1.4.iv Some disadvantages of the case study
The net result of these objections, according to Grünbaum, is the conclusion that psychoanalysis cannot be evaluated by reliance on clinical data alone because material gained in this intimate and intense setting is far too liable to distortion. Assessment needs to be made, therefore, by appeal to extra-clinical findings from experimental and epidemiological studies.
Grünbaum is not alone in his mistrust of case material as an empirical tool. Fisher and Greenberg (in Erwin 1988) also reject case studies because of the problems involved in determining quality, validity and reliability of such reports. (They concede, however, that a single case study might be able to falsify an hypothesis.) To use the case history as an acceptable scientific procedure is 'to mistake a mirror for a window' argues Masling (1986). The patient's words are not immune to reflections from both patient and analyst. These reflections all too easily act as operant conditioners (reinforcers or inhibitors) on verbal behaviour. And there is another, even more basic, difficulty in using case studies to confirm psychoanalytic hypotheses - they talk about unobservable, multi-determined processes. Philosopher Edward Erwin concludes his paper on the adequacy of clinical evidence in psychoanalysis with the statement: 'I remain sceptical about both the actuality and the possibility of non-experimental confirmation of psychoanalytic causal views ... The vindication of Freudianism requires sound and extensive experimentation' (Erwin 1988).

The views of Grünbaum and his fellow sceptics have had an immense and influential impact upon philosophers of science and psychoanalysis. Responses to his challenge varied considerably but many analysts were forced to admit that the foundations of Freudian theory were often built on insecure ground. This didn’t mean, however, that they were about to shut up shop. As Edelson phrased it, 'We all build on a swamp. Does that mean that we should give up and sink?' (Edelson 1988). Edelson represents a growing number within the psychoanalytic community who combine a continuing allegiance to Freudian theory and therapy with the realisation that objectively unverified (and currently unverifiable) data gleaned from 'self-congratulatory clinical histories in the case literature' (Malcolm 1982) do not establish the credibility of a hypothesis.

Nor, as every first-year psychology undergraduate knows, does correlation imply causality. Freud uncovered a good many associations between events (for instance, the connection between repression and neurosis) and tended to jump to the rather premature conclusion that the earlier event had caused the
later to occur. Such aetiological inferences will always remain unproven if we are to rely solely on clinical evidence. It is, of course, possible to find in the literature compelling examples of manipulation of an independent variable in a case study (some kind of analytic intervention, for example) which had an immediate and dramatic effect (able to be measured in the dependent variable). Meehl (in Erwin 1988) refers to several of these but they are problematic, as such instances are bound to be, both because of the impossibility of isolating the patient from extra-clinical influences which may have determined the changed situation as much as, or more than, the analytic stimulus, and because of the analyst’s inevitable selective bias in memory of the way the effect was produced, the timing, the background and so on. It is because of such difficulties that Wallerstein advocates the use of recordings or process notes (another point of contention between analysts and their critics), thus retaining the case study method but going beyond it to study the data in ways that are ‘simultaneously clinically and scientifically relevant’ (Wallerstein 1989).

Even supposing clinical data were sufficiently pure to fulfil the criteria of empirical investigation, aetiology would still be difficult to determine because few of Freud’s major hypotheses are ‘risky’ enough in Popper’s terms. To support the assertion that repressed wishes cause neurosis it would be necessary to declare what would count as disconfirmation. Perhaps we should look for someone repressed but not neurotic. But who among us can claim total freedom from repression, conflict or neurosis? Indeed, Freud thought that this was the price we all pay for being members of a civilised society. Anthropological evidence has sometimes been cited either for or against certain Freudian theories, and Paul Kline cites a number of such studies with approval and claims that the results support the universal occurrence of certain psychoanalytic notions, including the castration

---

6 Glymour has criticised Freud for succumbing to what he calls the ‘causal inversion fallacy’ by which the chronology of time-remote events becomes inverted. He argues that it is not the memory which causes the dream but the other way about as the memory didn’t actually exist until generated by a dream image. Edelson convincingly disposes of this by inserting ‘the event’ before either the dream or the memory of the event.

7 Popper’s criteria of science are discussed on pages 35ff.
complex (Kline 1981a). However, terms of reference are usually impossible
to define cross-culturally with sufficient clarity.

Edelson concedes that Grünbaum and his allies make several valid and
persuasive remarks regarding the evidential value of clinical data and the lack
of enthusiasm shown by analysts in actively seeking ways in which their
work might be evaluated appropriately. He agrees that failing to test will be
more disadvantageous for psychoanalysis in the long run than failing tests.
But despite the evident failings of analysis to come to terms with life in a
scientific community, Grünbaum is not allowed to get away with rejecting
clinical evidence out of hand. In its defence, it has been observed (Farrell
1981) that it is meaningless to expect to investigate an hypothesis about a
particular patient by empirical procedures. Only clinical experience can serve
in this situation - but, again, we have to try to maintain the distinction
between the 'proto-scientific' therapy and the theoretical assertions that are,
or may be, testable. However, Edelson is among those who have firm
convictions that case material is not just therapeutically useful but potentially
valuable in experimental enquiry as well. He believes that there is good
reason for regarding the therapeutic encounter as a 'source of otherwise
inaccessible phenomena' which is 'vitally needed to nourish and further the
scientific work.' The uniqueness of psychoanalytic clinical data, according to
Edelson, is that it flows from 'a special state of mind', more akin to primary
process thinking than our usual everyday secondary process correspondence
with the external world. The patient is assumed to have suspended 'critical
screening of what comes to mind' and is in an altered state of
consciousness.

Edelson may be overstating his case a little, describing a process that sounds
more like hypnosis than present-day psychoanalysis; furthermore, free
association is not confined entirely to psychoanalytic sessions, though it may
have originated there. Techniques for enhancing creativity and problem-
solving skills such as 'brainstorming' and 'synectics' also rely heavily on
uncritical production of ideas. Nevertheless, Edelson's conclusion is
convincing: the case study method has its own strengths and advantages in
obtaining data that experimental and epidemiological research cannot hope to attain. Neither method is inferior to the other; they are 'different modes of inquiry' and should be used in parallel.

1.4.v Case studies concluded

Case studies, then, as the evidence of choice in the evaluation of psychoanalysis, are not to be lightly dismissed. They can provide coherent and convincing explanations, not so much with respect to an isolated phenomenon which is probably best studied in the laboratory but, far more importantly for the credibility of the human sciences, for the complicated connections and inter-connections between whole armies of phenomena. This lends immense power to the psychoanalytic explanation®.

However, it is not enough to assert that important aspects of the theory are confirmed daily in the consulting room. We also need to know whether Freudian theory is the only (or, at least, the best) explanation of the evidence. What do rival theories say? Why should we reject these in favour of psychoanalysis? What would analysts accept as disconfirmatory evidence for the theory? How 'risky' is the test hypothesis - or does any and all evidence count in its favour?

Lester Luborsky, a psychoanalyst who has taken up the challenge of operationalising central psychoanalytic concepts and looking for relevant empirical methods by which to test them, makes the point that analysts 'know' a great deal in the clinical sense but not in the controlled research sense. For example he says, 'it is "known" that psychoanalysis works better with patients who have high ego strength, but we can find no research evidence for this' (Luborsky et al 1975). This should not be allowed to detract from the very real value of clinical expertise, understanding and intuition but, as research tools, they are only starting points. Analytic insight

® Nevertheless, although an argument could be put forward for the psychoanalytic account as a necessary explanation of human behaviour, it is still essentially incomplete and by no means a sufficient description (Spitzer and Klein 1976). The gaps are particularly noticeable in the areas of normal cognitive and emotional development.
can be used to form hypotheses but is too subjective, too prone to bias and human error, too overloaded with assumptions, to be used as the prime tool in any discipline that covets, as psychoanalysis does, a place among the sciences.

Supporters of the case study method have tended to take a rather cavalier attitude towards a responsible debate of the pros and cons of the case study as a research tool. Despite the caveats issuing in increasing number, reliance on data from the consulting room is still the predominant source of support for the tenets of psychoanalytic theory. At the same time, psychoanalysis continues to assert its scientific basis and to follow Freud's vision of a psychology rooted in biological determinism, a natural science with its own law-like generalisations of mental functioning. This has brought the analytic community into fierce dispute with scientists and philosophers of science who argue that psychoanalysis should not demand scientific status if it is not willing to allow its claims to be empirically tested.

1.5 Scientific Criteria
The analyst Charles Rycroft has pointed out that 'the proposition "Psychoanalysis is not a science" can be made true or untrue by choosing the appropriate definition of science' (Rycroft 1966). Various criteria of demarcation between science and non-science have been proposed, of which by far the most influential has come from Karl Popper (1980). Building on Hume's exposure of the logical deficiencies of attempts to confirm scientific statements by verifying them, Popper proposed instead that the hallmark of true science should be that the null hypothesis has a significantly better than even chance of being supported by the data. Scientific standing is thus defined not by whether a particular statement is true or false but by whether it can generate clear predictions vulnerable to falsification. The riskier a
hypothesis, the better its potential to expand the boundaries of scientific knowledge.

Within these parameters, Popper considers psychoanalysis to be unscientific, not primarily because of Eysenck's objection that it is untestable but because, even if tests could be set up, the statements of psychoanalysis are essentially unfalsifiable. There is, according to Popper, 'no conceivable human behaviour which would contradict them' (1972). Once again, though the focus of the argument is different from Eysenck's, the complaint is the same: psychoanalysis employs immunising strategies, 'self-confirmatory' rather than 'self-corrective' procedures (Farrell 1981), to protect itself from evaluation. It is, therefore, unscientific.

Popper called psychoanalysis a 'prescientific myth' (Popper 1972). We can, I think, allow psychoanalytic therapy to be described as 'proto-scientific' - in common with most, if not all, psychological treatments (and a good many physical therapies as well). It is a contentious point as to which treatments, if any, might be excused from offering further proof of their efficacy. Even behavioural treatments, founded on theoretically well-established principles of learning, reinforcement schedules and so on, are 'contaminated' by a great many non-specific factors, which are difficult to isolate and which have not been properly studied. But it is surely the theory that Popper wants to term prescientific and mythic. The philosopher Brian Farrell (who himself regards psychoanalysis as a 'premature' theory, a juvenile not yet come to maturity) does not agree that it has the attributes of a myth (Farrell 1981). Popper presumably wishes to liken analytic theory to legends and fairy-stories which purvey truth only in symbolic vessels; the great difference, says Farrell, lies in the open-ness of psychoanalysis. It continues to evolve and mature and is capable of modification in a way that a myth is not. Nevertheless, though

---

10 Popper is sticking his neck out in assuming that it is possible to define, once and for all, the kinds of issues that fall within science's domain and those that lie outside its jurisdiction. Nicholas Rescher, writing on the unpredictability of future science, believes that we cannot know what questions will be up for debate on the scientific agenda in years to come, and that we cannot say clearly what it can and cannot accomplish. To categorise whole ranges of phenomena as being uninteresting to science is, therefore, 'a risky and unprofitable business' (Rescher 1983).
psychoanalysis probably contains signposts to the truth, it has not yet demonstrated its truthful insights to the satisfaction of the empiricist. Farrell sees no need to be perturbed by this: 'such imprecise or vague pointers are not uncharacteristic of the early stages of a scientific enquiry, and they may be indispensable to further advance' (op cit). What he does take issue on is the indifference of analysts to claims made by their theory which are, so far, unsupported or, worse, which point away from the truth.

The 'prematurity' description of psychoanalysis is supported by psychologist Paul Kline who views the theory as a premature empirical synthesis offered in advance of the evidence (Kline 1981) - in other words, a working model, which is heuristically useful but needs a great deal of transformation and revision to get into empirical shape. Prematurity need not be an embarrassment; all sciences are cognisant with it and have subsequently built on its foundations. William Harvey's conceptions on the circulation of the blood around the body and Newton's particle theory of matter and light are two such embryonic sets of ideas which needed refinement and adjustment but which turned out to be abundantly fruitful. The High Level postulates of psychoanalysis similarly need much modification before they are suitable for the derivation of testable hypotheses. But some of the Low Level conjectures are certainly capable of being translated into operational definitions and, indeed, have been.

1.6 Experimental evidence
In fact, experimental evaluation of core concepts within psychoanalytic theory is more extensive than is often realised. Reviews of a number of these studies, have been published in the past twenty years. Areas covered by empirical investigation include dream theory, oral, anal and oedipal character structures and the origins of homosexuality and of depression. In total, more than 1000 objective studies of psychoanalytic theories have been cited in the experimental literature. The results and conclusions do not lend unqualified support to Freudian theory; neither, however, are they able to refute it. It emerged very early that Freudian theory is less a seamless garment than a
patchwork quilt, a massive collection of hypotheses, some of which resist falsification while others repeatedly fail to demonstrate their predicted effects. The studies are so numerous and so contradictory that judicious selection and sifting can provide satisfactory ammunition for the most diametrically opposed of views, thus running the risk of merely strengthening already entrenched positions. So it is that Fisher and Greenberg, psychologists sympathetic to psychoanalytic ideas, conclude from the available evidence that 'sizable portions of Freud's thinking gain support when judged by the scientific literature' (Fisher and Greenberg 1977), whereas the philosopher Edward Erwin, reviewing the same literature, finds his scepticism of Freudian theory and therapy justified by the empirical results which 'fail to provide strong support for any part of Freud's theory' (Erwin 1988).

Failure to produce clear-cut results will not surprise those who object that symptoms and character traits are over-determined and not amenable to study by experimental investigation in which all variables except the one under scrutiny are held constant. Empirical methodology lacks even face validity when applied to the complex world of psychoanalysis. Fisher and Greenberg tackle such complaints head-on by pointing out that potential violation of 'ecological validity' is common to all psychological ventures. They instance the study and measurement of intelligence with its multiple aetiology and mass of interlocking variables (Fisher and Greenberg 1977). Unravelling its intricacies was not quickly achieved but, it could be argued, the development of sensitive and sophisticated psychometric techniques has given psychology its one and only genuine claim to scientific status. Be that as it may, the history of experimental psychological research should encourage those deterred by the conflicting and often difficult-to-interpret results so far obtained by showing that further systematic study of psychoanalytic issues is in order and should certainly be attempted.
1.7 The deterministic substrate of psychoanalytic theory and method

Freud's firm and unswerving conviction that mental phenomena were the same as physical phenomena in being 'rigidly and lawfully determined by the principles of cause and effect' was the basis for his belief that psychoanalysis adhered to the same explanatory criteria as did the natural sciences. Freud's argument that this applied down to the least significant of the processes of the mind ran counter to intuition and he went to great lengths in his lectures and written papers to lay out his evidence persuasively. In 1901 when he wrote The Psychopathology of Everyday Life he ended the work with an entire section devoted to the non-random selection of numbers, including 'lucky' numbers. 'I have known for some time,' he writes, 'that one cannot make a number occur to one at one's own free choice any more than a name. Investigation of a number made up in an apparently arbitrary manner ... reveals that it is strictly determined' (italics added). He illustrates this belief with examples taken, at some length, from his personal experience. These are not altogether convincing and the convolutions he enters into to explain determined number choice sound like the arithmetical tricks of a child ('Think of a number ... double it ... add your birth-date ... now subtract the number you first thought of').

Several years later, in a public lecture on parapraxes, he asks, 'If I make a slip of the tongue, I might obviously do so in an infinite number of ways ... Is there something that compels me to make the slip in one special way or does it remain a matter of chance?' This is, of course, a rhetorical question. He is aware that his audience is very likely to hold to 'the illusion of there being such a thing as psychical freedom' and uncompromisingly states, 'I disagree with you categorically on this' (Freud 1917).

The importance of Freudian determinism is its implications for clinical psychoanalytic method. The free-association technique derives from the conviction that the intrusions into the patient's mind from the unconscious are in no way random elements but are strictly and lawfully ordained, and thus lead unerringly back to their source. Equally, the principle of determinism can answer the criticism noted earlier that patients are
influenced by suggestion emanating from their therapist. Absolutely not, said Freud, 'the patient can be influenced only in a direction that suggests itself to him' (op cit).

Psychic determinism was intended to put psychoanalysis on a footing with other deterministic sciences, though the evidence in its favour was decidedly weaker and much less appealing to commonsense than the 'proofs' of cause-and-effect in, say, physics. Freud's attempts to establish causal status for intangible entities is much more acceptable in the late twentieth century than it was 80 or 90 years ago and, therefore, we no longer need to rely on rather unconvincing arguments about numbers being part of a long trail of associations back to the significant event to establish psychoanalysis as a science. After all, these days the philosophical underpinnings of physics are no longer a matter of common sense either. The quantum world is inherently uncertain, stochastic and conjectural. 'It is not just that we cannot know what an electron is up to, it is that the electron simply does not possess a definite position and momentum simultaneously. It is an intrinsically uncertain entity,' writes theoretical physicist Paul Davies. Only statistical predictions can be made; there is an indeterminacy about the world that we had not previously realised. 'We cannot know the precise behaviour [of fundamental particles] but only a collection of likely behaviours' (italics added) (Davies 1988). In nineteenth-century science the use of probability reflected limitations of human knowledge; in twentieth-century quantum mechanics it looks as if probability may be an inescapable feature of the physical world (Salmon 1984).

This new scientific paradigm, the replacement of scientific determinism with more probabilistic models of causation, can only be of benefit to psychoanalysis. In assessment of treatment outcomes in psychoanalytical therapy, the adoption of statistical predictions and 'collections of likely behaviours' as evidence, the understanding that trends and patterns and relationships are as valid as laws and theorems (and have more in common with human life as well) can enable psychoanalysis to take its place with the other natural sciences. In psychology, statistical explanations are often all we
have; we can only explain a diagnosis of depression with, say, reference to a preceding bereavement, on the grounds that 'many' ('most', 'almost all' if you like - but never 'all') bereaved people become depressed. Only statistical levels of explanation are adequate. Employing techniques of assessment which are more appropriate to a science which explores the complex nature of the human mind is now more credible than it has ever been.

Similar arguments apply to the difficulties of inferring the presence of intangible psychoanalytic concepts. The Unconscious, said Freud, is a psychical process 'whose existence we are obliged to assume - for some such reason as that we infer it from its effects - but of which we know nothing' (Freud 1933). But to have to postulate the existence of unconscious motivations and associations from the presence of symptoms, resistances and defences is no different, in principle, from the extrapolation, in cosmology and physics, of black holes or bodies in space, or the existence of subatomic particles from the behaviour of other, observable, phenomena.

Experimental validation is that much more difficult to achieve in the case of entities like the unconscious whose effects, through which it is known, are distorted by the very process that they seek to explain. But twentieth-century physics is no less fraught with difficulty, with gravity-warping space and the curvature of light and the many strange events of subatomic particles that do not even exist until they are measured and, thus, observed. The confounding effect of suggestion in the phenomenon of interest is not only a problem for psychoanalysis, it seems!

---

11 Or, indeed, as many commentators on quantum physics have pointed out, from the inferred action of micro-organisms from the resulting disease processes, or the propagation of electromagnetic waves through space from television transmission. Electron microscopes do not 'see' atoms, which are below the limit of visible light; they 'infer' them. The quantum world has replaced the Newtonian 'action-by-contact' with a new concept of 'action-at-a-distance'. Causal influences are transmitted instantaneously from one part of space-time to another by processes that co-exist in both space and time. The old world of former causes and subsequent effects has been shattered at the most basic levels of matter (although, of course, continuing to exist very comfortably at macro levels). There is no reason to suppose that the unconscious may not operate according to similar principles.
1.8 Psychoanalytic Therapy

So far we have tried to confine our discussions of the scientific status of psychoanalysis to the empirical validation of its theory. The therapy is another branch altogether, despite the interdependence between the two enterprises, and despite the confusion of those who try to validate or falsify both with reference to one or the other. It is an irony of the highest order that the psychoanalytic enterprise does not know its own mind. It has a strangely ambivalent nature and cannot decide whether it wants to be a set of scientific injunctions or a compassionate attempt to alleviate human misery and suffering (nor how it might successfully combine the two).

Unable to tolerate this essential ambiguity, some scholars of Freudian theory have felt obliged to take a stand on one side of the fence or the other. Most notable among them are members of the hermeneutic school giving predominance to the therapy, categorising psychoanalysis as a humanistic endeavour rather than a scientific activity. They may recognise that 'Freud's work has a curious double form; it is, or pretends to be, at one and the same time, science and narrative' (Putnam 1984), but they impute 'scientistic self-misunderstanding' (Habermas 1971) to the founder, believing that he was in error when he attributed scientific principles to a clinical theory.

This premise accepted, there is, therefore, no merit in attempting to modify psychoanalysis to fit a strictly empirical mould; it is simply not designed to do so. Freudian explanations, say the hermeneutists, are part of the Verstehen tradition, an idiographic narration which is 'truthful' in the way that myths and fairy tales are universally and symbolically significant. Peter Caws makes the distinction between 'reality' and 'truth', setting psychoanalysis firmly on the side of psychically-perceived reality (Caws 1986). This path of inquiry has attracted some honourable explorers, including Jacques Lacan, an influential French analyst whose school of thought distinguishes between the Real, the Imagined and the Symbolic. The assumption of a truth is achieved not in the Real, but in the Symbolic, Order. This is because the central concern of Lacanian theory is with the concepts of loss, lack, and the impossibility of unification. These converge in the notion of desire - the impossible hunt for the Real.
For Lacan, there is no possibility of reconciliation; an object is only perceived as desirable when it has already become lost - regardless of externally verifiable truth. This is very much the position that Freud himself came to occupy after he abandoned the extreme environmentalism of the 'seduction theory'. This new stand asserted that the actual event is unknowable and therefore unable to be investigated. 'In the world of the neuroses,' wrote Freud in 1913, 'it is psychical reality which is the decisive kind'. It is this 'act of the mind' (Edelson 1988) that is the psychoanalytic object of study, not some objective 'truth', verifiable by others but perhaps of little meaning for the patient. Freud was not so interested in making conscious the exact original event, wish, desire, that had been repressed (even were this possible) as in producing in the patient 'an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory' (Farrell 1981).

However, although understanding the importance of personal narrative and the unique meanings which need to be unravelled from each patient's material, and prioritising psychic reality, Freud, as we have already seen, did not give the greater emphasis to therapeutic narrative. His prime concern was for that part of psychoanalysis, the universals of the theory, that he considered to be explanatory in nature, part of the Naturwissenschaften along with other deterministic disciplines. He would certainly not have agreed with Peter Caws who remarks that 'clinical findings cannot reliably be extrapolated beyond the case from which they are drawn. Every new patient who walks into the analyst's office is a new world to be explored' (Caws 1986). For Freud, running parallel with the idiosyncrasies were universals, which were common to every individual. Arthur Caplan is surely correct when he concedes that it may be possible to construct a hermeneutical psychoanalysis but that this completely 'misses the point of Freud's theoretical enterprise' (Caplan 1986). Such an undertaking might be valid but it would not be Freudian.

The hermeneutic position, however interesting and viable of itself, is untenable within Freudian psychoanalysis for the simple reason that Freud
wanted to do far more than understand and interpret in the therapeutic situation; he believed that he had discovered law-like generalisations about the workings of the mind which enabled psychoanalysis to take its stand firmly in the scientific arena. It should be viewed as 'a body of scientific knowledge that is used to make causal inferences about the mind or to give causal explanations of products of the mind' (Edelson 1988). Psychoanalysis is particularly concerned with showing how certain nomothetic themes are worked out idiomatically (op cit). It is guided, in doing this, by the assumption that different causal scenarios may be responsible for the same kind of observable outcome in different cases or, conversely, that a variety of effects may result from the same cause. 'Permanent character traits,' said Freud (1908), 'are either unchanging perpetuations of the original impulse, or sublimations of them or reaction-formation against them' (italics added).

This 'heads I win, tails you lose' attitude encourages Eysenck (and others) to accuse psychoanalysis of constantly moving the goalposts so that almost any event counts as evidence in its favour. Indeed, a central issue in the epistemological and methodological debates surrounding psychoanalysis is term-definition. The philosopher and sociologist Ernest Gellner criticises the psychoanalytic community for using words like 'cure', which have a public consensual meaning, in a way which allows for redefinition should psychoanalytic treatment not make a good showing in comparison with other forms of therapy (Gellner 1985). As an example, he quotes Anna Freud's statement: 'In competition with the psychotherapists, [analysts] are justified in maintaining that what they have to offer is unique, i.e. thorough-going personality changes as compared with the more superficial symptomatic cures'. This may well be a perfectly justifiable claim to make; the point at issue is that it is a sine qua non of scientific evaluations of treatment outcome that terms should be rigorously defined and procedures operationalised.
1.9 Therapies compared
Psychoanalysis qua therapy has always made a poor showing in contrast to other psychological treatments. This may be one reason for its reluctance to expose itself to comparison. On the other hand it has been poorly served in meta-analytic research by being forced into frameworks it was never intended to fit in order that as many inter-treatment variables as possible should be held constant. The assumption that this is the correct way to proceed seems debatable, to say the least. If we are to have fair and impartial evaluations of theories and therapies we must, surely, take into account their differing techniques and allow them to show their wares in the situation which is most appropriate for each treatment. To compare ten sessions of systematic desensitisation with ten sessions of psychoanalysis is, quite simply, ridiculous. Gene Glass who has been involved in a number of comparative, meta-analytic studies of psychological approaches, acknowledges that there is, as yet, no satisfactory outcome procedure for orthodox psychoanalysis (Erwin 1988).

Edelson (1988) makes rather a nice distinction between competing paradigms and competing conjectures, suggesting that the spirit of controlled enquiry which Grünbaum and others advocate for analysis does not necessarily require pitting one paradigm against an opposing one (such as behaviourist and psychoanalytic theories of neurosis) but is better served by intra-paradigmatic investigations (the relative weight of pre-oedipal and oedipal factors in the genesis of neurosis, for instance). If this point of view could be adequately justified it would benefit psychoanalysis enormously. Analysts could be reassured that the relatively small effect size of psycho­dynamic therapy in meta-analyses of treatment outcome evaluation compared with cognitive and behavioural approaches is altogether irrelevant. However, it is debatable whether rival paradigms can actually co-exist over a period of time in the way that behaviourism and psychoanalysis have done. That they are able to do so would suggest, following Kuhn, that psychological and therapeutic theories may still be in a pre-scientific stage of evolution. This may explain why the therapy, in contrast to the theory which
has begun to be tested extra-clinically, has not yet been evaluated in any serious way.

Once again, psychoanalysis finds itself swimming against the tide when it comes to deciding which criteria count as indicators of therapeutic efficacy. Most other treatments against which it is matched look for factors such as symptom alleviation or removal. Base lines are measured, the variables to be treated are targeted, and experimental or quasi-experimental designs are set up with control groups, time limits and strict operational guidelines. Psychoanalysis has traditionally refused to follow the same path. Symptom removal is not important in its own right but only in so far as it allows the instinctual energy which has been bound up in maladaptive behaviours to be freed, making it available for ego processes. Even analysts (and we have already seen that Freud was the first to do so) concede that 'the evidence that psychoanalysis cures anybody of anything is so shaky as to be practically non-existent' (Storr 1966).

In therapy, as with the theoretical testing, the case study has been the method of choice for analysts. Psychoanalysts are not seduced by the attractions of comparisons, cross-matching, reversing and alternating treatments, but cleave faithfully to their single case studies - to the irritation of more empirically-minded researchers. Alan Kazdin (1981) has listed 5 characteristics of the case study which he would count as weaknesses when used as evidence of therapeutic efficacy. Firstly, case accounts are anecdotal - the assertion that an improvement has occurred is simply a statement from client or therapist or both. Rarely, if ever, is it substantiated by any more objective psychometric procedure. Secondly, assessments are one- or two-shot. Evaluation takes place only at termination with no reference to baseline conditions. At most, two assessments are made, pre- and post- treatment, which is insufficient to rule out the testing itself as the source of change. Thirdly, the status of acute or episodic conditions by definition, changes over time, regardless of treatment intervention. Without control groups this basis of amelioration cannot be ruled out. Allied to this is Kazdin's fourth point, spontaneous remission, which applies to chronic conditions as well. And,
lastly, he objects to the use of studies that use only a single subject. To this list of offences against scientific credibility, placebo factors might be added, those non-specific variables present in all psychological treatments - the patient's commitment to treatment embodied in his decision to seek help; the optimism engendered by his expectations of receiving help; his belief that this therapy will be effective; the relationship between him and the therapist; the relief experienced simply through discussing the problem with someone who listens and doesn't condemn - and so on.

Many of these deficiencies can be eliminated through tighter control of variables; those that remain have to be borne in mind as alternative explanations. Like all therapeutics, psychoanalysis must be evaluated, assessed and held accountable for the effects of its intervention. The prime responsibility for this lies within the psychoanalytic community (Bachrach et al 1991) which has shown a general reluctance to expose its therapy to the harsh glare of rigorous assessment. Wallerstein points out that assessment of the therapy necessarily implies assessment of the therapist. 'The tensions and resistances that this generates merely points to the fact that we are doing research in emotionally-significant areas and not involved in trivia' (Wallerstein 1986). Few analysts seem to be as honest or as aware as Wallerstein, however\(^\text{12}\), and the usual reason given for the refusal of analysis to make its products accessible to outside evaluation is the 'old and well-known claim ... this old war-horse' (Farrell 1981) that only the analysed understand analysis\(^\text{13}\). Not only is a personal analysis neither necessary nor sufficient to inquire into the nature of analysis, some would go so far as to state that 'in so far as analysts and others remain the prisoners of their own professional training, their capacity to assess these theories rationally is

---

\(^{12}\) Edelson is another who is. He notes that 'it is one of the paradoxes of science that some psychoanalytic investigators make so little use of psychoanalytical knowledge in thinking critically about their own research and conclusions' (Edelson 1988).

\(^{13}\) This line of argument, like so many that we have looked at, started with Freud. 'The teachings of psychoanalysis are based on an incalculable number of observations and experiences and only someone who has repeated these observations on himself and on others is in a position to arrive at a judgement of his own upon it' (Freud 1940). Other similar references include Freud 1905a and Freud 1911.
impaired; and that detached outsiders may be better at doing so' (Farrell 1981).

The arguments which analysts muster to shore up their already fairly well-entrenched position have been well-rehearsed and are widely known - patient confidentiality, the privileged relationship of the therapeutic dyad, the special nature of the material and so on. It is not that these are not good arguments; they are excellent reasons for caution, but should be advanced as items on the agenda for discussion and not as stone-walling tactics. Psychoanalysis is vastly more difficult to evaluate than most forms of treatment and than most personality theories but we need to consider ways in which this might be done without violating the patient's rights and without interfering with the analytic ambience in the treatment room. The secrecy with which analysis is so often conducted, the treasures it so fiercely guards from the uninitiated, the passwords which seem to be 'under guild control' (Malcolm 1982) and vouchsafed only to the elect, is counter-productive to the spirit of frank critical enquiry to which all science is supposed to comply.

Perhaps our intellectual investigations are merely a sublimation of 'infantile sexual researches' (Freud 1910). Perhaps what we like to think of as our scientific integrity is merely a disguised voyeurism. Like children outside the parental bedroom, we are curious to know what is going on behind closed doors. Perhaps, then, there is some justification in the implicit, and often explicitly stated, view among analysts that those with no direct knowledge or experience of psychoanalysis should not interfere in what they cannot fully appreciate or understand. But psychoanalytic ideas have weaved their way into our life, have generated 'a whole climate of opinion' (Auden 1940), have permeated our culture, have taught us new ways to understand ourselves, have influenced and inspired us all to varying degrees. It belongs to us all. It is a public institution, making sweeping claims and providing radical treatments.
1.10 Two universes
As Home astutely points out, 'Psychoanalysis, growing up amidst the triumphant application of scientific method, understandably adopted the method for itself without considering whether it was logically appropriate. It has landed itself in a morass of reified concepts' (Home 1966). It has got itself entangled in the intricate attempt to answer two sets of questions at the same time, coalescing the methods without always realising that the questions belong to different categories. It wants to answer questions about motivations through hermeneutic acts of interpretation - (this is why the event occurred), and questions about mechanisms and causes through scientific acts of explanation - (this is how it happened). Seymour Kety, the biochemical researcher in psychiatry, has remarked that, 'There can some day be a biochemistry of memory but never of memories' (in Wallerstein 1976). Phantasies and defences can be the subject of systematic, rigorous study, perhaps, but this is not at all the same as being able to operationalise the process of phantasying and the concept of defence mechanisms.

These are two separate universes of discourse which cannot easily be forced together into some sort of Procrustean fit. The question then is, can the ambiguities of the interface between the two universes be tolerated? Can the empiricists accept that uncertainty is a necessary component in current explanation? Can the purists allow that psychoanalytic data is not sacrosanct but should be subjected to empirical test where appropriate? Can we live with those with other points of view from our own, discuss with them, learn from them, be challenged and stimulated by their contributions to the debate? Perhaps this is the greatest task for psychoanalysis as it moves into its second century.

1.11 Conclusion
We have already noted that many psychoanalysts, from the Founder onwards, have shown a casual disregard for empirical procedures designed to put their theories to the test. This seems to us to be a regrettable, but at least partially remediable, gap in the psychoanalytic account. This thesis is
not predominantly concerned with psychoanalytic process - that is, with validating, modifying or augmenting the theory as it is worked through in therapy - but with outcome questions. We take a first look at the available data with respect to outcome and make a preliminary attempt to formulate some of the relevant questions relating to child psychoanalysis. Is the therapy beneficial to the patient? Is depth analysis the best way of intervening into distorted developmental processes? Are the processes to which we are subjecting unhappy and disturbed children the best available? Can they be improved? Are shorter and/or less intensive regimens able to compete in efficacy?

Psychoanalysis as a treatment must be accountable to those patients, perhaps especially the children, whom it aims to serve and claims to help. Are these aims met and these claims justified? We don’t really know. Extraclinical findings are in very short supply. Research by those from outside the sacrosanct circle of the élite is almost non-existent. These lacunae need to be filled so that evidence both from within and outside, from clinical, anecdotal and empirical investigations, can all be brought to bear on the consideration of the validity and usefulness of psychoanalysis, theory and therapy.

The traditional psychoanalytic attitude of indifferent rejection towards statistical procedures of comparison and accountability is held up to question in this present work. We try to bring a recalcitrant psychoanalysis into line by partially quantifying base lines, by using well-designed and reliable research instruments and methodology, and by formally operationalising measures of improvement and effects from treatment. At the same time we recognise the importance of assessing psychoanalytic effects within a specifically psychoanalytic context. By forcing psychoanalysis to perform against an invalid ecological background, meta-analysis has heavily weighted the odds against psychodynamic treatments and in favour of behavioural techniques. We allow psychoanalysis to be practised in an optimal environment as practised at the Anna Freud Centre, a therapeutic clinic and training institution in London. We shall be attempting to identify those factors,
individual, familial, diagnostic or therapeutic, which lead to particular treatment outcomes for the child.

But before we can do so we should sketch in the background to this thesis - the epidemiology of child psychiatry, the import of chronic medical conditions on children, the existing outcome literature and, first of all, the history of child psychoanalysis.
Chapter Two

The Psychoanalysis of Children
2.1 Children in Psychiatry and Psychoanalysis

One of the central assumptions of psychoanalysis is that the development of the individual personality through the organisation of mental structures is crucially instructed by the experiences of infancy and early childhood. A comprehensive and profound understanding of this period of life is, therefore, essential if any worthwhile psychoanalytic work is to be carried out. The problem lies in how such information might be collected. A discipline like psychoanalysis, with its emphases firmly on unobservable, unconscious processes, faces tremendous difficulties of data collection, and has to answer questions concerning the reliability and validity of inferring internal states from overt behaviours. When the subject under study is a baby or young child, the complications increase. The introspection and insight of the adult (problematic tools, at the best of times) are quite obviously unavailable from babies and very young children. 'Whenever we break through the barrier which divides articulate life from the preverbal period,' wrote Anna Freud, 'we find ourselves on uncertain ground, left with conjectures, reconstructions and interpretations which, of necessity, have to remain unconfirmed by the individual with which they are concerned' (A. Freud 1954b).

Psychoanalysis has gained its information about the beginnings of mental life through four main sources:

A. Freud's adult analytic patients demonstrated, through the material extracted in the consulting room, that their symptoms were, conceivably, linked with earlier experiences. Whether these earlier experiences were straightforward memories of objective happenings like childhood seductions, or whether, as Freud's later theoretical amendment suggests, phantasy was interposed between the event and the memory, with all the distortions that this implies, the fact remains that the emphasis was on the past, on historical, childhood emotions. Freud went on to speculate that the alliance between the patient and the doctor was also a transference from the first relationships in life. He therefore hazarded the possibility of reconstructing
the incidents of childhood from this assumed reactivation of the emotions which had originally accompanied infancy.

This method of deducing the mental life of children from adult behaviour and reminiscence has been subjected to a great deal of criticism. The adult’s childhood, revealed many years later on the analytic couch is likely to express 'not so much a reality experienced as a dream betrayed' (Mannoni 1970). How much individual psychic constructions have in common with consensual external reality is usually difficult to determine. In addition, we don’t know how valid it is to generalise from adults to children. Even if the existence of infantile sexuality is convincingly asserted, sexuality cannot possibly mean the same thing to a child as it does to the adult with all the later additions and ramifications. How valid, then, is it to extrapolate history from the present situation? Freud's tendency to identify early states of normal development with later psychopathological conditions is equally debatable for some (Frosh 1989). Longitudinal research does not support the idea that childhood developmental stages are best described in terms of pathology, as being, in Freud's phrase, 'polymorphously perverse'. Without going along with the substance of this criticism (because it is surely reasonable to suggest that the pathology resides not in childish realities but in the retention of earlier modes of being that should have been assimilated into a wider frame of reference), it certainly highlights the difficulties in using adult analysands to confirm theories about child development.

B. A second means of obtaining information about infancy is through the direct observation of children. Freud claimed that psychoanalysis was based on 'an incalculable number of observations' (Freud 1940). The 'incalculable' boast should be taken with a small pinch of salt but, nevertheless, in principle this is obviously a reasonable way of confirming suppositions. Do children actually behave in ways which the theory predicts? The disadvantage is that the observations of those who are not psychoanalytically trained are generally regarded (by analysts!) as being too shallow for psychoanalytic purposes. But to learn to observe in ways that the psychoanalytic community finds acceptable takes years of training - and
years of training tend to ensure that observers are so grounded in the theories that any pretence at objectivity is indefensible.

C. The findings of developmental psychology over the past few decades have added cognitive input to the affective conclusions of psychoanalysis. Of special interest in this context is the work of researchers like Joseph Lichtenberg (1983), a psychoanalyst who has combined the experimental methods of developmental psychology with the clinical techniques of analysis. Neither discipline by itself asks the entire gamut of relevant questions; together, their range is greatly expanded. Lichtenberg is interested not only in what an infant can do (the traditional focus of attention for developmental psychologists) but also in what the developmental phenomenon called infancy must be like in order to be able to nurture an unfolding sense of self in the maturing child. Any explanation must have sufficient power to explain the emergence of the neuroses, character disorders and patterns of personality that make up the raw material of psychoanalysis. The specific weakness of classical Freudian teaching that the neo-nate is motivated to seek relationships with objects simply as a drive-reducer, to lessen tension, is exposed as inadequate by the findings of developmental psychology which present newborn infants in a state of innate readiness for an intricate perceptual-motor-affective dialogue with their caretakers. Babies have more autonomy, more ability to organise and control their interactions than was previously thought possible.

D. The fourth method of gathering data about the origins of mental life is through child analysis. This possesses all the drawbacks of observation - problems of reactivity and theory-laden assertions - but its one great advantage is that it offers the 'possibility of observing in children at first hand and in all the freshness of life the sexual impulses and wishes which we dig out so laboriously in adults from among their own débris' (Freud 1909b). Any evidence that it uncovers for, say, psychic conflicts, enable the phenomenon in question to be investigated in the very act of genesis (Freud 1926).
2.2 The First Child Patient

In 1908, Freud was indirectly involved with the analysis of a five-year-old boy, Little Hans. To modern eyes, Hans' analysis was, in many ways, an unsatisfactory affair. It was conducted primarily by his father, Freud seeing him only once. The father conveyed Freud's ideas to the little boy, making free and sometimes rather blatant interpretive suggestions. Hans' phobia disappeared but whether this was due to the analytic intervention or to other factors such as spontaneous remission is highly debatable. However, the case convinced Freud that not only was interpretation with children a viable proposition but, moreover, that this was psychoanalysis in its purest form. From 1914 onwards, Freud regarded child analysis as an appropriate vehicle to confirm theoretical ideas (Mannoni 1970; Freud 1918; Freud 1914).

The therapeutic work with Hans had involved a straightforward transfer of the methods used with adult patients. However, further experience and consideration made it clear that there are, in fact, substantial differences between adults and children as analytic patients. For a start, children are still literally reliant and dependent on their parents which necessarily changes the nature of the transference. Some schools of thought go so far as to argue that it is impossible for an analytic transference to emerge in children, given that the relationships assumed to be replayed in analysis are still current. Secondly, children have less motivation in seeking treatment than adults. They may be unaware of, or unconcerned by, their problems and are generally encouraged, or coerced, into treatment by their parents, teachers or doctors. Thirdly, the technique of free association is difficult to use with children. Not only are their powers of introspection not well-developed but, in contrast to adults whose freely-elicited phantasies tend to contain sexual material, freedom of action for the child often invokes aggressive tendencies - which may have to be curtailed, making a mockery of analysis' fundamental rule of free, uncensored action.

These inherent characteristics of child patients made changes in technique essential. The first analyst to deal with children in their own right was Hermine von Hug-Hellmuth, a Viennese disciple of the Swiss pastor and...
analyst Oskar Pfister (Freud 1925c). During the years of the First World War she introduced new non-verbal techniques like drawing and playing, symbolic techniques which can be interpreted in the same way as symbolic verbal utterances can be, but which were easier for children to use to express their phantasies (Smirnoff 1971).

Hug-Hellmuth's work was something of a watershed in the history and development of psychoanalysis with children. By discounting the significance of psychic reality (Mannoni 1970), she effectively split child analysis into two different strands: the classical variety, with its emphases on the Oedipal Complex and the implications of the transference, and a second branch which focused more on environmental disturbances in the child's life.

2.3 Ego Psychology

The emphasis on the aetiological importance of biological drives relative to the causal significance of social/environmental events, sometimes referred to as the debate between the ego or genetic approach and the dynamic approach (Smirnoff 1971), is one of the major differences between the various schools of child psychoanalysis. The dynamic viewpoint was the explanation favoured by Freud and describes psychic conflict in terms of the structure and interactions of the particular strategies involved (defence mechanisms, for example).

In contrast, the genetic perspective is more interested in explaining, in terms of an individual's life experiences, how this particular arrangement of internal forces or this particular conflict has arisen and why it persists. Ego analysts concern themselves less with metapsychological concepts than with more easily verifiable historical data, prioritising the child's actual experience over the psychic phantasies of classical theory. Nevertheless, a mere collection of anamnestic details is misleadingly inadequate and ego psychology retains the framework of sequential psychosexual stages from which to determine the significance of life events. The influence a life incident asserts on subsequent life developments largely depends on which specific phase of the child's
development is in the ascendant at the time: 'The question is not that at some time in childhood a tonsillectomy was performed or that a child was left in hospital care, but under what conditions and when these events took place' (Hartmann and Kris 1945).

Heinz Hartmann and Ernst Kris, writing in support of the ego approach, describe psychoanalysis as an 'applied social science' which requires that the child should not be observed in isolation but as a subject with an environment. They make the point that psychoanalysis is best able to predict behaviour when it looks at evidence based on both dynamic and genetic propositions. Genetic propositions explain why, in past situations of conflict, a specific solution was adopted, and describe the relationship between these solutions and later developments. Individual behaviour can, therefore, be historically traced to its origins. This has led to the practice of grouping character traits according to their common genetic roots so that individuals can be described in psychoanalytic shorthand as, for example, oral or anal characters.

The libidinal phases of oral, anal, phallic and genital organisation are, however, felt by some to be less discrete than Freud made them out to be. Overlap is certainly considerable; in fact Phyllis Greenacre believes that 'all lines of activity are present in some degree at birth or shortly thereafter, but rise to a peak of maturational activity at different rates' (Greenacre 1958). Lichtenberg takes a similar view, stating that Freud's theory of erotogenic zones and psychosexual stages deserves to be retained in any genetic theory of child development but 'in a markedly modified form'. Like Greenacre, Lichtenberg thinks the specificity and immutable order of the developmental stages to be an unproven, and probably incorrect, assumption. Infants quite possibly experience bodily sensations in a less localised way than that described by Freud. Rather than being centred on one rather precise part of the body, the stimulation might be experienced simultaneously in 'all the body excitement-sensitive modalities - mouth, anus, genitals, eyes, skin, and motion equilibrium' (Lichtenberg 1983).
2.3.1 Ego origin

The origins of the ego is another point of debate between the ego psychologists and those of a more classical persuasion. Early Freud had allowed for the appearance of the ego at the start of life but from the 1923 publication *The Ego & The Id* he revised his opinion, claiming primacy for the id instead and viewing the ego as a precipitate of the id formed partly through having the autistic, primary-process corners knocked off in its contacts with the external world and partly as a 'mental projection of the surfaces of the body' (Freud 1923), the modelling of internal states on somatic events. It is this later conception of the relationship of id and ego that represents Freud’s final understanding.

Ego psychology, however, continued to propound the existence of the ego from the very beginnings of conscious life, suggesting that both id and ego are equally primitive, that both are present from birth and that both develop in tandem from a source which is unspecified and probably unspecifiable in principle. One of its main proponents, Anna Freud, expanded her father’s biological insights to take additional account of social and cultural factors. Her pragmatic perception of the import of here-and-now reality helped her to understand that often the only viable aim for analysis might be to enhance the child’s ability to survive a damaging environment. She claimed that her understanding of the relationship between id and ego actually varied very little from her father’s version. And it is certainly true that the avowed aim of Freudian therapy was to enlarge the ego’s territory at the cost of the id: 'From the beginning analysis, as a therapeutic method, was concerned with the ego and its aberrations: the investigation of the id and of its mode of operation was always only a means to an end. And the end was invariably the same: the correction of these abnormalities and the restoration of the ego to its integrity' (A. Freud 1941). However the theoretical Freud remained firmly in the domain of the biological instincts and the subversive and conflict-ridden id, paying relatively little attention to the functioning of the ego and in particular to those many aspects of the ego which, according to
Hartmann (Hartmann and Kris 1945), are entirely free from conflict - functions like perception, language, intention, motor skills and so on\textsuperscript{14}.

The Object-Relations school of psychoanalysis goes even further in relegating the id to a peripheral position. Most of its protagonists, with the exception of Winnicott, regard the unconscious as simply an unwanted offshoot produced by a split in the personality when the true potential of the individual is thwarted through some environmental deficiency. This is essentially a theoretical quibble because, in practice, such splits between the ideal and the actual are unavoidable. Nevertheless, the Freudian concept of the Id as a psychic region which is never wholly accessible and able to be known is anathema to some Object-Relations theorists, such as Guntrip, because of the obstacles it presents to achieving whole and mature self-hood. (Freud was altogether more pessimistic about notions of self-actualisation. He would have agreed with Guntrip's conclusions but would have rejected the underlying philosophy.)

In fact, one of the principal criticisms of the ego psychology approach to analysis is that its strong emphasis on the ego and the reparative effects of therapy risks concealing the revolutionary notion that 'there may be parts of ourselves which are always profoundly at odds with other parts, and with the world' (Frosh 1987). This censure is primarily directed at the work of those like Erik Erikson who advocate conforming to society at the expense of individuality, thus legitimising even the stultifying and oppressive facets of culture. For the most part though, ego psychoanalysis has tried to go beyond the findings of genetic epistemology. Anna Freud, for example, in rejecting the idea that mothers and the vicissitudes of child-rearing are responsible for the entire range of infantile neurosis understands the concept of the 'rejecting' or 'depriving' mother as a symbolic rather than a literal reality, in the same way that fathers are often perceived as 'castrating'. She suggests

\textsuperscript{14}We agree with Hartmann that, as noted in the footnote on page 34, psychoanalysis has failed to take account of the importance of normal cognitive processes. However, these processes are also available for symptom formation in the guise of parapraxes, wish fulfilments, hysterical blindness and paralysis and so on, and are, therefore, not entirely outside the sphere of psychic conflict.
that ‘the mother is merely the representative and symbol of inevitable frustration in the oral phase just as the father in the oedipal phase is the representative of inevitable phallic frustration which gives him his symbolic role of castrator’ (A. Freud 1954).

But the point of intervention in Anna Freudian therapy, influenced by the British Child Guidance Movement, remains on the level of reality in matters of family life. This doesn’t go anywhere near far enough to satisfy the requirements of some branches of analysis. Maud Mannoni, a Lacanian, is scathing in her disapproval, accusing Anna Freud and her followers of failing to make sufficient use of the child’s unconscious phantasy link with its mother (Mannoni 1970). And indeed it is phantasy and the rôle it is perceived to play in the life of the child which marks the greatest difference between the two best-known schools of child psychoanalysis, led by Melanie Klein and Anna Freud. Melanie Klein was not interested in behaviour seen from a reality perspective, and she broke with the criteria of adjustment and educability that Anna Freud had adopted as her guidelines. For her, phantasy, as the basic ingredient of all mental life, operating independently of words, inevitably distorts the reality of the external world which Anna Freudsians pay so much attention to. Any attempt to take account of objective reality brings one straight up against the highly subjective factors of unconscious motives and desires.

A more specific criticism which Mannoni directs to Anna Freud is that her ‘reliance on reality is the hallmark of a school and a technique which fail with psychotic children.’ Klein, on the other hand, succeeded in applying Freudian and other concepts to work with psychotic children. Freud himself had believed that psychosis was inaccessible to analysis (a view shared by his daughter), but many post-Freudian developments have queried this pessimism. The Kleinian school, with its theoretical emphases on the prevalence of innate ambivalence, the importance of the death instinct and, above all, the vivid and violent phantasy life of the child, has directed its interpretations not to the defences of unconscious impulses but to the unconscious phantasies themselves (Rycroft 1968) and has found it possible
to undertake an effective analysis of psychotics. Indeed, some schools nowadays believe that 'little by little ... analysis has been proving itself as the best approach to schizophrenia' (Rycroft 1968). Many current approaches have revised or even jettisoned altogether traditional Freudian instinct theory (Eagle 1983), in favour of emphasising object relations or self psychology, enabling clinicians like Kohut, Mahler, Fairbairn and Guntrip to treat much more severe pathology (including narcissistic personality disorders and schizoid and borderline conditions) than was previously deemed possible.

2.4 Conclusion

Whatever the differences and distinctions between psychoanalytic theories and techniques - and they are probably fewer and of less importance than the respective adherents would admit - there has been a decided lack of empirical research in respect to all the various approaches. The next chapter takes a look at what has been done over the years in the field of therapy outcome evaluation.
Chapter Three

Outcome Research
3.1 Outcome versus Process

Psychotherapy research into the comparative effectiveness of treatments has been pulled in two different directions over the 40 years since Eysenck began the debate (Eysenck 1952). Historically, therapeutic *process* took precedence over *outcome* for practitioners (Spitzer and Klein 1976) but a recent review of empirical studies of psychotherapy by decade has shown a changing trend indicative of a 'flight from theory into pragmatics' (Omer and Dar 1992) - a decline in theory-guided research with its emphasis on the processes underlying therapeutic change and a rise in pragmatic, clinically-oriented research which focuses attention on the outcome of treatment. The proportion of investigations using case studies dropped from 14.25% in the 1960s to none two decades later. The use of treatment manuals has grown in popularity, allowing for more objective validation of therapy, and the most widely-used classification system, the DSM has, in the same period of time, moved from a psychoanalytically-informed to an atheoretical approach. The authors feel that the therapeutic *Zeitgeist* has changed and that schools and theories no longer hold sway as imperiously as once they did.

Psychoanalysis, however, continues to swim against this changing tide in therapy evaluation. Freud was much more interested in process than in outcome (see page 19) and this strong commitment to a particular technique rather than to empirical evidence (Kazdin 1988) continues to a large extent among present-day psychoanalytic clinicians. The exigencies of controlled outcome research (use of controls, random assignment to groups, standardised treatments, objective evaluations) are regarded as inappropriate for the peculiar intensity, depth and intimacy of psychoanalytic psychotherapy.

This means that psychoanalysis as classically practised has not contributed to any of the meta-analytic studies on treatment outcome and comparative efficacy, and that the outcome literature to date has had little to say about it. The claims that psychoanalysis makes a much poorer showing than other therapies are only upheld by imposing incongruent criteria and limitations and making psychoanalytic failure into a self-fulfilling prophecy. So far, there has
been no useful comparison of the effectiveness of psychoanalysis with other forms of treatment (Bachrach et al 1991). Insight-oriented psychotherapies in general have been poorly represented; long-term, intensive treatment in particular is notable primarily for being a 'glaring omission in the research literature' (Luborsky, Singer and Luborsky 1975).

3.2 The Self-Evaluation of Psychoanalysis

The psychoanalytic world-view is essentially divergent from that of other therapeutic approaches in assuming not only that the roots of behaviours, cognitions and affects lie deep in the unconscious and are, by definition, not directly accessible, but that, more complicated still, they may be multi-determined, often satisfying a number of conscious and unconscious needs at the same time. Further, unconscious ideas have been subjected to a variety of defence mechanisms which distort and disguise and make their relationship to the observable event difficult to ascertain. Expressed thoughts, feelings and actions may be diametrically-opposed reaction-formations, displacements from other objects or situations, projections or introjections or rationalisations. Responses differ across individuals, across events, across situations. Nevertheless, although it is not possible to say that stimulus A always and invariably leads to response B, response patterns or tendencies (across individuals, across events, across situations) to react in one way rather than another, can be noted. Preference of defensive manoeuvre can be identified, and predictions made that attach higher probability to one event than to another. Even if a strict determinist framework does not do full justice to the intricacies of human psychology, the concepts of internal consistency and construct validity can be employed to predict one event as more probable than another.

The complexity of psychoanalysis makes its evaluation a greater challenge than that faced by champions of other schools of therapy. Psychoanalytic cases have traditionally been reported as individual narrative rather than as tests of scientific hypotheses and, despite the fall of the case study observed by Omer and Dar (1992), this is still the preferred method of reporting in psychoanalytic exegesis. There is, in principle, nothing to prevent case
records being used as part of an experimental design in a quantitative study (Fonagy and Moran 1993) and some process research of this kind has been attempted in the last few years (op cit).

When it comes to evaluating psychoanalytic therapy outcome however, all results to date seem unsatisfactory, despite the fact that psychoanalysts have been monitoring their interventions with patients since the 1930's (Bachrach et al 1991). Early studies showed that the majority of 'neurotic' patients gained 'substantial therapeutic benefit' from their analysis whereas 'psychotic' patients were more likely to come out of the experience unchanged (at best) and often worse. All psychoanalytic centres had, and still have, stringent criteria for selecting patients, taking on average only about 10% of applicants (Bachrach et al 1991). With such an embarrassment of riches there is no need to take on anyone who does not seem 'suitable' which leaves the door wide open to another of psychoanalysis' tautological truisms: patients suitable for psychoanalysis derive substantial therapeutic benefit from it. This is not a million miles away from stating that patients who do badly or who terminate prematurely (and about half the cases in all psychoanalytic research studies do not stay the course) were not really suitable in the first place.

Ernest Jones, the foremost British analyst in the 1930s when such general assessments began, was the first to voice concern that the (descriptive) statistical reports from various analytic institutions in Europe and the United States may not have been comparing like with like. Terms like 'substantial therapeutic benefit' and 'analysability' were being bandied around with no evidence that analysts were using standard criteria to assess these rather vague notions. That psychoanalysts don't always understand one another is

---

\[15\] In the same year that Jones made this criticism, Freud published *Analysis Terminable and Interminable* in which he described psychoanalysis as one of three 'impossible professions' - the others being bringing up children and governing nations - that is doomed to produce unsatisfactory results. He expressed the belief that, until intervention into unconscious wishes and conflicts could be made at a biochemical level, 'we must not be surprised if the difference between a person who has not and a person who has been analysed is, after all, not so radical as we endeavour to make it and expect and assert that it will be' (Freud 1937).
illustrated by the fate of a central fact-finding committee set up by the American Psychoanalytic Association. Its task was to try to find a way of pooling data from individual psychoanalytic practices. Questionnaires were completed by hundreds of analysts on thousands of cases but no conclusions were reached because 'it was difficult to understand the meaning of the responses' (Bachrach et al 1991)! Nine years later a fresh attempt was made with exactly the same result.

In any case, the many psychoanalytic centres that have published results have confined themselves to little more than compilations of numbers of cases treated, with a very broad breakdown of those which seemed to the treating therapists to have successful outcomes and those which did not. Apart from the difficulty of validating such assessments due to the lack of explicit criteria as to what constitutes a successful outcome, it is very likely that such partisan evaluation overestimated improvement rates. We are not aware of any comparisons in psychoanalysis between therapists' and patients' evaluation of the same treatment but a study which attempted to do this for other applications of therapy found that the 57% of therapists who claimed benefit in the form of symptom relief for their patients were matched by only 27% of the patients themselves. Similarly, 47% patients acknowledged improvement on the criterion of behavioural change compared to 71% therapists (Rachman and Wilson 1980). Similar impressions have been recorded in child therapy as well. Therapists, observers and parents attribute larger effects to the treatment than do teachers, peers and the child (Casey and Berman 1985). The implications are clear. Evaluations of therapy outcomes should not rely wholly on those who have a vested interest in the issue under study.

Systematic outcome studies on psychoanalytic treatment have been few and far between. The most rigorous and methodologically-aware of these is the Menninger Foundation Psychotherapy Research Project set up by Robert Wallerstein and his colleagues. Forty-two Menninger patients - 22 in analysis and 20 in less intensive psychoanalytically-informed psychotherapy - were studied throughout their treatment and followed up, both formally and
informally, for up to 30 years after termination. The usefulness of the project lies in the detailed mass of information collected and the care with which evaluations were made over a wide range of variables. This is an admirable and valuable piece of research. The care taken at every stage of the undertaking to describe the methods of assessment and the results obtained allow independent inquirers to come to their own conclusions without having the usual psychoanalytic conclusions forced upon them by the authors. Nevertheless, 42 subjects over two conditions is small in terms of sample size; in addition the Menninger clientele are unusually weighted on a number of demographic and diagnostic factors. The patients are almost certainly not representative of the analytic population as a whole, let alone a more general population.

A further difficulty that the Menninger work was not able to overcome is the usual analytic policy of refusing any kind of intervention into the clinical work. This leaves room for doubt over the objectivity of evaluation. Therapists (mostly trainees) were, of course, supervised, but 'the supervisory process does not guard against the introduction of systematic biases' (Wallerstein 1986). The Project also placed great store on careful, systematic evaluation of the treatments by trained, outside observers but such assessments had to be conducted through the medium of process notes compiled by the therapists themselves. The APA concluded in their recent report on the efficacy of psychoanalysis that there are differences 'between what analysts believe they say and what is observed in tape recording' (Bachrach et al 1991). Testers' ratings do not correlate highly with analysts' ratings on most dimensions. The balance between the research requirement to obtain reliable data and the clinical necessity to maintain the integrity of the treatment situation is a fine one. One of the central problems for psychoanalysis today is what status to attach to data generated in the clinical setting and how best to use such data (Fonagy and Moran 1990).

If adult analytic outcome studies are regrettably thin on the ground, even more alarming is the finding that the most intensive and potentially powerful form of psychotherapy yet developed has not, until now, yielded one single
systematic, large-scale evaluation of its child treatments. There are plenty of case studies and anecdotal reports. In addition to these, Heinicke and Ramsey-Klee (1986) have looked at frequency of session as a determinant of outcome (but the study comprised only 12 boys across 4 groups) and Fonagy and Moran have investigated the effect of adjuvant psychoanalytic psychotherapy on 22 patients suffering with brittle diabetes (Fonagy and Moran 1990). They concluded that psychoanalytic treatment was of help to the children in controlling their labile medical condition. However, these children were paediatric rather than psychiatric patients and not necessarily representative of the usual child psychotherapy population.

There are, of course, points of contact between child psychotherapy and child analysis, and between adult analysis and child analysis, and these will be briefly commented on below, but different techniques and different populations forestall any easy generalisations. The psychoanalytic treatment of children urgently needs to be assessed in its own right.

3.3 Child Psychotherapy Outcome Research

In fact, even the less intensive child psychotherapies have lagged well behind adult treatments in the importance they have accorded to outcome evaluation studies. A particular database used during the course of the present research gave 497 references to studies dealing with psychotherapeutic outcomes between 1983 and 1991, only 14 of which referred to child treatments. Casey and Berman (1985) reviewed as many as 75 studies of work with children between 1952 and 1983 but this included a number of group therapies as well as those which were "too unusual or too unclear in theoretical orientation to categorise" such as "brief puppet therapy" for children undergoing heart surgery, a psychotherapeutic day camp, and "therapeutic camping". Most of the approaches used (56%) were broadly

---

Kazdin lists over 230 separate psychotherapies which are used with children. These include automated hypnosis, bibliotherapy, colour-your-life technique, directed day-dreaming, exaggerated therapy, fair play therapy, horticultural therapy, new identity process treatment, office network therapy, self-puzzle, yoga and Z-process therapy (Kazdin 1988, 1990). It is hard to think of any other area affecting human life where we have allowed the unbridled growth of such a variety of
behavioural and only 7 looked at dynamic psychotherapy. A recent review by Shirk and Russell (1992) of studies that have attempted to estimate the efficacy of non-behavioural child treatments has criticised them as mostly inaccurate (with regard to estimate of efficacy) on the grounds of weak methodologies, the effects of investigator partiality for particular therapies, and unsatisfactory treatment representativeness. There is clearly a great need for further work in this area.

Early reviews of child psychological treatments (eg Levitt 1957, 1963) uncovered similar rates of recovery as the adult studies had done - about two-thirds to three-quarters of patients were substantially helped through psychotherapy, essentially the same as the 'spontaneous remission' rates so vigorously advanced by the critics of dynamic and insight-oriented therapies. These figures have not changed substantially in the intervening years (Weisz et al 1987; Casey and Berman 1985). The oft-made clinical observation that children improve even more rapidly and more often than adults is supported by a number of pieces of research including a study of phobics of all ages (Agras et al 1972) which found that many of them improved over 5 years without any treatment at all - including 100% of the children.¹⁷ Rachman and Wilson suggest that "it may turn out in the long run that psychotherapy does no more than provide the patient with a degree of comfort while the disaster runs its natural course" (Rachman and Wilson 1980). This is reminiscent of George Bernard Shaw's famous dictum that 'A doctor is a man who helps pass the time while Nature performs the cure'.

¹⁷Spontaneous remission rates have remained relatively constant across time and social conditions (Rachman and Wilson 1980). What does seem to make a difference is diagnosis. Anxiety neurosis, for example, is probably more likely to remit untreated than are obsessional complaints (op cit). Some meta-analyses have shown significantly different effect sizes (p<0.02) for different presenting problems (Casey and Berman 1985), though the reliability of these findings are now being debated. Psychotherapy has considerable impact on somatic problems and anxiety states but is much less effective with problems of social adjustment, self-esteem and global adjustment levels (op cit).
We need not, of course, be cynical about such 'holding' effects of therapy. Even if treatment merely speeds up recovery or gives support through a difficult phase it is worth it. In any case, as Rutter points out, this is not unique to psychological treatments. In most branches of medicine, 'the goals of treatment are to relieve suffering and to hasten recovery. Only rarely can treatment be thought of as providing a cure for a condition which would otherwise prove chronic' (Rutter 1975).

However, intensively-trained therapists, and psychoanalysts in particular, believe that they are offering more than a metaphorical shoulder to cry on. The biggest problem in outcome research is trying to define exactly what it is that therapists think they provide, and how this can be measured and its effects evaluated. Barnett et al's 1991 review of the child psychotherapy research since 1963 concluded that 'summary impressions of the literature could not be made due to the magnitude of the flaws in basic psychotherapy research methodology... Operationalisation and standardisation of specific treatments are needed.' Such flaws need to be addressed and remedied before child outcome research can provide useful information. The factors needing to be addressed in any treatment evaluation are many and complex and they may interact with one another and confound one another in unknown ways. It is worth looking at some of the more obvious problems more closely.

3.4 Specific Issues in Outcome Research

3.4.i Ecological Validity

Much child outcome research is in the form of controlled laboratory interventions that may not represent typical clinic therapy. As research findings consistently show a difference between treated and untreated groups, and clinical findings, such as those mentioned above, consistently find no difference between children who drop out of treatment or who never enter, and those who persist, it suggests, firstly, that research findings may not be generalisable and, secondly, given that good results are obtained from
research studies, clinical treatment needs the control and operationalisation of research (Weisz et al 1992). Psychoanalysis, in any case, cannot use these experimental designs for brief focal interventions, complete with control groups and randomisation of subjects.

There are also problems in defining the criteria for efficacy: that is, what should change and by how much in order to qualify as effective (Kazdin 1988)? In addition, the study of groups tells us little about how individuals react to treatment.

The Anna Freud Outcome Study, reported on in this present thesis, makes use of what Kazdin calls an Amenability to Treatment Model (Kazdin 1988). Enough variables were collected on each patient to investigate which specific factors might make psychoanalytic treatment effective with certain types of children and less effective with others. Bergin has put forward an average therapeutic effect argument (Bergin 1966) which stresses that while there may be little average effect of a particular treatment, some individual patients may benefit greatly while others are made worse. It is incumbent upon clinicians to try to identify the members of both these groups.

3.4.11 Treatment length

Meta-analyses of child treatments (Kazdin 1988) report the average duration of treatment to be 9.5 weeks. An average completed psychoanalytic treatment at the Anna Freud Centre lasts between 2 and 3 years (about 500 sessions). These are non-comparable statistics. In psychoanalytic terms, a patient who has turned up for a mere 9 or 10 sessions has not even begun his or her treatment properly, let alone terminated with measurable changes.¹⁸

¹⁸This is not to assert that brief psychoanalytically-oriented therapy may not be a useful intervention in some circumstances. A paper by the psychoanalytically-trained Susan vas Dias records her dealings with 50 child patients whom she saw in far from optimal surroundings for 30-40 minutes at a time, one after the other, for a median of 7 sessions over an average of 4 months. Interpretation and transference were kept to a minimum. 86% of her patients were discharged improved, their referral symptom having remitted (all had presented with a physical problem such as soiling, chronic disease or psychosomatic symptoms); 10% were referred elsewhere and only 4% were unimproved. Vas Dias believes that 'Our lengthy psychoanalytic training prepares us in
3.4.iii Treatment defectors

This leads on to the question of 'defectors' from treatment. What criteria are used to deem a patient to have started treatment, to have terminated prematurely or to have seen the process through to a mutually agreed conclusion? There is much debate in the literature on the characteristics of a treatment defector. McAdoo and Roeske define defectors as children who had completed the diagnostic procedure and were offered, but declined, clinic treatment. Continuers, on the other hand, had had at least 6 treatment sessions. The only major difference between the two groups was that continuers' symptoms tended to be more long-standing. The authors argue, therefore, that defectors are similar enough to continuing patients to be used as a natural control group (McAdoo and Roeske 1973).

A number of other studies have confirmed the essential parallels between defectors and continuers (Rachman and Wilson 1980). Weisz, Weiss and Langmeyer, for example, found no differences on demographic, clinical or other variables between those who attended for the diagnostic assessment but didn't turn up for treatment and those who continued for an average of 13 sessions. Moreover, no differences materialised as the result of treatment. When compared 6 months later when 98% of the treatments had finished, and a further twelve months after that again, the continuers could not be distinguished from those who had dropped out of treatment on either symptom checklists or on parents' and teachers' reports (Weisz et al 1987).

Garfield eschews the definition of defector used by both McAdoo and Roeske and Weisz et al to refer to children who never entered treatment, claiming that 'the use of varying definitions and criteria of drop-outs or premature terminators makes it difficult to compare studies and to secure meaningful generalisations' (Garfield 1989). Wiesz et al's reply that the diagnostic

---

a way, unknown in other disciplines, to listen with a "third ear" to the inner world of the child, both conscious and unconscious, and equips us with the therapeutic skills necessary to work with the communications we receive' (Vas Dias 1990). The point to be made is that this, though psychoanalytically informed and very valuable work, is not full psychoanalysis. 

73
assessment process is so intense that any child undergoing it has made a start in treatment is rejected on the grounds that this makes it difficult to 'specify one point at which therapy began'.

The problem for psychoanalysis is even more acute. Its rates of defection are very high partly because the continuers of most therapeutic approaches are the defectors from psychoanalysis. Attenders of 6 or 13 sessions, or even a great many more than that, would not generally be considered to have even begun their analysis, let alone to have terminated it with mutual consent. It is such an open-ended treatment that it falls easily into the danger of defining everyone who leaves without substantial improvement as having 'defected', dropped out, terminated unilaterally and prematurely. We do not know clearly what constitutes a therapeutic failure in psychoanalysis (Rachman and Wilson 1980).

3.4.iv Follow-up

The question of follow-up is another contentious issue. Many financially-constrained projects leave out follow-up assessment, but this may be a false economy because we then have no way of knowing whether treatment effects can be maintained over time and, therefore, whether the treatment is valid in its own right or whether transient effects were merely transmitted through, perhaps, the charisma of the therapist or other 'non-specific effects' (Frank 1965). Some reviewers (Casey and Berman 1985; Nicholson and Berman 1983; Frank 1972) have found results at follow-up to be so highly correlated with assessment at termination of treatment (p < .001, as analysed by Nicholson and Berman) that they maintain that follow-up is an unnecessary addition to any research study, adding nothing new to the

---

19Follow-up has additional complications for psychoanalysis because of the potential dangers of plugging into, and thus perpetuating, transference fantasies.

20But, as Wallerstein points out, 'Adequate follow-up study is recognised everywhere in clinical medicine as a most vital aspect of the understanding of the course of an illness and the success of its treatment. In cancer research, the five-year follow-up has been widely institutionalised; before this point one rarely speaks, even cautiously, in terms of probable cure' (Wallerstein 1986). Studies that reject the necessity to follow-up may be leaving out an essential component of all competent treatment evaluation.
information gained at termination. Although the average length of time until 
follow-up in the studies reviewed by Nicholson and Berman was 8½ months, 
which is arguably not long enough for differences to emerge, the range 
varyed between 1 and 114 months and no differences were found that might 
have been dependent on the time scale.

Other work has reached different conclusions, advancing evidence which 
suggests that evaluation of effect may change considerably, in the direction 
of either increased or reduced improvement, over time. In 1981, Kolvin and 
his colleagues published the results of a school-based treatment for neurotic 
and conduct disorders. The measures at the end of treatment (which 
included a number of different therapies) showed, inter alia, few 
improvements for either the neurotic or the anti-social children who were 
treated with group therapy or behaviour therapy. However, 18 months later, 
these groups showed marked improvement. The initial conclusions that the 
treatment had had no impact needed to be revised. Some meta-analytic 
work, too, has found a greater therapeutic effect size 5-6 months after the 
ending of treatment (0.93 compared with 0.79). This supports the 
observation that patients leaving therapy 'uncertain and discontented with its 
results may realise benefits many months or even years after therapy has 
ended' (Sargent in Nicholson and Berman 1983).

The reverse may equally be true and Kazdin's review shows that it is 
sometimes the case that 'the treatment that appeared more or most effective 
at post-treatment did not retain this status at follow-up'. Goldstein et al 
(1979) and Smith, Glass and Miller (1980) found that there were many more 
studies reporting positive results at the end of therapy than there were 
reporting positive results at follow-up.

Follow-up assessments in any outcome evaluation of child therapy are 
particularly indispensable because of maturation effects in children. It is 
possible that 'treatments that appear effective or differentially effective in 
the short run may not surpass the impact of developmental changes' (Kazdin 
1990).
Most of the therapies examined in the above review papers are behavioural in approach. Psychoanalysis requires different criteria to be evaluated in its exploration of maximum effectiveness. In place of symptom alleviation, analysts look for the 'accomplishment of an essential personality change which is the outcome of a redistribution of psychic energy' (Smirnoff 1971). None of this is well-defined or easily operationalisable but the importance of fundamental, integral changes in analysis is clearly implied. Therapies that make a good showing at immediate post-treatment assessment but whose effects decline rapidly from that point might, we could speculate, have offered greater possibility of permanent modification of pathogenic cognitions, affect or behaviour had they been conducted over a more extended period of time. This offers important possibilities for treatments like psychoanalysis in which change is asserted to take effect only over long time scales.

The little available research evidence suggests that psychoanalytic outcome does indeed vary over time, at least with adult patients. Thomas McGlashan's retrospective study of 446 adult patients and their psychoanalytic treatment at Chestnut Lodge, Maryland, demonstrates the importance of follow-up at various points after treatment, ideally over a period of some length (McGlashan 1984a;1984b;1986a;1986b;1986c). It was already known that treatment effects can extend over a period of at least two years after the end of an active phase of therapy (Kolvin et al 1981) but McGlashan found significant changes in functioning in certain diagnostic groups over much longer time-scales. General indications that the majority of patients with affective disorders had tended to improve by follow-up and the majority of schizophrenic sufferers to deteriorate are not discordant with epidemiological data. The outcome of these patient cohorts varied little over time. That is to say, the depressed patients maintained improvement while the psychotic patients stabilised somewhat although the trend remained downward. The unexpected finding was the long-term outcome results from patients diagnosed as fulfilling the criteria for Borderline Personality Disorder. For this group, global functioning does seem to vary over time on a shallow inverted U-curve. Borderline patients are at their best
in the second decade after discharge from hospital and treatment (McGlashan 1986a). This may well be attributable to age or other variables and have nothing to do with the treatment itself but it does underline the importance of looking for cohort effects and of attempting to determine which diagnostic groups at which age benefit most from which treatment.

Wallerstein, whose outcome study of adult psychoanalysis has already been cited, also found changes in functioning between termination and the very intensive and extensive follow-ups which continued for up to 30 years (Wallerstein 1986)! Eighteen out of his 42 patients consolidated and enhanced their position at termination; most of these had been assessed at termination as having made significant improvement, but this was not so for all the patients and one had been categorised as a failure at the end of treatment. Ten demonstrated no change at follow-up and 10 regressed, including two whose achievement at the end of therapy was classified as 'very good'. (Of the other 4, 1 had died and 3 had become 'therapeutic lifers', still in treatment of one sort or another.) It is obvious that although the future of many patients can be accurately predicted at termination this is by no means true for all. And the unexpected operates in either direction.

3.4.v Diagnostic profiles

One of the essentials in treatment outcome methodology is precise specification of the diagnostic categories into which patients fall. Different symptom profiles may respond in totally different ways to a particular intervention. The patients in some of the earliest reviews (eg Levitt 1957;1963) were broadly classified as suffering from 'neurosis'. This goes some way to providing useful information because it is known that 'neurotic' children respond better to all types of treatment than do delinquent or psychotic children (Levitt 1963) and we might therefore be justified in asking whether the results obtained could be regarded as biased in favour of treatment.

This is specially important to know if the conclusions are illegitimately generalised to the whole population of referred patients, because the most
common reason for referral to a child guidance clinic is conduct disorder and other aggressive and disruptive behaviours (Task Force on Intervention Research 1988) which cannot adequately be subsumed under a 'neurotic' label. But a term like 'neurosis', though excluding some behaviours, is still not nearly rigorous enough to be used as an operational research concept. It would normally be regarded as including all 'internalised' symptoms such as anxieties, depressions, phobias, withdrawn and obsessional behaviour - a heterogeneous collection of problems indeed. It is as meaningless to measure effectiveness of psychotherapies by combining a variety of diagnoses as it is to evaluate general medicine by assuming homogeneity between diseases as dissimilar as diabetes, cancer and pneumonia (Kazdin 1988). Chronic illness, viral infections, immune deficiency syndromes, all require different treatments and all have different prognoses. So it is with psychological disorders.

Diagnostic criteria have become more strictly defined and standardised over the past 15 or 20 years so that it is now no longer necessary (nor would it be methodologically acceptable) to use vague descriptions such as 'emotionally disturbed' or 'disruptive' to refer to subject-patients. In the 1960's attention was drawn to the vast differences in diagnostic patterns between countries, regions, hospitals and individual clinicians (e.g. Lader 1977) and it became imperative to produce specifications of particular syndromes that were universally recognisable. Consequently, revisions of the Diagnostic and Statistical Manual for psychiatric disorders have become increasingly explicit in category specification. The first edition in 1952 identifies just over 100 categories into which symptom profiles might fall. Sixteen years later the classifications had increased to more than 180. The most recent revision of the latest edition (DSM-III-R 1987) offers more than 260 possible psychiatric diagnoses with strict criteria to be fulfilled before a particular diagnostic label can be applied.

There is now much less excuse for vague definition of patient category than there was in the past; however, assigning patients to the correct diagnostic category for research purposes is still very much a live issue. There is
increasing evidence that children who meet the criteria for one disorder are very likely to meet criteria for other diagnostic categories as well (Kazdin 1990). This 'co-morbidity' presents problems for treatment evaluation. The principal diagnosis will probably be selected as the focus of treatment but an apparently homogenous group of children may respond to their treatment according to secondary diagnoses such as depression or hyperactivity. Unless all possible factors are taken into account the results may be impossible to interpret correctly. There may be important indications for and against applications which have been overlooked by conflating two groups of patients who seemed, on the surface, similar.

There are no 'easy' solutions to such problems; individual factors, many of which fall outside the reach of diagnostic and clinical scrutiny and may pass unrecognised, mediate treatment outcome for all patients in some way or other. Recent meta-analyses of child psychological treatments (Casey and Berman 1985; Weisz et al 1987) indicate the depth of the complexity with suggestions that effective outcome is dependent on a variety of patient, therapist, and treatment characteristics. We are making slow progress towards an understanding of how best to measure and assess psychological treatment outcomes, and how to combine methodological exactitude with clinical sensitivity and non-violation of treatment integrity, but we are still a long way from being able to give any sort of definitive answer to the question, 'What treatment, by whom, is most effective for this individual with that specific problem under which set of circumstances?' (Paul 1967).

3.4.vi Maturational effects
Maturational effects in childhood raise at least two important issues for outcome research. Firstly, diagnosis of clinical problem cannot be made independently of the age of the child. Problem behaviours are highly correlated with age (Schwartz and Johnson 1981), younger children showing greater levels of instability because of their uncertainty about, and dependence on, the outside world. Some behaviours that might be generally considered as disturbed or maladaptive are so commonplace in young children that they are statistically 'normal'. A toddler, a pre-adolescent and a
teenager will all require different assessment and treatment. The practice of combining children of all ages into evaluative reviews of treatment efficacy has little value.

Secondly, *assessment of therapy outcome* has to take into account maturation of the child during the time of treatment. Many childhood problems do alleviate with time with or without treatment (MacFarlane et al 1954). Differentiating between problems which will disappear of their own accord and those which require intervention to prevent consolidation and permanent adoption as part of a personality structure is extremely difficult. In the few evaluations of adult psychoanalysis that have been published, it proved impossible to predict at the beginning of treatment which patients would benefit and which would not (Wallerstein 1986.). How much more difficult, then, with children for whom constant change and development is part of the natural maturational process. The longer the treatment the more difficult it becomes to separate maturational from therapeutic effects.

3.4.vii Long-term retrospective studies
A problem unique to long-term retrospective outcome projects like the Anna Freud study is that, in any undertaking which lasts for years rather than weeks or months, the field itself moves significantly over the time span (Wallerstein 1986). In the forty and more years since the first child patients were seen at the Hampstead Clinic, vast changes have taken place in psychoanalytic technique, in diagnostic categorisation, in child-rearing practices, in attitudes towards child guidance and so on. Over the years parents have become better informed and more flexible about bringing up children. The old divisions between parents and experts have, to some extent, been broken down. No longer do parents often have to relinquish their child totally to the ministrations of hospital or special school without visiting rights. There is, perhaps, more understanding about the needs of children.

Much of this progress is directly attributable to the work of psychoanalysts like DW Winnicott, John Bowlby and James and Joyce Robertson, combined
with a general shift in the *Zeitgeist* from an expected submission to authority to greater demands for personal control in all areas of life. The challenge that this presents is in trying to disentangle historical and current assumptions from objective evidence. It is difficult to steer a clear passage between being influenced by the prevailing attitudes pervading, say, a particular diagnostic report, and rejecting them out of hand as being out of kilter with contemporary requirements of tolerance and impartiality. When making retrospective judgements about pathology and pathogenesis these are serious issues to bear in mind.
Chapter Four

Child Psychiatric Epidemiology
4.1 Introduction

Before narrowing our focus of attention to the specific population at the Anna Freud Centre, a rather broader sweep of the current epidemiological evidence is called for. The naturalistic experimental design of the present outcome study, originally dictated by the retrospective nature of the data but with the added advantage of showing psychoanalysis in its rightful setting without any artificial manipulation of variables, has meant dispensing with the usual taken-for-granted methodological inclusion of control groups. This inability to compare psychoanalytic patients with untreated or other-treated children increases the need for tracing the natural history of child psychiatric disorders within the epidemiological and clinical literature, thus setting up a framework within which the patient sample looked at in this thesis can be properly placed.

This chapter looks then, first of all, at the prevalence rates of child psychological dysfunction in the general population and in clinic attenders. Secondly, it catalogues the most common diagnostic categories into which dysfunctional children fall, all of which were widespread in the Anna Freud sample, and, thirdly, it identifies the major parameters which increase a child’s risk of psychological disorder. The section as a whole is intended to highlight those variables relating to child, family and diagnosis, which might be critical to outcome and should set the scene for subsequent discussion of the Anna Freud sample relating to, for example, representativeness and amenability to treatment, both in terms of general child psychiatry and in the light of a more idiosyncratic psychoanalytic background.

To start with, we will glance briefly at the general incidence and prevalence of emotional and behavioural problems in childhood.

Child psychiatrists Lee Robins and Michael Rutter have recently claimed that individuals who fail to conform to adult norms have nearly always shown behaviour problems in childhood. Substance abuse, for example, is rarely found without a background of diagnosable conduct disorder (Robins and Rutter 1990). The direction of causality is only retrodictable, however; earlier
conduct disorder can often be identified in the lives of substance abusers but is by no means *inevitably* linked with later pathology. The development of childhood neurotic symptoms into adult psychiatric syndromes requires the presence of additional requisites such as adult stressors (op cit).

Current thinking in the field of developmental psychopathology espouses an interactional approach, and shies away from linking adult disorders uniquely to single traumatic early experiences or present circumstances or innate predispositions. Nevertheless, the on-going vulnerability noted by Robins and Rutter highlights the importance of investigating the prevalence and associated factors for childhood disturbance and attempting to identify optimal treatments. Effective intervention may help to keep later problems as low a statistical probability as possible.

4.2 Epidemiology

The history of child psychiatric epidemiology began with Lapouse and Monk in the 1950s. Although they didn’t assign medical diagnoses to their subjects they came to the general conclusion that emotional and behavioural disorders occurred at a high level of frequency in 6-12 year-old children. For example, 80% showed occasional temper loss, and 43% had 7 or more fears and worries. Michael Rutter’s innovative Isle of Wight study in the following decade confirmed this finding. He surveyed an entire population, using multiple data sources which included direct questioning of the children themselves. This study identified specific behaviours such as poor peer relations and hyperactivity/inattention syndromes which had a strong association with psychiatric caseness; other so-called 'neurotic' traits like nail-biting and thumb-sucking were only weakly linked and were too widespread to differentiate between troubled and untroubled children.

This and subsequent research suggests that on average\(^\text{21}\) over the course of

\(^{21}\) Mean prevalence typically varies under certain conditions. Urban situations have higher recorded incidences than rural conditions. Rates of 18.1% were recorded in Ontario (Boyle et al 1987) and 25.4% in an inner London borough (Rutter 1989).
a year, 5-15% of children exhibit emotional symptoms (Levitt 1963). About 2-4% of these children suffer from psychotic or other severely handicapping disorders (Kazdin 1988); the remainder are mostly 'neurotic'. This range is reported consistently over epidemiological studies (Kazdin 1988; Pless and Roghmann 1971), despite the known difficulties of comparing various studies with different populations and different understandings of what constitutes a case (Dohrenwend and Dohrenwend 1974).

The large numbers of troubled children represented by these figures is even greater than it may appear at first glance in that, although percentages remain fairly constant, their constituents do not. As Lapouse and Monk showed, at one or other stage in their life, the vast majority of children experience at least one diagnosable disorder (Rutter et al 1970), thus becoming part of the epidemiological statistics. Many of these disorders are transient, often developing in response to some identifiable stimulus and resolving over the course of time, regardless of whether or not they have been subjected to professional scrutiny. Agras, Chapin and Oliveau found that all the phobic children they looked at improved over five years without any treatment (Agras et al 1972). This is also true of troublesome behaviours that are not formally psychiatrically diagnosable. MacFarlane, Allen and Honzig, for example, found that lying was considered a problem for 53% of boys and 48% of girls aged 6. By age 12, these figures had decreased to 10% and 0% respectively (MacFarlane et al 1954). The 'shifting scene' of maturation means that 'during development, symptoms, inhibitions and anxieties do not necessarily carry the same significance which they assume at a later date'22 (A. Freud 1962).

Some disturbances, however, do not remit, and evidence suggests that spontaneous improvement for certain conditions may be the exception rather than the rule. Although much deviant behaviour disappears over a period of

---

22 The Diagnostic Profile (see page 151) was developed by Anna Freud precisely for this reason. The underlying assumption is that the child's achievements and regressions in terms of levels of development are more informative to the diagnostician than are symptoms seen out of context.
about two years, bed-wetting, food fads, nail-biting, restlessness, reading
difficulties, irritability, disobedience and thumb-sucking have been found to
continue in between one-half and two-thirds of all children (Shepherd et al
1971). This conclusion is supported by other research, including a
longitudinal study of London children (Richman et al 1982) which found that
about 60% of disorders experienced at age 3 persisted for the entire 5-year
course of the investigation.

Emotional and behavioural problems in childhood are thus extremely
common. Mostly, of course, as Rutter reminds us, 'these difficulties
constitute exagerations of or deviations from the normal, rather than mental
illnesses, or diseases' (Rutter 1975).

With normal and abnormal behaviour overlapping and merging as it does in
children, it is no easy task to determine which symptoms interfere with
normal development and require some form of intervention. Who decides
when behaviour has crossed some more-or-less arbitrary line into a clinical or
statistical region of unacceptability? Shepherd found that teachers and
parents evaluate their charges differently. Only about 1 child in 5 is identified
as being a problem both at home and at school (Shepherd et al 1971).
Similarly, in the Isle of Wight study (Rutter et al 1970), 284 children scored
above a cut-off point on symptom questionnaires filled in by parents and
teachers but only 19 children were selected from both questionnaires. One
possible reason for this might be the unreliability of the measures used.
However, other reports on low correlations between child, parents, teachers
and mental health professionals show that the data is usually internally
consistent, corresponding with other criteria (Kazdin 1988) and that a more
plausible explanation is simply that not only are certain symptoms, such as
bed-wetting and specific learning difficulties, very obviously context-specific,
but also that child behaviour in toto varies highly across situations. At the
very least, these findings indicate the wisdom of using more than one
informant.
4.2.i Clinic referrals

What happens to the 10% of children who are picked out in epidemiological surveys as having emotional and behavioural problems? Well, most of them receive no treatment. Only about one in ten becomes a clinic referral (Brook and Cooper 1975) and these are not necessarily the most seriously disturbed. Rutter and colleagues found that 'for every child receiving treatment there were four other children with disorders of roughly comparable severity who were not receiving any help' (Rutter et al 1970). Another study of psychological disorders among urban children, carried out by Langner et al also found that less than half of the seriously impaired children were referred, and only one in five received treatment of six months or longer (Langner et al 1974).

In fact, a number of studies have failed to distinguish in terms of symptoms and behaviour between clinic attenders and those not referred (Griffiths 1981). When children displaying psychiatric problems are matched with children without problems, 75% of the matched pairs fail to be correctly identified by at least 1 rater in 5 (Shepherd et al 1971). Level of disturbance is not, then, the key variable but these children do differ from non-treated peers on a host of other parameters.

The best discriminator between clinic 'patients' and epidemiological 'cases' (to use Brown and Harris' terminology) is parental perceptions of the child's behaviour (Bond and McMahon 1984). Given that parents usually initiate the referral or, at the very least, agree to it and need to comply with it, it makes sense that it should be their attitudes towards the problem which determine which children become patients. Parents who bring their children for treatment tend to have lower tolerance thresholds for the child's behaviour than their counterparts who cope without recourse to treatment (McAdoo & Roeske 1973). Whereas non-clinic mothers reframe the difficulty as simply a phase that the child is going through, or displace the focus of concern from psychiatric to educational or physical issues, clinic mothers feel worried,
irritated and helpless (Shepherd et al 1971)\(^\text{23}\). In addition, mothers of clinic attenders are more likely to suffer from 'nerves' or psychosomatic symptoms (op cit) or to be mildly depressed and feel unable to cope (McAdoo and Roeske 1973). These empirical studies bear out Erik Erikson's unchivalrous comments in 1937 that the psychic origin of disorder in a young child invariably has its corollary in a neurotic conflict in the mother.

### 4.3 Major Child Psychiatric Diagnoses

Having ascertained that a substantial percentage of children show clinically-diagnosable difficulties at some stage or other in the development process, the next question must relate to the nature of the disorders they present with. What follows is a brief account of each of the most common neurotic and behavioural diagnoses of children. All of them are recognised in the literature as applying to a considerable number of children; all of them were also found in the main Anna Freud sample and in the subsamples of chronically-ill children. In this respect our clientèle differs little from that seen in any child guidance unit. Later discussion will touch on which, if any, of these diagnostic categories respond favourably to intensive psychoanalytic intervention.

#### 4.3.1 Learning disorders

Learning disorders are among the most common problems in school-age children (Rutter 1974). There is a long-observed association between emotional and behavioural problems and scholastic under-achievement but direction of causality has not been satisfactorily determined. Prognosis is poor for the 3-10% of children in the general population whose reading ability is more than 2 standard deviations below expectation, taking mental age into account (Yule 1973). Low achievement across all subjects in the school curriculum relates to persistent aggressive or conduct disorders.

\(^{23}\) An Australian study of parental attributions of child emotional disturbance found that one-third of both mothers and fathers considered the behaviour to originate with the child. But, of the remainder, mothers were more likely than were fathers to consider themselves responsible for the problem. Such self-held attributions correlated positively with a successful therapeutic outcome (Watson 1986).
(Douglas in Rutter 1974) - but, again, the primacy of one over the other is not established.

4.3.ii Specific Reading Retardation
Specific Reading Retardation (SRR) is quite distinct from general educational backwardness in terms of sex (SRR shows marked male preponderance) and IQ distribution, neurological correlates, prognostic indications and associations with other educational problems (Rutter 1974). Reading problems correlate highly with antisocial behaviour - the Isle of Wight studies uncovered conduct problems in 25% of children with SRR, a rate several times higher than that in the population as a whole. SRR is also associated with speech and language difficulties, poor concentration, fidgetiness, restlessness and impulsiveness\(^2\). Rutter rejects 'highly speculative psychoanalytic interpretations' which talk of 'emotional blocks', preferring to emphasise the neurological, organic deficits related to the presence of SRR (Rutter 1974). However, this is not to disclaim all secondary links with emotional disorder. Difficulties with reading mean school failure and it would be surprising if the spiralling effects of SRR did not sometimes, perhaps often, lead to low self-esteem and other neurotic pathologies.

4.3.iii Under-achievement
Under-achievement is strongly linked to conduct and antisocial behaviours (Rutter 1974). 'There seems to be general agreement in the literature that the home environment is a most potent factor in determining the child's attainment at school' (Herbert 1974). Early identification of under-achieving children is important because childhood academic dysfunction predicts subsequent psychiatric impairment (Kazdin 1988). Along similar lines, academic functioning at the end of treatment predicts maintenance of both academic and behavioural adjustment thereafter (op cit).

4.3.iv Problems in Speech and Communication

\(^2\)Pervasive hyperactivity has a strong relationship with all forms of cognitive impairment (Rutter et al 1970). Both affect mainly boys.
Language, being the most recent major evolutionary achievement of humankind, is particularly vulnerable to disruptions and breakdown. Inability either to communicate or to understand usually leads to serious emotional problems (Herbert 1974). Stephenson et al showed that speech and language delay at age 3 predicts the development of emotional and behavioural disorders over the next 5 years in children who were without disorder at age 3. Many studies since, both clinical and epidemiological, have underlined this association between speech or language disorders and psychiatric disturbance (Rutter 1989). Dynamic theorists have traditionally regarded all non-organic language difficulties as being 'the outward and visible manifestation of conflicts over sexual or hostile instinctual impulses (Fenichel 1945). This is made tenable, in psychoanalytic terms, by the plasticity of infant development, making displacement from one area of activity to another relatively easy. Language acquisition and anal concerns develop in parallel; the hostility and conflict which attaches to the latter may, therefore, be all the more readily transferred to the area of speech and language (Greenacre 1954).

4.3.v School Refusal
The phrase 'school phobia' was coined by Johnson et al in 1941, but the more commonly-used term nowadays is 'school refusal'. This is a more accurate description given that the child’s anxieties are not usually focused on the school itself but around the issue of leaving home (mother) to go to school. This excessive anxiety also distinguishes school refusal from truancy. School refusal is seen most commonly in boys, particularly if they are only children (Moore 1966). The peak incidences in Britain coincide with changes of school from primary to junior at age 8, and from junior to secondary at age 11 or 12, but other life events, such as the illness or death of a parent, or the child’s illness, accident or operation, are also common instigators in contributing to difficulty in attending school (Hersov 1960). The families of refusers have a high incidence of neurosis, especially affective disorders. One-fifth of mothers of school refusers suffer from some form of psychiatric disorder, usually with anxious or depressive symptomatology (op cit). They tend to be either over-indulgent or controlling; the fathers are passive and
relatively ineffective parents. It has been found that school-refusing children experience less parental absence than either truants or controls. They are often passive, dependent, overprotected children who tend to be timid and poor in social skills. Their behaviour and work at school, when there, is good, and any oppositional behaviour is confined to the home (Herbert 1974).

4.3.vi Fears and Anxieties
Nearly all children have fears of one kind or another. In a very early investigation, Jersild interviewed 400 children aged 5-12 years old. Only 19 claimed to have no fears at all. The number of fears shown by a child correlates at .67 with the number of fears shown by the mother (Jersild et al 1933). Prevalence rates for clinical levels (symptoms plus severe social impairment) of anxiety states tend to vastly underestimate the very high true incidence of these conditions. Separation anxiety, for example, is clinically diagnosed in 4-5% of children (Rutter et al 1970) but symptom check-lists alone indicate that 26% of 9-12 year-olds and 13% of 13-18 year-olds, experience some separation anxiety. Similarly, over-anxious disorder rates, although present at caseness levels in only about 2% of the child population, affect to some extent 19% of 9-12 year-olds, 17% of 14-16 year-olds, and 10% of older adolescents.

4.3.vii Enuresis
General stress in the first 6 years of life, especially involving parent-child separations, has been implicated as one factor in the genesis of enuresis (Herbert 1974). DSM III guidelines set a lower age limit of 5 for diagnosis of enuresis as a clinical condition, but evidence and experience suggest that this is too low for boys who not only have a virtual monopoly on wetting after this age but who also suffer from it in such numbers that it can scarcely be called abnormal. Verhulst et al argue that the lower age limit for boys should be raised to age 8 (Verhulst et al 1990).

4.3.viii Sleep disturbance
Sleep disturbance in children, both boys and girls, between 15 and 30 months of age is so common as to be almost universal (Gesell and Ilg 1943).
Anna Freud (1966) explains this as the result of ego development and the strengthening of object-relations in the maturing child. No longer can he or she automatically and willingly revert to an undifferentiated, narcissistic state of being, as sleep requires. Later on, when the ego is sufficiently strong, this ceases to be such a threat, but in the transitional stage in the second year of life when 'withdrawal of libido and of ego interests to the self becomes a prerequisite for sleep', anxiety is aroused which 'makes the toddler cling all the more tenaciously to wakefulness'. In this phase, many children suffer from nightmares and night terrors.

One of the most interesting contributions to the understanding of the aetiology of sleep disturbance in young children is James Herzog’s paper on what he terms the "Erlkönig" syndrome. *Erlkönig* is the title of a poem by Goethe which describes a father’s inability to protect his son from the fatal seduction of the Erlking, who takes the boy by force because the father has failed to recognise the dangers and thus is prevented from taking action against them. Herzog identifies a link between 'father hunger' and sleep disturbance in a group of young boys aged 18-24 months. All had lost their father through divorce or separation less than 4 months before their night terrors began. There was no other apparent variable common to all the children. Herzog suggests that 'each boy perceived his father's presence or return as a vital element in controlling or combatting the fear.' The children seemed to want the father, the parent who was like them, to help and defend them against danger (Herzog 1980).

Herzog quotes a number of sources that report that an appreciation of sexual differences first appears between 14-18 months of age. Abelin, for instance, argues that, at this time, the little boy is biologically and hormonally programmed to turn away from the mother and towards the father in an attempt to dissolve the child's 'primary femininity' (in Herzog 1980). If the father is not available at this stage, sexual and aggressive urges are less easily contained and are liable to erupt in demonstrations of anxiety, especially when ego control is relaxed in sleep. For little girls, the crucial period to have a father around is later, during the Oedipal period.
4.3.ix Conduct Disorders

Conduct disorders affect three times as many boys as girls and the more serious delinquent behaviours are 10 times as common in male juveniles as in females (Rutter 1975). For conduct disorder and its associated education problems, especially reading difficulties, (q.v.), prognosis is poor. Alan Kazdin suggests that conduct disorder, together with other psychological syndromes like hyperactivity and major depression that may require life-time monitoring and intervention, should be viewed as chronic disorders, in the same way that diabetes and epilepsy are perceived as on-going states in physical medicine (Kazdin 1988). The psychological equivalent of a short course of antibiotics to overcome an acute infection (a short course of behavioural therapy, perhaps) might be appropriate for a discrete phobia or for mild panic attacks, but is not suitable for long-term treatment. The implication is that conduct disorders may need to be managed over a long period of time rather than subjected to techniques which attempt a once-for-all cure.

4.4 Children at Risk

In addition to having a knowledge of the probability of occurrence of childhood disturbance and the types of disorders most often exhibited by the young, it is also important to define the most salient parameters which expose a child to elevated risk of psychological breakdown. Such risk factors suggest some of the critical variables that exert a potential influence over treatment outcome, some of which (age, sex, social class, family type) will be able to be controlled for in the subsequent matching of pairs of chronically ill and physically well children (described on pages 187 ff). Physically-impaired children, in particular, are also at risk from the increased psychological liability associated with a number of other factors mentioned below such as hospitalisations, serial separations and, possibly, marital distress and parental illness linked to the strain of coping with a child with chronic illness or disability.
Specific markers of vulnerability to psychiatric disturbance in the child include gender, age, family size, separation experiences and a whole number of parental characteristics including marital status, illness and criminality.

4.4.i Age
Younger children have higher rates of incidence for nearly all symptom items (Shepherd et al 1971). At 2½ year follow-up, Shepherd et al found that many symptoms had dropped away.

4.4.ii Sex
More boys display emotional and behaviour difficulties than do girls (Kazdin 1988; Shepherd et al 1971). They are more likely to suffer from bed-wetting, reading disorders, school phobias, anti-social behaviour and restlessness. Only in the category 'fears' do girls predominate. In Shepherd's study, the small number of children whose deviance scores were increasing at follow-up relative to the original assessment diverged across gender lines in the type of symptoms they were now displaying for the first time. Girls were more likely to show extreme shyness of other children or extreme destructiveness. Boys had began to suffer from constipation, or to soil. (The nature of these symptoms suggest that children whose pathology increases with age, contrary to the more normal pattern of improvement, are indeed unusual children. Soiling is very rare in older children; similarly, destructive behaviour from older girls is uncommon).

4.4.iii Social Class
Most studies find no significant major relationships between social class and psychiatric risk in children (Shepherd et al 1971; Pless and Roghmann 1971), though certain researchers maintain that clinic referrals are weighted towards the lower end of the socio-economic scale (Kazdin 1988). In one investigation, the opposite effect was found: clinic children were shown to be twice as likely as non-clinic children to have fathers working in non-manual occupations, and three times as likely to have fathers in managerial

25 The same is not true for adults (Dohrenwend and Dohrenwend 1974).
or supervisory employment. However, the same study found no association between the child's total deviance score and father's socio-economic status (Shepherd et al 1971) so it seems likely that, as the authors suggest, there were sampling biases. These are difficult to avoid altogether because of the many variables correlated with SES such as educational standard, income and family size. Any of these, singly or in combination, might affect referral patterns in unpredictable ways. We have already seen that referrals are determined less by level of disturbance than by parental characteristics.

4.4.iv Family size

Children with 3 or more siblings are at a psychosocial disadvantage, not accounted for by social class (Rutter and Cox 1985). In particular, they are twice as likely to develop conduct disorders or to become delinquent than are children from smaller families. This is counterbalanced by the finding that children with emotional disorders tend to come from smaller families. As Shepherd pertinently observes, 'It is not difficult to think of good reasons why a child in any ordinal position, and in families of whatever size, might be maladjusted' (Shepherd et al 1971). For instance, emotional disorder may occur quite as frequently in large families but might be overlooked or dismissed as trivial in circumstances where there is little time for individual parent-child interaction. And perhaps it is not family size but, for example, criminal tendencies in the father or older brothers, identified with by younger children, that account for the large share of conduct disorders and anti-social behaviours in large families.

4.4.v Ordinal position

Once again a minefield of possible confounds presents itself, family size being the most obvious to control for (Rutter and Cox 1985). There is a slight inclination for the eldest child in the family to develop emotional problems (Rutter 1975, Rutter and Cox 1985) a tendency which increases in probability for girls under 11 with several younger siblings (Rutter 1975), but their scholastic and work achievement is high in comparison with their last-born brothers and sisters who run the greatest risk of school failure (Belmont
et al 1976). Singletons are the least likely of all to have psychological
difficulties (Shepherd et al 1971).

4.4.vi Migration
Moves from one country to another constitute a psychiatric risk (Rutter
1975). The reasons for this are not entirely clear but seem linked with the
findings on separations in general (see below) and with the higher likelihood
of adverse experiences in a new country, such as discrimination.

4.4.vii Family type
The type of family a child is a member of has a potential effect on his or her
behaviour and development (Wadsworth et al 1985). Five-year-old children
from one-parent- and, to a lesser extent, step-families, have higher anti-social
scores on items including disobedience, destructiveness, lying, aggression,
irritability and restlessness than do children from two-parent families. They
also score higher, though to a much less marked degree, on 'neurotic' scales
which measure levels of worry, misery, fearfulness, fussiness, solitariness
and psychosomatic symptoms. Family disruptions and separations are nearly
always problematic for a child, often acting as long-term risks, especially
when break-up occurs early in the child's life (Wadsworth et al 1985).
Rutter's London survey exposed rates of child dysfunction twice as high as
those on the Isle of Wight largely because of greater incidence of family
disorganisation and discord. Parental re-marriage can also affect all types of
psychological problems (Cohen et al 1990).

However, it is probably not single- or step-parenting *per se* that exposes a
child to risk but a combination of factors that correlate with 'family type'.
Single mothers, for example, are often younger than their married colleagues,
experience greater poverty and have had less education. They also take a
less active interest in their child's life (Steinberg 1987); this lack of parental
participation is associated with psychiatric disorder in children.

In any case, gross adverse effects from family break-down are by no means
inevitable. The Midtown Manhattan Project found that children from broken
homes ran only a slightly higher risk of developing psychiatric problems than did children from intact backgrounds. Without major financial worries, there was no elevated risk at all (McCord and McCord 1959). The McCords had already shown that less juvenile delinquency resulted from broken homes than from apparently intact homes with much parental quarrelling and child neglect (McCord 1990). Broken homes predicted antisocial behaviour from the children only when parenting was either ineffective or when the father was alcoholic or criminal (op cit). It is, therefore, distortion, rather than disruption that has the more serious consequences for delinquency (Herbert 1974) though separations do lead to an increase in neurotic and emotional dysfunctions. This supports Rutter and Quinton’s conclusions (1984) that no risk factor has much effect on its own - but then, of course, few factors occur in isolation. Broken homes are associated with discord, separations, unhappiness, economic insecurity and so on - an aggregation of adversity that can be very damaging to a child's psychological well-being.

In such a complex interaction as child pathology and family type, direction of causality needs investigation. Richman's longitudinal study of London children from age 3 to age 8, reported above, showed that family discord was associated with subsequent child psychiatric disturbance (Richman et al 1982). That is, discord within the family predated the child’s disturbance and may well have been an aetiological factor in the genesis of the latter. The evidence does not support the hypothesis that the child's psychiatric status put intolerable strain on the parents' relationship and was the cause of its break-up.

4.4.viii Marital distress
In a study of non-referred, non-clinic children, Bond and McMahon found a statistically significant link between marital distress, mothers' perceptions of themselves as anxious and depressed, and behaviour problems in the children, especially in the area of undercontrol (oppositional defiance and conduct disorders, primarily). Mothers also tended to show less appropriate parenting behaviour. There were no differences between the maritally-distressed and the non-distressed on any obvious demographic variable - age
of mother, age and sex of child, size of family, length of marriage and so on (Bond and McMahon 1984).

A 4-year prospective investigation by Rutter and Quinton noted that boys are particularly vulnerable to marital discord. 57% of boys from discordant homes were disturbed compared with none at all from more harmonious family settings. For girls the figures were 33% and 19% respectively, showing some effect but not to a statistically significant extent. However, although seemingly more resilient to temporary domestic crisis, girls develop psychiatric symptoms if the problems at home persist, whereas those boys who have not shown signs of distress from the start remain symptomatically unaffected (Rutter and Quinton 1984).

4.4.ix Parental loss

Children with psychological disorders have experienced a greater number of stresses than would be expected by chance (Heisel et al 1973). Among the most traumatic of these must surely be family disruption through death or desertion. Consequently, it is not surprising to find that 20% of clinic children have suffered the permanent loss of at least one parent compared with 6% of their non-referred age-mates (Shepherd et al 1971). They have also experienced an increased number of other parent-child separations (such as hospitalisations), especially in the first 6 years of life (Herbert 1974). The risk of psychological sequelae increases if the loss is of the same-sexed parent, particularly for boys (Shepherd et al 1971). A specific risk of delinquency presents in cases of parental separation and divorce but not in cases of death. This supports suggestions made earlier that it is disharmony in the home rather than the separation itself that is particularly conducive to any form of conduct disorder.

Loss as a provoking agent for a variety of psychosocial disturbance is well established in the literature from Freud onwards. Contemporary research from Brown and Harris has confirmed that loss is a powerful agent of depressive illness, stimulating it directly or increasing either patient vulnerability or illness severity (e.g. Brown, Harris and Copeland 1977). In
addition, 'sleeper effects' may incubate the impact of loss for some considerable time after the stimulus event, resulting in long-term risk of depression. This applies not just to parental loss but to any type of disadvantageous situation. Richman's measure of 'psychosocial adversity' in the child's life at age 3 predicted development of disorder in those children by age 8, even when no signs had been present at the earlier assessment. Moreover, improvement in circumstances didn't necessarily result in corresponding improvement to the child's psychosocial resilience, suggesting that the seeds of psychiatric problems are indeed sown at an early stage of life (Richman et al 1982).

4.4.x Separations
There is some evidence to suggest that the readiness of a woman to mother is highest at birth (Lichtenberg 1983). Separation from her child in the early days may, therefore, affect the development of a maternal attachment bond. Even a short separation may impair the caretaking rôle (Rutter 1975) and certainly one or more periods of separation increase the later risk of children scoring high on deviancy scales (Shepherd et al 1971).

An earlier claim by the World Health Organisation that the maternal separation experienced by children placed in day nurseries would cause permanent psychological damage (in Rutter 1975) has not been upheld by subsequent evidence. Rutter, for example, has found no evidence to suggest that working mothers produce disturbed children (op cit).^26

Some types of separation are certainly more distressing than others for children. Separations of under one month seem to carry little risk (Rutter 1975) - provided that the separation is not attended by divisive parental difficulties. There is, thus, no distinction to be made between holidays and

^26In fact, some research suggests a tendency in the opposite direction. Brown et al have shown that lack of either full-time or part-time employment is a contributory factor in maternal depression (Brown et al 1977) which, in turn, makes it harder for a mother to parent adequately (Bond and McMahon 1984).
hospitalisations. However, when children are separated from parents because of family discord there is a much greater risk of later antisocial behaviour. There is also some association between early separation and an increased probability of later bedwetting (op cit). The risk is minimal if the child, although separated from its mother, is looked after by someone familiar in a known environment but is raised if either caretaker or surroundings are unfamiliar, and increases markedly if both are strange to the child.

Children who are most vulnerable to separations are those aged between 7 months and 4 years when the development of secure attachment feelings may be most easily disrupted. Those with little experience of visiting other people's homes or who have difficulty in making friends find separations particularly difficult to cope with. In addition, a recent traumatic experience or general poor emotional adjustment or an unhappy home background add considerably to the stress of separation. Those children who respond with initial protest which turns to despair and then detachment (Bowlby 1953), are at particular risk of adverse psychological reaction in later life (Herbert 1974). Boys seem generally to be more susceptible to displaying adverse reactions than girls (op cit).

It should not be forgotten that psychological separations from parents because of, for example, indifference or rejection, are also harmful experiences for a child.

4.4.xi Hospitalisation
One of the commonest causes of extended parent-child separations is admission to hospital (Wolkind and Rutter 1985). Approximately one in three children in the United Kingdom will be admitted at least once, and 5% will have multiple admissions (Douglas 1975, Quinton and Rutter 1976, Wolkind and Rutter 1985). A single hospital admission does not seem to relate to later difficulties but multiple admissions starting in the pre-school years are associated with a small but significant increase in later conduct disorder or delinquency (Douglas 1975, Quinton and Rutter 1976, Wolkind and Rutter
1985). Subsequent emotional dysfunction is also associated with increased admissions to hospital, especially for girls, but it is not clear whether this is correlational only or whether there is a causal influence (Shepherd et al 1971). Children who are frequently hospitalised differ from their peers on certain important family and demographic variables (Martin 1970) but the relationship with later behavioural dysfunction remains even when these are fully controlled for.

4.4.xii Parental mental illness

One of the adverse factors that, even when no longer current, continues to exert effects on children, especially on internalising conditions such as anxiety and depression, is past parental psychiatric illness (Cohen et al 1990). Ongoing mental illness, however, seems likely to be more indirect in its consequences. That there are effects is not in dispute: three times as many children attending a Child Guidance Clinic with neurotic or behavioural problems as control children attending a dental clinic had a psychiatrically ill parent (Herbert 1974). Nevertheless, although an association has been uncovered between parental depression and depressive symptoms in children, depressive mood in parents putting children at a significantly greater risk of psychiatric symptomatology (Bond and McMahon 1984), few specific outcomes have been found for other diagnostic categories, including personality disorders (Quinton et al 1990). In an initial study looking at the effects on children of parents' psychiatric profiles, Rutter and Quinton (1984) concluded that, 'parental diagnosis carried little risk for children under 16 in the absence of family discord and disruption' (italics added).

The italicised caveat probably explains discrepant findings in the area. Parental mental illness is almost certain to bring in its wake a fair measure of disturbance in the home and, therefore, indirectly to lead to more vulnerable children. This supports the conclusion reached by Bond and McMahon, mentioned above, that anxious and depressed mothers find it more difficult to be adequate caretakers of their children and are also more likely to be maritally distressed. Forehand et al confirmed that mothers' depression occurs in parallel with perceptions of child maladjustment and with less-than-
optimal parenting. Depressed mothers issue more 'beta' commands - described by Forehand as 'vague or interrupted commands with which the child cannot comply' (Forehand et al 1986) - which, by definition, lead to greater noncompliance from the child and, thus, to parental perceptions of child oppositional behaviour.

Even more likely to lead to domestic disruption is the observation that psychiatric disorder in one parent tends to be associated with disorder in the other parent as well (Rutter and Quinton 1984). The two most obvious explanations for this finding are 'assortive mating' - like marrying like - and 'contagion' theory which is the better supported by the evidence. As we have already seen, parental diagnoses are not specially 'contagious' for the children except in the case of major depression (op cit), but many more marriages fail or are disharmonious when mental illness is present in one or both partner and this certainly results in the sort of 'family discord and disruption' that Rutter and Quinton identified as necessary for gross adverse effects on the children.

In looking for explanations for observed associations between psychiatric disorder in parents and that in their children, Rutter and Quinton reject not only theories of genetic transmission, but also that child disturbances occur as either a direct effect of the parents' pathology (children as targets for parental aggression or neglect) or as an indirect effect (such as the child being taken into care). They opt for the decisive rôle played by the correlates of mental disorder and, in particular, that of marital disharmony. This, they believe, accounts almost entirely for why children of psychiatric patients run a greater risk of being psychologically disturbed themselves than do other

---

27 These perceptions need not, logically, be distorted, Conrad and Hammen (1989) found depressed mothers perceived their child's behaviour more accurately than did non-depressed mothers. Clinical research on attributional styles also show depressed inferences to be well-grounded in reality (Alloy and Abraham 1979, Lewinsohn et al 1980).

28 Husbands of women patients have an excess of personality disorders; wives of male patients tend towards affective disorders. This is in agreement with epidemiological figures which consistently report neurosis as a primarily female preserve while men have the greater share of personality disorders (Dohrenwend and Dohrenwend 1974).
children. Above all, there is an excess of conduct disorders, especially among boys, in this group. This may be an inevitable development from the 'noncompliance' noted by Forehand et al (1986). Rutter and Quinton reach this conclusion on the basis of their 'family adversity index'. The rate of child emotional and behavioural dysfunction (in the school setting, at least,) is directly proportional to the number of family adversity factors (psychiatric disorder, criminality, overcrowding, 4 or more children at home etc) experienced. Children of psychiatric patients show no increase in disturbance once the family adversity factors have been controlled for. It is the combination and accumulation of psychosocial difficulties that co-exist with psychiatric illness that cause difficulties for the child (Rutter and Quinton 1984).

Boys run a particularly increased risk of becoming disturbed if either parent, but especially the father, is hostile towards them as a result of mental illness (Rutter and Quinton 1984). Seventy-one per cent of boys had emotional and/or behavioural problems in the presence of paternal illness; the figure dropped to 40% if only the mother was affected and father remained well. These results appear to conflict with the work of Shepherd et al who found childhood problems to have a greater association with psychiatric illness in mother than in father (1971) but become more consistent when the consequences for girls are added. For them, significant risk is only present when exposed to a high level of maternal hostility. 36% of girls showed disturbance when mother was herself disturbed and acting in a hostile manner; no girl was affected if only the father was disturbed provided that mother stayed relatively unimpaired.

4.5 Factors associated with improvement or failure to improve
Shepherd et al found a marked association (p<0.001) between a child's failure to improve and reported stress in the family (Shepherd et al 1971). The proportion of children suffering family stress was four times as high among those whose behaviour and symptoms had at a 2½ year follow-up deteriorated as among those who had improved.
Very generally, girls do better in treatment than boys (Kazdin 1988) and children respond more positively than adolescents (Kazdin 1988, Kolvin et al 1981, Weisz et al 1987). There are many conflicting findings, however. One recent study suggested that children between the ages of 11 and 13 may respond more positively to cognitive-behavioural interventions than do younger patients. This is possibly because a certain level of cognitive maturity in development is necessary before optimum benefits can be achieved in this kind of treatment (Durlak et al 1991). A few studies, including some clinic-based ones, have shown no effect of age on outcome (Weisz et al 1992).

Neurotic and somatic complaints respond better to intervention than conduct disorders and social problems. Neurotic boys do better than neurotic girls; conversely, girls with conduct disorders improve more than their male peers (Kazdin 1988).
Chapter Five

Medical Conditions in Children
5.1 Introduction
The Anna Freud Centre Psychoanalytic Outcome Study, of which this report is a part, comprises 769 retrospective cases in all. Although much of the preparatory work for this thesis was concerned with detailing and recording the characteristics from the total sample, a major focus of attention was also directed towards a subsample of the whole, a group of children who, in addition to the emotional problems with which they came into therapy, also suffered severe and chronic physical handicaps and illnesses. The unique records generated by the years of meticulous data collection and intensive therapeutic input allowed for unprecedented study of the response of these children to psychoanalytic treatment.

Very little is known about the reactions of physically ill children to psychological intervention. It is, however, widely recognised that emotional and somatic states may, and frequently do, interact, that each may exacerbate or even initiate the other, and that the most fundamental aetiology is often difficult to determine. Furthermore, the interest of psychoanalytic theories in illness and its effects on body image, self esteem and the development of the ego, make chronic physical disorder a particularly fitting item of investigation for a psychoanalytic report.

As a preliminary to looking at the Anna Freud sample itself we will sketch in the context within which physically ill children operate, looking at the incidence of physical disabilities in childhood, the association between physical and psychological problems, the reaction of others and of the children themselves to chronic illness and, finally, taking a brief look at some of the common and specific difficulties faced by these children. This will set the scene for an investigation of our own physically disordered patients who, we speculate, may well identify in significant ways with the general picture painted below of the implications of somatic and organic dysfunction.

5.2 Epidemiology
The reported frequency and incidence of chronic illness and disability among children is heavily dependent on definitions of chronicity, illness and
handicap. Shepherd and his colleagues found that more than half the children they investigated suffered at least minor physical illness or handicap (Shepherd et al. 1971). This is comparable with our own figure of 56.7% for patients with a medical history of some sort. By raising severity level and thus excluding minor ailments and also psychosomatic conditions such as asthma, eczema and migraine, Shepherd’s figures dropped to less than 8%, again corresponding reasonably well with our own findings that although 21% were initially considered to suffer from marked illness or disability, only 10.5% were finally selected as being sufficiently impaired to merit separate classification. Excluding psychosomatic conditions, as Shepherd did, lowers our figure to just over 6%. See Chapter 7 for our policy and methods of selection.

Philip Graham (1985) maintains that 5% of children overall are chronically ill, most commonly with asthma or epilepsy. He makes it clear that his figures exclude mental retardation, learning difficulties and emotional and behavioural disorders; not all studies discriminate in the same way, although Graham’s exclusions seem sensible. Rutter, defining his terms of reference as 'disability which impedes the child in some way in his daily life', estimated that 16.6% (1 in 6) of his Isle of Wight sample, aged between 9 and 12 years, had a chronic handicap (lasting one year or more) of a moderate or severe intensity (Rutter et al. 1970). This includes intellectual/educational retardation and emotional/behavioural problems as well as physical disorders, and thus artificially inflates the number of children affected. Our sample of 4% disability when severity was taken into account and 6% severe chronic illness, both organic and psychosomatic, is pretty much in line with both Graham, and with Rutter’s revised figure of 5.7% of children who were chronically physically disordered (as distinct from experiencing psychological or intellectual problems), either through illness or handicap.

Pless and Roghman’s investigation (1971) found that the only demographic variable to differ between chronically ill and healthy children was gender. There were more boys in the ill sample. Shepherd also found predominance of boys over girls when it came to psychosomatic complaints like asthma and
eczema, especially between the ages of 5 and 10 (Shepherd et al 1971). Our figures support these findings, but only for psychosomatic conditions. In our disabled and organically ill groups the percentages of boys to girls was exactly the same as in the sample as a whole.

5.3 The interaction between physical and psychological states
Our medical cases were taken from a sample of psychiatrically referred children and are, therefore, not necessarily as representative of the population as a whole as are more specifically epidemiological studies such as Rutter’s. This is particularly true for specialist units like the Anna Freud Centre which not only acts as a local child guidance centre but is also used for expert advice when other channels have dried up, or for patients who, for one reason or another, particularly desire or require intense psychoanalytic treatment. From time to time, the Centre also specifically solicits referrals of children in certain interest groups, such as the blind and the diabetic.

A large number of studies have found a significant correlation between somatic and psychiatric illness (Wallerstein 1986). Eastwood and Trevelyan, for example, investigated adult patients and were able to support the hypothesis of a positive association between physical and psychiatric disorder. Fewer subjects in their psychiatric group were free from physical disorder; both major and minor complaints were over-represented. The physical conditions ranged widely over the psychosomatic and organic field, including asthma, eczema, epilepsy and diabetes. Handicaps such as deafness and blindness were not looked at (Eastwood and Trevelyan 1972). This does not mean that there are no potential interactions between sensory and motor disabilities and psychiatric state, though the direction of causality may differ from that operative in other physical conditions. Proving a causal relationship between physical and psychological symptoms is fraught with difficulty (Hall and Beresford 1984); correlational associations are about as far as we can go, though there are several speculative routes along which such an association might proceed.
5.3.1 From the Psychological to the Physical

It is a common observation that physical functions such as sleeping, feeding, elimination and sexual behaviour can be disrupted by psychological stress. This happens at all ages and is often the first indication that something is wrong. Evidence from the Institute of Medicine (1982) suggests that hormonal, endocrinological and metabolic alterations caused by neurophysiological changes (which might be the result of emotional stress) influence cardiovascular, gastrointestinal and immune systems. Individual children exhibit idiosyncratic reactions to stress (Lacey 1950) consistent across different physical and psychological stresses to which the child is exposed. Life events that demand a considerable degree of psychological adjustment from the child may predispose him or her to develop somatic symptoms. Heisel et al (1973) show that twice as many paediatric patients have experienced major life events as would be expected by chance and that these events tend to be more severe than those experienced by well children. These happenings need not be adverse: 'outstanding personal achievement', 'beginning to date' and 'becoming a fully-fledged member of a church or synagogue' are among the items on Heisel's life-events scale. (Holmes and Rahe, the originators of life event measurement, also gave weight to events which, although pleasing and wanted, nevertheless required considerable adjustment). The great deal of research that has looked at the consequences of reaching a critical threshold of life event ratings show clearly that an unmet need to adapt to new situations can result in either physical illness or psychological difficulties, emphasising the truism that human beings are holistic organisms.

Although there is not much evidence for the rôlé of chronic family stress in the aetiology of childhood physical illness (Graham 1985), asthmatic wheezing often clears up when the child is separated from his family (Steiner et al 1982). This holds true not only when the child is temporarily removed from the home, and thus from possible environmental allergens as well as from the other members of the family, but also when the child remains in situ and the parents leave (Purcell and Weiss 1970). The implication that psychosocial factors play a decisive part, not necessarily in the aetiology of
asthma but certainly in its maintenance, is lent further support by the observation that either parents or the patient or both seem to have difficulty recognising or acknowledging any improvement that occurs during this temporary parting. Steiner et al comment that the family seem to need the illness and to adopt an inappropriate attitude towards it, being either over-anxious or excessively casual (Steiner et al 1982). Doctors' counter-transference feelings towards child asthmatic patients also tend to veer towards the extremes of either anger and rejection or over-protectiveness. Is this the reaction to an 'asthmatic personality', or have asthmatics in general learned to adopt similar attitudes in order to cope with the demands of their illness? A later paper by one of the same authors makes the important point that asthmatics are a heterogeneous group and that psychological factors are of variable importance for individual patients (Fritz 1983).

The issue of 'typical' personality profiles for specific diseases and handicaps has been much discussed. Is there a 'blind personality', for instance? On the whole, this assumption has not been supported by the evidence (Thomas 1978), correspondence between soma and psyche being too complex to be able to be encapsulated in such a simplistic way. However, an Indian study by Nigam and Singh found that asthmatic children differed significantly from children with functional disorders, with somatic illnesses and from 'normal' controls on 10 out of 17 traits measured on the Children's Personality Questionnaire. The authors dismiss the possibility that the differences could be reactions to being ill as the asthmatic children's responses were distinguishable from those of children with somatic disorders (Nigam and Singh 1988). But the implication that asthma, as a so-called psychosomatic condition, is linked to certain personality traits, is one that most research is not prepared to make. Cause and effect are particularly tricky to disentangle. As Michael Balint wrote, 'Do sour people eventually get peptic ulcers or does a peptic ulcer eventually make people sour?' (Balint 1971).

If we cannot often go so far as to distinguish the origins from the consequences in the psyche-soma debate, we can at least acknowledge the higher-than-chance likelihood of problems co-existing in both systems.
Compared to 7% of physically well children, 10% of Shepherd's psychosomatic sample, 16% of those with minor physical complaints and 22% of children with major physical illness showed emotional or behavioural difficulties (Shepherd et al. 1971). Other studies have also shown that disabled children fare significantly worse than normals on measures of general adjustment (Wallender et al. 1989).

5.3.ii From the Physical to the Psychological
The existence of a 'sick rôle' has been outlined and described by sociologists and others from Talcott Parsons onwards (Parsons 1964) and longitudinal investigations following children with physical and psychosomatic conditions over many years show how such rôles evolve over time (Thomas 1978). An initial unsettledness gives way to passivity in latency which leads to resistance and independence in pre-adolescence and a later rigidity and compulsion. We might therefore expect that psychiatric diagnoses would also change over the developmental span from, say, early anxiety or habit disorder to depression or social withdrawal in middle childhood, to oppositional defiant behaviour in pre-teens and, subsequently, to obsessive and compulsive disorders. Our sample did not really bear this out but numbers are small and it is not always possible to identify sub-clinical personality traits with caseness levels.

5.4 The reactions of others to illness or disability
Several commentators have suggested that any apparent personality 'type' associated with a specific disability has actually arisen from disturbed parent-child relationships which, themselves, are due to the particular demands of parenting a child with special needs. The interaction between the somatic and the psychological in these cases is more than usually complex. The assumption is that the physical disorder produces psychological effects, primarily in the reactions of significant others which leads, secondarily, to emotional consequences in the sick child. The stereotypical deaf profile of passivity and emotional shallowness, for instance, is presumed by some to be the result of problematic mother-child interactions (Boyd and Young 1981).
Similarly, Mayadas and Duehn found a significant correlation between the expectations of important others and the rôle assumed by the blind (Mayadas and Duehn 1976). Visually-handicapped children have been found to react to their handicap mainly in terms of the reactions of others close to them (Thomas 1978) and this is probably also true of children suffering other disabilities and illnesses. In addition, blind children, aware of their necessary dependence on others often avoid direct expressions of aggression which might antagonise those they rely on. This ostensible inhibition of organised aggressive energy can also lead to exaggerated guilt and fears of hurting (Burlingham 1979). Thus do children with similar disabilities come to be seen to possess similar personality characteristics.

5.4.1 The reactions of the family

The presence of a chronically ill child in the family evokes a variety of reactions from parents and others. Social psychologist David Thomas points out that 'children can be seen as gifts and all gifts have less value if imperfect' (Thomas 1978). Mothers do not respond in the same way to babies born with a congenital handicap as they do to an able-bodied child (Cummings et al 1966). The more the handicap affects the baby's appearance (especially facially as, for example, would be the case with blind babies born without eyes), the greater the mother's reactions are influenced (Wills 1979). Adjustment may be a long process, encompassing many stages similar to those outlined for dealing with grief and bereavement (Graham 1985). Indeed, giving birth to a physically imperfect child is a bereavement (Vas Dias 1990). Acceptance of a handicapped child is specially difficult if he or she is the first-born or if there are no other non-handicapped children in the family (Thomas 1978).

Parents demonstrate a wide range of reactions to handicap and chronic illness (Graham 1985, Thomas 1978) from 'benevolent over-reaction' (Thomas 1978) which perceives the child as more vulnerable than he actually is and tries to overprotect and infantilise him (Green and Solnit 1964) to rejection (either openly or in a disguised fashion), scapegoating and indifference. Most usually, parents are ambivalent, feeling guilty, responsible
and disappointed (Graham 1985). Denial of the enormity of the situation is common and is sometimes difficult to distinguish from more adaptive responses of adjustment. Marteau and Johnston asked the mothers of 193 sick children to rank a list of 11 illnesses in order of severity. There was a strong tendency for mothers of diabetic, asthmatic and epileptic children to rate the condition from which their child suffered as the least severe of all (Marteau and Johnston 1986). This may partly be the result of familiarity versus the unknown but deviance disavowal in parents is known to be very strong in these circumstances (Davis 1972).

Acceptance ideally involves both parents (Thomas 1978) but mother is particularly important. Neuhaus, looking at the relationship between parental attitudes and adjustment levels in deaf children, found that mother's expressed attitude to the child related to adjustment level at all ages. Father's attitude was not a major influence on the adjustment of younger children but became increasingly important as the child reached adolescence (Neuhaus in Thomas 1978). This probably has to do with body image and patterns of self-esteem which change as the child grows up. This will be looked at in more detail below.

5.4.ii The general public
Surveys of the level of acceptance from the general public towards a variety of chronic handicaps and illnesses have found that disorders such as asthma and diabetes, which are perceived as controllable through medical intervention, are among the disabilities most acceptable to others. Sensorimotor or neurological handicaps like deafness, blindness and epilepsy are less well tolerated, though still preferable to mental and learning difficulties (Abrams and Kodera 1979, Lindemann 1981). However, when it comes to intellectual stimulation, the physically handicapped fare least well. Cashden found that normal children have more stimulation than the mentally handicapped who, in turn are better served than the physically handicapped (Cashden 1968). This has implications for IQ level and educational attainment, which is borne out by our findings that the disabled children had a slightly lower mean IQ than children in other physically disordered groups.
5.4.iii The children themselves

Handicapped children's acceptance of themselves is likely to be strongly influenced by their understanding of what is 'normal' in the outside world (Thomas 1978). Thus, children whose illness or disability is acquired some time after birth tend to experience more difficulty in accepting themselves than do children with congenital difficulties whose primary identity through their body image is unchanging (Davis 1972, Shindi 1983). This 'noncategorical approach' to chronic childhood illness (Stein and Jessop 1982) does not deny specific implications that arise from particular handicaps (and some of these will be discussed below) but it places greater emphasis on those 'dimensions that carry across disease categories' (Pless and Roghmann 1971) - for example, whether the disorder is visible or not, whether it is life-threatening or not, whether it is stable or unpredictable. The effects of hospitalisations, separations from parents, operations, absences from school and so on, are also non-specific.

Phantom limb phenomenon offers some support, though evidence tends to be contradictory, to the thesis that congenital or early acquired disorder is easier to assimilate into the self-image than later disability. Most researchers in the area claim that phantoms do not exist for patients who undergo amputation in infancy (Kolb in Earle 1979) and that amputations under the age of 2 can be successfully accepted into the body image. However, a recent article maintains that phantom limbs exist even in children who are born with congenital deformities (Melzack 1992). This, together with the fact that, where phantoms are uncontroversially recognised as existing, the sensations disappear in the reverse order to that in which a body image is built up during childhood (Earle 1979), suggests the existence and importance of an unconscious postural model for the body (Schilder 1935). Indeed, one study reported that the content of every single response of amputees to the projective Rorschach test (Earle 1979) contained anatomical structures of the body. This has been interpreted by

---

29 Though Shirley Hoxter believes that the congenitally handicapped have a deep sense of shame, a 'feeling of there being something unmentionable [which], in my experience, is not present in those whose disabilities have been caused by road accidents' (Hoxter 1986).
psychoanalytic commentators such as Mahler as suggesting that the permanent trauma to the integrity of the body triggers some form of permanent feedback to castration anxiety.

5.5 Coming to terms with chronic disability
David Thomas (1978) lists three major stratagems by which deviancy of any sort is accommodated. If the handicap is invisible and containable, such as diabetes or asthma, the child may be able to pass as normal. This fits in with the findings mentioned above that such disorders are well tolerated by those around the child. The forfeit for such dissimulation is increased social anxiety as the child never knows when his persona of normality will let him down (Shakespeare 1975).

The second tactic is 'normalisation' which is practised by children whose problems are too visible or acute to allow them to 'pass as normal'. The sensory-impaired, for example, may be tempted to rationalise their limitations, to make light of the disability, to normalise their situation. The problem with this is that the wider world is often unsympathetic to such attempts and, as the child comes into contact with his peers, whether disabled or not, it becomes obvious that attempts to minimise the differences are often little more than whistling in the dark. In fact, there is excellent anecdotal evidence to demonstrate that the blind child comes only gradually to a realisation that other people possess a faculty he lacks (Burlingham 1979). And the same seems to hold true across other disabilities and in comparison with other handicapped children. Minde and his colleagues note that when disabled children start school, the realisation that the older pupils haven't 'grown out' of the disability as the fantasy dictates, but are still reliant on wheelchairs, hearing aids, white sticks etc, takes about a year to sink in and leads to depressive reactions in most children before a gradual emotional readiness to accept their situation (Minde et al 1972).
The third alternative for accommodating physical disability is **disassociation**. The child (and parents) simply withdraw from the outside world, refusing to face up to situations which underline the existence of the handicap.\(^3\)

The totally disabled tend to adapt more easily than the partially handicapped. Blind and deaf adolescents in France and America were assessed as being better adjusted than age-mates with partial sight or hearing (Shakespeare 1975). This can be explained in terms of the impossibility of 'passing as normal' for the more severely handicapped and the necessity to find other, probably more adaptive, ways of coming to terms with the situation. A large number of chronically ill children are also 'both well and ill at the same time; living but with a potentially fatal illness' (Winkley 1990). This comment, made with regard to children needing renal dialysis, is equally pertinent to the asthmatics, epileptics, haemophiliacs and diabetics of our sample. It is easier (though less beneficial) for them to disavow their difficulties, to enter into a state of both 'knowing and not knowing' (Hoxter 1986). This position of co-existent negation/denial and acknowledgement is familiar to psychoanalytic writers. 'Je sais bien,' wrote Octave Mannoni (1964), 'mais quand même....' It creates a complex, ambivalent tension, fruitful soil for the growth of maladjustment.

### 5.6 Unconscious reactions

Parents' reactions to their disabled child are often not consciously expressed, or even consciously recognised. Indeed, the psychoanalytic view emphasises unconscious anxieties and phantasies which can exert enormous influence with regard to body image and related issues. Winnicott pointed out that the child may suffer greatly from his mother's **unconscious** fears about his health and integrity (Winnicott 1958). He maintained that one of the mother's responsibilities was to act as a protective shield for her child against

\(^{3}\)There are several important differences between families who practise 'normalisation' and those who 'disassociate', including the extent of the handicap, the age of the child, the presence of sibs close in age to the index child and general family life style (Davis 1972).
overwhelming psychic or environmental trauma. But physical illness and physical handicap tend to mitigate against the possibility of calibrating increasing doses of reality in line with the child's developmental potential. Psychoanalyst Masud Khan sees physical disability as leading inevitably to consistent failure on the part of the mother, however well-intentioned she may be towards her child, to adequately fulfil her function of protecting against 'cumulative trauma' (Hoxter 1986). Trauma, in this context, refers to any experience which cannot easily be integrated into the personality (op cit). It is a psychic insult, an affront to the individual's sense of being, something that is felt to be so dangerous that to recognise and accept it as part of oneself risks 'either complete devastation or fragmentation of the ego or in its being overwhelmed by the portion which was early spilt off and which is dominated by trauma' (Freud 1940).

5.7 Self-esteem and the development of the ego

It is no wonder, then, that self-esteem and an integrated view of the self is lower in handicapped children than in their non-handicapped sibs (Harvey and Greenway 1984). A combination of the parents' fears and anxieties concerning the child and the particular difficulties of evolving a body image from disability with which one can be proud to identify leads to almost formidable problems for the chronically ill or handicapped young person. The 'looking-glass self', a sociological term referring to the image of self acquired from the reactions of others (Davis 1972) has special pertinence with regard to the chronically physically ill and handicapped. This view that the body image is built up through social contacts and sculpted by interaction with others implies that if interpersonal relationships are flawed in any way (and, as we have seen, this is very likely to be so for the ill or handicapped child), defects or inadequate development in body image will result (Schilder 1935). One of the most powerful determiners of self-concept is the reaction of others to the individual (Garner 1981).

Psychoanalytic theory teaches that the origins and aims of libidinous energy, whether advancing, diverting or fixating, are constantly being modified in line
with the exigencies of psychosexual development. Body-image is continually being redefined as, at different stages, varying amounts of narcissistic libido attach to different parts of the body. Certain body areas, notably the face, eyes, mouth and genitals which are particularly cathected by libido (Schilder 1935), are, therefore, more significant than other parts of the body in helping to determine body image. As Phyllis Greenacre observes, none of these most meaningful areas can properly be viewed on oneself, which helps to explain why others' perceptions, reactions, acceptances and rejections are vital for the construction of a viable self-image (Greenacre 1958).

Freud regarded body-image as fundamental to ego development. 'The ego is first and foremost a bodily ego' he stated in *The Ego and the Id* (1923). Body-image provides the framework within which the ego is able to evolve to the extent that the originally undifferentiated and primitive id-organism acquires both organisation and structure. The ego, then, is ultimately derived from bodily sensations, which are more central in the infant's life than they will be for the resultant adult. Joan Rivière aptly describes the ego as a 'mental projection' of the surface of the body (Lichtenberg 1983).

The emergence of the self is generally put somewhere between the second and fourth year of life (Herbert 1974), conditional on a certain cognitive level having been reached (Lichtenberg 1983). What Lichtenberg calls the 'self-as-a-whole', an increasingly ego-directed entity, is an emergent property, qualitatively different from the 'self-in-action' that went before. Some theorists regard the young child's actions which, successfully achieved, lead to 'competence pleasure' (op cit), as the basis for a stable sense of self. This has obvious implications for the handicapped whose motility may be severely

---

3"This is the view of the instinct-psychologists. Ego-psychologists, such as Hartmann, take the line that 'the newborn infant is not wholly a creature of drives', possessing a primitive ego from birth (Hartmann and Kris 1945). Melanie Klein also postulated an early, rudimentary ego constructed largely from psychic phantasies about objects being located inside or outside the organism. She differs, therefore, from the genetic school who assume that the object is real, whether gratifyingly present or frustratingly absent. For Klein, real experience maps onto phantasy: Reality factors are always distorted by inner emotions such as envy."
restricted and whose experience of efficacy is so often severely limited in comparison with their able-bodied peers.

Language acquisition, which brings with it the potential for representing experience symbolically, may be the biggest single influence in bringing to an end the autistic/symbiotic stage of ego-development (Lichtenberg 1983, Smirnoff 1971). But, in certain circumstances and for certain categories of children, language may constrain as much as it frees. Burlingham (1965) believes that, for the blind child, learning to speak may exacerbate his problems. He is not taught words which enable him to describe the dominant experiences in his life - tactile perceptions, body sensations and so on. He has to acquiesce to a consensual meaning of language with which he cannot fully identify. This increases the risk of withdrawing from the world into fantasy and pretence. Ego development for the blind may deviate from the route that is commonly followed. They may achieve goals of maturation at a different pace to the sighted.

It is, of course, not only blindness that challenges ego development and the evolution of a satisfactory body-image. Physical illnesses, defects and injuries of all kinds buffet the ego and render it more vulnerable to regressions and distortions. Freud and his successors have shown that we are all narcissistically invested in the integrity of our own body and have 'an instinctive knowledge of wholeness' (Judd 1990). Adler's concept of 'organ inferiority', the Jungian idea that the individual perceives his body as a 'mandala', a protective container, Winnicott's notion of the skin as a 'limiting membrane' - all these and more point to the concern with the phenomena of body-image in the most diverse branches of psychoanalytic thought (Fisher and Cleveland 1968). The bodies of the ill and disabled are very unreliable defences against trauma. For example, a diabetic child who has to receive daily injections of insulin cannot possibly perceive his skin as capable of fending off insult and environmental impingement (Watson 1990).

The occurrence of pain, too, dramatically affects body-image. In paradoxical addition to the tendency to isolate the painful area of the body and to form a
body-image which excludes that part, the painful region is magnified in importance, receiving greater attention than the rest of the body (Schilder 1935). Such bodily distortions help to explain the link between poor body image and difficulties in spatial and arithmetical tasks, including left-right differentiation, which has been found by a number of studies (Fisher and Cleveland 1968). This lends support to the thesis put forward by Seymour Fisher, among others, that a relatively intact body image provides the necessary starting point for the acquisition and performance of a number of skills and abilities (1970).

All these inevitable consequences of chronic physical disorders result in the lowered self-esteem, feelings of damage and negative self-references which are common to all diagnostic groups of chronically ill or disabled children (Garner 1981, Thompson et al 1990).

Making valid empirical test of many of these theoretical assumptions about ego development and its relation to chronic illness runs up against problems in operationalising concepts sufficiently stringently; few experimental verifications have therefore been attempted. An exception is an investigation by Silver et al which sets out to compare the effects of chronic illness on 'the psychological growth process known as ego development' in teenagers. Ego development stage was, with debatable validity, assessed by subjects' responses to Loevinger's Sentence Completion Test. The authors found no direct association between these scores and the presence, severity or duration of chronic illness. However, although chronic illness of itself did not seem to affect the level of ego development, the results did show that greater illness severity together with high verbal ability adversely affected ego development. This is possibly due to greater frustration experienced by young people of high intelligence who are subjected to the constraints and limitations of a severe illness (Silver et al 1990).
5.8 Common problems

It was mentioned earlier that chronically ill and disabled children have a great many commonalities, regardless of specific diagnosis. Before taking a look at some of the particular problems of being, say, blind or diabetic or asthmatic, we will first glance briefly at some of these shared experiences which have possible implications for subsequent psychological health and, thus, for ego development too.

5.8.1 Separations

Chronically ill or disabled children run an increased risk of mother-child separation and all its corresponding implications (Rutter 1975, Rutter 1971, Shepherd et al 1971), because of their increased need of specialist hospital treatment, one of the commonest causes of extended parent-child separations (Wolkind and Rutter 1985).

5.8.ii Hospitalisation

In the United Kingdom, approximately one in three children will be admitted to hospital at least once during the course of their childhood, and 5% will have multiple admissions (Douglas 1975, Quinton and Rutter 1976). Table 5.1 shows the number of hospital admissions experienced by our Target (T) samples of ill and handicapped children and their Control groups (C). The mean Control percentage (15%) of children who have been in hospital is necessarily lower than figures which refer to the entire span of childhood. Many of our Control children may yet experience a hospital admission at some point during the remainder of their childhood. By the same token, however, the 47% of ill and disabled children who, by the time they were referred for psychiatric treatment, had been in hospital, is also likely to rise. Children with physical disorders are thus seen to be much more likely to be admitted to hospital than could be expected by chance. Multiple admissions experienced by 3.7% of our Control groups, were the lot of 25% of the

32^The definitions of the three Target categories, Disabled, Ill and (Psycho)Somatic, and the procedures for assigning children to these groups and to the Control groups, is set out in chapter 7, section 5.
<table>
<thead>
<tr>
<th>N° Hospitalisations</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>1</td>
<td>22</td>
<td>13</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>&gt;1</td>
<td>31</td>
<td>3</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>Total % children with hospital experience</td>
<td>53</td>
<td>16</td>
<td>64</td>
<td>18</td>
</tr>
</tbody>
</table>

*Table 5.1  Child Hospitalisations*

*Key:*

T=Target group;  C=Control group;  Somatic=Psychosomatic
Target children, the fraction rising to about a third when psychosomatic (Somatic) conditions were excluded.

The significance and consequences of hospitalisation are somewhat unclear. Chronically ill children do not, in general, seem any more likely than children with acute illnesses to become disturbed by entering hospital or undergoing surgery (Wells and Schwebel 1987) but they do, as seen above, have more such experiences than do able-bodied children which makes them susceptible to accumulated effects and increases the likelihood of encountering adverse experiences from time to time.

Although the subsequent risk of long-term psychosocial disturbance following a single admission is relatively small, multiple hospitalisations beginning in the pre-school years (a situation much more likely to be experienced by those children contending with chronic physical conditions) increase the risk of later emotional or behavioural disturbance (Rutter 1975). This need not be a direct effect of hospitalisation, parental separation or surgery: it is difficult to isolate factors and control for all the variables and some research (eg Martin 1970) has clearly suggested that children who present frequently at hospital are not a random selection from within their own diagnostic categories. Nevertheless, the association remains.

Furthermore, temporary adverse reactions are the rule rather than the exception. Stacey et al, following 4 year-olds who entered hospital for tonsillectomies and adenoidectomies, concluded that 83% of children regressed in level of functioning during their hospital stay. This was mostly shown by sleep disturbances, tantrums, crying and general naughtiness. About one third of the children did not improve in the 6 months following discharge. Boys were specially vulnerable (Stacey et al 1970). Psycho-analytic theory would explain this as an artefact of Stacey’s sample: the high level of castration anxiety experienced by 4-year-old boys in the throes of the phallic-Oedipal stage of development would be exacerbated by invasive surgery. But Rutter, noting that the extent of psychological disorder is higher in boys than in girls, suggests that males of all ages are probably more
affected by unpleasant separations such as hospital stays. He cites cross-
species evidence in support of this thesis (Rutter 1975). The longer the stay,
the more likely it is to produce behaviour difficulties after the child returns
home (Shepherd et al 1971).

Age is another crucial factor to be taken into account when looking at
reactions to hospital admission. The full syndrome of protest leading to
despair which, in turn, results in a maladaptive detachment, was first
formally noted by John Bowlby (1953) and has since become widely
recognised and accepted. This is most likely to occur and, when it does, is
most marked, between 6 months and 4 years. Separations for children at this
age are probably perceived as a threat to the child’s secure attachment. The
specific focus of anxiety changes with age. For the pre-school child the
overall hospital experience is frightening. This continues into the 5-10 year
age groups as well, though 5-7 year-olds have additional particular fears of
operations and needles. Children aged 7-10 show heightened apprehension
of operations and narcosis which continues into early adolescence (Jessner
et al 1952).

Bowlby’s opinions were part of a large body of psychoanalytic theorising. He
shared the point of view expressed by Anna Freud that hospitalisation is a
serious matter for children because it not only confronts them with a series
of new experiences and challenges but also separates them from the 'rightful
owner of his body' (the mother) at the same time as it is threatened by both
internal and external dangers through illness or disability (A. Freud 1952).

Psychoanalytic clinicians - Anna Freud, Bowlby, the Robertsons and others -
did a great deal to improve the lot of hospitalised children, though, despite
the recommendations of the 1959 Platt report which drew on evidence from,
inter alia, James Robertson that the separation of young children from their
parents while in hospital was likely to lead to emotional disturbance, changes
were often slow to be implemented and Stacey et al found little difference
between the situation of the 1950’s and that in the middle years of the 60’s
(Stacey et al 1970). Nevertheless, improvements were eventually made, and
it is probably the case that the impact of hospitalisation on our medical samples was greatest in the first half of the time span of our study, the 1950s and 1960s. However, despite the better conditions for hospitalised children over the past decade or two, conscious and unconscious fears remain. A child cannot be fully protected against fears of anaesthesia, assaults on the integrity of his body and perceived lack of parental protection from pain and violation. Hospitalisation is a difficult experience for most children and our medical samples faced it more often than other children.

5.8.iii Operations
The physically-disordered children in the Anna Freud study had not, rather surprisingly, experienced significantly more operations than children without chronic conditions. Although the successful undergoing of an operation can potentially be a constructive experience for a child (Jessner et al 1952), stressful experiences, such as surgical operations, in the first five years of life may interfere with the natural development of maturational behaviours such as bladder control (Rutter 1975, Kolvin et al 1981, Douglas 1975).

5.8.iv Restraint
One of the factors which affects psychological adjustment to hospitalisation is the amount of sensorimotor restriction which the child has to endure (Graham 1985). Many ill and disabled children will have experienced either mechanical restraint (traction on deformed limbs or the restrictions of blindness and other sensory disabilities) or the psychological restraint on spontaneous activity dictated by diseases such as haemophilia, diabetes and epilepsy. Excessive restraint is known to heighten aggression (A. Freud 1952) and, sometimes, to artificially accelerate ego skills.

Besides these common medical experiences which cross the divides between medical categories, there will be further correspondences within groups and, of course, diagnostic-specific similarities as well. We will now look at each of our three medical samples separately.
5.9 Disabled Group

David Thomas defines disability as the 'lack or loss of a function or a capacity' (Thomas 1978). Our disabled group was made up of the blind and partially sighted, the deaf or hard-of-hearing and those with other disabilities, mostly limb deformities. The following section concentrates on the difficulties and challenges of ego development for those with sensory defects. This is primarily because blindness and deafness are disabilities which can grossly affect social relationships and, thus, ego development, to an overwhelming extent. This is not to deny or minimise the problems faced by other disabled children; much of what has already been said about chronically-affected children in general, and much of what is to be said about specific disabilities, applies also to them.

Sensory disability is 'deviant' because it affects the reciprocity of social exchanges. The blind, for example, cannot take part in encounters regulated by what Goffman calls 'the unique sociological function of the eye' (Goffman 1963) and the deaf are socially penalised in a similar way.

5.9.1 Deaf

The role of hearing is a central factor in early ego organisation. The ear may act as a probe to enable the baby to extend the boundaries of the visible world and thereby to acquire important information for the formation of ego and superego (Rutter et al 1970). It has been suggested that the baby's identification of the mother's voice, which is reliably discriminated from other voices by 4 weeks of age even in the absence of visual contact, is the earliest demonstration of ego function and psychic organisation, predating even the importance of facial configurations (op cit). The adverse implications for deaf babies are obvious.

As the deaf baby grows up, its problems are compounded. Pre-linguistically deaf children are often slow to learn how to self-regulate on moral and social issues because they have not heard, and therefore not been able to internalise, earlier parental regulatory words (Thomas 1978). Many don't belong to playgroups or the like where they could benefit from the corrective
influence of peers. In addition, parents of deaf babies may deny the baby's handicap for longer than is possible with a blind or limb-affected child. If the delay in obtaining appropriate specialist help is extended beyond the critical time for language learning the child may suffer irreversible social and educational disadvantage (Boyd and Young 1981). One study, confirmed by subsequent replications, found that only 14 out of 321 deaf school leavers had reading ages that matched their chronological age (Rutter and Hersov 1985).

Distorted body image and a failure to internalise appropriate male or female roles are also major problems for the deaf child (Thomas 1978).

5.9.ii Blind

In contrast to deaf children, the socialisation of the blind is usually very successful (Thomas 1978), probably because lack of sight does not affect language skills though, as we saw above (page 119), verbal descriptions are predominantly of visual perceptions and, if the blind child can find no words for his essential tactile, auditory and internally-sensate experiences, he runs the risk of becoming isolated, withdrawn and alienated from the world around (Burlingham 1965). And without the opportunity for pre-linguistic deciphering of the human face, vocal symbols may lack the significance they hold for sighted children (Lichtenberg 1983). But, overall, the blind child's difficulties lie elsewhere than with language.

The blind child's immediate environment is restricted to what is within hand-hold or ear-shot. This can lead to excessive preoccupation with his own body and to an extended period of egocentricity in Piagetian terms resulting, possibly, in a limited capacity to view events and social relations from another's perspective. The blind are not able to learn how to fulfil various rôles by observing and imitating as sighted children can.

Acoustic and tactile sensations are not as stimulating and as arousing as visual perceptions (Greenacre in Burlingham 1965) and the child's caretakers need to teach the child to reach out to the environment. For the blind,
making contact with the world around involves a high level of concentration on sound. This requires a certain amount of immobility and 'attentive stillness' (Boyd and Otos 1981) which, if mistaken for passivity and unavailability as so often happens, can make difficulties in the mother-child relationship (Wills 1979). It is specially unfortunate that the young child should need to remain still in order to listen intently at the very stage where motor development would normally be expected. The blind have to constantly curb the natural desire of children for action and movement (Burlingham 1965, Burlingham 1979, Boyd and Otos 1981). This may lead to over-control in ego development as emotionality and hyperactivity result in loss of orientation. Memory, concentration and self-control are essential for the blind child to retain a sense of where he or she is in the environment (Boyd and Otos 1981).

For some psychoanalytic commentators the relation of vision to touch and orality is the most consequential moment in the establishment of the body image (Greenacre 1958). Lacanians and others attach profound significance to the concept of mirroring (seeing oneself in the gaze of others), believing that this leads to a perception of bodily unity and, by extension, to an understanding of the unity of the self. The blind child has to retain the mother as an auxiliary ego for longer than is needed by other children (Wills 1979) precisely because of the difficulty in acquiring both object permanence and a firm sense of the relationship of self and others in the world.

Even researchers who do not fully share this psychoanalytic perspective agree that the absence of visual feedback must have far-reaching consequences for body-image (Thomas 1978) if adequate substitutions are not made. That lack of visual feedback can be compensated for was demonstrated by Tom Bower who set up an experiment to provide a blind child with auditory cues which allowed him to scan the world around him, using sound, in much the same way as a sighted child uses vision as its dominant sensory modality from about 5-6 months of age. This blind baby developed in parallel with his sighted peers in terms of acquisition of such functions as object permanence (Lichtenberg 1983).
5.10 Ill Group

Adherents of psychoanalysis claim that life-threatening chronic illness in childhood has major implications for ego development and body image, especially if the physical insult takes place in phase with the maturing of the ego. Even later illnesses can affect the ego's functioning (Kavka 1962). The 'maximum developmental insult' (Sarvis 1960) that can be imposed by illness is interference with one of the stages of psychosexual development and its associated cathected zone. For example, food allergies that arise during the oral stage or bowel disease during the anal stage are particularly noxious impingements on the body and the maturing ego.

Organic disease fundamentally changes the body image (Schilder 1935), partly directly by stimulating abnormal sensations in particular parts of the body and partly indirectly by subjecting the child to, for example, insulin injections, continual doses of medicine, hospitalisations and surgery, all of which are liable to provoke unconscious phantasies of attack, violation, impregnation and poisoning. Organic dysfunction is associated with slightly higher rates of emotional and behavioural problems in children (Rutter 1975) and with increased reading difficulties (Shakespeare 1975). The interaction between damage to brain tissue, as may be the case in epilepsy, and damage to self-esteem and the ego is complex. Illness affects the child's concentration and motivation both by making school absences more likely and restricting social relationships and physical activity, and also by diminishing self-esteem and levels of self-confidence. Both organic and psychiatric dysfunction are thus intermingled in the effect on ego functions such as school performance.

In addition, some studies have recorded a higher number of life stresses for children with psychological problems and with certain physical disorders than for children in general (Rutter 1975). Chronically ill children thus have a great many more challenges to overcome than their physically well peers.
5.10.1 Epilepsy

Epilepsy is the result of abnormal cortical discharge which may be caused by a variety of stimuli. It is characterised by irregular and unpredictable attacks during which the sufferer may lose control of motor, sensory and autonomic bodily functions. It can be controlled, to varying extents, by medication. Much early onset epilepsy remits, but one in four cases persists to become a chronic lifelong condition (Graham 1985). Adult mortality is about 10% and there are also a number of undesirable side-effects from the aggressive medication needed to control fitting.

The uncertainty of predicting when a fit will occur creates a constant background of psychological stress. This is exacerbated by the apprehension and anxiety at having one's non-visible handicap humiliatingly exposed to public scrutiny. Epileptics report that the reactions of others to seizures is more stressful than the medical condition itself and sufferers sometimes put themselves at unnecessary risk by withholding information about their illness to prevent embarrassment and misperception (Terdal 1981). 'The handicap shaped by social pressure may be far out of proportion to the medical condition itself' reports Leif Terdal who reminds us that medication allows most epileptics to lead seizure-free lives (op cit).

The stresses are probably greatest for child sufferers. The initial shock of diagnosis is compounded by the unfamiliarity of the condition and a high level of uncertainty about future implications and prognosis. The factor of greatest import, however, is central nervous system involvement which may lead to a variety of behavioural and emotional disorders. A number of findings have shown that children with chronic epilepsy are significantly more disturbed than other children (Hoare 1984, Thomas 1978), even than those with other chronic conditions such as diabetes. Child psychiatrist Philip Graham quotes figures showing that psychiatric disturbance in epileptic children is five times higher than in the general population and 3 times higher than children with chronic illnesses not involving the brain (Graham 1985).
In one study, 56% of epileptic children were assessed as having behavioural problems; the same percentage had educational problems. Only one in 4 had no problem additional to their illness. Cognitive deficits and various types of learning difficulty were widespread (Graham 1985). All 4 children with epilepsy in our sample had major school problems, supporting these findings. Such extensive educational disorder is multi-determined. Children with petit mal may experience anything up to 100 micro-seizures a day, leading inevitably to loss of concentration. In addition, hyperactivity and associated reduction of attention span is a frequent side-effect of inhibition-suppressant anti-convulsant medication (Rutter et al 1970).

Onset of epilepsy between 5 and 10 years is specially liable to lead to psychological complications, with high incidences of later personality disorder, aggressive behaviour, in-patient treatment and psychosis (Terdal 1981). Again, all 4 epileptic members of our sample conformed to these parameters. One was autistic, two had pervasive developmental disorders, one with an organic personality disorder as well, and the fourth had a number of diagnoses including Attention-Deficit/Hyperactivity Disorder (ADHD) and conduct disorder.

The combination of epilepsy with a disturbed family background places the individual at very high risk of psychiatric breakdown (Terdal 1981). In our study all 4 epileptics had experienced above-average family difficulties. One, who had had frequent changes of caretaker was living, at referral, in a specialist unit. Another had a violent, unpredictable schizophrenic father, now leucotomised and resident in a mental hospital. This child had had 3 fostering placements, all of which had broken down. The third child had also had many changes of primary caretaker and was now living in an autistic unit. Father had a history of personality disorder and violence. The fourth child had been evacuated during the war while father was away in the services, and had also spent an unhappy period in a open-air school. This child, on the surface the least disrupted, was the one diagnosed with Pervasive Developmental Disorder (PDD) and personality disorder. After 9 years of analysis, one of the longest periods of treatment in the whole
sample, he emerged unhelped and unchanged. With such familial factors to cope with in addition to the epilepsy and other diagnoses, both physical and psychological, it is difficult to disentangle the factors most responsible for the finding that epileptics have particularly poor psychological prognoses.

5.10.ii Diabetes

Diabetes is the most common childhood disorder and its prevalence continues to increase. It is a chronic unremitting disease lasting an entire lifetime with serious later complications such as blindness, renal failure and cardiovascular disease (Garner 1981). Many diabetics have low self-esteem, feel damaged, are overanxious and depressed and exhibit oral preoccupations (not surprisingly as the clinical foci of attention centre around eating, drinking and excretion). Diabetes has a genetic basis but onset may be triggered by a variety of factors including obesity and emotional stress (Garner 1981).

Patients suffering from badly-regulated brittle diabetes with its constant episodes of hypo- or hyper-glycaemia are among those most likely to be referred for psychological treatment. It is thought that psychogenic factors play a large part in such management difficulties (Fonagy & Moran 1993, Tattersall 1981). The relationship between clinical and psychological state in diabetes is open to debate but there is evidence to suggest that families in which children are well in control of their diabetes are more likely to be emotionally open and expressive whereas diabetic children in families who habitually deny their feelings are less likely to be able to control their illness satisfactorily (Garner 1981). This is only a correlational association; it is always difficult to determine direction of causality in such cases.

Clinicians such as Minuchin working with families of diabetics have found relatively low scores on ratings of marital functioning (Minuchin et al 1975) although the four families of diabetics in our sample did not confirm this. However, all four of our mothers were anxious and/or depressed which tends to support the claim that maternal attitudes are crucial for the well-being of the diabetic child and that the mothers' initial adjustment to the child's
diagnosis strongly predicts the child's long-term emotional symptomatology (Kovacs et al 1990).

5.10.iii Haemophilia
Haemophilia affects 1/4000 males. It is usually transmitted through the mother's genes although about one in three patients are apparently chance mutations, showing no previous family history (Lindemann 1981). Unusually, the father is thought to play a more important rôle than the mother in helping his haemophiliac son to emotionally adjust to his illness. Common psychological difficulties include low self-esteem, delay in masculine identification and a general prolonged immaturity (op cit). The one haemophiliac in our sample was too young, at 3 years, to assess for any of these manifestations.

5.11 Psychosomatic Group
Schilder maintains that organic disease, such as epilepsy, diabetes and haemophilia, is perceived by the patient as peripheral to the ego rather than holding the central place with respect to the personality that functional illnesses like asthma and eczema occupy. Organic disease is understood in his view as a foreign body, an enemy alien, whereas functional disorders are 'connected with the innermost problems of the individual - with the centre of his Ego' (Schilder 1935). Psychoanalyst Mary Sarvis agrees that, although handicap and organic illness may be the object of embarrassment or shame, they are not subjected to neurotic repression and distortion in the way that psychosomatic disorders can be (Sarvis 1960). Our observations above that chronic disability and illness have major implications for the ego's development is not disputed by psychoanalytic writers like Schilder and Sarvis. The point they are concerned to make is that certain physical disorders may be termed psychosomatic on the grounds that psychological factors play a much more decisive role in their causation or maintenance than is the case with purely organic conditions.\(^{32}\)

\(^{32}\)Nevertheless, psychosomatic is not a synonym for psychogenic. Aetiology is varied and, frequently, over-determined.
Psychosomatic patients have been described as neurotics with a particularly characteristic lifestyle, defences and coping mechanisms (Bastiaans 1977). They habitually project onto the world the fiction of being well-balanced and mentally healthy. The increased stress that goes into maintaining this attitude results in the bodily symptom that becomes the focus of attention (op cit).

Generally, the various therapies have been more effective in the treatment of psychosomatic disorders than they have been with more straightforward neurotic complaints (Malan 1973), although family therapist Salvador Minuchin and his colleagues have sounded a note of caution. They warn against conflating the undoubted progress in 'interpreting the mediating mechanisms whereby emotions cause bodily changes' with therapeutic effectiveness which, they say, has not increased to the same extent (Minuchin et al 1975).

However, this may simply reflect the shortcomings of one particular treatment approach and certainly psychoanalysts would not necessarily hold such a pessimistic view. Psychoanalysis has often been cited as the treatment of choice for the chronically psychosomatically sick because it offers deeper, more radical, opportunities for change which needs to be fundamental enough to be adopted into the structure of the personality and thereby retained outside the clinical setting, in a way that family therapy and other treatments may fail to do. The Dutch psychiatrist and psychotherapist Jan Bastiaans, for example, has noticed in his own psycho-analytic psychotherapy practice that a noticeable alleviation of the psychosomatic symptom occurs as soon as the patient becomes able to express his hitherto unconscious aggressive phantasies (Bastiaans 1977). An early series of studies by French and Alexander (1941) reported a substantial improvement in bronchial asthmatics treated with long-term psychoanalytically-oriented psychotherapy, as have subsequent studies carried out in the 1950s and the

---

34Often, but by no means always. Mayer-Gross, Slater and Roth in their authoritative textbook on clinical psychiatry state that 'the psychoanalytic interpretation of psychosomatic disorders is, of all applications of Freudian theory, the least satisfactory' (1961).
This is not to downplay the insights that systems models used in family therapy have given us. The suggestion that children's psychosomatic symptoms play a major role in maintaining family homeostasis may help to explain our own finding that the percentage of broken families was lower in the psychosomatic sample than in the other groups, even though incidence of marital difficulties was no different. Equally useful is Minuchin's conceptual model of the type of family interaction that most encourages the onset and/or maintenance of somatic processes in the child. An over-invested, over-protective, rigid family with little or no ability to satisfactorily acknowledge or resolve inter-familial conflicts may use an already physiologically vulnerable child in its overall pattern of conflict avoidance (Minuchin et al 1975). The child becomes the one on whom attention is focused, leaving more fundamental and 'dangerous' issues in abeyance. However, as Backman's work has shown that a child's asthma may itself threaten the intra-familial balance, provoking anxiety both within and outside the family (Backman et al 1981), we are reminded that the direction of causality is difficult to infer and, in all likelihood, operates in both directions.

(Given that families with psychosomatic children appear to have such high levels of conflict avoidance and an unconscious desire to retain the illness for their own purposes, we would not expect a great many of them to bring their children for psychotherapeutic treatment. It needs, therefore, to be borne in mind that those in our study who have accepted the offer of very intensive and invasive therapy may be atypical along important dimensions).

It is regarded as especially important to treat psychosomatic disorders in children before they become a 'fixed and difficult-to-eliminate structure of adult life' (Gaddini 1977). In addition, psychosomatic illnesses, especially asthma, are among the commonest causes of absence from school (Herbert 1974) and this leads to all sorts of secondary difficulties for children. Because childhood development has biological roots, the baby's psycho-
logical needs are at first difficult to differentiate from biological, life-preserving essentials. Food, warmth, protection and support are somatically organised in the neonate before acquiring later psychical representation in the maturing infant. As development proceeds, bodily and psychological needs begin to be felt as separate but the split is never more than partial. For the purely (or mainly) biological infant, physical and material deficiencies can easily become psychological deficits.

Many psychoanalysts are of the opinion that psychosomatic conditions rank high among the vulnerabilities to illness and physical injury caused by early mother-child disturbance (Green and Solnit 1964, McDougall 1974), as the psychosomatic child uses the symptom to communicate with the mother, trying to develop a bond with her that has not been created psychologically. (It is important to note that such disturbance need not be gross and objectively obvious. It is enough that the baby’s subjective perceptions of the situation cause him or her to react as though he or she is insufficiently nurtured.) Individual children can, of course, only create those symptoms that correspond to their level of psychological development. The skin (the bodily organ affected by eczema), and the respiratory apparatus (affected by asthma), are among the earliest cathected body parts, together with the mouth and the eyes (Gaddini 1977). A long-term approach is indicated if one accepts the premise that the disturbance arises from early mother-child interactions.

5.11.1 Asthma

Asthma has been described as 'the psychosomatic condition par excellence' (Thomas 1978). A number of studies have failed to reveal a particular personality type for asthmatics although there is anecdotal evidence of an association between specific psychosomatic illnesses and the patient’s

---

36Our language testifies to the fact that even adults retain a psychological need for the same aspects of being which were once entirely physical, seeking out relationships with people who are 'warm' and 'supportive'.

36Digestive problems, rumination, psychogenic vomiting and squinting are other frequent psychosomatic symptoms, not dealt with in the present study.
predominating attitude to life. The profiles of the 'typical' asthmatic tend to vary from study to study (Herbert 1974) but high levels of maladjustment and dependency are commonly reported.

Physically, asthma is an 'inborn lesion causing hyperactivity to the bronchi' (Graham 1985), but there is both experimental and clinical evidence to suggest that psychological factors can influence pulmonary function in asthma either adversely or beneficially (Knapp 1977). It is probable that genetic and biological components are implicated, compounded in many instances by emotional conflicts. Kelly and Zeller put forward considerable evidence for the contribution of psychological factors to the precipitation of asthmatic attacks (Kelly and Zeller 1969).

A general assertion within the body of Freudian theory that asthma is related to pregenital fixation has been empirically tested in a number of studies including one by Seiden (1965). He administered the Blacky pictures to a sample of asthmatic children to determine whether the age of onset of the attacks was related to the child's predominant fixation level. Forty-five children were divided into three groups defined by age of onset at either the oral, anal or phallic stage of development. Freudian theory was supported to the extent that each group showed most conflict in the psychosexual area related to the age of onset of attacks and subsequent studies also have implicated developmental factors in asthmatic aetiology (Kline 1981b). However, cause and effect are often poorly distinguished. Acquiring asthma may be sufficiently traumatising to focus fixation and regression onto the particular developmental phase in which it arises. In addition, none of the experimental designs included control groups. It is also true to say that psychoanalytic theory fastens on to pregenital fixation as an explanation for a great many phenomena.

A related assumption within psychoanalysis declares that asthma is associated with a disturbed mother-child relationship. French and Alexander, among the earliest analytic contributors to the debate on psychosomatic illness, believed that fear of separation from the mother brought on asthmatic
attacks (1941). As already noted above, more recent non-analytic work has confirmed the existence of idiosyncratic family patterns in asthmatic cases. In particular, Minuchin's theory that psychosomatic illness serves as an important equilibration within the family offers one explanation for the oft-observed family reluctance to acknowledge improvement in the child's condition after treatment (see page 110). Studies that have shown that wheezing actually clears up when the child is separated from his family (page 109) seem to contradict the psychoanalytic thesis of fear of separation but there may, of course, be important differences in meaning for the child between the apprehension and phantasy of possible separation and dealing with an actual situation as it occurs. Unexpressed and unacknowledged ambivalence between the child and his parents could lead to both anxiety towards potential separations, and relief and the ability to cope in actual separation situations. Lask and Matthew (1979) have shown in a controlled trial how family therapy, aimed at improving communication between family members, can improve the child's physical prognosis. Research has shown that communication about feelings is often inhibited in families with an asthmatic child by unspoken fears of the child dying (Graham 1985), anxieties not entirely without foundation in this 'physiologically treacherous disease' (Knapp 1977).
Chapter Six

Linking the Conceptual to the Empirical
Psychoanalysis is a sophisticated and intricate conceptual system. Most of life's vicissitudes are able to be accommodated within its complex explanatory system. Dreams, symptoms, the origin of gender differentiation, personal and universal sexual development, personality structures, character types, motivations, attitudes, the seemingly inexplicable and the supposedly banal, the trivial and the exotic, the normal and the abnormal, all find a place within the corpus of Freudian thought and theory.

Dazzled by the Master's genius, and proudly self-sufficient with the assurance of the chosen and initiated, psychoanalysts have been reluctant to dilute their insights and revelations with the pedestrian scepticism of the researcher and objective observer. But as the ultimate accolade of being granted scientific status increased in desirability among those who formulated human and social explanations of events, explanation without clear and unambiguous prediction began to seem embarrassingly inadequate.

If there is a pragmatic facet to psychoanalysis - pragmatic in the technical, philosophical sense whereby practical consequences are seen as the test of truth - it is most easily demonstrated in the therapy. The theory circles and spirals, retracting an insight here, advancing an interpretation there, making assumptive and imaginative leaps, hedging its bets, a mishmash of wild and brilliant threads making up a colourful patchwork of clinical observation, anecdotal tales and autobiographical understanding. It combines truth and speculation to an alarming extent. The therapy, however, despite its apparent dependence on the theoretical and conceptual tenets of classical Freudianism, is able, if necessary, to stand alone, to be subjected to test and to be modified in the light of the results of such tests.

The epistemological problems of psychoanalysis, rife when evaluating the theory, do not seem insurmountable in respect to therapeutic efficacy. It should be a relatively straightforward task to compare a child at the beginning of treatment with the same child at the end of treatment. Classificatory systems exist for diagnostic purposes and scales of measurement for the assessment of global functioning. In principle, we
should be able to evaluate the therapeutic efficacy of psychoanalysis.

The difficulties of so doing begin to emerge when we try to elicit the co-operation and assistance of the analysts themselves. They tell us that psychoanalysis as an intervention into human misery and uncertainty requires a certain purified atmosphere in which to work. Furthermore, the relationship between patient and doctor makes no sense out of context, but this context is inaccessible (and, we are led to believe, probably incomprehensible) to the outsider. Ongoing analysis is, thus, generally kept out of reach of lay research methodology.

A sufficiently intrepid investigator, willing to confront the analyst’s refusal to participate in a study of the efficacy of his methods and techniques, faces further, more practical, barriers. Analysis is a lengthy enterprise, open-ended and without strictly formulated goals. As in the theory, almost any outcome might count as a success. Circular definitions are widespread. Intellectual integrity is challenged when lack of progress is redefined as premature termination - usually with the onus of responsibility on the patient. Successes confirm the analyst’s skill; failures highlight the irredeemable developmental flaws of the patient.

An alternative to hacking through this jungle of confusion and opposition in which any current psychoanalytic treatment is going to be entwined is to restrict the assessment of therapeutic efficacy to cases that have already terminated. Using retrospective data, as we have elected to do, by no means solves all the operational problems posed by psychoanalytic outcome research but we can at least be sure that the goalposts are not going to shift in the course of the investigation. It allows for a large number of cases to be looked at, compared, assessed, evaluated.

We have noted the paucity of outcome research in psychoanalysis, especially that which concerns the treatment of children. The present retrospective investigation has brought together more than 750 cases which span 40 years. Longitudinal observations can be made and epidemiological variables
compared to other, non-analytic, studies. This enables us to confirm or to question findings from other investigations, something which would not be possible using the very small samples available from currently-proceeding analyses. Previous research which has identified which children are at particular risk of psychological breakdown has been relied upon to suggest variables that might usefully be controlled for in our matched pairs of physically ill/physically well children. The background provided by methodologically-sound surveys such as those carried out by Michael Rutter and his colleagues have provided us with a base line against which to compare our own findings. Knowing the main risk factors for children, the most likely diagnostic profiles in terms of age, sex and a variety of other characteristics, and the types of children, families and disturbances that respond best to psychological intervention, has enabled us to augment the existing research with our own, uniquely psychoanalytic, information.

Our total sample comprises, naturally, a great variety of patients and their families who can be differently grouped along a number of dimensions. Of particular concern to the author of this thesis is the therapeutic careers of children with chronic medical conditions. This interest initially arose from observing a blind friend with his sighted children. The contrast between father and sons and mother was striking. Lacking the possibility of eye contact, of major importance to both mother and children in their interactions, he communicated with the babies through touch rather than vision. What were the implications of this, if any, for the development of the children? Possibly these were minimal as the boys had contact with sighted people, which provided them with ‘mirroring’ experiences thought by some psychoanalytic theorists to be crucial to healthy emotional development in the child. Winnicott suggests the following historical process in the maturing of the ego:

When I look I am seen, so I exist.
I can now afford to look and see.
I now look creatively and what I apperceive I also perceive.
I take care not to see what is not there to be seen.

(Winnicott 1971)
Winnicott makes it clear that he is talking only about babies with sight. My friends’ children, having good vision, had many opportunities for seeing themselves mirrored in the faces and eyes of those around them so that, hopefully, their father’s visual unresponsiveness, given that he reacted extremely positively to them in all other ways, was of minimal significance. But I began to think about their father’s own babyhood. How do blind children themselves develop a sense of self? If, as Winnicott claims, the child exists for himself because he is seen - and sees that he is seen - what implications might that have for ego development in the case of children who do not see that they are mirrored in the regard of others? More specifically, will handicapped and disabled children be able to use the ego-enhancing experience of an analytic treatment in the same way as able-bodied children?

The Anna Freud Centre, especially in its earlier days as the Hampstead Clinic, also had a special interest in blind children. In 1954 the Royal National Institute for the Blind asked Anna Freud’s colleague, Dorothy Burlingham, to assess and analyse a number of blind children who were difficult to accommodate in the Institution’s own facilities. This meant that ‘the analytic results could be compared with established educational methods. In theoretical terms, Dorothy Burlingham set out to learn as much as possible about the rôle of visual perception in the building up of children’s personalities’ (Young-Bruehl 1988).

A good deal of the Clinic’s services for the blind was in the form of parental guidance, including home visits for observational purposes, nursery school facilities and other social and educational provision. Analysis was only one of many resources that might be offered in appropriate circumstances. In fact, it turned out that too few blind children went into a full analytic treatment to make it possible to conduct a full-scale investigation into these therapies alone. Our research was, therefore, expanded to take in children with other chronic illnesses and disabilities.

From its beginnings, the presently-named Anna Freud Centre has had a strong tradition of offering practical help and intervention to children and
families. The Freuds, father and daughter, left Jewish-persecuted Vienna for London just before the start of the Second World War. Before long, the Jackson Nursery, which had been set up by Anna Freud and her colleagues back in Austria to care for needy children, was recreated in England under the name The Hampstead War Nursery. This residential Nursery, along with the Babies’ Rest Centre and a country home for evacuated children, and the later additions of baby clinics, toddlers’ groups and so on, provided a unique opportunity for Anna Freud to harness the theoretical concepts of psychoanalysis to practical effect.

The Centre has also had, from its inception, a policy of fostering psychoanalytically-oriented research projects. Children are ideal subjects for rigorous and systematic observation and the facilities offered to them during the War and afterwards provided the first generation of child analysts with plenty of raw material to test and refine their theories about child development and the aetiology of disturbance. The twin emphases of research and a practical and robust concern for the children in their care has made the Anna Freud Centre an ideal base from which to make the leap from abstract conceptualising to empirical investigation. The specific interest of this report in chronically ill and handicapped children was also well fostered and supported from the clinic’s archives.

We can now turn our attention in detail to the Anna Freud Centre Psychoanalytic Outcome Study.
The Anna Freud Centre Project
7.1 Selecting Subjects

The grounds for selecting cases to be included in the Anna Freud Centre Psychoanalytic Outcome Study were easily determined - we took all terminated cases from the earliest days of the Centre's activities (then known as the Hampstead Child Therapy Clinic) in 1950 up to and including 1989 when the Project was first set up. Cases which finished over the 2½ year period while the raw data were still being collected (1989-1991) were added as they became available.

There were some relatively minor exceptions to this all-inclusive policy:

1. Some children had participated in more than one period of treatment. Although subsequent treatments were noted as part of the total volume of data collected on each child, only first treatments were used for statistical purposes.

2. Access to a small number of cases (about 20) was vetoed by the Clinic director, who had ultimate power of sanction, before the Project began. These included analyses of children whose names would have been publicly known or children of staff members at the Centre or the staff themselves when young. This was to maintain the high level of confidentiality which every patient has a right to expect and was consistent with the written undertaking signed by members of the research team not to work on any case where they had any knowledge of, or about, the patient; in fact, with the most sensitive cases removed, this eventuality never occurred.

3. Ten cases were so poorly documented that they yielded little but missing values. These were taken out of the data base.

Only children who entered into treatment for at least one session were included. The large number of 'treatment offer refused' cases at the Centre whose files contain the Part A diagnostic information below but not the Part B treatment information were not included in the final data base.
With these exclusions, the number of individual child analytic and therapeutic treatments available for study was 769 cases of children and young people between the ages of 2 years 1 month and 19 years 2 months at start of treatment.

7.2 Information extracted

The information that had been collected on each patient varied considerably in both volume and quality, depending partly on parental co-operation in disclosing material and partly on the diligence of the staff members concerned in collecting, and more especially in recording, material. The large majority of cases were very fully documented. A fairly average file included all or most of the following:

7.2.i Assessment Procedure

A) The Referral material consists of a typed record of the telephone call or letter from the referrer who would typically be a parent or the family doctor, and copies of all correspondence between the Centre and parents/child and referrer. A more formal Referrer's Report from agencies such as other Child Guidance Clinics or hospitals is available in 42% of cases.

B) The Social History is taken usually from the mother by a Psychiatric Social Worker and instances important developmental milestones and significant life-events. (See below for a more detailed description of the material obtained in this way.) This stage in the process might be omitted in the case of an adolescent, especially one who had self-referred. Social Histories are present in the files of 80% of children.

C) Diagnostic Interviews are held with parents and with the child (usually separately) to determine the nature of the presenting problem. The number of interviews per case varies considerably but averages one with the parents and two with the child. Table 7.1 shows the recorded number of parental interviews; Table 7.2 the number of child diagnostic interviews.
<table>
<thead>
<tr>
<th>Parental Diagnostic Interviews</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>213</td>
</tr>
<tr>
<td>Percentage of Total Sample</td>
<td>28%</td>
</tr>
</tbody>
</table>

Table 7.1 Diagnostic parental interviews for the total sample (N=769)

<table>
<thead>
<tr>
<th>Child Diagnostic Interviews</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>77</td>
</tr>
<tr>
<td>Percentage of Total Sample</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 7.2 Diagnostic child interviews for the total sample (N=769)
D) **Psychological Testing** was carried out on 85% of referrals. Most of these (81%) undergo intelligence testing using standard psychometric instruments such as the Revised Wechsler Intelligence Scale for Children (WISC-R), the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) or the Stanford-Binet (SB) scales. Reading Age and Arithmetic Age may also be measured where this is appropriate to the nature of the presenting problem. Projective testing is also carried out when this seems indicated (for 39% of the children in our sample) using a variety of measures including the Children's Apperception Test (CAT), the Thematic Apperception Test (TAT) and the Blacky Picture Stories.

E) A **Psychiatrist's Interview** to assess the child from a medical perspective is sometimes conducted.

F) **School Reports** are often obtained (in 53% of referrals) to evaluate the academic performance of the child and to obtain the opinion of his or her teachers of the behaviour in the school setting. A standard form is provided by the Centre to try to ascertain that certain questions are answered, relating to whether this child is working to potential and the quality of relationships with both peers and teachers, though schools are not restricted to containing their information to this.

G) Some cases are supplemented by **Additional Records** from the various institutions of the Anna Freud Centre such as the Nursery School (7%), the Baby Clinic (7%) or the Toddler Group (2.5%) in a referral where the child is a current or past member of one of these.

H) Based on all the above, a **Diagnostic Report** is compiled for each new referral. This Profile is presented to a Conference made up of both senior and experienced child analysts and students on the analytic training course. Staff members who have had contact with the referred child and family (e.g. the Psychiatric Social Worker and the Psychologist) are usually present. Anna
Freud was also a very active member at most cases conferenced from 1950 until her death in 1982. The discussion of the Profile is minuted and is also on file as a record of the assessment team evaluation. Available Profiles exist for 54% of cases on our database; the minutes are present in slightly more instances.

1) The Anna Freud Diagnostic Profile

This Profile is a central diagnostic measure used at the Hampstead Clinic (now the Anna Freud Centre) over the past 30 years. It was developed by Anna Freud (1962) to facilitate precision in the location of pathology in an individual personality structure. The original Child Profile was extended and modified for use with adolescents (Laufer 1965), adults (A Freud, Nagera and W E Freud 1965), babies (W E Freud 1967, 1971) and the blind (Burlingham 1975).

The origins of the Diagnostic Profile lay in the attempt to build some sort of rapprochement between the two divergent and often opposing, methods of categorising psychological disturbance - the psychoanalytic model, which Anna Freud admitted has a tradition of indifference to pre-treatment symptomatic assessment (A. Freud 1962), and psychiatric nosology which concentrates almost exclusively on signs and symptoms, paying little attention to the underlying determinants of distress with which psychoanalytic theory is so concerned. Anna Freud believed that 'developmental considerations take precedence over consideration of symptomatology and manifest abnormal behaviours' (A. Freud 1962). The latter are frequently misleading in their implications because abnormal behaviour in children is often transient and not necessarily a sign of fixed pathology, anxieties in children shifting quickly from one object to another (A. Freud 1970). Of much greater concern is any 'pathological turn in the child's development' (op cit) which points to an abnormality more fundamental than the overt disturbance. This is why the Developmental Profile was developed.

The Profile's subheadings are as follows:
I  **Reason for referral** (Developmental retardation, behavioural concerns, symptoms, inhibitions etc.)

II  **Description of child** (personal appearance, manner etc.)

III  **Family background and personal history** (this is essentially the social history section as described above.)

IV  **Possibly significant environmental influences** (this includes both positive and adverse factors, - for example, the relative stability of the parents' marriage, the effect of having a grandparent living with the family, births of siblings, hospitalisations, the substitute care of an *au pair* - any event that may have had significant meaning for the referred child. Such influences may have happened in the past or may be current.)

V  **Assessments of development:**
   a)  **Drive development**, further subdivided into the twin psychoanalytic pillars of libido (the position of the child along the psychosexual stages of development; his characteristic pattern of libido distribution and cathexes, and object relationships) and aggression (the quantity and quality of aggressive expression available to the child and whether it is directed primarily towards the outside world or towards the self).
   b)  **Ego and superego development** - the intactness of the ego apparatus and the ego functions (whether a child has any physical or intellectual deficiency) and a detailed account of his individual defence organisation.
   c)  **Development of the total personality** according to the position it occupies along each of several lines of development (see below).

VI  **Genetic assessments** based on the Freudian assumption that neurotic disorders result from regression to fixation points appropriate to an earlier phase of development. The existence of these psychoanalytical 'strange attractors' may be betrayed by aspects of observable behaviour (often in the form of anxieties, phobias or obsessions), by the child's phantasy life (usually not accessible in diagnostic stages except through the projective testing), or
by the referred symptom pattern which may suggest to the trained clinician certain areas of vulnerability. In children, regression does not always presuppose fixation; the immaturity may be temporary and in response to 'developmental strain'; the nature of the regression in any particular child should be clearly noted in this section of the Profile.

VII Dynamic and structural assessments where conflicts between the various intrapsychic agencies (id, ego and superego) and external reality, are noted. Evaluation of the success or otherwise with which a child deals with conflictual situations allows the diagnostic team to make a judgement of the level of maturity gained by the child and how far this could be seen as age-appropriate, precocious or retarded. Internal conflicts also point to the severity and depth of the disturbance and to the most suitable help which might be offered - whether this is intensive analysis, less frequent psychotherapy, a period of observation, mother guidance, referral to another agency or, indeed, the recommendation of no treatment.

VIII Assessment of general characteristics are possible indicators of the extent to which a child will make good use of psychoanalytic treatment. Factors looked for include the ability to tolerate frustration, the extent of the child's potential for sublimation and his or her over-all attitude to anxiety. This can be expressed in shorthand as the relative dominance of progressive or regressive inclinations in the child under review which Anna Freud understood as equivalent to an adult's potential capacity for lieben und arbeiten (A. Freud 1962).

IX The final section consists in placing the child in the most relevant of 5 Diagnostic Categories.

These are, in brief:

1) Essentially normal.

2) Developmental strain - transitory pathology only.

3) Permanent regressions causing symptoms and inhibitions and leading to neurosis (or possibly delinquency).
4) **Atypical, retarded or defective development.** Children who have suffered early deprivation (with the implication that this has permanent adverse effects on their subsequent development) or who have had to contend with organic disabilities such as blindness may be placed in this category.

5) **Substantial disruption of mental growth** due to destructive processes of an organic, toxic or psychic nature. Children who would be considered psychotic, autistic or with pervasive developmental disorders would be likely to be placed here.

Although each new referral to the Anna Freud Centre is still 'profiled' in the way described above, the Categories have not been used as part of the diagnostic procedure since about 1970. Nevertheless, about 45% (N = 339) of children in our sample had been assigned to a category, making this a partially-quantitative classification. Table 7.3 shows the breakdown of classification of children according to the Anna Freud Categories.

**J. Developmental Lines**

The Freudian theory of child development is predicated on a sequence of psychosexual stages (oral, anal, phallic, latent, preadolescent and adolescent genitality) distinguished by particular libidinal organisations and distributions. These are initially correlated with chronological age but, once reached, contain the possibility of attracting the 'adhesiveness of the libido' (Freud 1915) and becoming partial or total fixation points, always thereafter available for later regressions of the sexual instincts. Observing that every facet of personality shows developmental progress from immature, dependent (id-based) behaviour to an increasing self-reliance and (ego) control, Anna Freud (1963) suggested a number of Developmental Lines along which a child might be placed according to his relative immaturity, age appropriateness or precocity. The Lines, like the rest of the Profile of which they are a part, are cognisant of the significance of environmental and historical realities whilst still retaining allegiance to classical psychoanalytic (drive) theory.
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>%</th>
<th>% of total categorised</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0.001%</td>
<td>0.003%</td>
</tr>
<tr>
<td>2</td>
<td>84</td>
<td>10.9%</td>
<td>24.8%</td>
</tr>
<tr>
<td>3</td>
<td>203</td>
<td>26.4%</td>
<td>59.9%</td>
</tr>
<tr>
<td>4</td>
<td>32</td>
<td>4.2%</td>
<td>9.4%</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>2.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Not categorised</td>
<td>430</td>
<td>55.9%</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 7.3  Numbers and percentages of children assigned to one of Anna Freud's Diagnostic Categories for the total sample (N = 769)
The Lines suggested by A. Freud in her paper setting out a draft version (1963) are:

1) From dependency to *emotional self-reliance* and adult object relationships
2) From suckling to *rational eating*
3) From wetting and soiling to *bladder and bowel control*
4) From irresponsibility to *responsibility in body management*
5) From egocentricity to *companionship*
6) From the body to the toy and from play to *work*

No developmental psychologist, psychoanalytically-oriented or not, could take exception to these common-sense areas of potential maturation or retardation. The Lines imply clearly the importance accorded the external world by psychoanalysts of the school of ego psychology. Any Line can become distorted through internal phantasy, as the classical version of psychoanalytic theory dictates, but external contingencies also are important sources of deviation. They are able to point out where a child is achieving and where he is lagging behind his peers. Of particular diagnostic significance is the correspondence between the Lines. It would normally be expected that a child would attain similar levels of maturation across Lines; significant imbalance suggests areas of present or potential difficulty. This information is available for most children in our sample and can be looked at in the light of subsequent findings.

7.2.ii Treatment and Termination Material
If the child and his or her parents accept the treatment recommendation of the Case Conference, the designated therapist will usually meet with the patient and parents to discuss the practical arrangements for therapy. All these meetings are (or should be!) recorded and are often a source of further relevant information about the child and his family. Intensive treatments (4 or

---

37 In fact the main criticism raised against the Lines is precisely that they contain normative elements, emphasising adaptation at the expense of personal subjective experience (Frosh 1989).
5 sessions a week) are optimally written up as Weekly Reports; less frequent therapy may be written up fortnightly or monthly. Therapists vary greatly in their commitment to carrying out this task and also in the quality of the material they present but some weekly material is available for 80% of our sample.

Lack of sequential reporting is a particularly serious obstacle to enquiry into the analytic process (a part of the Anna Freud Project not reported on here), but if the final phase of the treatment is not written up it is also often difficult to retrospectively determine treatment outcome. We relied heavily on these final accounts of the child's working through of his or her problems as reported in the Weeklies, plus school reports, recorded interviews with parents and so on that covered the final period of treatment. In a small percentage of cases (less than 5%), a Terminal Profile was provided (see Profile section above) which more-or-less did the work of assessment for us. A greater percentage of cases (21.5%) included a closing summary which was less systematic than a Profile but still often contained enough information to paint an adequately clear picture of the treated patient. Follow-up material was sometimes available which might refer back to the terminating phase of treatment. Some cases were written up as a conference or a journal paper which also helped our evaluative attempts. For a few cases where termination material was substantially or completely lacking, the therapist or her or his supervisor, or the Psychiatric Social Worker who had met regularly with the parents for the duration of the child's treatment, were still working at the Clinic during the research period and were able to sufficiently clearly remember the child's diagnostic and symptomatic status and level of general functioning at treatment termination to enable some of the gaps to be filled in. After having used all these channels we were still left with 9% of cases for whom the available termination information was insufficient to allow us to make a judgement of the child's final condition.

7.3 Data elicited
It will be clear from the above sections that, for many cases, a great deal of
material had to be sifted through to elicit the data of interest. The most fully documented cases ran to hundreds of pages. The information relating to each case was systematically combed for a total of 232 variables. A sample of the data proforma completed for each case can be found in Appendix A and a list of elicited variables in Appendix C1.

Most of these variables related to demography (sex, religion, parental occupation, number of siblings etc) or straightforward facts such as percentage of weekly reports available or length of treatment. Gathering such data took time but was relatively uncomplicated. There were a number of variables, however, that required training and a certain level of clinical expertise to tease out from the material. These are described in more detail below.

7.3.1 The Child Behaviour Checklist
A Child Behaviour Checklist (CBCL) (Achenbach and Edelbrock 1983) was completed for each of the 769 children in the study. This symptom-based list contains 118 items identified by the authors as relevant to mental health referrals and able to be reported by parents. Each item is scored as Not True (score = 0); Somewhat or Sometimes True (1) or Very True or Often True (2). There is space for further descriptions after 19 of the less straightforward items. This was primarily to check on the validity of the responses of informants (parents or surrogates) by whom this measure was originally intended to be completed. Thus, a positive scoring of the item 'Eats or drinks things that are not food' would be disregarded if the parent further commented that these 'things' were sweets or junk foods (Achenbach and Edelbrock 1983). The item refers to pathological pica and not the 'normal' sub-optimum nutritional habits of children. Similarly, 'Repeats certain acts over and over' is intended to capture clinical levels of compulsive behaviour; the elaboration 'keeps hitting his brother' would disqualify the item from scoring (op cit).

The original scale was intended for children aged between 4 and 16. In their manual the authors make clear the reasons for this. Subsequently, a modified
version of the Checklist was produced for children between the ages of 2 and 3 years 11 months inclusively. This scale contains 100 items. Many are similar to the senior scale but certain behaviours, such as those relating to drug and alcohol addiction, truancy from school, poor school work and so on have been omitted as not relevant. Additional items ask about, for instance, resistance to toilet training, breath-holding and getting too upset when separated from parents. These have age-appropriate aspects to them but can cause anxiety if carried to excess. A sample of both age-related checklists is included in the Proforma in Appendix A.

From factor-analyses of all 118 items of the checklist, administered to 2300 clinic-referred children, Achenbach and Edelbrock have been able to provide 'typical' profiles, six in all, for both sexes across three age ranges, thus reflecting the changing nature of psychopathology across the developmental span of childhood and adolescence. Good concurrent validity between the CBCL and other similar measures leave many researchers in 'little doubt that this is the most well-developed, empirically derived behaviour rating scale currently available for assessing psychopathology ... in children' (Barkley 1988).

7.3.1.8 Our use of the Achenbach checklist
We used the standard CBCL (ages 4-16) and the modified version for younger children (ages 2:0-3:11) for all our patients despite the fact that 19 of them exceeded the age range, being 17 (n = 14) or 18 (n = 5) at assessment. These 'children' cannot really be assessed reliably according to instruments developed for their younger counterparts as Achenbach and Edelbrock make clear (1983) as the scale contains possibly non-relevant material (such as items referring to school) and has not been standardised with or compared to referred or non-referred age-mates. The Achenbach assessment on this small number of patients is therefore less reliable than it should be ideally. (Achenbach does concede that small age variations should not affect the usefulness of the measure and many of our older patients are less mature emotionally than their chronological age would suggest.)

159
A Child Behaviour Check List (CBCL) was filled in on each of the 769 cases on the Anna Freud data base. The majority of these were filled in by the current author and a graduate assistant psychologist. Both were trained to follow Achenbach and Edelbrock's original criteria. Inter-rater reliability was informally checked at various stages in the data collection process and remained at a high level throughout. The mean intra-class correlation coefficient over 100 cases was .87 (range = .71 to .96). Random cases were additionally selected for double-checking by the research co-ordinator who had trained them originally.

Internal consistency was also maintained over the 18 months of data gathering. In fact, our trained raters were almost certainly more consistent than a plethora of parents would have been (an advantage, given that our work was research in nature rather than clinically-oriented.)

The CBCL was able to be used in the rather tricky business of retrospective diagnosis and assessment without undue difficulty despite the fact that we were only able to rate a child in any symptom category if the relevant information was on file. Mothers who were frank and disclosing about problems gave more information than others who held back out of anxiety, guilt or other reasons. But it is likely that such parents would also have shown some measure of social desirability bias had they completed the questionnaire themselves at the time of referral. And we had other information to draw on as well - school reports, diagnostic impressions, the child's self-account - which, again, suggests that completion of the CBCL in our rather peculiar retrospective research situation may not have been adversely affected.

 Concealment of information is a major problem in diagnostic issues. A number of studies have found significant discrepancy between the amount of pathology disclosed in the assessment interview and that which later emerges during treatment (Wallerstein 1986, Wallerstein 1976, Bachrach et al 1991). Although there are occasionally issues that dominate the evaluation but do not subsequently appear in the analysis, the divergence is nearly always in the direction of underestimating pathology at the start. In the Menninger study, for example, 18/42 patients were misdiagnosed in this way (Wallerstein 1986). As many as 57% of Wallerstein's patients successfully concealed major symptoms and personality trends at assessment - and even afterwards. One patient who married seven years into the course of her treatment kept this information from her analyst for 3 months!
One of the problems with retrospective studies is that the original informant is not able to be contacted and asked to add to or clarify an earlier statement. But Achenbach and Edelbrock make it clear that researchers and clinicians should not interfere with the filling in of the form by asking for elaboration further to that provided by the comment fields already set out on the checklist, nor by guiding or framing responses in any way (1983). It was felt that the uneven quality of the material with which we were dealing was offset by giving researchers sufficient training to enable their assessments to be comparably reliable with forms completed by parents in a more traditional clinical setting.

In fact, some research has found only modest correlations between different informants' ratings of the same child (Rutter et al 1988). Ross and Ross (1982) found substantial differences between parents even when matched on a number of variables and Bond and McMahon conclude that characteristics of raters, such as level of marital distress experienced, may prejudice results (1984). In addition, different notions between raters (e.g. between a parent and a clinician) of the types of behaviours that are appropriately notable may lower correlations (Ross and Ross 1982). Our ratings actually compared favourably with such findings although we were only able to test the validity of our assessors on a very small number. The parents (all mothers) of five new referrals to the Centre (not included on our data base) were asked to fill out the CBCL on the referred child as part of the diagnostic process. The research co-ordinator (rater 1) who had introduced the scale to the mother and explained its use but who did not know how the mother had filled it in completed a CBCL on the child from the notes on file (exactly as all the retrospective cases had been assessed). Similarly, the present author (rater 2) also completed a form from the file material without having had any contact with, or knowledge of, the mother or child.

The correlations (using the kappa statistic) between these three assessments compared equivalently to the associations reported by Achenbach and Edelbrock between the Youth Self-Report (YSR) (a subsequent development
of the CBCL), and the original form\textsuperscript{39}.

<table>
<thead>
<tr>
<th>Correlation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Mother and 1st rater</td>
<td>0.76</td>
</tr>
<tr>
<td>Between Mother and 2nd rater</td>
<td>0.62</td>
</tr>
<tr>
<td>Between 1st and 2nd raters</td>
<td>0.85</td>
</tr>
</tbody>
</table>

7.3.ii The Diagnostic and Statistical Manual (DSM)

Although the CBCL is a descriptive rather than a diagnostic instrument its development was impelled by the need to fill a gap created by the lack of available classificatory psychiatric taxonomies of child and adolescent disorders. As Achenbach states as an Introduction to his Manual, 'The study and treatment of child and adolescent psychopathology have been handicapped by a lack of standardised procedures for describing the relevant behaviour' (Achenbach and Edelbrock 1983).

The categorisation of psychiatric syndromes most widely used in the United States at the time of Achenbach's writing was the 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published by the American Psychiatric Association (APA) in 1980. In 1983, the year of publication of Achenbach's CBCL, the APA began a substantial revision of DSM-III, taking into account the wide-ranging field testing and clinical use to which the Manual's latest edition had been subjected. Twenty-six committees of experts, numbering more than 200, were assembled for an extensive overhaul of the Manual in an endeavour to remove some of the inconsistencies, ambiguities and contradictions. It was this edition, DSM-III-R, 1987, that we used in our study.

The range of possible diagnostic categories was augmented for the third edition and its revision to a total of 235 specific diagnoses, grouped into 17 major classes of disorders. Additionally there are 13 'V' codes which refer to 'conditions not attributable to a mental disorder that are a focus of treatment

\textsuperscript{39} The child's and mother's ratings correlated at .37 (p<.01), the child's and clinician's at .55 (p<.001) and, the one most comparable to our use, the mother's and clinician's at .70 (p<.001).
or attention'. These include Marital Problem, Parent-Child Problem, Academic or Occupational Problem, Uncomplicated Bereavement, Other Interpersonal Problem, Other Family Circumstances and Phase of Life Problem.

The descriptive criteria to be fulfilled before diagnostic status is reached has been clarified and the conditions for meeting criteria tightened, giving precedence to relatively unambiguous behavioural signs and symptoms and reducing the need for large doses of clinical inference. This stringency is intended to facilitate inter-judge reliability in diagnosis (APA 1987).

In strict categorical systems of psychiatric nosology (as opposed to dimensional systems like the CBCL), only one disorder would ideally be described as present (McConville and Steichen-Asch 1990). DSM-III-R, however, allows children to fulfil several sets of diagnostic criteria (Rutter and Tuma 1988), encouraging multiple diagnoses where there are sufficient grounds for making them, though requiring that they be marked Principal or Additional. The Principal diagnosis is generally the current presenting problem but may on occasions refer to a chronic or personality disorder against the background of which a more acute syndrome has become apparent.

DSM-III-R also permits the severity of disorder to be specified within the categories mild, moderate, severe, in partial remission and in full remission. These categories are not stringently operationalised but take into account the number and intensity of symptoms and the resulting impairment.

7.3.ii a  Our use of the DSM
As far as was possible within the constraints of wholly retrospective material, we applied the DSM-III-R as intended by its publishers. Each child in our sample was evaluated for caseness levels at two periods of time - at assessment (before treatment began) and at the end of treatment. Diagnoses were also made for past conditions that met the relevant criteria. As it is well-documented (e.g. Quinton et al 1990) that parental pathology affects children in various ways including nature of the child's own problems and response to treatment, it was considered important to record parental
disorder where this was possible. Accordingly, both mothers and fathers
were also diagnosed using DSM-III-R criteria for both past disorders and for
symptoms present at referral. Parents were not re-evaluated at the
termination of their child's treatment.

All cases were recorded according to DSM-III-R guidelines - diagnostic criteria
met, whether such diagnoses were principal or additional and a severity
rating for each identified disorder. This had occasionally to be omitted for a
past diagnosis where, for example, a problem was mentioned as part of the
anamnesis but no details given. For past problems, where the information
was available, the child's age at start and completion of problem, the
duration of the problem and treatment received (if any) was noted. Where no
diagnosis was given for an individual, a distinction was made between
'criteria not fulfilled' and 'insufficient information'. The latter was used when
there were implications in the material of psychiatric disturbance but not
enough detail to make even a 'possible' diagnosis.

Partly to avoid the uncompromising 'yes/no' bipolar assignment of psychiatric
labels and partly as a reflection of the limitations inherent in retrospective
research where the patient is not there to be further queried about his state
of mind, we introduced gradations of certainty of diagnosis - possible,
probable and definite. These, like the severity scores were easily codifiable
numerically for later analysis. As the study proceeded we decided to omit all
diagnoses that had been rated both 'mild' on the severity scale and 'possible'
on the certainty scale, on the grounds that these implications of disorder
were too vague to be useful. Thus we were left with 8 categories: severe-
possible, severe-probable, severe-definite; moderate-possible, moderate-
probable, moderate-definite; mild-probable and mild-definite. We
operationalised the use of these categories as follows:

**Definite:** All required criteria specifically described in material.

**Probable:** All but one or two criteria described, remaining features very
likely to be present (e.g. specific developmental disorder where sufficient
impairment is clear, but required tests not administered; mood disorder in
parent, where treatment is described but individual symptoms not listed.)

Possible: Clear suggestion of disorder, e.g. report that relative was
depressed, but no details. Or possibility that another disorder underlies
manifest symptoms, e.g. depressive state in case of solitary conduct disorder
and poor self-esteem.

The APA rightly point out that 'the proper use of DSM-III-R requires
specialised clinical training' (1987). Our diagnosticians were the same two
researchers previously described, the author of this report and an assistant
psychology graduate, plus the research co-ordinator. Only the latter had
received formal clinical training though all three had experience in clinical
settings. Because of the retrospective nature of the material no judgement
made had any implications, however minor, for any patient or family. The
main requirements of diagnoses were that they should show inter-judge
reliability and should be comparable with diagnoses that would be made on
the same set of facts in a clinical setting. The first requirement was met by
training the researchers to recognise and select relevant information from the
mass of data on file, using clinical interpretation sparingly when necessary
and discussing any diagnosis that seemed doubtful or difficult to make.
Discussion in such cases proceeded until unanimity was reached.\textsuperscript{10}

The second requirement was fulfilled by a random sample of files being
evaluated by two workers and results compared. Inter-rater agreement was
high though not analysed statistically. A more formal assessment of reliability
was made through two independent raters, a consultant adult psychiatrist
and a senior registrar child psychiatrist, both of whom were given two sets
of files to investigate. The first set of files contained particularly tricky
diagnoses to be double-checked; the second set were a random sample of

\textsuperscript{10}It has been suggested that, for research purposes, consensus ratings of 2 or more raters, after
discussion, may be better for outcome studies that want to measure change over time than simply
taking the average of 1 or more ratings (Liebowitz et al 1988). Such discussion may help to
eliminate oversights.
139 child cases and 43 adult cases from the total population. Agreement between the Centre and these independent raters ranged from .35 for adult depressive disorders and .42 for child sleep disorders to 1.00 for a variety of very clear-cut disorders. There was higher concordance of diagnoses of conduct and most behavioural and habit disorders than for mood disorders. This order of rankings is common among the research literature (eg Boyle et al 1987). Evidence suggests that inter-rater assessment of mood disorders would correspond better if depression and anxiety were seen as separate categories and not conflated into one (Rutter and Gould 1985).

Tables 7.4 and 7.5 show the frequency of diagnoses made by our internal and external raters and the correspondences between them.

7.3.iii International Classification of Diseases (ICD)
Besides being diagnosed according to DSM-III-R criteria, all cases were also assessed along ICD guidelines. The International Classification of Diseases (published by the World Health Organisation) includes a section containing 'clinical descriptions and diagnostic guidelines for the mental and behavioural disorders, including disorders of psychological development' (WHO, 1992). When the Anna Freud project was first set up, ICD IX was the edition in current use and our initial diagnoses were made according to this. When a limited distribution of a draft version of ICD X became available to us in the spring of 1991 (although not expected to be in effective use until 1992) we switched to this, because the diagnostic guidelines in ICD X are much fuller and more precise than in the previous version (Rutter 1988). Changes were made to diagnoses already given from ICD IX where either criteria or classification code had been altered. Few new categories had been added but the majority had been revised (Steinhousen and Erdin 1991a). Subsequent study has shown that the improved conceptualisation of the latest edition over the previous one has resulted in higher inter-rater reliability of child and adolescent psychiatric disorders (Steinhousen and Erdin 1991b). Each disorder in the ICD is described in terms of its main clinical features.
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Frequency (Internal raters)</th>
<th>Frequency (External raters)</th>
<th>Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overanxious Disorder</td>
<td>22</td>
<td>21</td>
<td>0.60</td>
</tr>
<tr>
<td>Separation Anxiety Disorder</td>
<td>9</td>
<td>13</td>
<td>0.69</td>
</tr>
<tr>
<td>Avoidant Disorder</td>
<td>6</td>
<td>4</td>
<td>0.54</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>6</td>
<td>5</td>
<td>0.71</td>
</tr>
<tr>
<td>Phobia</td>
<td>7</td>
<td>7</td>
<td>0.69</td>
</tr>
<tr>
<td>Major Depression</td>
<td>13</td>
<td>16</td>
<td>0.64</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>8</td>
<td>7</td>
<td>0.64</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>7</td>
<td>6</td>
<td>0.42</td>
</tr>
<tr>
<td>Adjustment and Post-Traumatic Stress Disorders</td>
<td>8</td>
<td>6</td>
<td>0.85</td>
</tr>
<tr>
<td>Somatic Disorders</td>
<td>7</td>
<td>7</td>
<td>0.86</td>
</tr>
<tr>
<td>Attention-Deficit-Hyperactivity Disorder</td>
<td>9</td>
<td>7</td>
<td>0.80</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>16</td>
<td>17</td>
<td>0.75</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>12</td>
<td>14</td>
<td>0.73</td>
</tr>
<tr>
<td>Antisocial Behaviour ('V' code)</td>
<td>8</td>
<td>5</td>
<td>0.75</td>
</tr>
<tr>
<td>Developmental Reading Disorder</td>
<td>6</td>
<td>6</td>
<td>0.65</td>
</tr>
<tr>
<td>Developmental Expressive Writing Disorder</td>
<td>5</td>
<td>4</td>
<td>0.65</td>
</tr>
<tr>
<td>Tic Disorder</td>
<td>5</td>
<td>5</td>
<td>1.00</td>
</tr>
<tr>
<td>Sexual/Gender Disorder</td>
<td>6</td>
<td>6</td>
<td>1.00</td>
</tr>
<tr>
<td>Speech Disorders</td>
<td>5</td>
<td>5</td>
<td>1.00</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>7</td>
<td>6</td>
<td>0.92</td>
</tr>
<tr>
<td>Enuresis</td>
<td>14</td>
<td>13</td>
<td>0.96</td>
</tr>
<tr>
<td>Encopresis</td>
<td>8</td>
<td>8</td>
<td>1.00</td>
</tr>
<tr>
<td>Autistic Behaviour</td>
<td>5</td>
<td>5</td>
<td>1.00</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder</td>
<td>6</td>
<td>7</td>
<td>0.92</td>
</tr>
</tbody>
</table>

Table 7.4 Frequency of specific diagnoses between internal and external raters for 139 child cases.
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Frequency (Internal raters)</th>
<th>Frequency (External raters)</th>
<th>Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive and Bipolar Disorders</td>
<td>31</td>
<td>32</td>
<td>0.35 ''</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>19</td>
<td>13</td>
<td>0.51</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>21</td>
<td>21</td>
<td>0.67 ''</td>
</tr>
<tr>
<td>Sexual/Gender Disorders</td>
<td>5</td>
<td>5</td>
<td>1.00</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>4</td>
<td>4</td>
<td>1.00</td>
</tr>
<tr>
<td>Schizophrenia/Delusional Disorder</td>
<td>3</td>
<td>3</td>
<td>1.00</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>3</td>
<td>3</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Table 7.5 Frequency of specific diagnoses between internal and external raters for 43 adult cases

\[\text{Frequency of diagnosis was similar but identification of disorders did not always overlap.}\]
Diagnostic guidelines are laid down to indicate the criteria required for fulfilment before a confident decision can be reached. There is much overlap between the DSM and the ICD nosologies, but there is by no means one-to-one correspondence. ICD-X has more categories than DSM-III-R and permits diagnosis of conditions that are not classifiable under DSM criteria, such as Mental Disorders associated with the Puerperium; Atypical Anorexias and Bulimias, and Sibling Rivalry (Steinhousen and Erdin 1991a). The nearest to the latter category in DSM-III-R is the V-code Other Specified Family Circumstances. There are a few conditions, such as Borderline Intellectual Functioning and Over-Anxious Disorder that can only be recorded in DSM codes. For an equivalent of the latter in ICD we used the catch-all category Other Emotional Disorder of Childhood and Adolescent, with the bracketed qualification (Over-Anxious).

ICD diagnoses were evaluated for validity by independent child and adult psychiatrists in the same way as described above for the DSM diagnoses, and with very similar levels of concordance. Diagnostic validity between the two systems was, in fact, almost identical. This is probably because subsequent revisions of both classifications have been influenced by empirical research findings in the same way and have therefore moved closer together (Rutter 1988).

7.3.iv Children’s Global Assessment Scale (CGAS)
The Children’s Global Assessment Scale (Shaffer et al 1983), is one of the many revisions and modifications of Luborsky’s (1962) Health and Sickness Rating Scale for adults (HSRS). Otto Kernberg, in his discussion of methodological issues in psychotherapy research, refers to the use of the HSRS within the Menninger outcome study. ‘[This] relatively simple, quantitative measure of outcome was as accurate as the major qualitative write-ups of change involving multiple, individualised, criteria. In contrast to our earlier theoretical thinking that psychotherapy outcome implied change along various dimensions which could not be integrated into one global measure of improvement, our findings convinced us that an integrated and quantified measure of improvement was possible and indeed, simple’ (1976).
Because there are, as yet, no standardised methods of assessing clinical effectiveness of therapeutic interventions (Kazdin 1988), normative levels of global functioning are often used. The experience of researchers such as Kernberg (quoted above) convinced us that the CGAS (and the Global Assessment of Functioning (GAF) scale for adults) would be a suitable instrument to use as our main dependent measure.

CGAS is a 100-point scale divided into 10 deciles, each section being anchored by a short description of the overall level of functioning represented by that particular category. This is a successful attempt to overcome typically poor inter-rater reliability on rating scales which is caused by response bias (Kline in Griffiths 1981). (Some raters typically use extreme ends of the scale for their evaluation; others use only middle categories). CGAS ratings demonstrate high inter-rater reliability, and low variability. Raters, regardless of theoretical perspective or clinical experience, can reach a very satisfactory level of agreement over the relative ratings of children (Liebowitz et al 1988). One-hundred-point scales have very good discriminatory power (kappa = .65 on caseness/non-caseness distinctions; .72 on global rating of functioning according to Bird et al, 1987) - which is about as valid as it is possible to get, given the lack of independent operational definitions of child and adolescent disorders (Achenbach 1988).

CGAS correlates highly with other measures of functional impairment. Its relationship with total scores on the parents' scale of the CBCL shows a Pearson correlation of about -.65 (Bird et al 1987). That is, the more symptoms a child exhibits, as reported by its parents on a checklist, the lower he or she tends to rate in terms of global functioning. However, CGAS has the edge on the CBCL in terms of outcome measures; it is generally accepted in the research literature that global ratings are more sensitive measures of change over time and of the effects of treatment than are measures, such as symptom checklists or diagnostic classifications, that only reflect one aspect of the child’s life (Liebowitz et al 1988, Shaffer et al 1983, Bird et al 1987, McConville and Steichen-Asch 1990). A copy of the CGAS rating scale is in Appendix D.
7.3.v Global Assessment of Functioning Scale (GAF)
Axis V on the DSM is a 90-point assessment scale, similar to CGAS but designed for ratings of adult functioning. Its reliability is high, typically in the region of .8 (Achenbach et al 1988). A copy of the GAF scale is in Appendix E.

7.3.v.a Our use of the CGAS and the GAF
Children were assessed at the start and end of treatment and both parents, where information was available, at the beginning of treatment. Training was given to the research raters and internal (AFC) measures were checked independently by two experienced psychiatrists. The correlations between their ratings and those of the internal assessors are shown below. It will be seen that all scores, and particularly the CGAS change score, which was our main outcome measure, were very reliably assessed by the research team.

Correlations between internal and external assessors on the CGAS rating scale (child)

- At assessment $r = 0.75$
- At termination $r = 0.85$
- Change between assessment and termination $r = 0.93$

Correlations between internal and external assessors on the GAF rating scale (parents)

- Mothers’ scores $r = 0.86$
- Fathers’ scores $r = 0.81$

7.3.vi Parental Symptom Checklist
There was one other measure used in our assessment of parents’ pathology. This was the parental symptom checklist, a list of 18 items relating to psychiatric dysfunction, mental subnormality, hospital or therapeutic
treatment and major marital problems. Parents were assessed separately for both past and current occurrences. In addition to simple presence of any symptom, severity of symptomatology was also able to be recorded (rated as 1 or 2). Rating 1 for psychosis and mood disorders indicated that the parent in question was likely to need (or to have needed) out-patient treatment or medication from the family doctor for a period of at least one month. Rating 2 was for inpatient, or equivalent, degree of impairment. For personality disorder, addictive behaviour and sexual dysfunction, behaviour causing significant but not major interference socially, at work etc was classed as '1'; if the parent was unable to work or maintain usual social relations, or if the disorder was a severe threat to his or her health, a '2' was given.

Violent behaviour within the family was rated according to whether it was minor though causing injury or a frightening atmosphere and the more severe life-threatening or imprisonable. Antisocial behaviour and suicide attempts were similarly divided into the more trivial incidents and serious episodes. Treatment was recorded simply on a yes/no basis; marital problems were deemed to be serious if they were liable to lead to divorce or if they involved violence or constant arguments. A detailed breakdown of the criteria required for each rating category is in Appendix B.

The checklist helped to prevent the loss of information. Conditions were not always clinically diagnosable but could still cause considerable distress and disruption. A copy of the Symptom Checklist is part of the proforma in Appendix A.

7.4 Summary of Instruments used
It has been the practice of the Centre, since its inception, to look at the data relating to children from a number of perspectives. Anna Freud, a practical and down-to-earth woman was, as we have already noted, well aware that the description of, and explanation for, childhood disturbances could not be exclusively contained within classical Freudian concepts. Children have inner lives and phantasies but they also act within and on a more objective,
external world. They have to cope not only with the effects of subjective perceptions but also with the realities of school and family life, of poverty, parental illness, divorce and separation, and - for some of our patients - with their own long-standing physical illnesses and handicaps.

Anna Freud went ‘beyond infantile neurosis’ to find ‘developmental pathology’ (Young-Bruehl 1988). ‘This phrase summarised a wide range of developmental irregularities or complete arrests producing not psychic conflict but defects in a child’s psychic structure and personality’ (op cit). She did not, however, consider the traditional medico-psychiatric classificatory systems to be particularly useful in describing the ecology of the child. The symptoms manifested by children, unlike those presented by adults, may not be signposts to a fixed, well-organised, underlying pathology as psychoanalytic tenets had taught, but neither could they be entirely explained away by a medical model.

Subsequent research supported Anna Freud’s convictions that assessments need to be arrived at from a variety of standpoints by showing, for example, that 'caseness' and 'impairment' are different concepts (Vaillant and Schnurr 1987). Diagnostic taxonomies such as the DSM-III or ICD (which are valid categorisations of ‘case’) complement the use of rating scales such as the GAF which measure impairment (op cit).

There now exist a number of paradigms used for classification purposes (Achenbach 1988). The ones used by us to assess the children and their families have been described in detail above. In summary, these were:

1) The traditional Kraepelinian paradigm (ICD and DSM).
2) A psychodynamic paradigm (the Anna Freud Categories)
3) A developmental paradigm (the Profile, Developmental Lines).
3) Multivariate paradigms - factor analyses etc. (the CBCL).
4) Global functioning approaches (CGAS, GAF).
5) Clinical perspectives (symptom checklist).
This use of a variety of measures to categorise childhood and parental impairment was an attempt to bypass the limitations inherent in looking at the situation from only one angle (Achenbach 1988). Important though this is in any outcome research it seemed essential when looking at data collected within such an extremely idiosyncratic viewpoint as the psychoanalytic. Approaching the raw material from so many different angles has, hopefully, enabled it to gain in validity, allowing it to be both quantitatively and qualitatively analysed and discussed.

7.5. Selection of Target Groups
Choosing the most appropriate sample from any population is fraught with difficulties. In most research it is important to adhere to basic parametric assumptions, ensuring that subjects are representative members of the total target population, that they have been randomly selected from all those who match the stated profile, and that all these variables constraining final selection of the group of interest have been tightly and rigorously defined so that the sample meets the requirements for acceptable levels of validity and reliability.

In our research we were trying to identify all the members of a particular group (children with long-standing physical conditions in addition to the emotional and behavioural difficulties which had brought them to the attention of child guidance). We did not, therefore, face the challenge of ensuring that our final selection represented all those who could possibly have been in the sample, nor that the requirements of randomness had been met.

However, the retrospective nature of our data did present us with the challenge of having to interpret the case material on file to decide whether any particular child was sufficiently ill or handicapped for our purposes. We had not seen any of the children or parents ourselves and we could not go back to clarify information in uncertain cases. Using secondary data also meant that the original data collectors had not been research workers. Not
only had they not been trained to follow scientific (as opposed to clinical) guidelines of data collection - for example, by using standardised questionnaires from which little or no deviation is permitted - but they had not even known at the time when they questioned the parents and children that this material would be subsequently used for a large outcome study.

In order to look in some detail at the chronically ill and handicapped children from within the total sample we had, firstly, to define the target characteristics in which we were interested, and then operationalise the parameters by which these would be identified. The final sample was chosen by applying these parameters to all children with a recorded medical history to determine which of them matched our requirements. The following sections describe the procedures we adopted for deciding which children fulfilled the specified criteria.

7.5.i Subset of Chronically Ill and Handicapped Children

Among the great number of variables recorded during the first stage of data collection, the medical history of each subject was categorised under 4 headings: - Accidents, Operations, Chronic Conditions and Acute Illnesses. There was originally a fifth "catch-all" category named, rather unimaginatively, Other but this turned out to be superfluous and was never used.

Early categorisations were crude and relatively undiscriminating. They were recorded by psychology final-year undergraduates who, because of their lack of research experience, were not asked to make judgements regarding severity or implication of any condition but merely to record any data in the case files that related to either past medical history or present medical condition of the child. However, to avoid being totally overwhelmed by a mass of data they were encouraged to apply common-sense criteria and to omit minor cuts and bruises or mild attacks of 'normal' childhood infectious diseases such as measles. If there was any doubt about the significance of any incident it was included. Over-inclusion of events at this early stage of data processing is clearly a better direction of bias than missing out potentially significant incidents altogether.
This first review of cases suggested that 436 children (56.7% of the total) had a significant medical history (many of them being recorded in several categories). This very high percentage threatened to bring into question the definition of 'significant'! For example, incidents noted under the heading Accident ranged from a cut finger that required nothing more than a sticking plaster, to horrific and lasting bomb injuries that had lifelong implications. Chronic conditions included mild squints and total blindness, occasional migraines or frequently-recurring epileptic fits. Acute illnesses included normal childhood ailments such as measles as well as tropical diseases and life-threatening, near-fatal toxicities. (Operations were, by definition, almost always of significance - with one exception, to be discussed on page 177).

The effect of employing a liberal opt-out policy for inclusion combined with a general lack of research confidence resulted in inconsistent recording of trivial episodes. This meant that substantial revision of the material grouped under each category was needed before the information collected could be used in any adequate way for analysis.

Consequently, the entire class of medical history was revised almost from scratch. The only assumption that was allowed to stand was that important medical conditions if present, would have been correctly recorded in this first round of data collection. This is based on the finding that recording had been over-inclusive, noting unnecessary minor and trivial periods of being unwell. Providing that the illness or handicap was significant enough for the parent to have mentioned it during the diagnostic process our researchers would have been very unlikely to have missed it, erring instead in the other direction.

Disclosing medical events during the diagnostic interview depends, at least in part, on perception of significance of such events which may differ between the main protagonists in therapy. Peter Bloš describes 3 cases of cryptorchism (undescended testicle), none of which was ever disclosed spontaneously, let alone being mentioned in the history-taking, but all of which, according to Bloš, 'blurred the diagnostic and prognostic assessment of the cases to a considerable extent' (Bloš 1960). The psychoanalytic framework within which he was working predicts that deficiency in body image, especially concerning the genitals, will influence symptom choice and a variety of other behaviours, and Bloš was able to accurately infer, and later confirm, the medical condition through symptomatic acts of the child. However, we relied more on medical criteria than on psychoanalytic assumptions to determine severity and it is probable that these 'undisclosed' cases would not have been rated sufficiently severe for inclusion in any case. This underlines the problems inherent in making judgements from two or more perspectives which are not isomorphic.

\footnote{Disclosing medical events during the diagnostic interview depends, at least in part, on perception of significance of such events which may differ between the main protagonists in therapy. Peter Bloš describes 3 cases of cryptorchism (undescended testicle), none of which was ever disclosed spontaneously, let alone being mentioned in the history-taking, but all of which, according to Bloš, 'blurred the diagnostic and prognostic assessment of the cases to a considerable extent' (Bloš 1960). The psychoanalytic framework within which he was working predicts that deficiency in body image, especially concerning the genitals, will influence symptom choice and a variety of other behaviours, and Bloš was able to accurately infer, and later confirm, the medical condition through symptomatic acts of the child. However, we relied more on medical criteria than on psychoanalytic assumptions to determine severity and it is probable that these 'undisclosed' cases would not have been rated sufficiently severe for inclusion in any case. This underlines the problems inherent in making judgements from two or more perspectives which are not isomorphic.}
From the information provided by the first research team, a substantial revision took place. First of all, the most minor instances in each category were deleted. A variety of cuts and bumps had been unearthed from the files which we decided the average child would take in his or her stride. If the overall reading of the file in question implied that the accident or illness was of only momentary consequence, causing minimal distress and with no subsequent implications, we counted this as indistinguishable from the career of any child.

7.5.1.a Accidents
After these very slight incidents had been disregarded, operational criteria for severity were worked out. Each remaining incident was categorised as either severe (major) or minor. Remaining accidents were classed as minor unless the child had to spend a minimum of two days in hospital, or the child spent a minimum of 1 month in some restraint (e.g., leg in plaster, arm in sling) or some permanent injury or disability resulted. Broken limbs were only counted if they had necessitated an operation, or restraints (as above) or if any complication had arisen. These three yardsticks were chosen because of the importance accorded in the literature on child psychology and child psychoanalysis to the issue of separations (including hospitalisation), the import of operations, anaesthetics and restraint, and the significance of body image and its related issues such as self-esteem.

7.5.1.b Operations
Very few operations had been noted unnecessarily. As already suggested, most operations are significant events almost by definition, requiring hospitalisation, anaesthetic, surgery. However, we decided on an extra criterion for omission which was motivated by the extreme unrepresentativeness of our sample in terms of religious membership. More than two-thirds of recorded parental religious affiliations were Jewish which produced a rash of circumcisions performed routinely by Rabbis and GPs under local anaesthetic. Circumcisions were not, therefore, included in our operation category if they were simple routine fulfilments of Jewish law. If the operation was undertaken for reasons other than for hygiene or religious
duty, say for medical reasons, or if the child was past infancy when the
operation was carried out, or if a complication resulted (as with one child
whose haemophilia was discovered when the bleeding from circumcision
could not be controlled) this counted as minor or major, depending on
circumstances. All other operations were rated unless they were done under
local anaesthetic in, say, a GP's surgery. There were very few instances of
this. Any operation which required the child to undergo anaesthesia and/or
be admitted to hospital was regarded as at least minor.

Operations were counted as minor if they were routine settings of broken
limbs, or straightforward tonsillectomies, appendectomies and the like.\(^2\)
Anything out of the ordinary—surgical complications, subsequent infections,
extreme pain or distress, emergency admissions, severe restraint and so on,
was sufficient to consider reclassifying the operation as a major medical
event in the life of the child. Our criteria were not entirely medically-based
but were also dependent on the circumstances surrounding the episode. It
was not always possible to tell from the files how traumatic an incident had
been; where this was so, inference was kept to a minimum so that false
positive ratings were much less likely than false negatives.

7.5.i.c Chronic conditions

Chronic conditions were split into chronic illness and chronic disability. We
used a 'medication criterion' to distinguish between the two. Any condition
which had the possibility of being alleviated or controlled by the use of
medication\(^3\) or other medical intervention either on a regular basis or as crisis

\(^2\)Of course even routine operations can cause considerable distress in some children - the level
of anxiety invoked by minor surgery seems to depend on the child's pre-operative personality
(Jessner et al 1952). For some, in contrast, an operation can be 'a constructive experience,
enhancing the development of the ego' (op cit). It is not possible in retrospective studies to make
a full assessment of individual reaction, though we attempted to do so as best we could. Nor were
we able to determine whether hospitalisation in the early decades of the study was more traumatic
than more recent admissions which, in general, demand less rigorous separation from parents and
offer better understanding of the difficulties for both child and parents.

\(^3\)We recognise that a small percentage of chronically ill children (about 12% of epileptics, for
example - Terdal 1981) do not, in fact, respond to medication.
intervention at times of attacks (for instance, diabetes, epilepsy, asthma, eczema, haemophilia) was classified as 'illness'.

Disabilities included deficient sight (not necessarily total blindness but sight that was sufficiently poor to be inadequately correctable by glasses), bad hearing (again, the child may not have been completely deaf and may have made use of hearing aids but these will not be sufficient to fully compensate for the hearing loss), and motor abnormalities that were not, and were unlikely to be, fully surgically correctable. Disabilities were required to be chronic (assumed to be permanent); temporary disabilities arising from an accident did not count (although would probably have been recorded under the accident category). Often a child was born with a particular disability but sometimes it would be acquired through illness or accident. In these cases the child was noted under two or more appropriate categories. Disabilities were also separated into major and minor. To determine whether a case should be regarded as sufficiently severe for inclusion as a major disability we applied Rutter's 'restriction' scale (Rutter et al 1970). Children that showed marked inability, or difficulty, in performing tasks easily accomplished by non-handicapped age-mates, and who also needed special facilities in order to cope with life (usually special schooling), were regarded as severely disabled.

Chronic illness could not necessarily be assumed to be permanent in the same way that disabilities were (and this distinction formed the basis for one further subsection of cases which will be fully described on page 182. However, the illness had to have been present for a substantial period of time before referral (the exact period was not formally set down and was somewhat dependent on age; in practice it tended to be at least 6 months and was usually longer).

7.5.i.d Acute illness

Acute illnesses required hospitalisation to be of sufficient severity to be rated. Thus, normal cases of, for example, measles, tonsillitis and bronchitis were generally discounted unless the child had needed inpatient treatment.
The distinction between major and minor acute illnesses was made on a rather ad hoc basis, primarily dependent on clinical judgement of the file material.

For the purposes of the present investigation, only children with chronic conditions were studied. Accidents, operations, and serious acute illnesses experienced by the final selection of children in our three target groups were noted.

A case example from each of the three ‘chronic’ groupings can be found in Appendix F.

7.5.ii Severely Disabled Target Group
Having broken down the chronic conditions into illness and disability and categorised these as major or minor dependent on the information recorded, 64 children with a chronic disability were identified (see Table 7.6).

From the previous recordings and categorisations some cases were confidently rated as having been correctly assessed. A child with multiple handicaps of total blindness and deafness quite obviously qualified for inclusion as experiencing severe disability. The remainder were checked from the original data in the files. Four cases were removed from the 'severe' list. A child with a past history of malformed limbs had had these surgically corrected by the time of the diagnostic process; two children with a collapsed lung and encephalitis respectively were regarded as having been incorrectly classified under chronic disability. The fourth case, a little girl with precocious sexual development was certainly labouring under quite extreme disability at this, pre-adolescent, stage of life. However, applying the criteria rigorously, this was not assumed to be a life-long handicap. Although the suffering and problems with body image of this child were undoubtedly extreme she was not an adequate match with the others in her group and was therefore excluded.
<table>
<thead>
<tr>
<th>Disability</th>
<th>Number</th>
<th>Number Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Partial sight</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>Squint</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Brain damage</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Malformed limbs etc</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Deaf or hearing loss</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>64</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Table 7.6 Chronically Disabled children

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness</td>
<td>6</td>
</tr>
<tr>
<td>Partial sight</td>
<td>9</td>
</tr>
<tr>
<td>Brain damage</td>
<td>2</td>
</tr>
<tr>
<td>Malformed limbs etc</td>
<td>9</td>
</tr>
<tr>
<td>Deaf or severe hearing loss</td>
<td>5</td>
</tr>
<tr>
<td>Other (lip deformity)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

Table 7.7 Breakdown of final list of Chronically Disabled subset
In addition to the 21 remaining severely disabled children, the 'not so severe' cases were re-checked and 11 were reclassified as constituting severe and chronic difficulties for the child. The final list is shown in Table 7.7.

7.5.iii Severely Ill Target Group

100 children were originally recorded as being chronically ill, 21 of them severely so. This broke down as shown in Table 7.8. At this stage the decision was taken to subdivide the 'ill' group as mentioned on page 179. On the grounds of permanence there was some validity in separating diseases such as diabetes and haemophilia from asthma and eczema which are frequently grown out of by adulthood. This is not a very clear-cut dividing line but it was strengthened by the oft-cited distinction, especially in the psychoanalytic literature, between the so-called 'psychosomatic' diseases like asthma and eczema which often seem to be caused and/or exacerbated by psychological factors such as stress and anger, and diabetes, haemophilia and epilepsy which have well-recognised and accepted organic aetiological components. This is a risky decision to make: there is also plenty of evidence, some of which is looked at below, to suggest that organically-caused conditions are also very susceptible to emotional variation. Equally, it is very probable that at least some asthmas and eczemas have a very strong physical basis in allergen-sensitivity. The files had to be carefully combed for any hint of possible aetiology, bearing in mind the traditional and often opposing biases of psychoanalytic centres and medical practice! Where there was ample evidence that a skin or respiratory condition was caused by physical irritants it was included under the 'ill' category; otherwise, physical disorders in which psychological or emotional factors seemed to play a decisive rôle were recategorised as 'psychosomatic'.

7.5.iv Limitations to the validity of psychosomatic as an aetiological category

7.5.iv.a Organic illnesses

Even diseases with proven and observable physiopathological genesis are not
<table>
<thead>
<tr>
<th>Illness</th>
<th>Number</th>
<th>Number Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>37</td>
<td>5</td>
</tr>
<tr>
<td>Eczema</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Migraines</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Anaemia</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Haemophilia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tubercular disease</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rheumatic disorders</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

*Table 7.8 Chronically Ill children*
separated entirely from the psychological. It is always possible that emotional trauma is the source of a symptom which is otherwise presumed to be organic in origin. The literature contains a number of case studies illustrating just this point, predominantly written by clinicians influenced by psycho-dynamic hypotheses (Mannoni 1970).

**Epilepsy**

The vulnerability of epileptics to visual stimulation has led some psychoanalytical theorists to associate epileptic reactions with psychological conflicts about looking (Gottschalk 1956). Few would dispute the neural correlates of epilepsy, simply suggesting, in the traditional manner of analysis, that seizures may be over-determined, having symbolic functions in addition to the undisputed physical attributes. The most widely accepted view is probably that represented by Gottschalk who dismisses talk of symbolic significance and the associated aetiological implications, claiming merely that psychic factors 'contribute to the form and frequency of [epileptic] seizures and associated clinical manifestations' (1956).

**Diabetes**

Diabetes mellitus, actually a heterogenous collection of related syndromes, was first identified by Thomas Willis, a 17th century physician. Perceptively, he noted its relationship with 'prolonged sorrow' (Garner 1981). Since that time, the association between clinical and emotional factors in diabetes has remained a topic of debate. Stein and Charles (1971) found that 69% of diabetics in their sample had experienced a major personal loss of a parent compared to only 19% in a control group of patients with other, non-diabetic, heritable blood diseases. As with epilepsy, emotional factors are not generally held to be responsible for the cause of the illness but seem associated with its management. A number of studies have demonstrated a relationship between episodes of stress and the physiological oscillations of cases of 'super-labile' diabetes (Garner 1981). Hinckle et al, for example, were able to relate the occurrence of significant life events to blood glucose concentrations. Other research has succeeded in reducing blood glucose levels through experimentally-induced stress.
In a specifically psychoanalytical context, Fonagy and Moran (1990) showed that improvement in diabetic control could be predicted by the emergence of certain unconscious themes in treatment, and that physiological measures of long-term psychological adjustment to chronic illness could be taken as a measure of therapy outcome. In brittle diabetes, especially, the patient may have feelings of guilt and anxiety about his or her violation of treatment requirements; if such conflict is able to be expressed in analytic sessions it may reduce the need to displace the ambivalence onto the treatment.

**Haemophilia**

Agle et al (1967) describe reports of 'spontaneous bleeds' in haemophiliacs following periods of emotional stress or anticipation. He reports an improved clinical state in patients who are able to change from an attitude that is predominantly passive to a more aggressive independence, and even notes an example of clinical regression in a patient reverting to his previous passive state. The inference that clinical condition is influenced by psychological factors is supported by Steinhausen (1975) whose work with haemophiliacs uncovered a statistically significant correlation between levels of neuroticism and increased risk of bleeding during periods of emotional stress, and by Lucas (1965) who showed a relationship between the psychiatric state of the haemophiliac and amount of bleeding experienced during dental surgery. Agle et al (1967) also described spontaneous bruising produced by hypnotic suggestion.

**7.5.iv.b Psychosomatic illnesses**

We have seen that so-called organic diseases may have considerable psychosomatic components to them; conversely, there is evidence to show that differentiation between biologic and psychologic varieties of a prototypical psychosomatic condition like asthma is often difficult to find (Graham et al 1867, Jacobs et al 1967). Variations that exist tend to be overshadowed by the overlap between the two groups (Block et al 1964). Rutter concludes that 'The evidence to date suggests that although asthmatic children differ in the extent to which their attacks are due to allergic, infective, emotional and other factors, there does not seem to be
any clear-cut differentiation into meaningful subgroups of somatically
determined asthma and psychologically determined asthma' (Rutter et al
1970). Psychological factors play a part but are rarely the sole determinant.

Psychoanalytic writers have also always argued strongly that 'there is no gap
between the organic and the functional ... Psychic processes have common
roots with other processes going on in the organic' (Schilder 1935).

Nevertheless, despite sufficient grounds for not dividing our illness group,
there is considerable face validity for separating eczema and asthma from
diabetes, epilepsy and haemophilia. Apart from the issue of chronicity already
discussed we have validated our decision with reference to Minuchin's
distinction between primary psychosomatic symptomatology and secondary
psychosomatic symptomatology (Minuchin et al 1977). In the former
category, a physiological disorder is already present (e.g. diabetes, allergic
asthmas). The psychosomatic element is simply emotional exacerbation of
the already existing symptom. No such predisposition exists for the
secondary classification. Instead, emotional conflicts are transposed directly
into somatic symptoms (non-allergic asthmas and eczemas). This distinction
also offers space to the psychoanalytic explanation (Mannoni 1970) that
psychosomatic symptoms reveal difficulty in expressing anxiety and conflict
symbolically, choosing a more direct communicative route. This division
between 'ill' and 'psychosomatic' children is recognised as being, to some
extent, artificial; nevertheless it was at least partially vindicated by finding
quite marked differences in a number of variables and results between the
two groups.

Having removed the asthmas and eczemas, the remaining cases were
rechecked for severity and chronicity and 17 cases were selected as being
suitable for inclusion in the chronically III category (Table 7.9).

The other sub-division of the III group - the psychosomatic ('Somatic')
children - took a lot of reclassifying. For each case the original files were
returned to and the cases recategorised in terms of severity and chronicity.
<table>
<thead>
<tr>
<th>Illness</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
</tr>
<tr>
<td>Haemophilia</td>
<td>1</td>
</tr>
<tr>
<td>Allergic Conditions</td>
<td>3</td>
</tr>
<tr>
<td>Stomach Problems*</td>
<td>2</td>
</tr>
<tr>
<td>Rheumatism/Heart Disease</td>
<td>2</td>
</tr>
<tr>
<td>Encephalitic sequelae</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

* Caused by enzyme deficiency and colon constriction

Table 7.9 Breakdown of final list of Chronically Ill subset

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>19</td>
</tr>
<tr>
<td>Eczema</td>
<td>5</td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

Table 7.10 Breakdown of final list of Chronically Somatic subset
The criteria already mentioned on pages 177-9 - that is, the necessity for hospitalisations relating to the target condition, recurrent absences from school, constant inhibition of sleep and so on constituted sufficient severity for inclusion. The final breakdown can be seen in Table 7.10.

It was entirely by chance that the final figure of 32 in the Somatic group equalled the number in the Disabled Group.

7.6 Finding Controls for Target Groups
Once the 81 ill and handicapped children (32 Disabled, 32 Somatic and 17 organically ill) had been selected out from the main sample of 769 children, the next step was to match each with an individual control case.

From the remaining subject pool of 688 possible controls 80 were removed because they had a chronic physical condition not severe enough to have been included in the target groups. Operations, accidents and acute illnesses were not selected out. The population from which the control sample was taken thus numbered 608 cases.

More than 200 variables had been amassed on each patient; it was clear that only a very few of these could be adequately matched for. Which factors in therapeutic outcome research are considered necessary to control is a matter of debate (Kazdin 1988). One researcher's artifact or confounding variable is another's central treatment component. In the present study the principal dependent variable was CGAS change (change in the Child’s Global Assessment Score between assessment and termination). The child’s medical condition was one of the independent variables.

7.6.i Selected variables
Nine factors were held as constant as possible between the target and control case of each pairing. These were sex, age, year of coming into treatment, type of treatment (intensive versus non-intensive), type of therapist (staff or trainee), IQ, social class, category of diagnosis (neurotic,
psychotic, no diagnosis, learning difficulty or specific developmental disorder, habit disorder, conduct disorder), and whether the child's family was broken or intact. Chronicity of psychiatric diagnosis was, unfortunately, too seldom recorded to be usable. An attempt to include family size was only partially successful; 9 factors seemed the maximum number that could be adequately controlled. No pair was a perfect match but, overall, they were as close as it was possible to get with a limited number of cases from which to choose.

7.6.i.a The rationale for the selection of certain variables

A) Sex
There is widespread recognition that sex differences play a major rôle in most aspects of human behaviour (Maccoby 1966, Bem 1974), including psychiatric vulnerability (Kazdin 1988, Shepherd et al 1971) and response to treatment (Kazdin 1988).

B) Age
Anna Freud's emphasis on the importance of the developmental and maturational aspects of childhood (1965) has been subsequently reinforced by the work of child psychologists and psychiatrists who stress the need for a child to be assessed according to age norms (Rutter et al 1970). It was decided that it was specially important to match children within broad psychosexual stages - pre-latency, latency and adolescence. Younger children have been found to respond better than teenagers to treatments of all kinds (Kazdin 1988). Psychoanalysis, with its inherent regression and transference phenomena, is particularly difficult for older children to contend with (A. Freud 1965) and many drop out when they reach adolescence. To avoid an excess of premature terminations in any group, the sample subjects needed to be matched for age.

C) Social class
The literature varies in its assessment of the importance of social class to psychological disturbance and response to treatment. Rutter found only a
weak association although there is a stronger positive correlation with certain medical conditions such as asthma (Rutter et al 1970). In contrast, in their review of a number of studies which looked at social and cultural influences on psychopathology, Bruce & Barbara Dohrenwend found 'considerable evidence of a high concentration of psychopathology in the lowest class compared to all other classes'. The most consistent result reported was an inverse relationship between overall rates of psychopathology and social class (Dohrenwend and Dohrenwend 1974). In many respects this seems a dubious finding, though, holding more for personality disorders than for neurotic and psychotic conditions and, again, there may be a confound of labelling and diagnostic practices. A re-analysis of the data suggested that the higher incidence of schizophrenia in lower social classes was balanced by increased rates of manic-depression higher up the social scale. The situation, then, is complicated. Nevertheless, it is possible that social class interacts with other factors to mediate treatment effects and, therefore, we decided to control for this.

More relevantly in terms of controlling appropriate variables for the present study, it is a feature of psychoanalysis as a treatment that it attracts mostly middle-class patients (Bachrach et al 1991) because they are generally supposed to be more articulate and disposed towards introspection and self-examination, attributes deemed necessary to make best use of intensive therapy. The families of our referred children therefore needed to be matched in terms of social class to control for the possible effect of social class on treatment outcome.

D) IQ
A low IQ rating is associated with an increased risk of psychiatric disorder (Rutter 1975). As high IQ may also interact with other factors such as social class which, in turn, may predict a beneficial response to psychoanalytic therapy (Bachrach et al 1991), it was necessary to match target and control children on their IQ ratings so that outcome ratings should not be confounded by intelligence levels.
E) Year of starting treatment:
Nearly forty years of psychoanalytic assessment and treatment - from 1950 to 1989 - were represented and it was felt important that some attempt should be made to match children at least within a decade of starting treatment. Both psychoanalysis and, more especially, child-rearing and education, have changed dramatically over four decades and the child coming into treatment in the 1980s and 90s would be a very different entity from his or her parent or grandparent.

F) Number of sessions
Heinicke (1965) and Heinicke and Ramsey-Klee (1986) reported that children seen in 4-times weekly psychoanalysis for a year improved on a variety of measures over children seen in once-a-week psychotherapy, even when the therapists used the same general approach. Although they only studied 12 subjects, their results suggested that our patients should be matched on intensity of treatment. A distinction was made between intensive treatment (4 or 5 psychoanalytic sessions per week) and non-intensive treatment (1-3 psychoanalytically-oriented psychotherapy sessions a week). Data had been recorded on both initial number of sessions and maximum sessions attended. Some children had started off in psychotherapy and increased attendance as they settled into treatment; for others the reverse occurred, and many children reduced sessions towards the end of their therapy in preparation for final termination. Initial number of sessions was the variable controlled for as reductions and increases were seen to be largely a result of treatment effects.

G) Type of therapist
Outcome studies on adult psychoanalysis have generally found greater benefit for patients treated by experienced staff therapists than by student candidates (Bachrach et al 1991) though this effect is often confounded by...

"For example, Martin Herbert has documented changes in the average age for starting toilet training with children (1974). In 1935 training was begun, on average, at 6 months of age. Twenty years later the mean age had risen to 11 months; in 1966 it was 18 months. In the 1990s training is often postponed until still later. Psychoanalytic theory predicts that such changes may have profound effects on personality and predisposition to psychological disturbance."
shorter analyses as candidates graduate and move away. It is recognised that treatment length correlates with more favourable outcomes (Erle in Bachrach et al 1991). Meta-analyses of child treatments have found that, whereas experienced therapists are equally successful with all client groups, student therapists are more effective with younger children (Weisz et al 1987a, 1992). Where possible, therefore, the subjects in the present study were matched for type of therapist.

H) Diagnosis
Psychoanalysis is often claimed to be of greatest use for patients with neurotic or psychosomatic conditions (Eissler et al 1977a, Bachrach et al 1991, Wittkower and Warnes 1977) and of dubious merit, if not positively counter-indicated, in cases of psychosis and conduct disorders (Mannoni 1970). Clinicians differ considerably in their evaluation of conditions that can be appropriately treated with intensive psychotherapy but there is little dispute over the assumption that diagnostic category is an important factor in determining response to treatment.

I) Family broken or intact:
There are a variety of family factors which may affect a child's overall level of functioning and his or her ability to use psychological intervention. Rutter found a slight positive association between psychiatric disorder in children and large families, broken homes and parents' emotional difficulties (Rutter et al 1970) These are all unknowns in terms of treatment outcome. No attempt was made to control for parental health, either physical or mental, as it was felt that this might be a factor of the child's illness or handicap and thus be regarded as a partly-independent variable. Efforts to control for family size were only partially successful although singletons were matched where possible. Family status in terms of broken and intact homes was taken into account in finding controls for the target children.

Besides parental pathology, length of treatment, reasons for termination, and parents' and children's GAF (global assessment of functioning) scores, were all variables that were not held constant but were assumed to be
Contributory factors to relative success or failure of treatment.

7.6.i.b Closeness of match on the selected variables

A) Sex
The sex of all 81 target cases was appropriately matched with the controls.

B) Age
Ninety-three per-cent of cases were able to be matched within broad age-groups (under 6, 6-11, over 11); 41% were matched to within one year. Taking the groups as a whole, the total mean age of subjects was within one year for targets and controls in all three groups (Table 7.11).

C) Social class
We recorded social class according to the Registrar-General's Classification of employment. This is by no means a very satisfactory way of demonstrating the rather intangible differences between the social classes but is the best we could do with the retrospective information. Father's job was taken as indicative of the position of the family in the class hierarchy; if the father did not have a job, or the classification was unknown, mother's employment was considered.

Despite the Dohrenwends' review findings, cited above, that psychiatric disturbance is related to low social class, our families, consistent with psychoanalytic populations, fell into the top 4 categories on the RGC. Our intention was to match pairs of children within one class. That was achieved with 90% of the pairs - 56% of pairs where social class was known (70 out of 81) were matched exactly; a further 34% fell within one class. Table 7.12 shows the social class breakdown for all the target and control groups. Overall, each medical subgrouping was matched to within .6 of a class.

D) IQ
IQ scores proved fairly difficult to match as tests were not uniformly administered. Children, if assessed at all, might be tested before, during or after treatment, or any combination of this. Patients who had two or more
### Table 7.11  Mean age of Target and Control groups

<table>
<thead>
<tr>
<th>Mean Age in Years</th>
<th>Disabled</th>
<th></th>
<th>II</th>
<th>Somatic</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Control</td>
<td>Target</td>
<td>Control</td>
<td>Target</td>
<td>Control</td>
</tr>
<tr>
<td>8.5</td>
<td>8.8</td>
<td>10.1</td>
<td>11.0</td>
<td>8.6</td>
<td>8.8</td>
<td></td>
</tr>
</tbody>
</table>

Table 7.11  Mean age of Target and Control groups

### Table 7.12  Social class of Target and Control groups

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Disabled</th>
<th></th>
<th>II</th>
<th>Somatic</th>
<th></th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>I</td>
<td>19</td>
<td>22</td>
<td>6</td>
<td>18</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>II</td>
<td>34</td>
<td>50</td>
<td>18</td>
<td>29</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>III</td>
<td>41</td>
<td>13</td>
<td>53</td>
<td>35</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>IV</td>
<td>3</td>
<td>9</td>
<td>18</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Not Known</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Mean Social Class</td>
<td>2.3</td>
<td>2.0</td>
<td>2.9</td>
<td>2.3</td>
<td>1.9</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Table 7.12  Social class of Target and Control groups

### Table 7.13  Year of coming into treatment for Medical and Control children

<table>
<thead>
<tr>
<th>Mean Year of coming into Treatment</th>
<th>Disabled</th>
<th></th>
<th>II</th>
<th>Somatic</th>
<th></th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Control</td>
<td>Target</td>
<td>Control</td>
<td>Target</td>
<td>Control</td>
</tr>
</tbody>
</table>

Table 7.13  Year of coming into treatment for Medical and Control children
separate testings sometimes obtained very different results. Often, only a verbal score or only a performance score was given. Evidence suggests that the verbal score is the more reliable of the two (Herbert 1974) and, if that is so, it may not be valid to compare two single scores, one verbal and one performance, from different children. Verbal ability is highly reliant on upbringing. Children whose upbringing is extremely verbal sometimes show considerable discrepancy between their verbal and performance scores (Griffiths 1981). Field (1960) reported that 25% of the 10½ year-old children he studied showed divergence between verbal and performance scores of at least 14 points and 10% of them deviated by at least 20 points. Other studies have not been able to confirm this but it is acknowledged that even a full IQ score is not an entirely stable indication of ability; over the course of his or her school career a child’s IQ is known to deviate by about 15 points (Rutter 1975).

It therefore seemed adequate to attempt to match to within one standard deviation (16 IQ points), and this was generally able to be achieved. 86% (N = 19) of the disabled children where the IQ of both members of the pair was available (N = 22) were matched to within 1 sd; similar matchings were obtained for 85% (N = 23) of the available Somatic group (N = 27) and 71% (N = 10/14) of the III children. The group mean of the scores was identical in the III sample and showed a difference of 3 and 4 points respectively for the Somatic and Disabled groups.

**E) Year of treatment**

We fulfilled our intention to match cases to within a decade of beginning treatment for 85% of the target-control pairs. More than half the pairings (56%) started treatment within 5 years of one another. The mean year of beginning treatment differed between the Somatic target and control children by just a year. The Disabled children showed a mean difference of two years and the III children five years (Table 7.13).
F) Initial number of sessions
More than two-thirds (68%) of the 81 pairs were matched exactly on initial number of sessions; a further 23.5% were matched for sessions within one per week. Another 4 pairs (5%) were matched within the non-intensive/intensive dichotomy (1-3 sessions a week/4-5). This amounted to a total of 96.5%. Only 3 pairs (2 disabled and one somatic) were not able to be adequately matched. Taking the groups as a whole we can see from Table 7.14 that, within each category, equal percentages of Disabled and III target and control children received intensive treatment (62% and 59% respectively). The Somatic children differed from their controls by a couple of percentage points only (88% to 90%).

G) Type of therapist
74 of the 81 pairs (91%) were matched correctly on whether initial treatment was given by a staff or student therapist. Five pairs of subjects from the Disabled subgroup and one pair from both the III and Somatic categories were mis-matched. The Disabled category as a whole tended to even out so that all three categories had an over-all mismatch of one pair.

H) Principal diagnostic category
It was not possible for us to always match specific diagnosis for specific diagnosis. However, matching children within broad categories of neurosis (which included psychosomatic conditions, depression, habit disorders and learning problems), psychosis, conduct disorders and no diagnosis, proved feasible in most cases. This approach was justified on the grounds that research investigation has supported the validity of diagnostic lines of demarcation only with regard to wide-sweeping categories such as internalising emotional disturbance and externalising behaviour disorders. These account for the bulk of childhood disturbances (Rutter and Tuma 1988) and it is possible to distinguish between them but not so easily within them. The finer lines of division of classificatory systems such as DSM-III-R and ICD-X do not hold up under close examination (Rutter and Tuma 1988), although we matched many of the neurotic subdivisions, such as habit disorders, as closely as possible. We were not, unfortunately, able to control
<table>
<thead>
<tr>
<th>Number of sessions</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>16</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>56</td>
<td>59</td>
<td>47</td>
<td>41</td>
</tr>
</tbody>
</table>

Table 7.14  Initial number of sessions for Target and Control Groups
for comorbidity or level of chronicity, although additional diagnoses were used to match in difficult cases. The III children were the easiest to match and the Somatic children the hardest, partly due to the fact that, by definition, their physical condition was psychologically determined and was often diagnosed as such, a condition inevitably absent for all controls. There were few serious mismatches. Four target children with no diagnosable disorder were matched with, respectively, a probable mild avoidant disorder, a probable over-anxious disorder, a probable encopresis in a 4-year-old and a parent-child V-code specification. None of these diagnoses were either certain or severe. Three children for whom there was insufficient information to diagnose had to be paired with patients with probable dysthymia, a probable non-specified developmental disorder and a disorder of social functioning. Out of the 81 pairs there were only 2 which were seriously problematic. An adolescent girl with probable Tourette's Syndrome (the only such diagnosis made in the entire sample of 769 cases) was matched to a similarly-aged child with a severe specific developmental learning problem (in arithmetical functioning). A blind child with a pervasive developmental disorder (categorised as a childhood psychosis on broad classification principles) was matched with a control diagnosed as having a parent-child problem and a possible developmental disorder. This pair compared well on other variables including being under 5 years of age and having low IQs, both of which were difficult factors to match. Table 7.15 shows the break-down of broad diagnostic categories within each medical subgrouping and its control.

I) Family broken or intact
In the III group, all but 2 pairs of children (88%) were correctly matched; these cancelled one another out so that the over-all figures in target and control groups were identical. Thirty-one out of 32 pairs (97%) were correctly matched for the Somatic children. Four Disabled pairs were mismatched on this variable (12.5%) but again these cancelled each other out to leave the same number of broken families (N = 6) in both control and target groups.
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Neurosis</td>
<td>50</td>
<td>59</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Psychosis</td>
<td>22</td>
<td>25</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>9</td>
<td>3</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Not Known/No Diagnosis</td>
<td>19</td>
<td>13</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 7.15  Primary diagnostic category at assessment for Target and Control groups

<table>
<thead>
<tr>
<th>Number of Sibs</th>
<th>Disabled %</th>
<th>III</th>
<th>Somatic %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Control</td>
<td>Target</td>
</tr>
<tr>
<td>0</td>
<td>19</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>1</td>
<td>53</td>
<td>28</td>
<td>47</td>
</tr>
<tr>
<td>2</td>
<td>22</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>&gt;5</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>1.16</td>
<td>1.78</td>
<td>1.56</td>
</tr>
</tbody>
</table>

Table 7.16  Number of siblings for Target and Control children
J) Family size
Ideally, we would have liked to control for the number of sibs each child had. Previous evidence has highlighted differences in the amount and kind of psychological difficulties experienced by children from small and large families (see page 95). However, the explanations for these findings are confused and it is easy enough to find reasons for increased maladjustment in singletons, oldest children, youngest children, children in middle ordinal positions, and children with both large and small numbers of brothers and sisters (Shepherd et al 1971). Consequently, we decided that this variable was of less importance than those described above. On the rare occasions where there was a choice between two equally good matches, information on family size was able to sway the final choice. Otherwise it was omitted from our considerations. Table 7.16 shows that the Ill and Somatic children did not, in any case, differ from their controls in this respect. The Disabled children, however, came from smaller families than did their controls. This seems largely due to a few larger than usual families from among the control children, and is probably of no great significance.

7.7 Conclusion
To find 81 close controls was no mean feat, matching on such a large number of variables, and, although not always successfully achieved for individual pairings, was generally sufficient to enable overall means within the groups to be within acceptable limits. There were no statistically significant differences between Target and Control samples on any of the nine main variables matched for. Sex, social class, initial number of sessions, type of therapist, diagnosis and family status were well matched; age, IQ, and year of coming into treatment were less well, but still adequately, controlled for. Information regarding the persistence of the presenting complaint was not often available in the files but its omission was regretted, as was our failure to take into account the incidence of co-morbidity in patients. If we had had unlimited access to possible controls we should also have opted to match the severity and certainty of diagnoses.
Chapter Eight

Characteristics of the Non-Medical Sample
8.1 Introduction
The most salient demographic and epidemiological characteristics of child psychology referrals are well recognised (chapter 4). It is also known that adult psychoanalytic cases differ from other therapeutic clientèle along a number of dimensions (Bachrach et al 1991). However, there has, as yet, been no reported profile of the typical child analysand. We do not know, therefore, whether our sample is representative of the entire population of children who undergo a psychoanalysis. All we can do, for the moment, is to detail the many characteristics of our subjects as recorded in the case notes so that we can compare them with child referrals for other psychological treatments. This will also permit us to compare our various subsamples (for example, the children with chronic medical conditions) with the total sample.

Our first task is to describe the larger group of children without severe physical problems.

8.2 Method
8.2.i Sample
The total number of patient-subjects studied retrospectively in the present investigation was 769. The Target Medical groups of Ill, Disabled and Somatic children, being a specific focus of attention, were looked at separately. This left 688 children, including the children who acted as Controls for their Target pairs, comprising the total (Non-Medical) sample. This section reports on the characteristics of this group.

8.2.ii Instruments
A wide range of assessment techniques were used to ascertain the child’s status along the continua of importance. These have been fully described in chapter 7 and include:

a) The Anna Freud Diagnostic Profile (A. Freud 1962)

b) The Anna Freud Developmental Lines (A. Freud 1963)

c) The Child Behaviour Checklist (Achenbach and Edelbrock 1983)

d) The Diagnostic and Statistical Manual, 3rd edition, revised (published by the American Psychiatric Association 1987)
f) The Children’s Global Assessment Scale (Shaffer et al 1983)
g) The Global Assessment of Functioning Scale (in DSM-III-R 1987)

A variety of internally-generated data, including completed parental symptom checklists, IQ tests, projective testing, school reports, interview schedules, social histories and diagnostic interviews were also used.

8.2.iii Procedure

All the case files were systematically combed for a total of 232 variables, as described in chapter 7, section 7.3. A full list of these variables can be found in Appendix C1. Some, such as age and sex of the child, IQ scores, source of referral, and type of therapist to whom they were assigned, were present in nearly all cases and simply needed to be recorded for input into the computer database. Other characteristics, such as social class, medical history, learning difficulties, separation experiences, and reason for termination, often had to be inferred from the anamnestic and treatment information supplied by the families and therapists. Still further data was dependent on clinical interpretation in order to draw out the required information. Diagnostic details, parental symptoms and illnesses, and global functioning ratings all came into this category. Most of this information was recorded on the proforma (example in Appendix A).

Not all of these variables turned out to be of great interest. Some applied to very few children (attendance at the Anna Freud Baby Clinic and details about dead siblings, for example) others (such as father’s social class (and religion) and mother’s social class/religion) were able to be combined without much loss of information. A revised list of 99 variables of particular interest was drawn up (Appendix C2). These fell roughly into the six categories looked at below - variables relating to 1) the child; 2) the family; 3) the referral and diagnosis; 4) the parents; 5) the treatment and 6) the termination.
8.3. Descriptive findings

8.3.i Child variables

Male and female subjects in the Non-Medical group were in the ratio 59:41 (Table 8.1). The children ranged in age from 2 years 1 month to just over 19 years at the start of treatment, with a mean of 9 years 8 months. The median and mode of age at start of treatment were also around 9 years. One-third of the children were between 6 and 10 years old when they entered analysis. 56 (7%) were under 4 years old and 47 (6%) were 16 or over (Table 8.2).

The children had a mean IQ of 115, one standard deviation higher than normal populations (Table 8.3). Eleven children (2.2% of those tested) scored lower than 75 while 127 (over 25%) achieved scores of 126 or higher. Mean verbal IQ was 5 points higher than performance scores. Only three-quarters of the total sample was tested but it is probable that, if anything, this depressed the mean result as children with no obvious difficulties intellectually or at school would have had less reason to be assessed in this way. In fact, despite their obvious intelligence, the majority of children did have learning difficulties ranging from school refusal to serious underachievement and including poor peer relationships, disruptive behaviour at school, specific learning difficulties and problems secondary to a physical handicap. Only 36% of children were judged to be completely free of educational problems.

More than half the sample had a recorded medical history (Table 8.4); for 21% this was of some severity and slightly less than one in four children had been in hospital on at least one occasion (Table 8.5).

8.3.ii Family variables

Almost two-thirds of the children were of British parentage. Of the remainder, the largest group had parents from other European countries (approximately 16% of both fathers and mothers). A number of these were, like Anna Freud and Sigmund Freud themselves, Jewish emigrés, escaping from continental persecution. This shared heritage with the roots of
<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>409</td>
<td>59</td>
</tr>
<tr>
<td>Girls</td>
<td>279</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>688</td>
<td>100</td>
</tr>
</tbody>
</table>

*Table 8.1 Sex Distribution for Non-Medical sample (N = 688)*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 6 years</td>
<td>153</td>
<td>22</td>
</tr>
<tr>
<td>6-10 years</td>
<td>225</td>
<td>34</td>
</tr>
<tr>
<td>11-14 years</td>
<td>198</td>
<td>29</td>
</tr>
<tr>
<td>&gt; 14 years</td>
<td>102</td>
<td>15</td>
</tr>
</tbody>
</table>

*Table 8.2 Age group for Non-Medical sample (N = 688)*

<table>
<thead>
<tr>
<th>IQ level</th>
<th>Number</th>
<th>% of all children tested (73% of sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 75</td>
<td>11</td>
<td>2%</td>
</tr>
<tr>
<td>76-90</td>
<td>31</td>
<td>6%</td>
</tr>
<tr>
<td>91-110</td>
<td>145</td>
<td>29%</td>
</tr>
<tr>
<td>111-125</td>
<td>187</td>
<td>37%</td>
</tr>
<tr>
<td>&gt; 126</td>
<td>127</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Table 8.3 IQ for Non-Medical sample (N = 688)*

Mean Performance IQ = 110
Mean Verbal IQ = 115
### Table 8.4 Medical History for Non-Medical sample (N = 688)

<table>
<thead>
<tr>
<th>Medical History</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations</td>
<td>158</td>
<td>23</td>
</tr>
<tr>
<td>Accidents</td>
<td>69</td>
<td>10</td>
</tr>
<tr>
<td>Chronic Physical Conditions</td>
<td>80</td>
<td>12</td>
</tr>
<tr>
<td>Acute Physical Conditions</td>
<td>69</td>
<td>10</td>
</tr>
</tbody>
</table>

### Table 8.5 Hospitalisations for Non-Medical sample (N = 688)

<table>
<thead>
<tr>
<th>Number of Hospitalisations</th>
<th>Number of children</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>526</td>
<td>76</td>
</tr>
<tr>
<td>1</td>
<td>119</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>33</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.3</td>
</tr>
</tbody>
</table>

### Table 8.6 Social class distribution for Non-Medical sample (N = 688)

<table>
<thead>
<tr>
<th>Social Class (mean: 2.2)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>141</td>
<td>20</td>
</tr>
<tr>
<td>II</td>
<td>309</td>
<td>45</td>
</tr>
<tr>
<td>III</td>
<td>164</td>
<td>24</td>
</tr>
<tr>
<td>IV</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>Not Known</td>
<td>31</td>
<td>5</td>
</tr>
</tbody>
</table>
psychoanalysis had sufficiently familiarised them with this form of treatment to bias our sample towards a much higher proportion of middle-class Jewish families than would have been expected by chance. Religious affiliation was recorded for only 394 fathers and just over 400 mothers but nearly 70% of these were Jewish.

Social class was similarly skewed away from normal distributions, showing a mean of 2.2 with more than one-fifth of families presenting for treatment coming from social class 1. No family was recorded from social class V in the forty years of treatment covered by this survey (Table 8.6).

Sixty-nine per cent of children from the Non-Medical sample lived with both natural parents and a further 19% with a single or remarried mother. Nine per cent of children lived with neither natural parent, usually with relatives or in a childrens' home (Table 8.7). Closely related to these figures is the statistic that nearly three-quarters of the total sample came from intact homes. This slightly higher figure is accounted for by 27 stable adoptions among the children (Table 8.8).

197 children (29%) had suffered a significant separation from major attachment figures (Table 8.9a). A few had been taken into local authority care; more had been sent away to school at a young age (under 10 years). For 151 children (22% of the total sample) an important person in their life had died or otherwise departed before they were 5 years old. This might have been the departure of a much-loved Nanny or the death of a grandparent to whom they had been close or parental separations and divorce (Table 8.9b). Forty-five children (6.5%) had experienced the death of a parent (Table 8.9c).

A very high percentage (96%) of fathers were in full-time work. More than half the others were partially employed and only 13 fathers over the 40 years represented by this research had no job at all. The social class figures, quoted above, shows that at least 20% of fathers were in professional occupations and very few were in manual or unskilled employment. 53% of
### Table 8.7 Primary caretaker for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Lives with</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents</td>
<td>478</td>
<td>69</td>
</tr>
<tr>
<td>Mother/Mother + stepfather</td>
<td>129</td>
<td>19</td>
</tr>
<tr>
<td>Father/Father + stepmother</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Childrens' home</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Adopted</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 8.8 Family status for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Family Status</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact</td>
<td>508</td>
<td>74</td>
</tr>
<tr>
<td>Broken</td>
<td>179</td>
<td>26</td>
</tr>
</tbody>
</table>

208
### Table 8.9a Separations for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Type of Separation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>491</td>
<td>71</td>
</tr>
<tr>
<td>Death/departure important figure, child&lt;5 years</td>
<td>151</td>
<td>22</td>
</tr>
<tr>
<td>Boarding school, child&lt;10</td>
<td>38</td>
<td>6</td>
</tr>
<tr>
<td>LA care/fostering</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

### Table 8.9b Total parental separations occurring at any age for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Parental divorce/separation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>566</td>
<td>82</td>
</tr>
<tr>
<td>Yes</td>
<td>122</td>
<td>18</td>
</tr>
</tbody>
</table>

### Table 8.9c Total parental deaths occurring at any age for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Parental death</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>643</td>
<td>93</td>
</tr>
<tr>
<td>Yes</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>Type of maternal employment</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Full</td>
<td>138</td>
<td>22</td>
</tr>
<tr>
<td>Partial</td>
<td>160</td>
<td>25</td>
</tr>
<tr>
<td>No paid work</td>
<td>335</td>
<td>53</td>
</tr>
</tbody>
</table>

*Table 8.10  Type of maternal employment for Non-Medical sample (N=688)*

<table>
<thead>
<tr>
<th>Number of sibs (mean = 1.4)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>114</td>
<td>17</td>
</tr>
<tr>
<td>1</td>
<td>303</td>
<td>44</td>
</tr>
<tr>
<td>2</td>
<td>191</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>56</td>
<td>8</td>
</tr>
<tr>
<td>4 or more</td>
<td>24</td>
<td>3</td>
</tr>
</tbody>
</table>

*Table 8.11  Number of sibs for Non-Medical sample (N=688)*
the mothers were not engaged in any paid work at all, and only just over 1 in 5 had a full-time job (Table 8.10).

The mean number of sibs for the children in our Non-Medical sample was 1.4 (Table 8.11). Seventeen per cent of patients were singletons (some of these would acquire brothers and sisters in due course) and 44% came from two-children families (with the same qualification). Only 24 children (less than 4%) had 4 or more siblings.

8.3.iii Referral and diagnostic variables
Children were most likely to be referred by their parents or, in the case of a small number of adolescents, as a self-referral. Over 40% of children came to the Clinic via this route. Another one-quarter were referred by their GP or other doctors, with 15% coming to us from school or child guidance recommendations. Others were picked up through their membership of Anna Freud facilities such as the Baby Clinic or Nursery School or from a variety of miscellaneous sources, including relatives, mothers of other children, the social services and so on (Table 8.12).

Twenty-two per cent of the sample fulfilled psychiatric criteria for past conditions, now completed, and, for a further third (35%), problems were suspected though there was insufficient information for a definite diagnosis (Table 8.13). Eighty-six per cent were diagnosable at referral (Table 8.14). There was too little information available on about half the remainder to make a definite diagnosis, though most had probable psychiatric status. Only 7% of children were assessed as not fulfilling diagnostic criteria for any psychological problems at assessment with a further 25% being V-code rated only ('Conditions not attributable to a mental disorder that are a focus of attention or treatment' - see page 162).

For the rest, the diagnostic category that accounted for the highest percentage of children was Anxiety Disorders, including syndromes such as over-anxious disorder, separation anxiety, sleep disorders and specific phobias. One-quarter of children met the criteria for an anxiety disorder as a
### Table 8.12 Referral source for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/patient</td>
<td>282</td>
<td>41</td>
</tr>
<tr>
<td>GP/other doctor/hospital</td>
<td>166</td>
<td>24</td>
</tr>
<tr>
<td>School/Child guidance</td>
<td>105</td>
<td>15</td>
</tr>
<tr>
<td>Anna Freud organisations</td>
<td>51</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>84</td>
<td>12</td>
</tr>
</tbody>
</table>

### Table 8.13 Child's past diagnostic status for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Child's past diagnostic status</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>154</td>
<td>22</td>
</tr>
<tr>
<td>Criteria not fulfilled</td>
<td>295</td>
<td>43</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>239</td>
<td>35</td>
</tr>
</tbody>
</table>

### Table 8.14 Child's current diagnostic status for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Child's current diagnostic status</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>593</td>
<td>86</td>
</tr>
<tr>
<td>Criteria not fulfilled</td>
<td>51</td>
<td>7</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>44</td>
<td>6</td>
</tr>
</tbody>
</table>
principal diagnosis and a further 11% were classified anxious as a diagnosis additional to some other category. Eleven per cent of children were principally assessed as having a conduct or attention-deficit hyperactivity disorder; slightly more had a mood disorder, usually depressive. The remainder were divided between a variety of developmental, habit and personality disorders. Twenty-six children (4%) were classified principally under pervasive developmental disorder or psychosis, with another 7 having this as an additional diagnosis (Table 8.15).

All but 6 Non-Medical children were able to be categorised according to the 100-point Child Global Assessment Scale (CGAS). At the start of treatment the mean CGAS rating was 56 with a range between 15 and 91. Most (72%) had scores between 51 and 70 (70 is generally regarded as the cut-off point above which a reasonable level of psychological health is indicated). Seven scored above 80, and 7 below 40 (Table 8.16).

The Anna Freud Diagnostic Categories (see pages 153-5) were only applied to 45% of the total sample. As expected, most of these (60%) fell into the middle category of the 5, denoting permanent regressions leading to neurosis. Only one child was placed in the essentially 'normal' top category. One-quarter were seen as suffering transient pathology (category 2) and smaller percentages were regarded as atypical (category 4) or as showing 'substantial disruption of mental growth' (category 5). There were 20 children in this section, mostly psychotic or autistic (Table 7.3, page 155).

8.3.iv Parental variables
Where sufficient information was available on file, parents were evaluated according to the 90-point Global Assessment of Functioning (GAF) scale. 67% of fathers and 87% of mothers were able to be assessed in this way, with fathers scoring a mean of 69 and mothers 67. Scores described more-or-less a normal curve with a slight skew towards higher scores. Only 5 fathers and 11 mothers were assessed at 40 points or lower whereas 45 fathers and 34 mothers scored more than 80 points (Table 8.17).
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Principal Diagnosis</th>
<th>Principal plus Additional Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>163</td>
<td>24</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>80</td>
<td>12</td>
</tr>
<tr>
<td>Conduct disorders and ADHD</td>
<td>75</td>
<td>11</td>
</tr>
<tr>
<td>Pervasive developmental disorder, psychosis</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Enuresis</td>
<td>35</td>
<td>5</td>
</tr>
<tr>
<td>Encopresis</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>V-codes, no psychiatric diagnosis</td>
<td>224</td>
<td>33</td>
</tr>
</tbody>
</table>

Table 8.15  Diagnostic category at assessment for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>CGAS Group at assessment</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean: 56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range 15 - 91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 40</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>41-50</td>
<td>129</td>
<td>19</td>
</tr>
<tr>
<td>51-60</td>
<td>266</td>
<td>39</td>
</tr>
<tr>
<td>61-70</td>
<td>230</td>
<td>33</td>
</tr>
<tr>
<td>71-80</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>&gt;81</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Not Known</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 8.16  CGAS at assessment for Non-Medical sample (N=688)
Parents were psychiatrically diagnosed on both past and present information where possible, though more than half (49% of mothers and 58% of fathers) were unable to be assessed on past pathology because of lack of relevant information. One-third of both mothers and fathers were confidently assessed as not having had a past psychiatric history (Table 8.18). Ten per cent of fathers and nearly twice as many mothers did fulfil diagnostic criteria. It is likely that this is a function of availability of information rather than increased caseness levels for mothers.

Current diagnostic status similarly suffered from lack of information relating to fathers, 52% of whom could not be assessed compared with 39% per cent of mothers. Just under 40% of both mother and fathers fulfilled no diagnostic criteria. Eleven per cent of fathers and twice that percentage of mothers were judged psychiatrically diagnosable at the time of the child's assessment for treatment (Table 8.19). The majority of these parents had anxiety and/or depressive disorders. Four per cent (N=55), mostly mothers, were given the V-code rating 'Parent-Child Disorder', often in addition to a principal mood or neurotic condition, and a similar number, mostly fathers, were judged to have a personality disorder, though often in a relatively mild form. Just over 1% of parents had an alcohol or drug-related problem or a psychotic condition. There was also a miscellany of behavioural problems (connected with sleep, eating or sexual behaviour, for example) affecting a small number of parents.

Parents' past and present psychological states were also evaluated on an 18-point psychiatric symptom-cum-treatment checklist (included in the Proforma, Appendix A), covering major categories of psychological distress with, in addition, ratings of violent behaviour, suicide attempts, mental subnormality, marital problems, psychiatric hospital treatment and psychological therapy. Not all the incidences catalogued here were of sufficient severity to be clinically diagnosable. Two hundred and ninety-two mothers from the Non-Medical group (42%) were perceived as manifesting psychiatric symptoms either at the time of their child's assessment for treatment (N=178) and/or at sometime in the past. A high proportion of
<table>
<thead>
<tr>
<th>GAF Category</th>
<th>Father</th>
<th></th>
<th>Mother</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 40</td>
<td>5</td>
<td>1</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>41-50</td>
<td>11</td>
<td>2</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>51-60</td>
<td>90</td>
<td>19</td>
<td>106</td>
<td>19</td>
</tr>
<tr>
<td>61-70</td>
<td>147</td>
<td>32</td>
<td>250</td>
<td>41</td>
</tr>
<tr>
<td>71-80</td>
<td>166</td>
<td>35</td>
<td>180</td>
<td>30</td>
</tr>
<tr>
<td>&gt; 80</td>
<td>45</td>
<td>11</td>
<td>34</td>
<td>6</td>
</tr>
<tr>
<td>Not Known</td>
<td>240</td>
<td></td>
<td>93</td>
<td></td>
</tr>
</tbody>
</table>

Table 8.17  Parental GAF group for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Past diagnostic status</th>
<th>Father</th>
<th></th>
<th>Mother</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Diagnosable</td>
<td>68</td>
<td>10</td>
<td>122</td>
<td>18</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>218</td>
<td>32</td>
<td>229</td>
<td>33</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>402</td>
<td>58</td>
<td>337</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 8.18  Parental past diagnostic status for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Current diagnostic status</th>
<th>Father</th>
<th></th>
<th>Mother</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Diagnosable</td>
<td>75</td>
<td>11</td>
<td>155</td>
<td>23</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>256</td>
<td>37</td>
<td>262</td>
<td>38</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>357</td>
<td>52</td>
<td>271</td>
<td>39</td>
</tr>
</tbody>
</table>

Table 8.19  Parental current diagnostic status for Non-Medical sample (N=688)
both current and historical symptomatology (about 85%) was rated as severe; only 9% of mothers had experienced symptoms that were deemed to have been very severe in nature and few of these (only 16 from the entire sample of 769) were present conditions (see Table 9.23 below).

Although it was once again more difficult to extract sufficient information about the fathers to make a judgement regarding their psychological state, the very purpose of the checklist was to pick up material that was insufficiently clear or definite for diagnosis but nevertheless suggested some form of pathology and 203 fathers (about 30%) from the Non-Medical sample were included in at least one category. Just over half of these cases were current difficulties. As with the mothers, the vast majority of these problems were 'severe' (Table 9.24 below). About 8% of fathers showed 'very severe' symptoms, and one in three of these cases were currently active.

Most symptomatology was anxious or depressive in nature but, among fathers in particular, there was a sprinkling of personality disorders, drug/alcohol addiction and violent behaviour. More than one in five married couples displayed 'major marital problems'. Three per cent of parents had made suicide attempts. About twice that number had received out-patient psychiatric treatment with 4% of the total number of non-medical parents having been admitted to a psychiatric hospital at some point in their lives.

Fifteen per cent of fathers and 16% of mothers had a definite physical illness at the time of the child's assessment. The rest were either physically healthy or there was insufficient information to categorise them either way (Table 8.20).

8.3.v Treatment variables
Seventy per cent of the children were taken into intensive psychoanalysis (4 or 5 sessions per week) and a further 49 patients (6%) increased their initial number of sessions to full psychoanalysis during the course of their treatment (Table 8.21). The remaining 30% started off in non-intensive
<table>
<thead>
<tr>
<th>Physical illness status</th>
<th>Father</th>
<th></th>
<th>Mother</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>15</td>
<td>112</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>No/Not Known</td>
<td>582</td>
<td>85</td>
<td>576</td>
<td>84</td>
<td></td>
</tr>
</tbody>
</table>

Table 8.20  Parental illness status for Non-Medical sample (N = 688)

<table>
<thead>
<tr>
<th>Number of weekly sessions</th>
<th>Initial number of sessions</th>
<th></th>
<th>Maximum number of sessions</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>104</td>
<td>15</td>
<td>76</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>78</td>
<td>11</td>
<td>61</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>3</td>
<td>22</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>49</td>
<td>7</td>
<td>56</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>433</td>
<td>63</td>
<td>472</td>
<td>69</td>
<td></td>
</tr>
</tbody>
</table>

Table 8.21  Initial and maximum weekly number of sessions for Non-Medical sample (N = 688)

| Length of treatment | Number | % | |
|---|---|---|
| mean: 2.22 years | | | |
| < 3 months | 68 | 10 | |
| 3 months - 1 year | 134 | 20 | |
| 1 - 3 years | 336 | 49 | |
| 3 - 5 years | 92 | 13 | |
| > 5 years | 46 | 7 | |
| Not known | 12 | 1 | |

Table 8.22  Length of treatment for Non-Medical sample (N = 688)
treatment - that is, one, two or three psychoanalytically-informed psychotherapy sessions per week, half of these being seen just once weekly to begin with.

Two-thirds of the children were seen by a trainee student therapist under staff supervision and the rest were treated by a qualified member of staff. Most children (92%) stayed with one therapist for the entire treatment course but some had a change of analyst, normally because the student graduated and moved away from the Centre. Five children each had three therapists.

Length of treatment (Table 8.22) varied from one month to over 15 years with a mean of 2.2 years and a median of 1 year 10 months. Seventeen per cent stayed in treatment for 6 months or less. In psychoanalysis this would generally constitute a prematurely terminated treatment as, indeed, would most of the further 12% who failed to complete one year. At the other extreme, 46 children (7%) stayed in analysis for more than 5 years; 6 of these were still being treated ten years after the start of their therapy.

26 mothers and 7 fathers were treated at the Anna Freud Centre simultaneously with their child, though by a different analyst.

8.3.vi Termination variables
Slightly less than one-third of patients (32%) terminated their treatment by mutual agreement between themselves and the therapist (Table 8.23). Large numbers dropped out prematurely because they did not want to continue, or were pulled out of treatment by parents for a variety of reasons (13% in each of these categories). The same percentage finished for reasons unknown. These cases, where information is missing from the files so that reasons for ending cannot be inferred, suggest that the treatment just faded out and was unlikely, therefore, to have been satisfactorily completed. About 16% of children ended their treatment because of external circumstances, usually either the therapist or the family moving away from the area. Others were transferred elsewhere (3.5%), often to residential units and schools, or
had their analysis terminated by the therapist for lack of progress (7%).

Psychiatric diagnostic status at termination divided into three roughly equal groups. Thirty-seven per cent of children did not fulfil any diagnostic criteria; the remainder were almost equally split between being confidently diagnosable and presenting insufficient information for any decision to be made (Table 8.24). About three-quarters of the primary diagnoses at termination were of broadly-based neurotic conditions, chiefly anxiety syndromes and habit disorders (affecting sleep, feeding and eliminatory functions) with smaller numbers of children with mood disorders and specific developmental problems. Just under 17% of diagnosable children at termination were showing some degree of conduct disorder, though about one in three of these were only rated on the relatively mild V-code category 'Parent-child problem'. Almost one in ten diagnosable children (N = 20) from the non-medical sample had psychotic or pervasive disorders such as autism.

CGAS scores at the end of treatment were calculable for 90% of the non-medical group and showed an average rise of 9.4 points, increasing from 56 points at assessment to 65 at termination (Table 8.25). More than half the children had a change in rating of between 1 and 20 points (Table 8.26). However, the range was wide and 56 children (7%) deteriorated - by up to 22 points - and a further 20% showed no change. Some of the latter terminated treatment in the first weeks before any substantial alteration in their functioning and symptomatology could be effected. One hundred children (16%) were assessed as having improved by between 20 and 48 points.
<table>
<thead>
<tr>
<th>Reason for termination</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual agreement</td>
<td>219</td>
<td>32</td>
</tr>
<tr>
<td>Premature (parent or patient)</td>
<td>184</td>
<td>27</td>
</tr>
<tr>
<td>No progress/child transferred/other</td>
<td>84</td>
<td>12</td>
</tr>
<tr>
<td>External circumstances</td>
<td>113</td>
<td>16</td>
</tr>
<tr>
<td>Not known</td>
<td>88</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 8.23  Reason for termination for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>Child's psychiatric status at termination</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>215</td>
<td>31</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>255</td>
<td>37</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>217</td>
<td>32</td>
</tr>
</tbody>
</table>

Table 8.24  Child's psychiatric status at termination for Non-Medical sample (N=688)

<table>
<thead>
<tr>
<th>CGAS at termination</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean=65  Range=20-95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 40</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>41-50</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td>51-60</td>
<td>96</td>
<td>14</td>
</tr>
<tr>
<td>61-70</td>
<td>191</td>
<td>28</td>
</tr>
<tr>
<td>71-80</td>
<td>167</td>
<td>24</td>
</tr>
<tr>
<td>81-90</td>
<td>66</td>
<td>10</td>
</tr>
<tr>
<td>&gt; 90</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Not known</td>
<td>69</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 8.25  CGAS at termination for Non-Medical sample (N=688)
<table>
<thead>
<tr>
<th>CGAS change points</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean: 9</td>
<td>Range -22 to +48</td>
<td></td>
</tr>
<tr>
<td>&gt; -10</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>-10 to -1</td>
<td>37</td>
<td>5</td>
</tr>
<tr>
<td>No change</td>
<td>121</td>
<td>18</td>
</tr>
<tr>
<td>1-10</td>
<td>202</td>
<td>29</td>
</tr>
<tr>
<td>11-20</td>
<td>139</td>
<td>20</td>
</tr>
<tr>
<td>21-30</td>
<td>76</td>
<td>11</td>
</tr>
<tr>
<td>&gt; 30</td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td>Not known</td>
<td>71</td>
<td>10</td>
</tr>
</tbody>
</table>

*Table 8.26  CGAS change for Non-Medical sample (N = 688)*
Chapter Nine

Comparisons between the Samples
9.1 Introduction
The children whose data is included in this study belong either to the Non-Medical group of children, whose profiles we have just detailed, or to the combined Target Medical grouping. The following sections compare these two subsamples according to variables relating to the six categories (child, family, referral and diagnostic, parental, treatment, termination) already identified.

The sub-total of ‘Medical’ children can be further subdivided into three separate groups - children with severe physical disabilities (Disabled), children suffering from severe psychosomatic conditions (Somatic), and children with severe organic illnesses (Ill). In addition to comparing this combined group with the Non-Medical sample, this section of the report also compares each of the Medical groups with each other.

9.2 Method
9.2.1 Samples
1) The Non-Medical group of children consists of 688 subjects.
2) They are compared here with 81 Medical children with severe physical disabilities and illnesses.

These 81 patients are comprised of
2a) 32 Disabled children
2b) 32 Somatic children
2c) 17 Ill children.
Each of these sub-groups is compared with the others.

9.2.ii Instruments
As listed in chapter 8, namely:
a) The Anna Freud Diagnostic Profile (A. Freud 1962)
b) The Anna Freud Developmental Lines (A. Freud 1963)
c) The Child Behaviour Checklist (Achenbach and Edelbrock 1983)
d) The Diagnostic and Statistical Manual, 3rd edition, revised (published by the American Psychiatric Association 1987)

f) The Children's Global Assessment Scale (Shaffer et al 1983)

g) The Global Assessment of Functioning Scale (in DSM-III-R 1987)

A variety of internally-generated data, including completed parental symptom checklists, IQ tests, projective testing, school reports, interview schedules, social histories and diagnostic interviews were also used.

9.2.iii Procedure

The data of interest was elicited from the files using the same procedures set out in chapter 8, page 203. It was divided into six categories relating to A) the child; B) the family; C) the referral and diagnosis; D) the parents; E) the treatment and F) the termination.

9.3 Analysis and Results

9.3.i Descriptive statistics

The tables show the data in summary descriptive form, including percentage occurrence, ranges and means.

9.3.ii Inferential statistical analysis

Much of the data was nominal and in the form of frequencies (the number of boys and girls, the presence or absence of learning difficulties in each of the subgroups, the frequency of diagnostic status at assessment, and so on) and was therefore analysed using the Chi-Square Statistical Test.

9.3.iii Results

A) Child variables

Gender distribution between males and females in the Ill and Disabled groups was identical to that of the Non-Medical sample (59:41); the Somatic group contained more boys and fewer girls in the ratio 69:31, though this difference was not statistically significant (Table 9.1). This sub-sample included children afflicted with either asthma or eczema or both. Table 9.2 shows that although nine Somatic boys (41%) suffered from both conditions,
this was true of only one girl and her asthma was secondary and much less severe than the eczema. More boys than girls had asthma (91% compared to 70%); they, therefore, much less frequently suffered from eczema alone (9%) than did the girls (30%).

Age range for the Target Medical children was also comparable with the Non-Medical sample, ranging from 2 to 17 years with a mean of just under 9 years. The Medical group as a whole comprised equal numbers of children in all three younger age groups - under 6, 6-10 and 11-14 (just under 30% of the sample in each age group) with the remaining 11% aged over 14 years. However, when the medical sample was split into its medically-differentiated subgroups, different age profiles became apparent, though numbers were too small to assess significance. Almost one-third (31%) of Disabled children and 38% of Somatic children were brought early to treatment compared with only 12% of III children who began analysis under 6 years of age (Table 9.3). This raised the average age at start of treatment for the III group to 10.1 years, slightly higher than the means for the Somatic group (8.8) and the Disabled group (8.5).

IQ tests were carried out on more children (89%) from the Medical subgroup than from the Non-Medical sample (74%). The mean over the three Medical groupings was 110. The Somatic children were identical with the mean of the Non-Medical sample at 115 while the other groups were only slightly lower at 109 for the III group and 105 for the Disabled group (Table 9.4). Scores for the Disabled children described an essentially normal curve but there was a skew towards the higher scores for the other Medical children, particularly the Somatics. Only 8% of Disabled children scored higher than an IQ of 125 whereas 19% of III children, 24% of Non-Medical children and 27% of Somatic children reached this level.
### Table 9.1  Gender distribution for Medical samples (Total N=81)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>Total medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>59</td>
<td>59</td>
<td>69</td>
<td>63</td>
</tr>
<tr>
<td>Girls</td>
<td>41</td>
<td>41</td>
<td>31</td>
<td>37</td>
</tr>
</tbody>
</table>

### Table 9.2  Gender and psychosomatic condition for Somatic sample (N=32)

<table>
<thead>
<tr>
<th>Sex of child</th>
<th>Asthma %</th>
<th>Eczema %</th>
<th>Both %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>59</td>
<td>9</td>
<td>41</td>
<td>69</td>
</tr>
<tr>
<td>Girls</td>
<td>60</td>
<td>30</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>16</td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 9.3  Age group at start of treatment for Medical sample (total N=81)

<table>
<thead>
<tr>
<th>Children's Age Group</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>Total medical %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean 8.5</td>
<td>Mean 10.1</td>
<td>Mean 8.8</td>
<td>Mean 9.0</td>
</tr>
<tr>
<td>&lt; 6 years</td>
<td>31</td>
<td>12</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>34</td>
<td>35</td>
<td>22</td>
<td>30</td>
</tr>
<tr>
<td>11 - 14 years</td>
<td>25</td>
<td>41</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>&gt; 14 years</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>
### Table 9.4 IQ levels for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>IQ level</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>Total Medical %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean: 105</td>
<td>Mean: 109</td>
<td>Mean: 115</td>
<td>Mean: 110</td>
</tr>
<tr>
<td>&lt; 75</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>76-90</td>
<td>12</td>
<td>19</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>91-110</td>
<td>54</td>
<td>37</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>111-125</td>
<td>23</td>
<td>25</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>&gt; 126</td>
<td>8</td>
<td>19</td>
<td>27</td>
<td>18</td>
</tr>
</tbody>
</table>

Percentage tested: 81% Disabled; 94% III; 94% Somatic; 89% Total

### Table 9.5 Type of learning difficulty for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Type of Difficulty</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>School refusal</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Specific learning difficulty</td>
<td>22</td>
<td>12</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Serious under-achievement</td>
<td>37</td>
<td>29</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>Poor peer relationships</td>
<td>19</td>
<td>12</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Disruptive behaviour</td>
<td>9</td>
<td>18</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Disabling anxiety symptoms (eg compulsions)</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Problems secondary to physical handicap (eg partial sight)</td>
<td>25</td>
<td>6</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Other inc. special school</td>
<td>19</td>
<td>35</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Percentage of children with at least one difficulty</td>
<td>78</td>
<td>82</td>
<td>66</td>
<td>74</td>
</tr>
<tr>
<td>No learning difficulties</td>
<td>22</td>
<td>18</td>
<td>34</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 9.5 Type of learning difficulty for Medical samples (total N=81)
The Somatic children were less likely to present with learning difficulties (34% with no recorded problems) than were either the Disabled children (22% problem-free) or the III children (18%). This was about the same proportion as in the sample as a whole (36%). The only significant difference between the Medical groups in terms of type of difficulty experienced was that more Disabled children (one in four) encountered school problems specifically related to their handicap ($\chi^2 = 5.9$, df = 2, $p<0.05$). See Table 9.5.

B) Family variables
The mean for social class in the combined Medical group was 2.3, very little different from the sample as a whole although Medical children were more likely overall to belong to families of social class 3 (38%) and less likely to belong to class 2 (33%) than were Non-Medical children (24% and 45%) as Table 8.6 showed. However, major differences were uncovered within the Medical samples (Table 9.6). More than one in three of the Somatic children claimed membership of the highest professional social class compared with only 1 (6%) of the III children. Conversely, only one in four Somatic children belonged to class 3 compared with one in two of the III children.

Patient families from the top two social classes make up 72% of the Somatic sample, 55% of the Disabled but only 25% of the III children. The figure from the Non-Medical sample is 65%. This resulted in social class membership for the Somatic group being, on average, one whole class higher (1.9) than for the chronically III children (2.9). This is statistically significant ($\chi^2 = 10.5$, df = 3, $p<0.02$). Even when the Somatic and Disabled groups are combined, the difference between them and the III sample approaches significance ($\chi^2 = 12.6$, df = 6, $p<0.06$).

A higher percentage of children in the Medical sample lived with both natural parents (81.5%) than in the Non-Medical sample (69%) though when the number of children living with mother, either with father or alone or with a stepfather was added up, the figures evened out (88% in the Non-Medical group and 85% of chronically sick children). (Tables 9.7 and 8.7). This
<table>
<thead>
<tr>
<th>Social Class</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>Total % *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean: 2.3</td>
<td>Mean: 2.9</td>
<td>Mean: 1.9</td>
<td>Mean: 2.3</td>
</tr>
<tr>
<td>I</td>
<td>19</td>
<td>6</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>II</td>
<td>36</td>
<td>19</td>
<td>37</td>
<td>33</td>
</tr>
<tr>
<td>III</td>
<td>42</td>
<td>56</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>IV</td>
<td>3</td>
<td>19</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

* Percentage of cases for which social class is known (92% of total).

Table 9.6  Social class for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Lives with</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>Total Medical %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents</td>
<td>81</td>
<td>76</td>
<td>84</td>
<td>82</td>
</tr>
<tr>
<td>Mother</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mother+stepfather</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Father/father+stepmother</td>
<td>9</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Home</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Adopted</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>12</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 9.7  Primary caretaker for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Family status</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact</td>
<td>81</td>
<td>88</td>
<td>91</td>
<td>86</td>
</tr>
<tr>
<td>Broken</td>
<td>19</td>
<td>12</td>
<td>9</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 9.8  Family status for Medical samples (total N=81)

230
suggests that family *intactness* was higher for the Medical groups and this was indeed the case for all chronically disordered conditions. Compared with 74% of the Non-Medical sample (Table 8.8), 86% of medical children overall came from intact homes; these figures ranged from 81% of Disabled children through 88% of Ill children to a high of 91% for the Somatic sample (Table 9.8). This latter figure is significantly different from that for the Non-Medical group ($\chi^2 = 4.5, \text{df} = 1, p < 0.05$).

The ‘intact’ variable in the Somatic group showed a slight negative correlation with social class ($r = -0.13, \text{df} = 30$) but this did not approach a level of statistical significance and, overall, there was no correlation ($r = 0.03$) between family intactness and social class.

When the specific figures for divorce and parental separation are looked at (highly correlated with, but not identical to, an intact home), the Medical groups again show lower incidence at 13% for the Disabled children, 9% for the Somatic group and no recorded instances at all for the Ill children than the Non-Medical sample at 18% (Table 9.9).

The same basic pattern also emerges when broader categories of loss are looked at. The Medical subgroups overall contain fewer children who have experienced major loss of, or separation from, attachment figures (23%) than the larger Non-Medical sample (28%), though this varies from 34% for Disabled children down to 12% in the Somatic group (Table 9.10). Three children, one from each Medical subgroup, had suffered the death of a parent, a slightly lower figure than from the Non-Medical group. More than one in four Disabled children had experienced other loss of major figures. At 28% this was not very much higher than the Non-Medical sample statistic of 22% (Table 8.9a) but considerably above the other two Medical groups, the Ill children at 12% and the Somatics at 9%.

There were no differences in rates of *paternal* employment between the Non-Medical sample and the Medical subgroups. The combined Medical groups' figures relating to *maternal* employment show that 19% of mothers were in
### Percentages of parental divorce/separation

<table>
<thead>
<tr>
<th>Type of group</th>
<th>18</th>
<th>13</th>
<th>0</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-medical group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9.9  Parental divorce/separation statistics by sample

### Table 9.10  Major losses for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Type of separation</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No major loss</td>
<td>66%</td>
<td>76%</td>
<td>88%</td>
<td>77%</td>
</tr>
<tr>
<td>Death/departure of important figure, child &lt; 5 years</td>
<td>28%</td>
<td>12%</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Boarding school, child &lt; 10 years</td>
<td>3%</td>
<td>6%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>LA care/fostering</td>
<td>3%</td>
<td>6%</td>
<td>0%</td>
<td>2%</td>
</tr>
</tbody>
</table>

### Table 9.11  Type of maternal employment for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Type of Maternal Employment</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>17</td>
<td>19</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Partial</td>
<td>21</td>
<td>37</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Not Employed</td>
<td>62</td>
<td>44</td>
<td>55</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 9.11  Type of maternal employment for Medical samples (total N=81)
full-time work, 26% worked part-time and 55% had no paid employment (Table 9.11). This is very similar to findings from the larger sample.

However, there was a slight, though statistically insignificant, tendency for mothers of III children to be more likely to work part-time (37%) and less likely not to work outside the home at all (44%). This compares with 62% of mothers of Disabled children who were unemployed. Only in the III group was there a notable negative correlation between the child's improvement rating and lack of maternal employment ($r = -0.52, \text{df} = 15, p < 0.05$). In other words, III children whose mothers worked outside the home tended to do better in treatment.

C) Referral and diagnostic variables
A breakdown of the primary sources of referral for the Medical samples show that the Somatic children had very similar referral profiles to the Non-Medical sample. The Disabled children differed principally in the kinds of services with which they were involved: several children were referred through agencies and organisations for the blind or deaf (classified under Other in Table 9.12). This accounted for more than one in four Disabled children (compared with 12% of the Non-Medical sample - see Table 8.12) which reduced the percentage referred by parents though, otherwise, the referral pattern was similar to the Non-Medical sample and to the Somatic children. The III children were more likely to come via their doctor or a medical specialist (41%) than were Non-Medical cases (24%).

Broadly similar percentages of children from each sub-group were deemed never to have fulfilled diagnostic criteria for a past psychological condition (Table 9.13). However, the remainder were divided between those who had a definite past psychiatric status and those for whom there was insufficient information to make any assessment and, when these figures were looked at, it was found that the III children were more likely than children from other samples to have had a definite past psychiatric diagnosis.
<table>
<thead>
<tr>
<th>Referral source</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/Self</td>
<td>16%</td>
<td>29%</td>
<td>41%</td>
<td>30%</td>
</tr>
<tr>
<td>GP/other doctor/hospital</td>
<td>22%</td>
<td>41%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>School/Child Guidance</td>
<td>25%</td>
<td>12%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Anna Freud Organisations (e.g. therapist of sibling, nursery school, baby clinic)</td>
<td>9%</td>
<td>0%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>Other/Not Known</td>
<td>28%</td>
<td>18%</td>
<td>6%</td>
<td>17%</td>
</tr>
</tbody>
</table>

*Table 9.12 Referral source for Medical samples (total N=81)*

<table>
<thead>
<tr>
<th>Child’s Past Psychiatric Status</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>19%</td>
<td>35%</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>47%</td>
<td>41%</td>
<td>53%</td>
<td>48%</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>34%</td>
<td>24%</td>
<td>28%</td>
<td>30%</td>
</tr>
</tbody>
</table>

*Table 9.13 Child’s past diagnostic status for Medical samples (total N=81)*
As with the larger, Non-Medical, group, most (83%) of the Medical children were diagnosable at assessment (Table 9.14) and the most common diagnosis was that of the anxiety disorders. One in five Disabled children and one in three Ill children fell into this principal category (Table 9.15), which is comparable to the one-quarter of the Non-Medical group whose principal diagnosis was also anxiety. However, the percentage of Somatic children who were principally anxious was 63% which differs significantly from the other medical groups ($\chi^2 = 13.04$, df = 2, $p < 0.01$). When additional diagnoses are added to the main classifications (Table 9.16), the Somatic percentage rises to 87%, compared to 25% for Disabled children, 43% for Ill children and 35% for the Non-medical sample (Table 8.15). This is also highly significant ($\chi^2 = 38.3$, df = 3, $p < 0.01$).

Mood disorders (primarily depressions) are almost completely absent in the Medical samples. Only one child out of 81 fell into this category, compared with 17% from the main sample, two-thirds of which were principal diagnoses. This is a significant finding ($\chi^2 = 13.7$, df = 3, $p < 0.01$). Enuresis, suffered by 13% of Non-Medical children (Table 8.15), was much lower for the Somatic group (3%) and non-existent in the Ill sample, though this was not statistically significant. Instances of conduct disorder which was the main diagnosis for one-quarter of the Ill children and one in five Disabled children was quite a lot higher, though not significantly so, than the 11% incidence of the Non-Medical sample and the 6% of the Somatic group. Cases of conduct disorder rose to 35% for Ill children when all diagnoses, principal and secondary, were considered, compared to 17% for the Non-Medical.

Pervasive developmental disorders, absent for the Somatic group and present as a principal diagnosis in under 4% of the Non-Medical sample were experienced by 4 (12%) of the Disabled children and 3 Ill children (18%). This is significant ($\chi^2 = 14$, df = 3, $p < 0.01$), though numbers are small. The Ill children were much less likely to have no psychiatric diagnosis or a V-code assessment only (18%) than the other groups, all of which included about
<table>
<thead>
<tr>
<th>Current psychiatric diagnostic status</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>81</td>
<td>88</td>
<td>81</td>
<td>83</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>13</td>
<td>6</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 9.14  Child diagnostic status at assessment for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Principal Category</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>19</td>
<td>35</td>
<td>62</td>
<td>39</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>19</td>
<td>23</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>13</td>
<td>18</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Enuresis</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Encopresis</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>V-Codes, no psychiatric diagnosis</td>
<td>37</td>
<td>18</td>
<td>28</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 9.15  Principal diagnostic category at assessment for Medical samples (total N=81)
### Table 9.16  Principal and additional diagnostic categories at assessment for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Principal plus Additional Categories</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>25</td>
<td>41</td>
<td>87</td>
<td>53</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>19</td>
<td>35</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>13</td>
<td>18</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Enuresis</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Encopresis</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0</td>
<td>12</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>16</td>
<td>12</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>V-Codes, no psychiatric diagnosis</td>
<td>41</td>
<td>29</td>
<td>44</td>
<td>40</td>
</tr>
</tbody>
</table>

### Table 9.17  CGAS by decile at start of treatment for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>CGAS Group at Start</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range 30-80</td>
<td>Range 30-78</td>
<td>Range 40-75</td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>3</td>
<td>12</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>41-50</td>
<td>25</td>
<td>35</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>51-60</td>
<td>53</td>
<td>29</td>
<td>50</td>
<td>49</td>
</tr>
<tr>
<td>61-70</td>
<td>13</td>
<td>18</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>71-80</td>
<td>6</td>
<td>6</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Mean:</td>
<td>56</td>
<td>50</td>
<td>56</td>
<td>55</td>
</tr>
</tbody>
</table>
one in three children in this category, though this difference didn't reach significance.

Mean CGAS rating at assessment for the Disabled and Somatic groups was 56, identical to the Non-Medical sample. Half the children from both these groups scored between 51 and 60 and a further quarter between 41-50. The Ill children scored a lower mean of 50, with one in three between 41 and 50 and only a quarter assessed at 51-60 (Table 9.17). Less than half the Ill group (47%) scored between 51 and 70, compared with 59% of Somatics, 66% of Disabled children and 72% of the Non-Medical sample. All groups showed a significant correlation between CGAS ratings and diagnostic status but this was particularly marked among the Ill children \( r = 0.63, \text{df} = 15, p < 0.001 \).

Anna Freud Diagnostic Categories were applied to 44% of Disabled children (more-or-less the same as the Non-Medical group) and to just over one in three children from the other Medical groupings. The distribution pattern for the Somatic group was identical to the Non-Medical children with two-thirds being placed in category 3 as essentially 'neurotic', and one-quarter in category 2, showing transient, often developmental, problems. At least half the members of the other two medical groups fell into category 4 - 'atypical' - (predominantly Disabled children) or 5 - 'substantial disruption of mental growth' - (mainly Ill children). See Table 9.18.

D) Parental variables
A higher percentage of parents of Medical children were able to be assessed on the GAF scale than was possible for the parents of Non-Medical cases. About 82% of fathers were able to be rated over the three categories, compared with 67% from the larger sample. Fathers of Disabled children were the least accessible; there was insufficient information for rating on 9 (28%) of them. The other two Medical groups provided information on 88% of the fathers. Ninety-one per cent of mothers were ratable.
<table>
<thead>
<tr>
<th>Category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>N=13</td>
<td>N=8</td>
<td>N=13</td>
<td>N=34</td>
</tr>
<tr>
<td>I</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>II</td>
<td>8</td>
<td>13</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>III</td>
<td>38</td>
<td>25</td>
<td>69</td>
<td>47</td>
</tr>
<tr>
<td>IV</td>
<td>46</td>
<td>12</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>V</td>
<td>8</td>
<td>38</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Mean:</td>
<td>3.5</td>
<td>3.5</td>
<td>2.9</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Table 9.18  Anna Freud diagnostic category for Medical samples
The mean score for fathers was 69-70 over all four groups (Table 9.19). Mothers of Disabled children averaged 72 (Table 9.20), 5 points higher than the Non-Medical group, but lower means were recorded for mothers in the Somatic group (65) and the Ill group (63). The difference between the mean score for mothers of Disabled children and mothers of Ill children approached an acceptable level of statistical significance ($\chi^2 = 8.9$, df = 4, $p < 0.07$). Only 1 mother (Somatic) scored under 40 points and 10% were rated at higher than 80 across the three target groups. Twice as many fathers were placed in this highest category and only 1 (Disabled) was given less than 50 points.

Insufficient information for past parental diagnoses made it impossible to assess over half the parents in the medical samples. Remaining numbers were therefore very small. However, the indications are that fewer parents of medical children had past psychiatric status than was so for parents of well children. Only 3 fathers (4%) and 9 mothers (11%) had been definitely diagnosable in the past (Table 9.21) compared with 10% of fathers and 17% of mothers from the Non-Medical sample.

Current parental diagnostic status also showed lower rates of incidence for parents of Medical children, especially for fathers (Table 9.22). Only 3 fathers, one from each medical subgroup, were definitely diagnosable (4%) compared with 11% from the Non-Medical sample (Table 8.19). Nor was this due to lack of information; 44% of fathers of Medical children were unable to be classified but this figure rose to 52% for fathers of Non-Medical children. In other words, more than one in two fathers (53%) of the chronically ill and disabled children fulfilled no psychiatric criteria whereas this was true for only just over one in three (37%) of Non-Medical fathers. The three psychiatrically-ill fathers had diagnoses of, respectively, schizophrenia, a personality disorder, and a reactive adjustment problem.

In terms of present diagnoses in mothers, 23% of Non-Medical mothers (Table 8.19) and 21% of ‘Medical’ mothers showed some signs of pathology (Table 9.22). However, there were a lot of 'doubtful' cases in our sample where there was insufficient information to be sure of diagnostic
### Table 9.19 Father's GAF scores for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Father GAF category</th>
<th>Disabled % Range 45-85</th>
<th>III % Range 53-86</th>
<th>Somatic % Range 52-85</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>51-60</td>
<td>3</td>
<td>29</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>61-70</td>
<td>19</td>
<td>18</td>
<td>44</td>
<td>28</td>
</tr>
<tr>
<td>71-80</td>
<td>28</td>
<td>23</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>&gt;80</td>
<td>19</td>
<td>18</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>NK/Not applicable</td>
<td>28</td>
<td>12</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Mean:</td>
<td>70</td>
<td>69</td>
<td>69</td>
<td>69</td>
</tr>
</tbody>
</table>

### Table 9.20 Mother's GAF scores for Medical samples (N=81)

<table>
<thead>
<tr>
<th>Mother GAF category</th>
<th>Disabled % Range 57-83</th>
<th>III % Range 47-85</th>
<th>Somatic % Range 35-90</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>12</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>51-60</td>
<td>9</td>
<td>35</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>61-70</td>
<td>25</td>
<td>18</td>
<td>38</td>
<td>28</td>
</tr>
<tr>
<td>71-80</td>
<td>44</td>
<td>18</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>&gt;80</td>
<td>6</td>
<td>12</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>NK/Not applicable</td>
<td>16</td>
<td>6</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Mean:</td>
<td>72</td>
<td>63</td>
<td>65</td>
<td>67</td>
</tr>
</tbody>
</table>

*241*
### Table 9.21 Past parental diagnoses for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Parent Diagnosable in Past</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Mother</td>
<td>6</td>
<td>18</td>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>

### Table 9.22 Present parental diagnoses for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Parent Currently Diagnosable</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father - Diagnosable</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- Criteria Not Fulfilled</td>
<td>53</td>
<td>53</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>- Insufficient Inf/inapplicable</td>
<td>44</td>
<td>41</td>
<td>44</td>
<td>43</td>
</tr>
<tr>
<td>Mother - Diagnosable</td>
<td>9</td>
<td>35</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>- Criteria Not Fulfilled</td>
<td>59</td>
<td>35</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>- Insufficient Inf/inapplicable</td>
<td>31</td>
<td>30</td>
<td>31</td>
<td>31</td>
</tr>
</tbody>
</table>
status. When only those cases where psychiatric criteria were definitely not met were looked at, mothers without psychiatric diagnosis contributed less to the Non-Medical sample (39%) than to the Medical groups where they accounted for almost one-half (49%) of the sub-sample.

Mothers were much more likely ($\chi^2 = 4.8, df = 1, p < 0.03$) to reach psychiatric levels, however, if they were parenting 'II' children (35%) than if they had Disabled children (10%). Only 35% of 'III' mothers met no criteria for diagnosis. This is much lower than the 61% of mothers of Disabled children who were judged psychiatrically healthy. The figures for mothers of II children in fact correspond closely to the figures for the Non-Medical sample, implying that mothers of Disabled children and, to a lesser extent, Somatic children, are more psychologically healthy than mothers of well children.

Like the mothers from the Non-Medical sample, most of the 'Medical' mothers who reached current psychiatric caseness levels had a primary diagnosis of anxiety and/or depression. Four - one mother of a Disabled child, one of an II child and 2 of Somatics - were given the V-Code rating 'Parent-Child Disorder'. At 5% this is just one percentage point higher than among mothers of the Non-Medical sample. Of the remaining two diagnosable mothers one was alcohol-dependent and the other had an unspecified personality disorder.

However, although mothers of physically ill children do not fulfil psychiatric criteria any more than - or even as much as - mothers of children without chronic disorders, they are most certainly not without psychological symptomatology altogether. More than half were rated on at least one category on the symptom/treatment check-list (Table 9.23). This compares with 42% of mothers of Non-Medical children. The Medical samples show significant intergroup differences ($\chi^2 = 8.1, df = 2, p < 0.02$), with symptomatic instances ranging from 31% of mothers of Disabled children, through 59% of 'III' mothers, to 66% of mothers of Somatics.
### Table 9.23 Summary of mother's psychiatric symptoms and treatments

<table>
<thead>
<tr>
<th>Mother's Psychiatric Symptoms</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>Total Medical %</th>
<th>Non-Medical %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Ever</td>
<td>31</td>
<td>59</td>
<td>66</td>
<td>51</td>
<td>42</td>
</tr>
<tr>
<td>Problem Now</td>
<td>19</td>
<td>47</td>
<td>37.5</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>Severe Problem Ever</td>
<td>19</td>
<td>59</td>
<td>56</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>V. Sev. Problem Ever</td>
<td>3</td>
<td>6</td>
<td>12.5</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety</td>
<td>12.5</td>
<td>35</td>
<td>28</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Marital</td>
<td>19</td>
<td>24</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>3</td>
<td>0</td>
<td>19</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

### Table 9.24 Summary of presence of father's psychiatric symptoms

<table>
<thead>
<tr>
<th>Father's Psychiatric Symptoms</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>Total Medical %</th>
<th>Total Non-Medical %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Ever</td>
<td>25</td>
<td>24</td>
<td>19</td>
<td>22</td>
<td>30</td>
</tr>
<tr>
<td>Severe Problem Ever</td>
<td>16</td>
<td>18</td>
<td>16</td>
<td>16</td>
<td>25</td>
</tr>
</tbody>
</table>

244
As with the Non-Medical group, about 60% of these episodes are current occurrences for the Disabled and Somatic samples, the remainder having happened in the past; for the Ill group, however, many more rated mothers (80%) have present pathology. Most problems for the Ill and Somatic mothers were rated 'severe' (though, as for the Non-Medical sample, few were assessed as being 'very severe'). Mothers of Disabled children seldom showed this degree of intensity in symptoms and significantly fewer had experienced a 'severe' problem either currently or historically ($\chi^2 = 11.8$, $df = 2$, $p < 0.01$).

Unlike their wives, fewer 'Medical' fathers (22%) were rated on the symptom checklist than were the fathers of Non-Medical children (30%) although this failed to reach significance (Table 9.24). About half of the problems noted were current difficulties. 'Severe' symptoms predominated; 'very severe' problems were rare and almost always in the past. Fathers of Disabled children were marginally the most likely to be assessed as ever having had psychological symptoms and/or treatment. This contrasts with the mothers of Disabled children who manifested symptoms far less often than mothers in other samples (Tables 9.25, 9.26 and 9.27).

The specific symptomatology of parents of Medical children was very similar to that of other parents. Anxiety and depressive conditions were much in evidence and personality disorder was also assigned to a number of parents, especially fathers. Fourteen percent had had out-patient psychiatric help and 4% had had at least one psychiatric hospital admission. As in the Non-Medical sample there was a relatively high incidence of major marital problems, affecting 21% of couples.

Numbers were small and no specific problems differentiated statistically between the Medical groups. However, it is worth noting (Table 9.27) that 4 mothers of psychosomatic children had been postnatally depressed after the target child's birth. This was not so for any other mothers. Past depressions of all kinds and past and present anxieties were more frequent among
<table>
<thead>
<tr>
<th>Psychiatric Symptoms (Parents of Disabled Children)</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other depressive</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Obsessional</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 9.25  Detailed symptom/treatment breakdown for parents of Disabled children
<table>
<thead>
<tr>
<th>Psychiatric Symptoms (Parents of III children)</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other depressive</td>
<td>18</td>
<td>35</td>
</tr>
<tr>
<td>Obsessional</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>24</td>
<td>18</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 9.26 Detailed symptom/treatment breakdown for parents of III children
<table>
<thead>
<tr>
<th>Psychiatric Symptoms (Parents of Somatic children)</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Other depressive</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>Obsessional</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 9.27  Detailed symptom/treatment breakdown for parents of Somatic children
mothers of III (Table 9.26) or Somatic children (Table 9.27) than among mothers of Disabled children (Table 9.25).

Psychiatric out-patient treatment was the province of the parents of Ill children, especially in the past, while ‘Somatic’ parents were the most likely among the mothers and fathers of Medical children to opt for psychoanalysis. It can be seen by comparing Tables 9.25, 9.26 and 9.27 that many more mothers of Somatic children have received, or were currently receiving, psychoanalytic treatment in their own right, than was the case for mothers of children in either of the other two Medical groups.

Nearly one in three mothers (31%) of physically disordered children have a definite physical illness (Table 9.28) compared to only 16% of mothers of healthy children (Table 8.20). This is a significant difference ($\chi^2 = 10.4$, $df = 1$, $p < 0.01$). Disabled and Somatic children, in particular, are more likely to have a mother who is physically ill than are well children. The levels of probability for these differences happening by chance are, respectively, $p < 0.01$ ($\chi^2 = 7.3$ $df = 1$) and $p < 0.03$ ($\chi^2 = 4.9$, $df = 1$). The difference is less marked for fathers (Table 9.29) but the percentage of ill fathers of children with Medical conditions is still higher at 22% than for other fathers (15%) - Table 8.20. Parents of Ill children, both mothers and fathers, are less likely to be physically unwell than are parents of Somatic and, particularly, Disabled children but the incidence of physical ill-health in parents of the Medical sample overall is significantly greater than those of parents of the Non-Medical sample ($\chi^2 = 5.2$, $df = 1$, $p < 0.03$).

E) Treatment variables
Seventy-two per cent of the combined Medical samples went initially into intensive treatment attending 4 or, more usually, 5 psychoanalytic sessions per week. A further 3 (4%) increased to intensive status during the course of therapy. This is similar to the Non-Medical sample of children but masks differences between the subgroups. The vast majority of Somatic children (88%) started in intensive analysis compared to 62% of Disabled children and only 59% of Ill children. Almost one-third of the latter category (29%)
<table>
<thead>
<tr>
<th>Mother Physical Illness</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>34</td>
<td>23</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>No/Not Known</td>
<td>66</td>
<td>76</td>
<td>69</td>
<td>69</td>
</tr>
</tbody>
</table>

Table 9.28  Mother's physical illness for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Father Physical Illness</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25</td>
<td>18</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>No/Not Known</td>
<td>75</td>
<td>82</td>
<td>78</td>
<td>78</td>
</tr>
</tbody>
</table>

Table 9.29  Father's physical illness for Medical samples (total N=81)
started in once-weekly therapy, and stayed in non-intensive treatment throughout (Table 7.14). This differs significantly from the pattern of treatment experienced by the Somatic group ($\chi^2 = 9.5, \text{df} = 4, p < 0.05$).

Like the Non-Medical sample approximately two-thirds of III and Somatic children were seen by a student therapist. Almost half the Disabled children were treated by a staff member (47%) though the difference has no statistical significance. This did mean, however, that all the Disabled children were able to stay with the same therapist throughout the entire treatment. Three Somatic children (9%) and 4 III children (23%) had a change of therapist and one III child had three analysts in total.

Treatment tended to be slightly longer for the Medical samples (mean = 2.5 years) than for the main group (2.2 years). This was in large part due to the III children who averaged 6 months longer in treatment (mean = 2.75 years). In fact, the III children formed something of a bimodal distribution with large numbers dropping out in the first 6 months (29% compared with 13% of the Somatic sample and 9% of the Disabled group) in addition to a higher percentage staying in treatment for more than three years (41% compared with one-quarter, or less, of the Somatic, Disabled and Non-Medical children). See Tables 9.30 and 8.22.

F) Termination variables

a) Reason for termination

Somatic children were the most likely to terminate by mutual agreement with the therapist after a satisfactorily-completed analysis (Table 9.31). Thirty-eight per cent of them finished in this way which is slightly higher than the Non-Medical sample rate of 32%. The III children were just marginally below this but only 16% of the Disabled sample terminated mutually. Nearly one in four (22%) of them had treatment elsewhere, often at a special school for the blind or deaf. More than half the III children (54%) left prematurely either through their own wish or that of the parents or were terminated by the therapist due to lack of progress. This compares with one in four Disabled children and 28% of Somatic children who left therapy in this way. The
### Table 9.30 Summary of length of treatment for Medical samples

<table>
<thead>
<tr>
<th>Mean Length of Treatment in Years</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.50</td>
<td>2.75</td>
<td>2.31</td>
<td>2.48</td>
<td></td>
</tr>
</tbody>
</table>

### Table 9.31 Reason for termination for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Reason for Termination</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>By agreement (completed)</td>
<td>16</td>
<td>29</td>
<td>38</td>
<td>27</td>
</tr>
<tr>
<td>Premature by parents</td>
<td>6</td>
<td>18</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Premature by patient</td>
<td>9</td>
<td>18</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>By therapist - not progressing</td>
<td>9</td>
<td>18</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>By therapist - external circumstances (eg departure)</td>
<td>13</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>By patient/parents - ext. circs</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Transferred to other treatment</td>
<td>22</td>
<td>6</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td>16</td>
<td>6</td>
<td>16</td>
<td>14</td>
</tr>
</tbody>
</table>

### Table 9.32 Child psychiatric status at termination for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>Psychiatric Status</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable</td>
<td>34</td>
<td>35</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>25</td>
<td>41</td>
<td>38</td>
<td>33</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>41</td>
<td>24</td>
<td>28</td>
<td>32</td>
</tr>
</tbody>
</table>

Table 9.30 Summary of length of treatment for Medical samples

Table 9.31 Reason for termination for Medical samples (total N=81)

Table 9.32 Child psychiatric status at termination for Medical samples (total N=81)
pattern of reasons for termination is not significantly different between subgroups; however, the Disabled and Somatic groups approach significance at ($\chi^2 = 7$, df = 3, $p < 0.07$).

b) Diagnostic status at termination

Psychiatric status for the Medical children at termination was not significantly different from that of the Non-Medical sample. Thirty-five percent of Medical children fulfilled criteria for diagnosis and this proportion was almost identical across all three sub-categories (Table 9.32). This compares with 31% of Non-Medical children with termination diagnoses (Table 8.24). Overall, just under one in three Medical cases (32%), more-or-less the same as the Non-Medical sample, offered insufficient information for psychiatric assessment at the end of treatment, but this was more apparent for the Disabled group (41%) than for the Ill children (24%) and the Somatics (28%).

Diagnostic status at termination did not correlate strongly with any other variable, although there was a weak association ($r = .23$, n.s) with CGAS score at end of treatment. There was also a slight negative relationship between termination diagnoses and length of treatment ($r = -.15$) which indicates that children who came out of treatment early were marginally more likely to retain their initial diagnoses. However, there was no notable correlation between the presence of termination diagnoses and the reason for ending treatment ($r = -0.06$). Over 20% of ill and control children ending by mutual agreement were still seen as diagnosable. This compares with a total of 40% of children ending other than mutually who are positively diagnosable. This figure is, however, reduced to under 25% when children who stay in treatment for less than 6 months are omitted from the calculations.

The kind of diagnoses applied at termination spanned a broad range but there was a discernible pattern between the Medical groups. Half the Somatic diagnoses were of the syndrome 'Psychological factors affecting Physical Condition' (included under Anxiety Disorders in Table 9.33) whereas the
Disabled children showed no residual anxiety conditions at all. Many of their diagnoses related to 'permanent' psychological disorders such as Tourette’s Syndrome, Pervasive Developmental Disorder, Mild Mental Retardation and Borderline Personality Disorder. There was also a couple of specific developmental problems and three disorders of conduct. As a principal diagnosis for the Medical samples, the latter syndrome was exclusive to the Disabled children. Two out of the 6 III children diagnosed at termination suffered with Somatoform (Conversion) Disorder. One had a Personality Disorder as well. There was, in addition, a case of Autism, an Over-Anxious Disorder and one case of Encopresis.

Nearly all termination diagnoses were continuations of assessment disorders. Two apparently new cases (one of Enuresis and the other a Personality Disorder) were diagnosed in children who, earlier, had been under the age for fulfilling these specific diagnostic criteria. One Attention-Deficit Hyperactivity Disorder had become a Conduct Disorder by termination. The only entirely new diagnosis was for an adolescent Ill child whose functioning, as measured by the CGAS, declined considerably a year after the start of treatment which was then terminated due to lack of progress. He developed a Somatoform Disorder that had not been apparent at the beginning of treatment.

c) **CGAS at termination**

Global assessment scores for the majority of children had increased by the end of treatment (Table 9.34), implying that their symptomatic behaviours had decreased and that their overall functioning in terms of social relationships and age-appropriate interests and abilities had improved during treatment. A score of 70 or above on the CGAS scale is generally regarded, rather arbitrarily, as representing a degree of psychological health that would be adequate for normal functioning. Seven per cent of children overall (N = 50) were at this level at the assessment stage before treatment started. By termination, this percentage had risen to 38%.
<table>
<thead>
<tr>
<th>Principal Category</th>
<th>Disabled %</th>
<th>III %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>0</td>
<td>50</td>
<td>73</td>
<td>39</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>36</td>
<td>17</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Enuresis</td>
<td>18</td>
<td>0</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Encopresis</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>18</td>
<td>0</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>V-Codes</td>
<td>9</td>
<td>17</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 9.33  Principal termination diagnostic category for Medical samples (total N=81)

<table>
<thead>
<tr>
<th>CGAS Change</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range-5 to +33</td>
<td>Range -13 to +35</td>
<td>Range 0 to 35</td>
<td></td>
</tr>
<tr>
<td>&gt;-10 CGAS points</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>-10 to -1</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>No change</td>
<td>22</td>
<td>23</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>+1 to 10</td>
<td>16</td>
<td>23</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>11-20</td>
<td>25</td>
<td>23</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>21-30</td>
<td>9</td>
<td>6</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>&gt;30</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Not Known</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 9.34  CGAS change for Medical samples (total N=81)
There was no difference in the mean termination CGAS between the Medical and Non-Medical samples. Both averaged 65 with a similar range of scores. The mean increase was 9 points for all samples bar the Somatic children who raised their score by an average of 11 points (Table 9.35). Their mean, separated from the other Medical groups, was 68, higher than that for the Disabled children (65) and the III children (59.5) although the difference in termination CGAS between the III and Somatic children was only significant at $p < 0.1$ ($\chi^2 = 10.6$, df = 6). Three III children out of 17 ended up with scores below 40 on the 100-point scale. In the other groups, only 3% of the sample were in this lowest category at end of treatment.

Associations were looked for between termination CGAS scores as a measure of change over the course of treatment and all other factors that had been measured or recorded. In fact, significant correlations were few and generally weak. Interestingly, the factors which did seem related in some way to termination functioning were not the same for all groups.

For the Non-Medical sample, termination CGAS was related to length of treatment, to total number of sessions undergone and to reason for termination. The association in the latter case was negative showing that mutual terminations were associated with higher global functioning. There was no association between number of sessions or length of treatment and termination CGAS for any of the Medical groups. And only the III children showed a significant (negative) correlation with reason for termination.

The Non-Medical cases showed a small but significant association between final CGAS level and age at start of treatment, suggesting that younger children do better in therapy. The Medical children, however, failed to show any association between age and termination CGAS.

The only correlation between termination CGAS and an independent factor to be found in all samples, Medical and Non-Medical, was that of IQ which demonstrates an interesting, and rather complex, relationship to level of functioning at the end of treatment. In the Non-Medical sample, both verbal
<table>
<thead>
<tr>
<th>CGAS Group at Term</th>
<th>Disabled %</th>
<th>Ill %</th>
<th>Somatic %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range 39-90</td>
<td>Range 35-88</td>
<td>Range 41-90</td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>3</td>
<td>18</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>41-50</td>
<td>9</td>
<td>12</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>51-60</td>
<td>16</td>
<td>18</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>61-70</td>
<td>31</td>
<td>23</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>71-80</td>
<td>13</td>
<td>12</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>81-90</td>
<td>13</td>
<td>18</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>&gt;90</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Not Known</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Mean:</td>
<td>65</td>
<td>59.5</td>
<td>68</td>
<td>65</td>
</tr>
</tbody>
</table>

Table 9.35 Termination CGAS score for Medical samples (total N=81)
and performance IQs relate significantly, though weakly, to CGAS score, but for the Medical groups the associations are rather different. For the Disabled and Somatic children, performance scores have no apparent connection with end functioning but verbal IQ scores show a very highly significant association with final CGAS level. But for the III children the relationship is reversed. There is no correlation with verbal IQ but a marked association with performance scores.

As noted above in the section on working mothers, the III children showed a correlation between final outcome and maternal employment, tending to show higher levels of functioning at termination if their mothers had paid work outside the home. Apart from this, mothers appeared to have less influence on the final outcome of the child than had been expected. Only the Disabled children showed a significant negative relationship between their level of functioning at the end of treatment and the presence of psychiatric symptoms (though not necessarily at clinical levels) in their mothers - and this related only to past symptoms in the parent. Moreover, this correlation was not all that high ($r = -.35; df = 30; p < 0.05$) and there was seemingly no link between present maternal pathology of any sort and the child's final CGAS score.

Nor was there any relationship between mother's level of functioning at assessment, as measured by the GAF scale, and improvement in the child during the course of treatment although increase in global functioning in Somatic children was highly significantly associated with Father's GAF score.

### 9.4 Discussion

#### A) Child variables

**a) Sex**

Most epidemiological research has found boys to be over-represented in clinic populations (Kazdin 1988, Rutter et al 1970, Shepherd et al 1971) and our study was no exception. The ratio of boys to girls in the Non-Medical sample
and in the Disabled and Ill groups was 59:41. The Somatic sample of asthmatic and eczematous children had even more boys and fewer girls (69:31). Girls in this group were very unlikely to suffer from both asthma and eczema; the boys, on the other hand, rarely displayed eczema alone (Table 9.2). This is consistent with two previous, and hitherto somewhat contradictory, findings. Rutter et al (1970) classified more boys (42%) with asthma than girls (39%) in their physically disordered sample but found a reversed trend for eczema (23% of girls and 15% of boys).

Shepherd et al, on the other hand, found a slightly increased prevalence of both asthma and eczema in boys (1971). This suggests that boys have greater predisposition to psychosomatic expression, particularly in the form of asthma and combined conditions. Incidence of eczema in boys, however, tends to co-exist with asthma. Incidence rates will therefore seem to vary dependent on whether eczema-only conditions are rated (in which case girls predominate) or whether eczema-with-asthma is looked at (boys predominate).

b) Age

It was noted that many more Disabled and Somatic children come into treatment in the pre-school years than is true of the Ill children (Table 9.3).

For many years the Anna Freud Centre had a nursery school for blind children and a special interest in the needs of the visually-handicapped which would be one possible explanation for the greater number of Disabled children being picked up in the pre-school years. But referral patterns (see table 9.12) suggest that a large number of Disabled children are referred from doctors and specialist centres and that there are no major differences between the various Medical groups in number of referrals from Anna Freud Centre organisations. It is more likely, then, that a severe physical handicap such as sensory deprivation or loss or deformity of limbs is such an obvious need for the child and has so many potential emotional sequelae that the increased contact with doctors and hospitals necessitated by such severe physical
disabilities leads to these children being referred easily and early. Mean age for referral for a Disabled child was 8.5 years.

The difference between the mean age at assessment for the Ill children (10.1) and the Somatic children (8.8) cannot fully be explained by age at start of illness. Many asthmas and eczemas started in babyhood or infancy but the conditions of the Ill group - epilepsy, diabetes, allergic complaints and others - also often began before 5. This suggests that parents of Somatic children are well aware of possible psychogenic factors in the aetiology of the so-called psychosomatic illnesses and consider psychotherapy early on. More than one in three of the Somatic sample were referred for treatment before their 6th birthday while less than one in eight of the Ill children are referred at this age.

The most likely explanation is that obvious organic dysfunctions are investigated medically to start with, adjuvant psychological treatment being considered only at a later stage. This is probably, given the increase in referrals for chronically ill children between 11 and 14 years of age, when puberty and all its associated changes leads to psychological difficulties in assimilating a serious illness into an adolescent body-image. This is consistent with previous observation that physical impairment only becomes intensely socially significant as the child enters adolescence (Davis 1972).

Interestingly, the only two under-fives in the Ill sample were at opposite ends of the psychiatric spectrum. One, whose haemophilia was discovered at circumcision, had no diagnosable psychological symptoms, was extremely well-functioning (scoring 78 on the CGAS scale) but was treated analytically because he had a psychiatrically-disturbed twin. The other (with a CGAS of 30) was autistic and living in a special unit. He was referred by his doctor and, in addition to his autism and epilepsy and a history of multiple hospitalisations for non-associated reasons, he was also asthmatic and had had frequent changes of primary caretaker.
c) IQ levels and Learning Difficulties

The mean IQ of the total Non-Medical sample of children was one standard deviation above population norms at 115 (Table 8.3). This is particularly remarkable as psychiatric disturbance in the general population is usually strongly correlated with below-average intelligence (Rutter 1975). Our atypical findings must owe much to the properties of intensive psychoanalytic treatment, appealing as it does to the verbally articulate (Bachrach et al 1991) who, by definition, score higher on linguistically-based IQ tests. In addition, verbal test scores can be artificially elevated (or depressed) by the home environment (Herbert 1974) so that our predominantly middle-class clientele were probably more likely to score high on verbal items than a more socio-economically random sample of children, regardless of actual levels of intelligence (Rutter 1975).

Only three-quarters of the main sample were tested during their diagnostic process and it is possible that those omitted were unrepresentative in some way. Preliminary speculation that children with learning difficulties are more likely to be tested than those without (thus lowering the real mean) is not supported. On the contrary, those with very severe educational problems due to pervasive developmental and autistic disorders were not usually tested. This also may keep the mean IQ high.

Children with chronic Medical conditions were more likely to be tested than those without. Nearly all Somatic and Ill children (94% from each group) were assessed in this way (Table 9.4). The percentage for the Disabled was lower, at 81%. Again, though, testing did not correlate with the presence of learning difficulties. In fact, the Somatic children had fewer learning difficulties than all other groups, including the Non-Medical sample. In many instances testing seemed due to more pragmatic considerations. Most of the Disabled for whom testing was omitted were blind or partially-sighted and, although IQ tests are available for the visually-deprived, sensory deprivations of this nature make testing difficult and less reliable.
All the Medical samples also scored above the population norm in terms of IQ, the Somatic children being identical to the high mean of the Non-Medical sample. This tends to correspond with Rutter's findings that asthmatics are IQ-rated significantly above control groups (Rutter et al 1970). He also found a similar, though statistically insignificant, trend for sufferers from eczema. In our case, of course, the mean of the larger control group was also higher than would be expected by chance. Disabled children scored an average of 105, 10 points below Somatic and physically well children, and the Ill children were 6 points adrift at 109.

This may be partly associated with schooling difficulties. Most Ill (82%) and Disabled children (78%) experienced educational difficulties (Table 9.4). Learning disorders are extremely common among school-age children (Rutter 1975) and 66% of the Somatics and 64% of the main sample were also affected. However, the higher incidence for Ill and Disabled children supports psychoanalytic observation that a 'deficient body image' (Blos 1960) often contributes to problems in learning.

In principle, schooling problems per se should not affect test scores as IQ measures are assumed to access what Gregory (1981) calls 'kinetic' intelligence, that raw, untrained, innate stuff which theoretically dictates the level of our limitations and achievements. The biasing effects of 'potential' intelligence - the mass benefits of education and received wisdom - are deemed minimal. In practice, the two kinds of intelligence are probably inseparable.

Furthermore, even if they were not, the kind of difficulties experienced at school by chronically ill and disabled children would be likely to affect their performance and behaviour on other tasks, such as IQ testing, as well. For instance, one in four of our Disabled children experienced school problems specifically related to their handicap. Absences from school also tend to be more frequent for the handicapped child (Shakespeare 1975). Similarly, the chronically ill child truants more frequently, is troublesome at school and socially isolated (Hall and Beresford 1984). The combined effects of these
difficulties would almost certainly generalise to other areas of life, affecting concentration, motivation, self-esteem and other factors which, in turn, have a bearing on test scores.

It has also been noted (Cashden 1968) that physically handicapped children receive less stimulation at home than either non-handicapped or mentally-handicapped peers. This shortage of intellectual *enrichment* might well account for the lack of positive skew among the Disabled scores compared to those from the Non-Medical sample and the other Medical groups.

**B) Family variables**

**a) Social Class**

Social class ratings, assessed according to the Registrar-General's classification of employment, uncovered significant differences between the mean of the Somatic group (1.9) and that of the III sample (2.9). Families of Disabled children corresponded exactly to the total mean of 2.3 (Table 9.6). Previous research has found a positive correlation between social class and the presence of psychosomatic asthma (Rutter et al 1970) and our figures support this link, though it has also been suggested that this may be simply a matter of terminology with working-class definitions of wheezing and bronchitis becoming full-blown psychosomatic syndromes in middle-class families (Thomas 1978).

Referral patterns may also help to explain class differences between the Medical groups. Although most studies (eg Rutter et al 1970) have not found any association between social class and emotional disorder in children (and, by extension, attenders for treatment), social class membership of the patients at the Anna Freud Centre is heavily weighted towards the top 3 classes. It is a feature of psychoanalysis as a treatment that it attracts mostly middle-class patients (Bachrach et al 1991). The greater percentage of III patients from social classes 3 and 4 seems to be a result of these children being referred *not* by their parents but by *in loco parentis* professionals such as doctors and child guidance units who are more likely to make middle-class therapeutic suggestions even for their working-class
patients. Ten out of twelve ill children from social classes 3 or 4 were referred in this way. This also applies, to a lesser extent, to the Disabled children who are more likely to be referred from sources classified under Other in the table. This includes agencies and organisations for the deaf and blind.

b) Broken/intact homes
It was somewhat unexpected to find higher percentages of intact homes in all our medical groups than in the total non-medical sample (Tables 9.8 and 8.8). The stress of parenting a child with chronic physical problems has been well documented (Thomas 1978, Davis 1972, Bachrach et al 1991, Minde et al 1972) and it might be supposed that this would lead to parents separating at a higher rate than is the case for physically-well children. However, Rutter had previously found only a slight association between severity of handicap and number of problems within the family (Rutter et al 1970) and this led him to suggest that the impact upon the family of chronic disability or illness is a function of many factors and cannot be attributed in great measure to the nature or even the presence of the physical disorder. Philip Graham also concluded that the rate of marital break-up does not seem higher for families of chronically ill and handicapped children (Graham 1985). Although disruption of routine and daily activity seems greatest in families with a handicapped or ill child, disruption of relationships is actually less frequent in these circumstances (Shakespeare 1975).

Social class status was considered as a possible explanation for the particularly high family intactness within the Somatic group (at 91% this was significantly different from the main sample). This line of enquiry was abandoned after finding that the correlation coefficient relating high social class with a lack of family breakdown within the Somatic sample was, in fact, too low to approach statistical significance. Nevertheless it was higher than the association between these two variables in any other sub-sample and it is not altogether infeasible that social class membership may play a small, contributory, rôle in keeping families intact.
A more psychological proposal is that children's psychosomatic symptoms play a major part in stabilising the family by providing a focal point of concern and permitting conflict avoidance on other issues (Minuchin et al 1975). Although this is dysfunctional for the individual member, the unit as a whole benefits by being enabled to remain intact.45

c) Divorce and other losses

A similar pattern emerged when parental divorce and separation figures were looked at (Table 9.9). This is not synonymous with the category of broken/intact homes though highly correlated with it. In fact, the finding that the Ill and Somatic children had experienced much less loss of major figures than had the Disabled or the Non-Medical children was, to a large extent, due to higher family intactness in the former two groups.

A brief examination of individual cases underlines previous researchers' views that it is not separations *per se* that have important consequences for the child but the circumstances surrounding them (McCord and McCord 1959, McCord 1990, Rutter, Quinton and Hill 1990). The two Ill children classified as coming from a broken, though non-divorced, home had had unusual and appalling experiences, far worse than that of most children from divorced families. One lived with an aunt and uncle after his Jewish parents and siblings had all been killed by the Nazis when the patient was 3 years old; the second had a schizophrenic father who had lived in a psychiatric hospital for many years. The child had experienced a series of foster families, all of whom had broken down. Similarly, the bald statement that a family is intact may hide a multitude of dysfunction. Intactness simply implies two parents living in the same house; it does not necessarily indicate a harmonious relationship.

d) Maternal Employment

45Two of the 3 broken Somatic families in the sample were highly unusual in that mother's alcoholism had contributed significantly to the break-down in family relationships. One of these mothers died of alcoholic poisoning during the child's assessment at the Centre.
Lack of employment for mothers of young children has been identified as a potential vulnerability factor, predisposing them to a higher incidence of depressive illness than that experienced by working mothers (Brown et al 1977). This seems to be the case regardless of social class or the child's chronic physical condition (Walker et al 1989). In turn, maternal depression is associated with emotional problems in the child (op cit). There is a mass of evidence that the once strongly-held view that children of working mothers are more likely to become delinquent or develop psychiatric disorder is not tenable (Rutter 1975). In fact, Rutter claims that children of working mothers may do better than other children although Shepherd found that children of non-working mothers improved more often in treatment (68%) than their peers whose mothers went out to work (52%) (Shepherd et al 1971). Our own finding that III children with working mothers tended to do better in treatment lends support to Rutter rather than Shepherd.

However, the mothers of the Disabled children, nearly two-thirds of whom had no outside work, had a higher mean GAF score than mothers in other groups who were more likely to have full or partial paid employment (Tables 9.11 and 9.20). Of the 4 ‘Disabled’ mothers with diagnoses or symptoms of depression only 1 was unemployed. This would not be expected from the findings, noted above, from Brown and colleagues and others. On the other hand, 71% (5/7) of the depressed mothers of Somatic children were not employed outside the home and 2 out of 3 unemployed mothers of III children also suffered with depression.

The mean unemployment rate for mothers of physically disordered children was 59%. This deviates substantially from the 25% in the Disabled depressed group and, to a lesser extent and in the opposite direction, from the 71% and 67% of depressed 'Somatic' and 'III' mothers. Because the figures are so small it is not possible to analyse them statistically but it does suggest that the effects of employment status on depression may be

---

"For example, a report from the World Health Organisation in 1951 stated that placement of children in day nurseries constituted separation experiences which inevitably caused permanent psychological damage (in Rutter 1975) (italics added)."

266
influenced by various confounds, including, possibly, the responsibilities of looking after a child with chronic physical problems. Perhaps parenting a disabled child offers more challenges or simply takes up more time and focuses the mind more clearly on the home environment so that such mothers are less likely to become frustrated and depressed despite a lack of outside employment.

C) Diagnostic variables

a) Past diagnoses

Ill children were more likely to have had a definite past diagnosis than were children from other groups (Table 9.13) but, as insufficient information for past diagnosis was less likely to apply to them than to all the other groups, this may simply reflect increased awareness on the part of parents and doctors as a consequence of the child being chronically unwell.

b) Current diagnoses

The high prevalence of Anxiety diagnoses within the Somatic group (Tables 9.15 and 9.16) is a consequence of our decision to interpret the syndrome ‘Psychological factors affecting Physical Condition’ as anxiety-based, and to assume that 'psychosomatic' children could be identified and separated out from the other children with chronic physical illnesses. It suggests the possibility of psychogenic states underlying the physical condition and supports the psychoanalytic line that psychosomatic conditions are an expression of suppressed or repressed emotion (Bastiaans 1977). All health-impaired children have been shown to report a significantly greater number of fears than physically well children (King et al 1990). However, this was not the case for our Disabled children who presented with less anxiety diagnoses than the Non-Medical sample.

Nor was the great deal of evidence linking depression with chronic illness or handicap (Milavic 1985, Garner 1981) upheld by our Medical samples. Impaired mobility and stressful treatment procedures are particularly associated with depressed mood (Milavic 1985) but the children in the Ill and Disabled samples to whom these descriptions applied did not manifest
depressive symptomatology. They were more likely to externalise their difficulties in conduct disorders. Pervasive and specific developmental disorders were also common.

It is difficult to know why this might be so but it should be remembered that, in addition to their medical condition, these children came to our attention as having psychological problems. They are therefore not necessarily typical of all physically unwell children. It may be that many of the instances of depression noted in other studies are actually below diagnostic caseness levels. Perhaps chronically unwell children are 'expected' to display some anxiety and depression and are more likely to come to the attention of psychiatric treatment centres only when they begin to manifest disruptive or anti-social behaviour or when their overall development is impaired.

c) CGAS ratings
Although global functioning was lower for the III children than for other samples (Table 9.17), numbers were small and the figures were not statistically significant. There was, generally, more clinical information available for the III children, which meant that they were relatively unlikely to be left undiagnosed because of lack of relevant details. This may have not only influenced global functioning assessment but also enhanced the association between CGAS scores and diagnostic status.

d) AFC categories
It was noted above that a large proportion of Disabled and III children who were assigned to a Diagnostic Category were placed in the lower two bands and labelled as either 'atypical' (Category IV) or as presenting with 'substantial disruption of mental growth' (Category V). These facts should be placed in context. Category IV (atypical), to which 6 Disabled and 1 III child were assigned (Table 9.18) does not imply that any of these children were grossly abnormal. They are 'atypical' simply in the sense that they deviate from the normal phases of developmental based on the average non-handicapped child. It is only to be expected that blind and other Disabled children will be difficult to categorise developmentally with physically well
children. The lowest Category (V) does have more serious implications. Children placed here generally have psychotic or organic conditions affecting the brain. However the number of children placed here is small comprising only one Disabled, one Somatic and two III children.

D) Parental variables

a) Past and present diagnoses and GAF scores

The percentage of diagnosable parents of physically-well children (Tables 8.18 and 8.19) was similar to that found in earlier research. For example, Shepherd et al (1971) had noted 16% of mothers of both child guidance clinic patients and non-patients to have had a previous psychiatric illness. And, with regard to present conditions, Rutter (1966) found 20% of children attending a CGC to have a currently ill parent, usually the mother. This was three times as high as for children attending a control (dental) clinic. Our Non-Medical sample concurred with both Shepherd and Rutter’s findings. However, when all the data was taken into account, our Medical groups manifested lower incidence and severity of parental past and present clinical psychiatric diagnoses and symptoms than did the families of the Non-Medical sample (Tables 9.21 and 9.22).

Why should mothers and fathers of physically ill children be less liable to attain psychiatric status? Is it perhaps that the irritation and bewilderment that parents experience in the face of emotional and behavioural problems in their offspring (Shepherd et al 1971) are felt to be more understandable and acceptable in children with obvious life-difficulties? And that this, therefore, leads to less guilt and anxiety in the parents? Rutter found that mothers with psychologically-disturbed children had higher 'malaise' scores (significant at p<0.001) than mothers with physically-disordered children (Rutter et al 1970). As noted above, the whole of our present sample were attenders at a psychiatric clinic, but there may well be differences in interpretation and attribution of cause of the emotional disorder between parents of unwell children where the disability has obvious aetiological significance, and parents of physically-healthy or psychosomatically-inclined children who must attribute their child's psychological dysfunction to other sources.
This, admittedly speculative, explanation accounts in part for the fact that, among the Medical groups, it is the mothers of Disabled, rather than Ill or Somatic, children who appear to have fewer psychiatric tendencies (Table 9.23). In fact the difference between the percentage of mothers who have, or who have ever had, a severe psychiatric problem is very significantly lower in mothers of Disabled children compared with mothers of children in the other Medical groups. This is contrary to previous findings that mothers of handicapped children tend to have lower self-esteem than other mothers (Fisher 1970) and that children whose every-day practical functioning is limited, as would be the case for severely handicapped children, have mothers who are more symptomatic (Jessop et al 1988; Minde et al 1972, Rutter et al 1970). Our 'Disabled' mothers went against this general observation, with higher global functioning scores, lower diagnostic rates and less symptomatology than all the other groups, Medical and Non-Medical.

The 'attribution' account still does not explain why mothers of Ill children have slightly lower GAF scores than the Non-Medical mothers, and a higher tendency to psychiatric status, unless we can assume that disability is seen by parents as 'externally' caused in contrast to more 'internal' sources of illness, whether psychosomatic or organic, which may lead to guilt, uncertainty and anxiety in parents. It was certainly the case that diagnoses of anxiety were made more often for mothers of Ill or Somatic children than for mothers of Disabled children.

In addition, mothers of Ill and Somatic children showed higher incidence of past and present symptomatology (mostly sub-clinical) as measured by ratings on the symptom checklist (Table 9.23). This suggests that their stress, although less often translated into full-blown psychiatric syndromes than is the case for Non-Medical mothers, is none-the-less clearly present even if it fails to meet sufficient criteria for medical diagnosis. The symptoms, often 'severe' in nature, comprised predominantly depressions.

---

It should be remembered that the mothers in all our samples had children with physical and/or emotional difficulties and that, therefore, the comparison with mothers in general can only be made with caution.

270
including puerperal syndromes, anxieties and marital difficulties, though the high rate of occurrence of the latter extended to Non-Medical families as well.

The 'Ill' mothers were showing current signs of distress but many of the 'Somatic' mothers had suffered from the recorded symptoms before the time of the child's assessment for treatment. Does this point to differing relationships of organic or psychosomatic conditions to parental pathology? For example, perhaps maternal tension predates asthmatic or eczematous signs, even to the extent of actually eliciting, or at any rate maintaining or exacerbating them whereas, in the case of organic conditions, causal direction is reversed, with the child's illness adversely affecting the mother's stress levels. This is certainly a possible explanation for the high rates of sub-clinical pathology for 'Somatic' and 'Ill' mothers. Positive rating of symptoms for 42% of mothers from the Non-Medical sample were bettered by the Disabled group (31%), but considerably exceeded by the 59% of 'Ill' mothers and, even more so, by two-thirds (66%) of mothers of Somatic children who were positively identified on the symptom checklist.

Although this may be a reasonable supposition for the Somatic sample who do indeed show high levels of anxiety it does not explain why mothers of Ill children, having rarely shown historical symptoms even when their child's illness is long-standing, suddenly manifest pathology at the time of assessment. We suggest, tentatively, that the likely reason for this is less a matter of sophisticated theory than of common-sense, a question of 'state' rather than 'trait' anxiety. Six mothers (19%) of Somatic children had had personal experience of psychoanalysis. No 'Ill' mothers had been analysed. The apprehension and fearfulness that attends the start of unfamiliar treatment is too often ignored by practitioners to whom the consulting room is as commonplace as home. This is not the case for patients and it is not surprising if current states of anxiety are observed in families about to embark on the unknown. This may well partially explain the high levels of current symptomatology in mothers of Ill children.
The earlier-stated 'attribution' theory is able to account for the fact that the parents, and especially the mothers, of Disabled children show less pathology at both clinical and sub-clinical levels, than do parents of other Medical children.

The apparent bias towards hospital outpatients' referrals for parents of Ill children and towards private analytic treatment for families of Somatic children may be a function of social class. Somatic families come predominantly from the top two classes while over half the Ill sample belonged to class III (Table 7.12). Psychoanalysis is primarily a therapeutic intervention for the middle classes, as we have already noted. In addition, children with chronic physical conditions have a great deal more contact with hospital amenities than do most children and a parent with psychopathology may be more likely to be referred from one department to another on an intra-hospital basis.

b) Physical illness

An important parameter to consider with respect to chronically ill and disabled children is physical health within the family. It was expected that there might be increased physical vulnerability within Somatic families and, to some extent, within Ill families too, but not for the families of Disabled children. This was because disability would not, generally, be heritable (although there was one blind child in the sample with blind parents), but that chronic illnesses may be, and that somatic reactions may be either inherited or learned. However, these expectations were not supported by the data which show increased rates of parental illness across all three medical groups, the Disabled sample being slightly higher than the rest, though not significantly so (Tables 9.28 and 9.29).

It appears, then, that parents of Disabled children do not escape without signs of stress at parenting a sick child but that the strain may have a tendency to manifest itself in physical rather than psychological illness.
The occurrence of increased parental illness among the Medical children is especially noticeable in the case of mothers. Sixteen per cent of the Non-Medical group had an unwell mother; this was almost doubled (31%) for the Medical samples. This can partly be explained by selective attention being paid to particularly salient facts by chronically-disordered families. Parents with ill or disabled children are likely to be medically-focused in a way that other parents may not be; additionally, interviewers may be more likely to ask questions relating to the physical health of the rest of the family when dealing with a child with a chronic condition. (There was one Disabled case where a child had acquired her deafness through a war-time bombing incident in which her mother also lost an eye and, as mentioned, one inherited blindness).

There were also a few Somatic cases where asthma and/or eczema appeared to run in the family and a number of parents who shared similar conditions with their Ill children - for example, rheumatism or heart disease. Many of the parental complaints in this group were psychosomatically-based - rheumatism, arthritis, ulcerative colitis, migraines and so on. There were a number of parents who suffered with migraines in the Disabled group, too. These conditions probably have greater significance for families with a physically ill member, resulting in artificially low figures for the Non-Medical sample. This is supported by the fact that previous research has found higher incidences of parental physical ill-health (about 25%) among psychically-disturbed children (Rutter et al 1970) than was the case in our Non-Medical sample.

None-the-less, it seems unlikely that this would account for the whole of the increase in maternal illness among the Medical samples. Parental illnesses and disabilities such as ataxia and cleft palate which appeared among the medical groups would not have been omitted from any history-taking, whether the child was physically well or not. Some of these conditions, such as the two just cited, almost certainly do not have psychological aetiology either. But the presence of a small number of stress-determined conditions, plus the enhanced reporting of medical facts from chronically ill families
would be enough to substantially increase the incidence of percentage of ill parents in small samples such as ours.

E) Treatment variables

a) Type of treatment

The treatment of choice for a psychoanalytic centre is nearly always intensive but other factors, both pragmatic and therapeutic, have to be considered before a child and his or her family are offered a particular type of treatment. Eighty-eight per cent of Somatic children were taken into 4- or 5-times weekly analysis compared with 62% of Disabled children and 59% of III children (Table 7.14). This, again, suggests differences between children with chronic organic, as opposed to assumed psychosomatic, conditions and is further vindication of our decision to separate these two samples.

This may be partly a bias at diagnostic stage, of course. Psychoanalysis has traditionally been regarded as enjoying particular success with psychosomatic patients (Malan 1973, Bachrach et al 1991, Mannoni 1970, Eissler et al 1977) and they may, therefore, have a higher chance of being offered treatment, especially intensive treatment, than children whose illnesses are perceived as having other aetiologies.

The profile of the average Somatic patient with his or her high social class and IQ rating is more characteristic of the typical analysand than is that of the III child. Furthermore, Somatics are, as we have seen, far more likely to exhibit anxiety as a principal or additional symptom than are children from other Medical groups. It is recognised in analytic practice that patients manifesting high anxiety have a generally good prognosis (Kernberg 1976). Luborsky, Singer & Luborsky (1975) found that, in nearly all the comparative outcome studies they reviewed, psychotherapy proved to be more beneficial for psychosomatic symptoms than a medical régime alone whereas for other psychological and psychiatric conditions drugs were as good as or better than counselling therapy. The authors suggest that the reassurance and support of a therapeutic relationship may be particularly useful for psychosomatic patients. Our Somatic children, with the assumed psychogenic cause
of their symptoms and their high, consciously experienced, anxiety, were seen by their diagnosticians as being able to benefit from the kind of treatment offered to them at the Anna Freud Centre. The high percentage of Somatic children given intense therapy acted, in a way, as a self-fulfilling prophecy. However, evidence from other sources has confirmed that this was a reasonable match of type of analysis with patient.

b) Type of therapist
The Anna Freud Centre is a training institution as well as a therapeutic centre and therefore most of the child analysts are still in training. The majority of children (two-thirds) are seen by a student. Staff therapists tend to take on the more complicated or unusual cases that would be regarded as too challenging for a beginning case. More Disabled children than children from other Medical groups or from the Non-Medical sample were treated by experienced analysts mainly because of the added difficulties of communicating with blind or deaf children. There were staff members with particular skill and expertise in these areas and such children would have been referred to them. Staff treatment in these cases does not imply that these children were more dysfunctional psychologically.

c) Length of treatment
The Ill children, who tended to stay in treatment longer than members of the other groups, were also functioning, on average, less well in terms of CGAS scores at assessment. They do not appear to be so obviously suitable for psychoanalytic treatment as either the Somatic or the Disabled children. Many of them drop out before treatment has really been established; others stay for a considerable time but are often best described as 'heroic indications' (Glover 1954). That is, they are often taken into psychoanalytic treatment as a last resort and are 'managed' rather than treated.

This was true of all of the Ill children who stayed in treatment for 4 years or longer. They included a child with badly-controlled diabetes, a little autistic boy with epilepsy, an organically brain-damaged child with a pervasive developmental disorder and a boy with aphasia and epilepsy and pervasive developmental disorder.
dysfunction. Only the latter child did well in therapy. They were all seriously ill, both mentally and physically, and experienced many hospitalisations and consequent breaks in treatment. This is another indication that the Ill and Somatic children should be considered separately.

F) Termination variables

a) Reason for termination

The differences in reason for termination between the Medical subgroups appear to reflect the assumed suitability for psychoanalytic treatment of each type of patient, as discussed above. The Somatic children were more likely to finish by mutual agreement with their therapist after a satisfactorily completed treatment (Table 9.31), presumably because of their initial profiles which indicate them as particularly suitable for intensive psychoanalytic treatment (high intelligence, high socio-economic class and primarily neurotic and psychosomatic symptoms).

The Ill children withdrew prematurely more often than children from other groups. This, combined with the therapist 'giving up' on them because of lack of progress, accounted for more than half the terminations in the Ill group, reflecting the difficulties in applying psychoanalytic techniques to children who have epilepsy associated with chronic brain damage, or other pervasive developmental problems. Not all the Ill children fell into this category, of course, and some did very well in treatment, terminating successfully, but the Ill category certainly contained high percentages of patients who are very difficult to treat psychologically. They were often taken into analysis as interesting research cases; therapeutically and prognostically the decision to offer them analysis could only be described, as noted above, as 'heroic'.

The Disabled children tended to stay in treatment until old enough, or until it was appropriate for other reasons, for them to transfer to special units dealing with their particular handicap. Many of them, therefore, finished early in order to complete their education, training or therapy elsewhere. This
applied to almost one in four. Very few children from any other group were transferred elsewhere.

It is worth noting that, overall, less than one in three children (N = 241) from the total sample of 769 children ended their analysis by mutual agreement. High drop-out rates are a particular problem for very intensive, long-term treatments. Even adult centres who select very rigorously from among those who request treatment (only about 10% of applicants are accepted) lose at least one in four patients prematurely (Bachrach et al 1991, Rachman and Wilson 1980) and often nearly half (Bachrach et al 1991). And this clientèle is undoubtedly extremely highly motivated and prepared to overcome stringent diagnostic and assessment procedures to obtain their treatment of choice.

The debate in outcome studies over whether drop-outs should be considered as part of the total data or should be excluded altogether continues to rage (Bergin and Lambert 1978, Rachman and Wilson 1980, McAdoo and Roeske 1973). For psychoanalysis, where so many patients drop out before the end of treatment, the inclusion or exclusion of premature terminators makes an enormous difference to the measured efficacy of the procedures. A study which investigated the therapeutic results from nearly 1000 adult analyses from a wide range of centres excluded analysands completing less than 6 months of treatment and found an overall improvement rate of 56%. When the treatment 'defectors' were included in the data, this percentage was lowered to 30% (Rachman and Wilson 1980). Even then, psychotic patients were excluded (and some of our III children with autism and pervasive developmental disorders would probably have fallen into this category).

In the present study all children were included if they turned up for their first session but, in psychoanalytic terms, treatment for those patients who drop out in the first few weeks (or even months) is not usually considered to have been properly established. It is no surprise, therefore, that such a high percentage of our patients ended prematurely. Our figures would have looked more encouraging if we had excluded those who failed to complete, say,
three months of treatment (9%) or 6 months (17%) or 9 months (23%) or a year (29%), remembering that the mean length of treatment is 2 years and 3 months (with a standard deviation of 1.96).

The high number of children who fail to complete their treatment raises the question of cost-effectiveness and therapeutic efficacy for the majority of patients. As Rachman and Wilson say (1980), 'Even if one were to conclude that psychoanalysis is an extraordinarily effective treatment it would be necessary to add the qualification that it has a remarkably narrow range of applicability'.

b) Termination diagnoses
The existence of a correlation, albeit a low one, between diagnostic status at termination and final CGAS score is unsurprising as the two variables measure overlapping aspects of global functioning. In other words, children without psychiatric symptoms would generally be more positively assessed in terms of level of operation in different areas of their life than would children with clinical dysfunction. There is a similar explanation for the association between termination diagnoses and length of treatment. A large number of children who finished very precipitately never really established themselves in treatment. It would, therefore, have been assumed by the research raters, in the absence of contradictory information, that they had experienced little or no change in their symptoms and degree of global functioning. CGAS scores and diagnostic status would, therefore, have remained the same as at assessment.

Nevertheless, once the ‘barely started’ children are accounted for, psychiatric diagnosis at end of treatment is almost as likely for children ending with mutual agreement as for those who finish prematurely or who are transferred elsewhere, indicating that even satisfactory analytic endings produce no guarantee of symptom alleviation and do scarcely better in this regard than premature terminations.
This is an interesting finding. Psychoanalysis has traditionally been less concerned than most other forms of treatment about symptoms, regarding them mainly as signposts to the real phenomenon of interest, the underlying psychic conflict. Nevertheless, in practice, even if the symptom is not specifically targeted it would normally be assumed that a successful treatment would include removal of the initial reason for presentation. But apparently it does not. Spontaneous remission rates in childhood are estimated to be about 72% (Rachman and Wilson 1980) over two years. We would therefore expect that about 28% of children would not improve without treatment. The finding that most of these children did not improve symptomatically even with treatment, and even when that treatment has been conducted according to very stringent psychoanalytic criteria and has been terminated by agreement with the therapist, is disturbing. In addition, approximately 15% of children were not diagnosable even at assessment. When this is taken into account we find that only 64% of children from the total sample of 769 who had been diagnosable at the beginning ceased to be so by termination. This is lower than spontaneous remission rates.

However, the situation is not quite as dismal as it appears at first sight. Co-morbidity at assessment was widespread, with many children fulfilling criteria for a number of syndromes. This had often improved by the end of treatment so that, although some states persisted, many had disappeared. Furthermore, most psychiatric conditions remaining were no longer as severe or as certain as they had been at the start of therapy. We can claim, therefore that, although large numbers of children were still diagnosable they were not as diagnosable as they had been previously! This rather strange assertion is lent support by the increase in level of global functioning as measured by CGAS scores which had increased for most children by the end of treatment, suggesting a positive therapeutic effect.

The diagnostic label ‘Psychological Factors affecting Physical Condition’ is simply another way of denoting the presence of psychosomatic states so, by definition, its absence in all groups bar the Somatic is tautologically unsurprising. Similarly, two of the six III children diagnosed at termination
were classified as having Somatoform (Conversion) Disorder, which is also probably associated with their physical condition.

b) CGAS scores
The Medical children did as well as, or better than, the Non-Medical cases in terms of change in their CGAS score between assessment and termination (Tables 9.34 and 8.26). This seems to indicate that chronic medical conditions permit a child to make particularly good use of analysis. There may, however, be factors that bias the chances of Medical children doing well and give them a better chance of elevating their termination scores. For instance, we have seen that the Ill children have longer treatments and that the Disabled children are more often treated by experienced staff therapists. Would these, and other variables that differentiate all or some of the Medical subgroups from each other and from the total sample, affect the level of improvement noted at the end of therapy?

In fact, any such associations found between termination CGAS (Table 9.35) and other factors were relatively weak. The Non-Medical children did show a relationship between their final functioning and treatment length, total number of sessions and reason for finishing. All these are expected results, especially taking into account the notoriously circular arguments for psychoanalytic efficacy that patients who remain unimproved have not yet been sufficiently analysed (Eysenck 1985). It follows, then, that patients who terminate by consent with the therapist are perceived as improved and functioning adequately. It is not surprising that this state of affairs will come about increasingly frequently as treatment proceeds. Whether improvement is due to spontaneous remission, developmental maturation or specific treatment effects, the passage of time will tend to improve matters. We are reminded of George Bernard Shaw's comment, quoted earlier, that 'The doctor is the person who passes the time while nature performs the cure'. Without subscribing wholly to such cynicism it is nevertheless true that, whether the 'cure' is performed by nature or by the doctor, time is on the patient's side, especially in child psychological dysfunction where death does not usually intervene!
Previous research which has usually failed to find a consistent relationship between the child's functioning at termination or follow-up and length of treatment is not appropriate comparative material for the present study. Such outcome studies have always looked at non-psychoanalytic treatments which offer the patient a very small number of therapeutic sessions, nearly always less than 15 (Shepherd et al. 1971). There are only two specifically psychoanalytically-oriented studies in the literature, and both of these, carried out twenty years apart by Christoph Heinicke, show considerable positive gains made by children seen in four analytic sessions a week as compared to those seen once weekly (Heinicke 1965, Heinicke and Ramsey-Klee 1986). Although our own research did not find any differences in improvement between children seen intensively (4- or 5-times weekly) and those seen less frequently (but always at least once a week), the number of sessions attended throughout the entire treatment is obviously not entirely unconnected with intensity of therapy.

Having said all this, however, we did not find any association between number of sessions/length of treatment and outcome for any of our Medical groups. And only the III children showed effects from their reason for termination. It is entirely possible that alleviation of psychological problems for children with chronic physical disorders depends partially on the intervention of other agencies such as special schools, hospital doctors, GPs, social workers and so on. We know that ending by mutual agreement was ruled out in a number of cases, not by premature termination on the part of patient or parents but by the handicapped child being transferred to more appropriate facilities. This would obscure any relationship between consensual or premature finishings and CGAS score. It is not a simple matter to decide when to terminate treatment for a physically ill child and the therapist may artificially prolong therapy to support the child through a period of ill-health or hospitalisation even if psychological objectives have already been achieved.

It was noted above that III children tended to finish prematurely more often than patients from other Medical sub-samples and this is, presumably, the
reason why they are the only group to show a marked correlation between premature endings and lower levels of global functioning. Those who stayed in treatment achieved ultimate CGAS scores comparable to those achieved by children in other samples.

Younger Non-Medical children tended to produce slightly better termination CGAS ratings, consistent with previous research (Kazdin 1988), but such findings are confounded by the fact that younger children start at a high level of symptom manifestation, regardless of their clinical status (Shepherd et al 1971). In fact, it is unusual for any young child to be completely asymptomatic (Lapouse and Monk 1958), but most disorders remit over time (Rutter 1975, Shepherd et al 1971). It is therefore difficult to extricate treatment effects from development and maturation factors.

In any case, the Medical children failed to show any association between age and final level of functioning. As their numbers are small and the association with age, even for the Non-Medical children, is weak, the Medical children with regressive complaints such as pervasive developmental disorder, mild mental retardation or autism, although few, would probably be sufficient to distort the true relationship between age and psychological functioning. That is to say, some, perhaps most, ill children are not developmentally comparable with their age-mates. Even when dysfunction is not pervasive, it is known that the presence of chronic physical illness or handicap affects ego functioning (Kavka 1962) which could make chronological age a less useful concept than for physically healthy children.

IQ is the only factor across all our samples to show a relationship with termination CGAS. We have noted previously that high verbal ability is almost a prerequisite for psychoanalytic treatment, at least in adults (This is what Eysenck (1970) disparagingly terms the YAVIS phenomenon - patients are nearly always young, attractive, verbal, intelligent and successful. For children, their families may well show at least some of these typical characteristics, although, as a research institute, the Anna Freud Centre has
also taken in atypical cases. Nevertheless, we observed earlier that social class and IQ were both higher in our total sample of patients than would be expected by chance.

As it is known that high IQ correlates negatively with psychiatric disturbance (Rutter 1975), we might well expect verbal scores, as a highly reliable component of the IQ test (Herbert 1974), to correlate positively with CGAS, and indeed they do - in all groups except that of the III children where no such association is found. On the other hand, performance scores would not generally be hypothesised to have any particular connection with level of functioning - but again, this is not so for the III children whose performance IQ showed a significant correlation with termination CGAS. Why should this be? Firstly, it should be stated that performance scores are generally considered slightly less reliable than verbal ratings (Herbert 1974); this, combined with the small number of III children assessed on the performance aspect of IQ (N = 12⁴⁰), may be enough to account for the discrepant findings.

However, there is another possibility. It is generally acknowledged that verbal items in IQ tests are more resistant to intellectual and organic impairment than are performance items (Herbert 1974). This implies that children with brain damage may well register lower on the performance scale than on the more resilient verbal ratings. The III sample contained a number of epileptics plus one child suffering chronically from the after-effects of encephalitis: all these had brain damage. Most were autistic or pervasively disordered developmentally. Few children with conditions affecting the brain did well in therapy. If the performance aspect of the IQ test is a better indicator than the verbal score of brain defects it is also likely to identify those children who are less able than their peers to respond positively to intensive psychoanalytic intervention. Our 4 epileptics had an average termination CGAS of 46.5, considerably lower than the mean 60-67 points scored by the rest of their group and the other samples. Our suggestion, then, is that it is

⁴⁰A greater number of III children (16 out of 17) were assessed verbally.
the higher incidence of brain damage in the III sample which makes the performance IQ so sensitive to final outcome.

The absent correlation between verbal and performance scores for the Disabled group reflects the very specific functional difficulties experienced by handicapped children. Sensory and motor deficits will greatly limit, and artificially lower, performance ability. This is why, for the Disabled group, verbal scores alone are associated with final CGAS. The Somatic children, may, in contrast, as already noted, have artificially high verbal scores because of their unrepresentatively high social class (Rutter 1975). For all three medical groups performance and/or verbal IQ seem to be artificially elevated or depressed according to the profile of that particular group. A more usual finding would be a low positive correlation between both verbal and performance scores and final level of functioning, as is the case for the sample of Non-Medical children.

The positive correlation between termination CGAS and working mothers for the III children supports conclusions reached by some previous studies (Rutter 1975) but not by others (Shepherd et al 1971). In any case, no other group in our sample shows this association. Mothers of III children were no more likely to work full-time than any other mothers, but they did show a higher rate of part-time working. Perhaps this is the ideal situation, allowing the mother to pursue her own employment (and thus reducing her vulnerability to depressive illness) but allowing time for the child's needs as well. In the case of most III children (the diabetics, epileptics and the haemophiliac), their needs would include a daily medical routine which might require parental help and supervision. A mother with sufficient time for these additional demands, plus a life outside the home, might provide an optimal environment for the child to function. With numbers so small, however, this can only be the most tentative of speculation. Further investigation is needed to determine the more subtle effects of maternal employment on the medical and psychological needs of children.
Other than this effect of maternal employment on ill children, no other maternal variable had much influence on the child’s final state. Research findings that had shown a relationship between physical and mental illness in parents, especially mothers, and the child’s emotional functioning (Herbert 1974), were not strongly upheld by the present study. Parental levels of functioning were of seemingly little relevance except for the Somatic children whose increase in global functioning was highly significantly associated with Father’s GAF score. Preliminary speculation that the Somatic groups differed in this respect because of the higher percentage of boys to girls in the group and the possible increased importance of adequate fathering for boys was not upheld. Improvement in both sexes related equally well to father’s initial GAF score. There is no obvious reason why this should be so only for the Somatic children, nor why mother’s level of functioning was not related to the child’s final outcome.

Both Michael Shepherd (1971) and Michael Rutter (1975) observed a link between father’s physical health and the child’s failure to improve. Shepherd’s sample of children with ill fathers was small (N = 9) but 7 of these showed no improvement. We did not find any such association. In fact, the 4 medical children who failed to improve after at least one month of treatment and who had physically ill fathers, had many other adverse circumstances in their lives which would be far more likely to account for low functioning. A profoundly deaf child aged 9, whose mother had already died of a heart attack, was being brought up by father and a children’s nurse. The father also died during the course of treatment. This child deteriorated and was eventually (after nearly 9 years of analysis) transferred to an in-patient hospital facility. The one Somatic child with a physically ill father who failed to make progress was terminated after only 7 months, although she was still suffering from separation and other anxieties. Her father, a lawyer, had had a heart attack while serving a two-year prison sentence on a political charge. He was freed just before his twelve-year-old daughter came into treatment but both parents were anxious, depressed and struggling to keep their marriage intact.
The two unimproved III children with unwell fathers were both epileptic. One had had changes of home and caretaker while father, who later developed severe rheumatism, had been in the services during the war. The boy came into treatment at 10 years old and left, unchanged, nine years later, still with pervasive developmental problems and a personality disorder which was related to organic disease. The second child had a violent leucotomised schizophrenic father in a mental institution and had been fostered unsuccessfully a number of times. He was only in treatment for a few months before being transferred to a special school because his level of functioning, already at a low level, was declining still further. It seems somewhat unnecessary to invoke paternal physical ill-health to account for these failures of treatment when there are so many other factors to consider. Other children with less traumatic backgrounds and who had parents who were physically unwell made similar progress to children with well parents so our results are not able to lend support to the previous research findings cited above.
Chapter Ten

Comparisons between Target Medical Groups and Matched Control Groups
10.1 Introduction
The Disabled, III, and Somatic children in the target medical groups were individually matched with a control subject as described in chapter 7. This gave us the opportunity to hold constant a number of variables which are assumed to have a possible effect on treatment outcome, and to investigate other differences which might emerge between the research and control samples. The following sections trace comparisons between these two groups. The variables to be discussed are divided, as previously, between the six categories relating to a) the child; b) the family; c) referral and diagnostic material; d) the parents; e) the treatment and f) the termination.

10.2 Method
10.2.1 Samples
1) 81 children with severe and chronic physical disabilities and illnesses. These were subdivided into:
   a) 32 Disabled Target children
   b) 32 Somatic Target children
   c) 17 III Target children
2) 81 children without any chronic physical symptoms, who provide the best individual match for each of the above subjects, on as many of the specified variables as possible. These are subdivided into:
   a) 32 Disabled Control children
   b) 32 Somatic Control children
   c) 17 III Control children

Both these groups were able to be studied in their totality (Total Target Group compared with Total Control Group) and as separate subdivisions (for example, Disabled Target compared with Disabled Control).

10.2.ii Instruments
The instruments used to elicit the data have already been fully described in Chapter 7. They include:
   a) The Anna Freud Diagnostic Profile (A. Freud 1962)
   b) The Anna Freud Developmental Lines (A. Freud 1963)
c) The Child Behaviour Checklist (Achenbach and Edelbrock 1983)
d) The Diagnostic and Statistical Manual, 3rd edition, revised (published by the American Psychiatric Association 1987)
f) The Children’s Global Assessment Scale (Shaffer et al 1983)
g) The Global Assessment of Functioning Scale (in DSM-III-R 1987)

A variety of internally-generated data, including completed parental symptom checklists, IQ tests, projective testing, school reports, interview schedules, social histories and diagnostic interviews were also used.

10.2.iii Procedure
The extraction of the relevant data from the files followed the procedure set out on pages 148ff.

10.3 Analysis and Results

10.3.i Descriptive statistics
The tables show the data in summary descriptive form, including percentage occurrence, ranges and means.

10.3.ii Inferential statistical analysis
Much of the data were nominal and in the form of frequencies (the number of boys and girls, the presence or absence of learning difficulties in each of the subgroups, the frequency of diagnostic status at assessment, and so on) and were therefore analysed using the Chi-Square Statistical Test.

10.3.iii Results
A) Child variables
a) Learning difficulties
The majority of factors which made up the demographic parameters of the Medical groups were matched within satisfactory limits. Sex, age and IQ
were thus among the child variables that were closely comparable between each Index sample and its Control. However, the presence and type of learning difficulties experienced by the individual groups did emerge as a meaningful discriminator (Table 10.1). Nearly three-quarters of the Medical children presented with learning difficulties as compared to just over one-half of their matched pairs. Nevertheless, this did not become statistically significant ($p<0.20$) until the Somatic children and their Controls were taken out of the analysis. The remaining Disabled and Ill Targets did show significantly higher levels of educational problems than their respective Control groups ($\chi^2 = 8.25, df = 3, p<0.05$). In fact, chronically disordered children from these two groups were less than half as likely as their Control peers to be without learning difficulties altogether. Many children, as can be seen from the table, had more than one school-oriented problem.

When the specific type of problem presented by the various groups of children was investigated it emerged that there were four categories of learning difficulty which showed major differences between the samples. 'Problems secondary to physical handicap' by definition applied only to the Index groups. Eleven children (14%), nearly all of them Disabled, had such difficulties which were usually related to poor sight or hearing. 'Serious underachievement' was also more likely to be the lot of Target Disabled and Somatic children, especially the former who showed a three-fold increase on this variable over their matches. Ill children scored lower on this category and in line with their Controls. The classification 'Other' also showed higher rates of incidence for Medical children. This includes learning difficulties as a result of constant absences from school (more often the lot of chronically ill children than others), and lack of concentration in class, also more likely to be shown by children with severe physical conditions that distracted their attention.

Poor peer relationships tended to be more common among the Control groups except for the Disabled Controls who showed very little evidence of social dysfunction at school.
<table>
<thead>
<tr>
<th>Type of Difficulty</th>
<th>Disabled</th>
<th>Medical Target</th>
<th>Medical Control</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>School refusal</td>
<td>3</td>
<td>44</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Specific learning difficulty</td>
<td>22</td>
<td>22</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Serious under-achievement</td>
<td>37</td>
<td>12</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Poor peer relationships</td>
<td>19</td>
<td>6</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Disruptive behaviour</td>
<td>9</td>
<td>3</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Disabling anxiety symptoms (eg compulsions)</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Problems secondary to physical handicap (eg partial sight)</td>
<td>25</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Other inc. special school</td>
<td>19</td>
<td>3</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>% children with at least one difficulty</td>
<td>78</td>
<td>50</td>
<td>82</td>
<td>59</td>
</tr>
<tr>
<td>No learning difficulties</td>
<td>22</td>
<td>50</td>
<td>18</td>
<td>41</td>
</tr>
</tbody>
</table>

Table 10.1 Percentage of children presenting various types of learning difficulty for Medical Target (N=81) and Medical Control (N=81) groups.
But perhaps the most interesting and surprising result was the extremely high levels of school refusal for Control III and Disabled children compared to their Target matches ($\chi^2 = 19.96, \text{df} = 3, p < 0.01$). Three III Controls showed school refusal compared with 1 Target III child. More remarkably, 14 Control Disabled children were school refusers with, again, just 1 Target child ($\chi^2 = 14.6, \text{df} = 1, p < 0.01$). There were no Somatic Target or Control children among the school refusers.

The entire sample of 769 children contained only 7% who were school refusers. This reduces to 5.7% (N = 35) when the Medical Target and Control groups are excluded. This is highly significantly different from the 44% of Disabled Controls who have difficulty attending school ($\chi^2 = 57.8, \text{df} = 1, p < 0.01$). Even when the III and Disabled Controls are combined, nearly one in three of them (31%) showed major signs of school refusal. This also differs considerably from the Non-Medical group ($\chi^2 = 49.8, \text{df} = 1, p < 0.01$).

Forty-seven per cent of school refusers from the Disabled groups (mainly the Control group) had clinically anxious and/or depressed mothers. This, although just failing to reach significance, is a much larger proportion than among mothers of school attenders.

There were statistically significant correlations for the Disabled Control children between the presence of learning difficulties of any sort and mother’s current diagnostic status, father’s past diagnostic status, age at start of treatment, reason for termination, physical illness in a parent and, negatively, with IQ scores. In addition, CGAS scores at both start and finish of therapy related inversely to learning difficulties for the total sample (769 children). School refusal by itself, however, had little or no association with most of these variables. We have already observed a degree of correspondence with mother’s psychiatric state; apart from this, only reason for termination was notably linked to school refusal. Refusers from the Disabled Control sample were very unlikely to finish treatment by mutual

---

$^{53}$ at p>0.05 ($\chi^2 = 3.6, \text{df} = 1)$
consent. Only one (7%) actually did so compared to 25% in the Disabled Control group as a whole, and one-third of all patients over the three Medical Control groups. Premature terminations, either by patient or parent, were frequent and were the reason for half the endings, twice as commonly as in the Control groups as a whole.

b) Hospitalisations
Table 5.1 shows that more than three times as many chronically ill children have experienced at least one period of hospitalisation compared to their Controls ($\chi^2 = 27.2$, df = 5, $p < 0.01$). Twice as many Medical children as physically well peers have had one stay in hospital; when multiple hospitalisations are considered the distinction is even greater. One in four ill children have been in hospital on more than one occasion, whereas this is true of only 4% of their matched pairs ($\chi^2 = 20.9$, df = 5, $p < 0.01$).

c) Medical history
The most obvious difference in medical histories between the Target and Control groups is the presence of chronic conditions for the entire former set and their total absence for the Control children (Table 10.2).

The total incidence of other medical conditions (operations, accidents and acute physical conditions) is not significantly different between the Target and Control samples, though, when unpacked a little more, there are some interesting variations between the specific groupings. Operations, for instance, have been experienced by more than one-quarter of the Disabled children but by only one Ill child (6%). Both these figures are marginally deviant, in different directions, from their Control samples ($\chi^2 = 4.6$, df = 3, $p < 0.20$). Nearly one in four children in Non-Medical groups had had an operation by the time of their psychiatric assessment. The samples are small in size, however, and the differences between groups in terms of operations are not statistically significant.

Accidents appear to be experienced fairly randomly among the Control and Target groups. Only one Disabled Control child and one Somatic child had
### Table 10.2 Medical History for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Category of Medical History</th>
<th>Disabled T%</th>
<th>Somatic T%</th>
<th>All T%</th>
<th>Ill T%</th>
<th>Somatic T%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
</tr>
<tr>
<td>Operations</td>
<td>28 16</td>
<td>6 18</td>
<td>13 16</td>
<td>17 16</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td>22 3</td>
<td>24 18</td>
<td>3 16</td>
<td>15 11</td>
<td></td>
</tr>
<tr>
<td>Chronic physical conditions</td>
<td>100 0</td>
<td>100 0</td>
<td>100 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute physical conditions</td>
<td>6 28</td>
<td>24 6</td>
<td>6 9</td>
<td>10 15</td>
<td></td>
</tr>
</tbody>
</table>

### Table 10.3 Parental loss/separation for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Type of loss</th>
<th>Disabled T%</th>
<th>Somatic T%</th>
<th>All T%</th>
<th>Ill T%</th>
<th>Somatic T%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
</tr>
<tr>
<td>Death of parent</td>
<td>3 6</td>
<td>6 0</td>
<td>3 3</td>
<td>4 4</td>
<td></td>
</tr>
<tr>
<td>Divorce/separation of parents</td>
<td>12 12</td>
<td>0 6</td>
<td>9 3</td>
<td>9 7</td>
<td></td>
</tr>
<tr>
<td>No parental loss</td>
<td>85 82</td>
<td>94 94</td>
<td>88 94</td>
<td>87 89</td>
<td></td>
</tr>
</tbody>
</table>

### Table 10.4 Major losses for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Major losses</th>
<th>Disabled T%</th>
<th>Somatic T%</th>
<th>All T%</th>
<th>Ill T%</th>
<th>Somatic T%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
<td>C%</td>
</tr>
<tr>
<td>Death/departure important figure before 5 years of age</td>
<td>28 16</td>
<td>12 12</td>
<td>9 9</td>
<td>17 15</td>
<td></td>
</tr>
<tr>
<td>Boarding school before 10 years</td>
<td>3 9</td>
<td>6 0</td>
<td>3 0</td>
<td>4 4</td>
<td></td>
</tr>
<tr>
<td>Fostering/other care</td>
<td>3 0</td>
<td>6 0</td>
<td>0 0</td>
<td>2 0</td>
<td></td>
</tr>
<tr>
<td>No major loss</td>
<td>66 75</td>
<td>76 88</td>
<td>88 91</td>
<td>77 81</td>
<td></td>
</tr>
</tbody>
</table>
been involved in an accident of any note, whereas nearly one in four Disabled Target and III Target patients had at least one accident on their medical history. The difference between the Disabled and Somatic Targets and Controls is significant ($\chi^2 = 8.21$, df = 3, $p < 0.05$) though it should be noted that for one category (Somatic) it is the Controls who have the more accidents and for the other (Disabled) it is the Target children.

We see this cross-over between one Target group and a completely unrelated Control group in the acute physical condition section as well. Somatic children match fairly accurately with their Controls but Disabled Controls and III Target children have what looks like more than their fair share of acute illnesses though the difference fails to reach a significant level ($\chi^2 = 6.2$, df = 3, $p > 0.1$).

**B) Family variables**

Not a single family variable showed any statistically significant difference between Target and Control groups. Many - for example, social class, family intactness and, by extension, the child’s primary caretakers - had been satisfactorily controlled for. The socio-economic difference between the III children and their Controls was greater than that between other matching grouped pairs but not significantly so (Table 7.12). Major losses, including parental death and marital separation (Table 10.3) and other deaths and departures (Table 10.4) had not specifically been looked at in selecting matching pairs for the Target children but no differences were found which suggests that the most common loss experienced by children results, almost by definition, in the break-up of the family and that once this has been adequately controlled for a number of other family variables correlate equally satisfactorily.

Paternal employment was uniformly high across all groups; rates and type of maternal employment (Table 10.5) was slightly out-of-kilter in the III children, as observed on page 233 (Table 9.11), but not significantly so. Their Controls tended more towards the mean in terms of partial employment and
### Table 10.5 Maternal Employment for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Type of employment</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Full-time work outside home</td>
<td>17</td>
<td>25</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Partial Employment</td>
<td>21</td>
<td>18</td>
<td>37</td>
<td>12</td>
</tr>
<tr>
<td>Not employed outside home</td>
<td>62</td>
<td>57</td>
<td>44</td>
<td>69</td>
</tr>
</tbody>
</table>

### Table 10.6 Referral source for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Parents/Self</td>
<td>16</td>
<td>50</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>GP/other doctor/hospital</td>
<td>22</td>
<td>15</td>
<td>41</td>
<td>35</td>
</tr>
<tr>
<td>School/Child Guidance</td>
<td>25</td>
<td>19</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Anna Freud Organisations (eg therapist of sibling, nursery school, baby clinic.)</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Other/Not Known</td>
<td>28</td>
<td>12</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>
unemployment. Overall, there was remarkable similarity between the work commitments of mothers from Target and Control groups.

C) Referral and diagnostic variables
There were few significant differences in any of the referral and diagnostic variables between Target and Control groups despite the fact that only current diagnoses were specifically controlled for. Primary source of referral (Table 10.6) was unique in yielding a statistical discrepancy, and that was only between the Disabled children and their matches ($\chi^2 = 10.1$, df = 4, $p < 0.05$). In particular the percentage of the Disabled sample and their Controls referred by parents showed notable disparity ($\chi^2 = 8.6$, df = 1, $p < 0.01$) with half the Control children presenting for treatment via this route compared to only 16% of the Target Disabled sample.

Diagnostic categories (Tables 7.15, 10.7 and 10.8) and present diagnostic status (Table 10.9) were very similar between Targets and Controls. This was to be expected as it had been one of the variables controlled for. Even the extremely high rates of anxiety among Somatic children (87%) (Table 10.8) were not significantly different from control levels (59%). However, no attempt had been made to match for past diagnostic status (Table 10.10) and this factor also showed remarkably high comparability between the various Medical samples and their pairs. Just under half the children (48%), from both Target and Control groups, had not fulfilled criteria for any past diagnostic condition. The remainder were split equally in the Controls between caseness levels (26%) and insufficient information (26%). The Index samples showed only marginally lower percentages of definite diagnosability (22%).

Less than half the children in our sample were placed in one of the Anna Freud Diagnostic Categories (Table 10.11) so numbers are small and differences between the groups are often more apparent than real. Of particular note, however, is the similarity between each target group and its control. Somatic children, for example, are hardly ever assigned to the two lower categories and their matched pairs are also absent from these
### Table 10.7 Principal diagnostic category for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Principal Category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T% C%</td>
<td>T% C%</td>
<td>T% C%</td>
<td>T% C%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>19 25</td>
<td>35 41</td>
<td>62 44</td>
<td>39 36</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>3 6</td>
<td>0 6</td>
<td>0 0</td>
<td>1 4</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>19 16</td>
<td>23 29</td>
<td>6 9</td>
<td>15 16</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>13 6</td>
<td>18 12</td>
<td>0 0</td>
<td>9  5</td>
</tr>
<tr>
<td>Enuresis</td>
<td>6 9</td>
<td>0 0</td>
<td>0 3</td>
<td>2  5</td>
</tr>
<tr>
<td>Encopresis</td>
<td>3 6</td>
<td>6 6</td>
<td>6 2</td>
<td>6  2</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0 3</td>
<td>0 0</td>
<td>0 3</td>
<td>0  2</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>0 6</td>
<td>0 0</td>
<td>0 6</td>
<td>0  5</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>0 0</td>
<td>0 0</td>
<td>3 3</td>
<td>1  1</td>
</tr>
<tr>
<td>V-Codes, no psychiatric diagnosis</td>
<td>37 22</td>
<td>18 6</td>
<td>28 25</td>
<td>30 20</td>
</tr>
</tbody>
</table>

Table 10.7 Principal diagnostic category for Medical Target (N=81) and Medical Control (N=81) groups
### Table 10.8 Principal and additional diagnostic categories for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>All Categories</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>25</td>
<td>37</td>
<td>41</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>87</td>
<td>59</td>
<td>53</td>
<td>48</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>19</td>
<td>25</td>
<td>35</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>19</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>13</td>
<td>6</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Enuresis</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Encopresis</td>
<td>9</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0</td>
<td>6</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>16</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>9</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>V-Codes, no psychiatric diagnosis</td>
<td>41</td>
<td>25</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>44</td>
<td>34</td>
<td>40</td>
<td>25</td>
</tr>
</tbody>
</table>

### Table 10.9 Child diagnostic status at assessment for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Current psychiatric diagnostic status</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Diagnosable</td>
<td>81</td>
<td>88</td>
<td>88</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>81</td>
<td>84</td>
<td>83</td>
<td>88</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>9</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 10.8 Principal and additional diagnostic categories for Medical Target (N=81) and Medical Control (N=81) groups

Table 10.9 Child diagnostic status at assessment for Medical Target (N=81) and Medical Control (N=81) groups
### Table 10.10 Child past diagnostic status for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Past psychiatric diagnostic status</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Diagnosable</td>
<td>19</td>
<td>25</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>47</td>
<td>47</td>
<td>41</td>
<td>35</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>34</td>
<td>28</td>
<td>24</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 10.10  Child past diagnostic status for Medical Target (N=81) and Medical Control (N=81) groups

### Table 10.11 Anna Freud diagnostic category for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>I</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td>8</td>
<td>14</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>III</td>
<td>38</td>
<td>50</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>IV</td>
<td>46</td>
<td>29</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>V</td>
<td>8</td>
<td>7</td>
<td>38</td>
<td>20</td>
</tr>
</tbody>
</table>

Mean: 3.5 3.3 3.5 3.5 2.9 2.9 3.3 3.2

Table 10.11 Anna Freud diagnostic category for Medical Target (N=81) and Medical Control (N=81) groups
placements. Disabled children, as was noted earlier, are much more likely to be placed in category IV (Atypical, retarded or defective), simply because of their physical status and its developmental implications. Ill children, who include epileptics and others with organic damage, are the most likely among the Medical groups to be in category V (Substantial disruption of mental growth). What is surprising is the high percentage of Disabled and III Controls who match their Index subjects in category placement despite the absence of physical conditions to account for this. They follow their Target partners in showing a close to significant difference between the categories assigned to children from each Medical group ($\chi^2 = 18.3$, df = 10, $p<0.06$).

CGAS ratings at start of treatment (Table 10.12), although not one of the variables matched for, nevertheless show similar means between Target and Control groups. The Ill children have a relatively low mean rating at 50.5 points and their Controls inevitably tend more towards the average (54 points) though this is not significant and is accounted for mainly by the larger range of scores in the Target sample, particularly at the lower end of the scale. As with other variables already discussed, the Ill Controls incline slightly away from the other Control groups and towards their Index Ill pairs.

D) Parental variables

a) Parents’ Psychological Adjustment (GAF score)
Although no parental variable was specifically controlled for there were very few significant differences between the mothers and fathers of physically ill children and those of the Control groups. Mothers’ mean GAF scores (Table 10.13) were virtually identical overall (67 for Target groups, 68 for Controls).

We have already seen that the individual Target groups vary considerably, with the mothers of Ill children functioning less well (mean GAF = 63) than the mothers of Disabled children (72). The total means for the Control groups were much more uniform, with only a 2-point difference between all three groups. However, the range of the Ill and Disabled Control mothers was considerable; despite the presence of one or two very disturbed parents in the Ill Control groups, mothers in particular were more likely to score over 80.
<table>
<thead>
<tr>
<th>CGAS Group at Start</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T% Range</td>
<td>C% Range</td>
<td>T% Range</td>
<td>C% Range</td>
</tr>
<tr>
<td>&lt;40</td>
<td>3</td>
<td>3</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>41-50</td>
<td>28</td>
<td>35</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>51-60</td>
<td>50</td>
<td>28</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>61-70</td>
<td>13</td>
<td>31</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>71-80</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Mean:</td>
<td>56</td>
<td>57</td>
<td>50.5</td>
<td>54</td>
</tr>
</tbody>
</table>

Table 10.12  CGAS at start for Medical Target (N=81) and Medical Control (N=81) groups
points than mothers from other Control groups. Scores ranged very widely from the highly dysfunctional to the extremely well-adapted.

These variations in parental global assessment were true, to some extent, for all groups. There were no statistically significant differences to be found between groups; nor were there for Father's GAF. It is, however, interesting that Mother's GAF varied between Target groups and was more-or-less identical for Control groups whereas the reverse is true for fathers (Table 10.14). The Medical groups were practically identical and the Control groups showed more variation. Overall mean scores showed a difference of only one point between Target and Control groups in respect to Father's GAF score.

b) Past and present diagnoses

Very few parents were deemed definitely diagnosable in the past (Table 10.15) and numbers were therefore too small to make any analysis worthwhile. Some of the diagnoses noted went back to the parent's own childhood - for example, sleep-walking for the mother of an Ill child, and reading disorders for fathers of both a Disabled child and a Disabled Control child. The diagnoses of all the mothers, regardless of whether or not they were parenting a physically ill child, were of depressive or anxiety conditions. The 6 fathers with past diagnoses were more divergent. Control fathers actually tended to have had more serious psychiatric states than Target fathers, though, of course, numbers are far too small to draw any conclusions from this. Apart from the reading difficulties already mentioned there had been a past gambling problem, a drug-induced manic condition, and delusional jealousy. Target fathers had suffered with depression and a psychosomatic syndrome.

Only a small number of fathers were currently diagnosable but three-quarters of these came from the Control groups (Table 10.16). The variation between Ill Target and Control fathers was not large but, with this group excluded, the Disabled and Somatic subsamples showed a significant difference between rates of current psychological illness in the Target fathers and the Control fathers ($\chi^2 = 10.67; df = 1; p < 0.01$). Diagnoses in the Disabled and
<table>
<thead>
<tr>
<th>Mother GAF category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>Range</td>
<td>Range</td>
<td>Range</td>
</tr>
<tr>
<td>&lt;40</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>3</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>51-60</td>
<td>9</td>
<td>9</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>61-70</td>
<td>25</td>
<td>38</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>71-80</td>
<td>44</td>
<td>31</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>&gt;80</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>NK/Not applicable</td>
<td>16</td>
<td>19</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Mean:</td>
<td>72</td>
<td>67</td>
<td>63</td>
<td>69</td>
</tr>
</tbody>
</table>

*Table 10.13  Mother’s GAF scores for Medical Target (N=81) and Medical Control (N=81) groups*
Table 10.14 Father's GAF scores for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Father GAF category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T% Range</td>
<td>C% Range</td>
<td>T% Range</td>
<td>C% Range</td>
</tr>
<tr>
<td>&lt;40</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>51-60</td>
<td>3</td>
<td>6</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>61-70</td>
<td>19</td>
<td>25</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>71-80</td>
<td>28</td>
<td>38</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>&gt;80</td>
<td>19</td>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>NK/Not applicable</td>
<td>28</td>
<td>31</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Mean:</td>
<td>70</td>
<td>70</td>
<td>69</td>
<td>74</td>
</tr>
</tbody>
</table>

Table 10.14 Father's GAF scores for Medical Target (N=81) and Medical Control (N=81) groups
<table>
<thead>
<tr>
<th>Parent Diagnosable in Past</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>τ%</td>
<td>C%</td>
<td>τ%</td>
<td>C%</td>
</tr>
<tr>
<td>Father</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Mother</td>
<td>6</td>
<td>9</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 10.15 Past parental diagnoses for Medical Target (N=81) and Medical Control (N=81) groups

Past parental diagnoses:

Mothers:

- **Ill Target** N=3: Depression, Anxiety, Sleep-Walking
- **III Control** N=0
- **Disabled Target** N=2: Depression, Phobia
- **Disabled Control** N=3: Depression, Anxiety, Bipolar Disorder
- **Somatic Target** N=4: Depression, Obsessional-Compulsive/Tic, Alcoholism, Dyspareunia
- **Somatic Control** N=3: Depression, Bipolar Disorder, Depression

Fathers:

- **Ill Target** N=0
- **III Control** N=1: Gambling
- **Disabled Target** N=1: Reading Disorder
- **Disabled Control** N=3: Delusional Jealousy, Reading Disorder, Psychotic/Manic/Drugs
- **Somatic Target** N=2: Psychosomatic, Depression
- **Somatic Control** N=0

306
<table>
<thead>
<tr>
<th>Parent Currently Diagnosable</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Father - Diagnosable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>16</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>- Criteria Not Fulfilled</td>
<td>53</td>
<td>47</td>
<td>53</td>
<td>41</td>
</tr>
<tr>
<td>- Insufficient Inf/inapplicable</td>
<td>44</td>
<td>37</td>
<td>41</td>
<td>47</td>
</tr>
<tr>
<td>Mother - Diagnosable</td>
<td>9</td>
<td>19</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>- Criteria Not Fulfilled</td>
<td>59</td>
<td>34</td>
<td>35</td>
<td>53</td>
</tr>
<tr>
<td>- Insufficient Inf/inapplicable</td>
<td>31</td>
<td>47</td>
<td>30</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 10.16 Present parental diagnoses for Medical Target (N=81) and Medical Control (N=81) groups

Current Parental Diagnoses:

Mothers:

<table>
<thead>
<tr>
<th>III Target</th>
<th>N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>III Mother</td>
<td>N=2</td>
</tr>
<tr>
<td>Disabled Target</td>
<td>N=3</td>
</tr>
<tr>
<td>Disabled Control</td>
<td>N=6</td>
</tr>
<tr>
<td>Somatic Target</td>
<td>N=7</td>
</tr>
<tr>
<td>Somatic Control</td>
<td>N=9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III Target</th>
<th>N=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>III Control</td>
<td>N=2</td>
</tr>
<tr>
<td>Disabled Target</td>
<td>N=1</td>
</tr>
<tr>
<td>Disabled Control</td>
<td>N=5</td>
</tr>
<tr>
<td>Somatic Target</td>
<td>N=1</td>
</tr>
<tr>
<td>Somatic Control</td>
<td>N=5</td>
</tr>
</tbody>
</table>

Anxiety; Parent-Child/Personality Disorder; Anxiety; Parent-Child; Schizophrenia
Dysthymia; Dysthymia; Parent-Child
Parent-Child; Depression; Depression
Phobia/Hypochondria; Parent-Child; Cyclothymia
Alcohol Dependence; Personality Disorder;
Anxiety/Depression; Depression; Dysthymia/Phobia;
Parent-Child; Parent-Child/Anxiety.
Parent-Child; Cyclothymia; Parent-Child;
Depression/Phobia; Parent-Child; Depression/Parent-Child; Personality Disorder; Parent-Child /Personality Disorder; Personality Disorder/Dysthymia.

Fathers:

<table>
<thead>
<tr>
<th>III Target</th>
<th>N=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>III Control</td>
<td>N=2</td>
</tr>
<tr>
<td>Disabled Target</td>
<td>N=1</td>
</tr>
<tr>
<td>Disabled Control</td>
<td>N=5</td>
</tr>
<tr>
<td>Somatic Target</td>
<td>N=1</td>
</tr>
<tr>
<td>Somatic Control</td>
<td>N=5</td>
</tr>
</tbody>
</table>

Schizophrenia
Parent-Child; Personality Disorder/Anxiety
Personality Disorder
Schizophrenia; Anxiety; Personality Disorder; Organic Mental Disorder; Personality Disorder
Adjustment Disorder/Anxious
Tic; Hypochondria; Premature Ejaculation; Tic;
Personality Disorder

307
Ill Target and Control groups tended to be major. Of the 9 fathers with clinical psychiatric states from these four subsamples, 6 had either schizophrenia or a personality disorder and one had an organic mental condition. Only two fathers could be said to be merely 'neurotic' - one was anxious and one was diagnosed as having a Parent-Child problem (a 'V' code and not recognised as a true psychiatric syndrome). One Somatic Control father also had a personality disorder but the remainder in the Somatic groupings (4 Controls and 1 Target) suffered with a variety of anxiety manifestations including tics, hypochondria and premature ejaculation.

The mothers reversed this finding with the more serious conditions tending to be found in the Somatic groups, although again it must be stressed that numbers are very small and none of these differences were significant. Apart from one III Control mother with schizophrenia, the other 16 mothers who reached caseness levels from the III and Disabled groups had a variety of anxiety and depressive diagnoses or Parent-Child Disorders. Most of the Somatic mothers (10 out of 16) were similarly diagnosed but, in addition, there was a case of alcohol dependence and several personality disorders, especially among the Control group. Over all three Target and Control groups there was a striking similarity in percentage of diagnosable mothers. Twenty per cent of Target mothers and 22% of Control mothers were assigned to a psychiatric category at the time of the child's assessment though Somatic Control mothers showed higher rates of diagnosis (28%) than III Control mothers (12%).

A number of parents from the Disabled and Somatic groups, especially the Control samples, were diagnosed as having a personality disorder. It is not possible to disentangle all the aetiological threads in a sample of children all of whom have psychological difficulties but there are indications that the majority of such children make little or no progress as a result of psychoanalysis if the personality-disordered parent is the mother. Three out of four children in this situation either deteriorated or improved only marginally (by 3 and 2 CGAS points respectively). All of them spent well over a year in treatment; one had as much as 6 years of therapy. The fourth
child went against this finding totally. Although both her parents had personality disorders she still managed to improve by 27 points after nearly four years of analysis. In her case, mother and father had GAF scores in the 60s, higher than all the other parents with similar diagnoses.

Fathers with personality disorders do not seem to inhibit the child’s progress. Three out of the 4 children who had fathers with personality disorder improved by an average or above average amount. The fourth had deteriorated by the end of her three-year analysis.

c) Symptoms and treatments
Tables 10.17, 10.18, 10.19 and 10.20 show the percentage of mothers and fathers in each Target and Control group who were recorded as experiencing, either currently or in the past, psychopathological symptoms or who had had psychological or psychiatric treatment. The small numbers and correspondingly low percentages precluded the finding of many significant differences between any of the subsamples, but there were some indications that, with larger samples, parents of certain groups of children might be able to be differentiated from one another on a number of factors. Puerperal depression after the birth of the index child, for example, had been experienced by more mothers of Somatic children. In fact, ‘Somatic’ mothers had a slightly elevated tendency to be prone to depressions of all kinds. Mothers of Somatic and Ill children were more likely to be anxious at assessment than mothers of Control children (or Disabled children), although there was no disparity between the Target and Control samples in terms of past episodes.

It has already been noted that mothers of Somatic children had more experience of psychoanalytic treatment in their own right than the mothers in other Medical groups. However, Somatic Control parents showed levels of psychoanalytic treatment that were even higher than their Index group. As many as one-quarter of the mothers, and a number of fathers as well, had been analysed before the child came for assessment. This is significantly different from the other Control groups ($\chi^2 = 6.3$, df = 2, $p < 0.05$).
<table>
<thead>
<tr>
<th>Psychiatric Symptoms</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td></td>
<td>T</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>T</td>
<td>C</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0 3</td>
<td>0 3</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0 0</td>
<td>3 6</td>
</tr>
<tr>
<td>Other depressive</td>
<td>13 19</td>
<td>13 22</td>
</tr>
<tr>
<td>Obsessional</td>
<td>3 6</td>
<td>0 3</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>9 6</td>
<td>3 13</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0 3</td>
<td>3 0</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>3 0</td>
<td>6 3</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0 0</td>
<td>3 0</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0 0</td>
<td>0 3</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0 0</td>
<td>3 3</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0 0</td>
<td>0 3</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0 6</td>
<td>6 13</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>3 3</td>
<td>6 9</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>0 13</td>
<td>3 3</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>9 3</td>
<td>9 16</td>
</tr>
</tbody>
</table>

Table 10.17 Detailed symptom/treatment breakdown for parents of Disabled Target (N=32) and Disabled Control (N=32) children
<table>
<thead>
<tr>
<th>Psychiatric Symptoms (III)</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td></td>
<td>T C</td>
<td>T C</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0 6</td>
<td>0 6</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Other depressive</td>
<td>18 6</td>
<td>35 6</td>
</tr>
<tr>
<td>Obsessional</td>
<td>6 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>24 6</td>
<td>18 6</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>12 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0 6</td>
<td>0 6</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0 0</td>
<td>0 6</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0 0</td>
<td>6 12</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0 12</td>
<td>24 12</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>6 0</td>
<td>18 12</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>6 18</td>
<td>18 12</td>
</tr>
</tbody>
</table>

Table 10.18 Detailed symptom/treatment breakdown for parents of III Target (N=17) and III Control (N=17) children
<table>
<thead>
<tr>
<th>Psychiatric Symptoms (Psychosomatic)</th>
<th>Mother %</th>
<th>Father %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOW</td>
<td>HISTORY</td>
</tr>
<tr>
<td></td>
<td>T</td>
<td>C</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other depressive</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Obsessional</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>6</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 10.19 Detailed symptom/treatment breakdown for parents of Somatic Target (N=32) and Somatic Control (N=32) children
<table>
<thead>
<tr>
<th>Psychiatric Symptoms</th>
<th>Mother % NOW</th>
<th>Mother % HISTORY</th>
<th>Father % NOW</th>
<th>Father % HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>C</td>
<td>T</td>
<td>C</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bipolar affective</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Puerperal depression</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Other depressive</td>
<td>15</td>
<td>19</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Obsessional</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>19</td>
<td>6</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Drug/alcohol addiction</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Violence within family</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>4</td>
<td>9</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Major Marital Problems</td>
<td>7</td>
<td>15</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

*Table 10.20 Detailed symptom/treatment breakdown for parents of All Medical Target (N=81) and All Medical Control (N=81) children*
Current marital problems were twice as common in Control groups, but past difficulties and overall incidences (past and present combined) gave equivalent figures for the total Target group and the total Control group. This means that the same numbers of parents have, or have had, difficulty with the marriage in both samples. There must be greater overlap between the Control couples with past difficulties and those with present problems (most of them appear in both time samples) than with the Medical parents. The 7% with current problems must be added to (rather than overlapping with) most of the 14% with past problems in order to arrive at the total of 20% who have ever experienced difficulties in the marriage. Problems with the marriage for the Control parents seem, therefore, to be the more long-standing.

d) Physical illness
Mothers and fathers of Target Medical children are more likely to have some physical illness of their own than are the parents of Control children (Table 10.21). This is specially true of mothers of chronically disordered children, of whom nearly one in three have a medical condition. This is twice the rate of illness found among Control mothers. Because numbers are small, statistical significance was not reached and, in fact, the Somatic Controls are very similar to their matched pairs with approximately one-quarter of parents showing a definite physical syndrome. When the Somatic Target and Control groups are excluded from analysis, the difference between the incidence of physical illness in the parents of Ill and Disabled children and the parents of Controls for these groups approaches significance ($\chi^2 = 6.65; \text{df} = 3; p < 0.1$).

E) Treatment variables
The two main variables in the treatment offered to children by the Anna Freud Centre - that is, whether the child is seen by a staff or student therapist and whether treatment is an intensive analysis (4 or 5 sessions a week) or a less intensive psychotherapy (1 to 3 sessions a week) - were controlled for when selecting suitable Controls and, therefore, no major differences were found between Targets and Controls for these parameters (see Tables 10.22 and 7.14). Length of treatment also showed no significant
<table>
<thead>
<tr>
<th>Parent Physically Ill</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Father</td>
<td>25</td>
<td>12</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>25</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Mother</td>
<td>34</td>
<td>16</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>22</td>
<td>31</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 10.21 Parental physical illness for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Type of therapist</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Staff</td>
<td>47</td>
<td>56</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Student</td>
<td>53</td>
<td>44</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>75</td>
<td>63</td>
<td>59</td>
</tr>
</tbody>
</table>

Table 10.22 Type of therapist for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Mean Length of Treatment in Years</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>2.50</td>
<td>2.04</td>
<td>2.75</td>
<td>2.61</td>
<td>2.31</td>
</tr>
<tr>
<td>2.31</td>
<td>2.21</td>
<td>2.48</td>
<td>2.23</td>
<td></td>
</tr>
</tbody>
</table>

Table 10.23 Summary of length of treatment for Medical Target (total N=81) and Medical Control (total N=81) groups

315
### Table 10.24 Extended table of length of treatment for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Length of Treatment</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Six months or less</td>
<td>9</td>
<td>22</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>6 months - 1 year</td>
<td>16</td>
<td>6</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>22</td>
<td>31</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2 - 3 years</td>
<td>28</td>
<td>25</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>3 - 5 years</td>
<td>19</td>
<td>13</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>6</td>
<td>3</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Not Known</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

### Table 10.25 Reason for termination for Medical Target (N=81) and Medical Control (N=81) groups

<table>
<thead>
<tr>
<th>Reason for Termination</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>By agreement (completed)</td>
<td>16</td>
<td>25</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>Premature by parents</td>
<td>6</td>
<td>9</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Premature by patient</td>
<td>9</td>
<td>22</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>By therapist - not progressing</td>
<td>9</td>
<td>3</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>By therapist - external circumstances (eg departure)</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>By patient/parents - ext. circs</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Transferred to other treatment</td>
<td>22</td>
<td>9</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not known</td>
<td>16</td>
<td>13</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
discrepancy between Targets and Controls. Medical children consistently tended to stay in treatment for an average of a few weeks or months longer than their Controls (10.23) but when the extended table (10.24) is looked at it can be seen that this is mostly due to an increased tendency by Control children to terminate treatment within the first 6 months. For those who make a commitment beyond this point there is little difference between the various groupings, although more Medical children have a treatment that lasts between 3 and 5 years.

F) Termination variables

a) Reasons for termination

No information about the ending of therapy was taken into account when selecting Controls for the Target children; such factors are obviously the main dependent variables in any therapeutic outcome study. It was therefore particularly interesting to find that there were few statistically significant differences between Target and Control groups on termination parameters. Reasons for termination (Table 10.25) were remarkably similar between the Medical children overall and their matched pairs.

However, slight variations appeared within each specific Medical grouping. We have already noted that Somatic children tend to be more likely than their III or Disabled peers to finish by mutual agreement with the therapist. Their Controls showed an even greater disposition to satisfactorily complete their treatment. Half of them ended in this way which is much higher than the 32% of mutual agreements of the Non-Medical sample (Table 8.23). Conversely, relatively few of the III Controls finished their therapy by agreement.

b) Psychiatric status and diagnoses

Psychiatric status at termination (Table 10.26) also showed a high degree of similarity between Target and Control groups, although III Controls had higher diagnostic levels at 53% than the other sub-samples, both of which contained only about one in three patients who were still psychiatric cases at the end of therapy. In all, 28 children (35%) from the combined Medical
groups and the same number from the combined Control groups were confidently judged to have a definite psychiatric condition.

Hardly any termination diagnoses were of conditions that had not been present at the child's assessment. Out of a total of 56 Medical children and their Controls who fulfilled diagnostic criteria at termination only 4 had new diagnoses (plus one V-code), and most of these were common progressions from previous syndromes. For example, there were 3 personality disorders at the end of therapy. All these children would have been too young to have been diagnosed with this condition earlier; their former attention-deficit hyperactivity and exhibitionism had developed into more stable configurations of disorder. Another child was enuretic at termination, again having been too young previously to meet the age specifications for criteria fulfilment. The 5th child, a teenager, showed a new V-coding - 'Parent-child disorder' - by the end of treatment but only additionally and much less severely than his principal obsessive-compulsive symptoms. Such coding (not strictly a psychiatric diagnosis) may be practically de rigueur for adolescents, in any case!

Table 10.27 indicates the broad diagnostic category into which the Medical children and their Controls were placed at termination of therapy. Target and Control children continue to match relatively well in terms of symptoms remaining after treatment has concluded. The Somatic groups are predominantly (wholly, in the case of the Target children) neurotic; psychotic conditions are experienced only by the Disabled and III and their Controls, while conduct disorders are more than twice as common in the Control groups than in the Index samples (but, of course, numbers are very small).

When the diagnostic category at termination (Tables 10.27 and 10.28) is compared with that at assessment (Table 7.15), it becomes clear that neurotic conditions are much more likely than either psychosis or conduct disorder to remit. Anxiety disorders, especially, tend to be alleviated for most children although those who are chronically organically or somatically ill have higher residues of anxiety than do other children. The most common anxiety
Table 10.26 Child psychiatric status at termination for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Psychiatric Status</th>
<th>Disabled</th>
<th>II</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Diagnosable</td>
<td>34</td>
<td>31</td>
<td>35</td>
<td>53</td>
</tr>
<tr>
<td>Criteria Not Fulfilled</td>
<td>25</td>
<td>41</td>
<td>41</td>
<td>12</td>
</tr>
<tr>
<td>Insufficient Information</td>
<td>41</td>
<td>28</td>
<td>24</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 10.27 Summary of termination diagnoses for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Disabled</th>
<th>II</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Neurosis</td>
<td>36</td>
<td>40</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>Psychosis</td>
<td>36</td>
<td>30</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>27</td>
<td>30</td>
<td>17</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 10.28 Summary of termination diagnoses, including non-diagnosable cases for Medical Target (total N=81) and Medical Control (total N=81) groups

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Disabled</th>
<th>II</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Neurosis</td>
<td>12</td>
<td>12</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Psychosis</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>9</td>
<td>9</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Not Known/No Diagnosis</td>
<td>66</td>
<td>69</td>
<td>65</td>
<td>47</td>
</tr>
</tbody>
</table>
disorder remaining among Somatic children was 'Psychological factors affecting physical condition' which accounted for half the diagnoses (6 out of 11) in this category.

On the whole, neurotic disorders had cleared up during treatment. Pervasive and specific developmental disorders, habit disorders, such as enuresis, and conduct disorders were much more resistant to therapeutic effect. The Medical children, who were diagnosed less often at the start of treatment, tended not to improve at quite such a high rate as the Control groups in terms of neurotic conditions. However, improvement was equal in terms of psychosis and more pronounced for the physically disordered children who had had conduct disorders - apart, that is, from the 3 Disabled children with marked behavioural problems, all of whom retained them past the end of treatment. Ill Control children were similarly unlikely to be relieved of conduct disorders. Overall, one in four Control children continued to present with major conduct disorders at the end of treatment (taking out V-codes relating to interpersonal difficulties with parents and siblings). This, as can be seen from Tables 10.29a, 10.29b and 10.29c makes up the largest single diagnostic category for the Controls, and approaches a significant degree of difference from the Target groups' incidence rate of 7% ($\chi^2 = 3.3$, df = 1, $p < 0.07$). The majority of children with a conduct disorder at start of treatment either retained it at termination or were classified as offering insufficient information for diagnosis. Only just over one in three (9 out of 25) were assessed with any confidence as having lost their conduct disorders during treatment. Five of these came from the Somatic groups. The Ill and Disabled Control children were the least amenable to change in this area; few of those who were diagnosed with conduct or oppositional defiant disorder had made any substantial progress at all, and a number had deteriorated.

There were no clinical cases of anxiety among the Disabled children (or their Controls) at treatment termination, but the Ill and Somatic samples were significantly more likely to retain their symptoms of anxiety than were their Controls. Half the Ill children and nearly three-quarters of the Somatics were
<table>
<thead>
<tr>
<th>Principal Category</th>
<th>Disabled</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>III</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Somatic</th>
<th></th>
<th></th>
<th></th>
<th>All</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
<td></td>
<td>T%</td>
<td>C%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>11</td>
<td>73</td>
<td>33</td>
<td>39</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>18</td>
<td>30</td>
<td>0</td>
<td>44</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pervasive Developmental Disorder,</td>
<td>36</td>
<td>30</td>
<td>17</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enuresis</td>
<td>18</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encopresis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality, attachment and stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>9</td>
<td>22</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other specific childhood disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg tics, mutism)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V-Codes</td>
<td>9</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>9</td>
<td>22</td>
<td>11</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10.29a  Expanded principal termination diagnostic category for Medical Target (total N=81) and Medical Control (total N=81) groups
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Disabled</th>
<th>Ill</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0</td>
<td>10</td>
<td>50</td>
<td>11</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>0</td>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>18</td>
<td>30</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>36</td>
<td>30</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>Enuresis</td>
<td>18</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Encopresis</td>
<td>9</td>
<td>10</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>9</td>
<td>10</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>V-Codes</td>
<td>9</td>
<td>0</td>
<td>17</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 10.29b  Expanded principal and additional termination diagnostic categories for Medical Target (total N=81) and Medical Control (total N=81) groups
<table>
<thead>
<tr>
<th>Principal Category</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T%</td>
<td>C%</td>
<td>T%</td>
<td>C%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conduct Disorders and ADHD</td>
<td>6</td>
<td>9</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder, Psychosis</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Enuresis</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Encopresis</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Personality, attachment and stress disorders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Specific developmental disorders</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Other specific childhood disorders (eg tics, mutism)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>V-Codes</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>66</td>
<td>69</td>
<td>65</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 10.29c  Primary termination diagnoses including non-diagnosable cases for Medical Target (total N=81) and Medical Control (total N=81) groups
<table>
<thead>
<tr>
<th>CGAS Group at Term</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T% Range 39-90</td>
<td>C% Range 40-87</td>
<td>T% Range 35-88</td>
<td>C% Range 40-85</td>
</tr>
<tr>
<td>&lt;40</td>
<td>3</td>
<td>3</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>41-50</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>51-60</td>
<td>16</td>
<td>19</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>61-70</td>
<td>31</td>
<td>25</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>71-80</td>
<td>13</td>
<td>28</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>81-90</td>
<td>13</td>
<td>13</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>&gt;90</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not Known</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean:</td>
<td>65</td>
<td>65</td>
<td>59.5</td>
<td>60</td>
</tr>
</tbody>
</table>

Table 10.30 Termination CGAS score for Medical Target (total N=81) and Medical Control (total N=81) groups
<table>
<thead>
<tr>
<th>CGAS Change</th>
<th>Disabled</th>
<th>III</th>
<th>Somatic</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T% Range</td>
<td>C% Range</td>
<td>T% Range</td>
<td>C% Range</td>
</tr>
<tr>
<td>&gt;-10 CGAS points</td>
<td>-6 to +33</td>
<td>-5 to +30</td>
<td>-13 to +36</td>
<td>-8 to +21</td>
</tr>
<tr>
<td>-10 to -1</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>No change</td>
<td>22</td>
<td>25</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>+1 to 10</td>
<td>16</td>
<td>28</td>
<td>23</td>
<td>41</td>
</tr>
<tr>
<td>11-20</td>
<td>25</td>
<td>19</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>21-30</td>
<td>9</td>
<td>16</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>&gt;-30</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Not Known</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean:</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 10.31 CGAS change for Medical Target (total N=81) and Medical Control (total N=81) groups
diagnosed with an anxiety syndrome. This differs considerably from the 11% of Ill Controls and 33% of Somatic Controls ($\chi^2 = 7.8$, df = 3, $p < 0.05$).

c) **CGAS score and CGAS change**
The Medical children improved their mean CGAS score by an average of 10 points which is almost identical to that of the Controls (Tables 10.30 and 10.31 compared with Table 10.12). The Ill Controls did lag a little behind their Index pairs though not significantly so; they had started 3.5 points clear at assessment and the Target children had simply caught them up during treatment. Mean level of functioning between each Target group and its specific Control is remarkably similar, with the Somatic samples showing highest overall CGAS ratings, followed by the Disabled groups and the Ill groups trailing in third place. Although there is nearly 10 points difference between the highest Control group (Somatic) and the lowest Medical group (Ill), the three matched pairings differ by no more than one point.

Six per cent of children from both Target and Control samplings deteriorated and nearly one in five showed no change (Table 10.31). The remaining three-quarters all improved to varying degrees.

### 10.4 Discussion

A) **Child variables**

a) **Learning difficulties**

Learning difficulties have been found to be extremely common in all school-age children, whether physically ill or not (Rutter 1975), and our study certainly confirmed this (Table 10.1). However, there was a significant difference between the Disabled and Ill children on one hand, four-fifths of whom had major school-related problems, and their Controls on the other, only about half of whom had such difficulties. This is partly due to differences in physical health. Twenty-five per cent of the Disabled group, for example, had problems directly attributable to their physical state. Partial sight or hearing, especially if the child is being educated in mainstream
schooling and trying to keep up with his physically sound classmates, will almost inevitably create challenges which may not be able to be fully met. We also know that absences from school are more common for the handicapped child (Shakespeare 1975) and this may be part of the reason for the high levels of under-achievement for the Disabled child. Somatic children, too, are seriously failing in school and for these patients, too, loss of school time as a result of illness is severe. Asthma, for example, accounts for as much as one-quarter of the total school days lost through all chronic illness (Herbert 1974).

It is, of course, not the case that failing at school is always due to physical health problems. In fact, emotional conflicts probably play a larger part. Douglas and colleagues found marked differences in school performance between 'well adjusted' and 'least well adjusted' children (Douglas et al 1968), and the high incidence of underachievement\(^5\) among our Non-Medical groups indicates that school performance is not simply dependent on good or poor states of health. Poor peer relationships, as shown by large numbers of our children, especially from the Control groups, is recognised as a particularly strong indication of psychological dysfunction (Rutter et al 1970) which will, in turn, affect classroom performance. Nevertheless, as Medical children do show higher rates of school difficulty in most areas it seems probable that their indifferent physical condition must often exacerbate an already emotionally-fraught situation in the classroom. Satisfactory psychological adjustment at school is particularly dependent on a positive self-concept (Herbert 1974) and, as we noted earlier, self-esteem and ego development tend to be considerably more fragile for the ill or handicapped child (Harvey and Greenway 1984, Schilder 1935) than for his physically well peers.

The most startling difference between Target and Control groups in terms of school difficulties was the extraordinarily large percentage of Disabled children...
Control children (and, to a lesser extent, Ill Controls) who showed school refusal. Determining why the Medical Controls showed such a marked aversion to school is not an easy task. For a start, the school refusers in the Ill and Disabled Target and Control samples did not, on the whole, fit the profiles of non-truanting, school-avoidant children which have been found in previous research. Moore (1966), for example found a predominance of boys, especially if they were only children. Only 10 of our 19 refusers were male, which is actually lower than the 60% of boys in the samples overall and only one child was a singleton. Children showing school refusal in our samples varied across the age range from 6 to 17 years and did not show peak incidences at ages 8 and 11-12 as previous studies have done (Hersov 1985).

The high incidence of neurosis among refusers (Hersov 1985) was also not borne out from our figures. It is true that most of the children did have affective (47%) or other neurotic (16%) disorders but this amounts only to exactly the same percentage (63%) as for the Control children as a whole. It is not significantly different from incidence of neurosis in the Medical children. The slightly lower percentage of neurosis in the total Non-Medical group is probably accounted for by selective matching which paired Control children diagnostically with their Targets.

There were only two aspects of the school refusers in our Control sample which did fit earlier findings. In addition to the higher than average number of neurotic symptoms presented by the children themselves, the families of refusers have also been shown to have high rates of neurotic, especially affective, disorders (Hersov 1985). It is rather difficult to compare our psychologically-dysfunctional sample with general epidemiological studies. 'High rates' in the latter, for example, constitute about 20% of mothers, mostly with symptoms of depression and anxiety. This is similar to the percentage of diagnosable mothers across our overall Control and Target samples. Thus, what is 'high' in normal populations becomes 'average' in our skewed sample in which all the children are clinic attenders. However, the percentage of diagnosable mothers of school refusers was indeed
considerably higher than mothers of children without school attendance problems. This suggests that, in terms of maternal symptomatology, our school refusers tended to correspond with the usual profiles. Furthermore, the school refusers had experienced almost no parental absences or separations which also supports previous research that such children have less experience of being away from parents than is true for either truants or controls (Herbert 1974).

It seems, then, that the school refusers from the Target and Control groups are likely to have an anxious or depressed mother. This supports the hypothesis that an unwillingness to go to school has rather more to do with separation anxiety than with dislike of school (Herbert 1974). This anxiety may be focused on the mother's unhappiness, making the child reluctant to leave her, or may be a family or environmental trait which the child has inherited or acquired in his or her own right so that leaving the security of home becomes fraught with tension. School refusers also show a marked tendency to come out of treatment early which suggests a possible collusion between parent(s) and child. Not wanting to go to school may suit the parent, especially the mother, as much as it suits the child.

Linking school refusal with collusive, anxious parents for the Disabled Controls still does not explain why this group in particular should display such characteristics. The answer, quite simply, is that we don't know. All the refusers had 'good' reasons for not wanting to go to school. Some were enuretic or encopretic; some had recently been hospitalised or had operations; one had just started at a new school; many had specific learning difficulties. It is known that these and similar reasons are enough to initiate a period of not wanting to go to school (Hersov 1985). But, of course, many other children in our sample also showed these characteristics but had no problem with school attendance and the Disabled Controls had not only been matched diagnostically with their Targets but had fewer experiences of operations and hospital stays in any case than the Index children. Perhaps the high number of school refusers among the Disabled controls was just a peculiarity of the sampling but, as 26% of the total number of refusers came
from this group even though the sample constituted a mere 4% of the total, it seems that there may be something here that needs explanation. For the present, though, it remains elusive.

b) Hospitalisations

Previous research has associated repeated hospitalisations in childhood with an increased risk of emotional disturbance (Rutter 1975) though a single admission does not generally jeopardise psychological adjustment. On the whole this was not confirmed in our study (Table 5.1). The Disabled and Ill children, many of whom had had multiple stays in hospital, did not differ significantly from their Control groups in terms of global functioning levels as measured by CGAS scores. This may, of course, be a consequence of matching on criteria such as diagnosis. Probably even more relevant is the fact that all our children, Targets and Controls, the frequently hospitalised and those who had never been treated for any physical medical problem, were patients at a psychiatric clinic which presupposes emotional disturbance in the vast majority, regardless of their medical status and treatments received. It was not possible to determine whether, and to what extent, the number of hospital in-patient visits had independently contributed to the child's emotional dysfunction.

c) Medical history

The presence of chronic physical conditions in the entire Target group and the absence of the same in the whole of the Control group is, of course, simply the result of the parameters of selection of these respective groupings. All severe chronic conditions became part of the target sample; a number of non-target children suffered with less serious ongoing complaints but these were not part of the pool from which the control children were selected. By definition, therefore, all medical children suffer chronic physical conditions and no control child has any persistent medical complaint (Table 10.2).

The majority of operations undergone by Disabled children related to their primary handicap - surgery for congenital deformities, detached retinas,
cataracts, removal of defective eyes and so on. In addition they had experienced a number of accidents that resulted both in an operation and in the subsequent chronic handicap. Although diabetic and epileptic children from the III group were so frequently required to undergo hospital treatment that two-thirds of them had been an in-patient at least once by the time of their psychiatric referral (Table 5.1), this was usually in order to stabilise drug régimes. The only operation noted in this group of children was an adenoidectomy/tonsillectomy. It is not surprising that operations did not relate to the Target chronic Illness but what was slightly surprising was that the 'common' operations of childhood - repair of hernias or removal of tonsils, for example, - were fewer among the III children than among the other samples, despite the fact that the III children were generally older at assessment than members of all other samples except for the III Controls. This difference was not, however, statistically significant.

B) Family variables
There were no significant variations between Target and Control groups on any of the family parameters looked at.

C) Referral and diagnostic variables
a) Primary source of referral
The only referral and diagnostic variable to distinguish between Target and Control children (and then only between the Disabled groups) was the source of their recommendation for therapy (Table 10.6). The Disabled children are not often referred by their parents or, indeed, as a self-referral. This is mainly because children with severe disabilities inevitably come under the care and treatment of professionals at special schools and (Other) organisations for the disabled who take over some aspects of the parental rôle including initiating and activating suggestions for adjuvant treatments.

The III children are also often recommended for treatment by parental substitutes, in this case in the guise of doctors and hospital agencies; what is particularly interesting with regard to the III groups is the similarity with which their non-ill Controls also used medical personnel in the place of
parents and self as referral sources. However, the doctors so consulted tended to be general practitioners rather than the hospital specialists treating the Target Medical children. The Ill Control children also included some rather unusual diagnostic cases such as a gender disorder and Tourette’s syndrome plus, in three cases, highly pathological parents who had made suicidal gestures, were violent or psychotic. Such skewed sampling among a total of only 17 children is bound to bias the profile of the group.

b) CGAS ratings at start of treatment
The observation that the Ill Control children are closer to their Target matches than to the other Control groups in terms of initial CGAS (Table 10.12) (and a number of other variables as well), suggests that the variables selected as controlling factors are regulating additional parameters not specifically taken into account when originally matching subjects.

D) Parental variables
a) Parents’ GAF
Previous studies have concluded that mothers with psychologically deviant children had higher 'malaise' scores than mothers with physically-disordered children (Rutter et al 1970). The emotional condition of the child, that is, appears to affect the parents' sense of well-being and ability to function more than the child’s physical illness or handicap does. Our findings suggest, in fact, that the medical condition of the child does not have a consistent relationship with parental functioning at all - mothers of Disabled children scored higher on average than other parents, including those of the Disabled Control subjects, while mothers and fathers of Ill children had noticeably lower ratings than their parental Controls (Tables 10.13 and 10.14).

It is known that where parenting function is disrupted through marital discord, mental illness or for any other reason, the children tend to show increased signs of psychological disturbance (Rutter and Cox 1985). This opens up the possibility that our Ill children, who did indeed produce lower CGAS scores than the other patients, are affected by their unusually
dysfunctional parents. On the other hand, it may be much more stressful to have the care of an epileptic, diabetic or haemophiliac child with all the uncertainties and paradoxes of such 'invisible' illnesses where the child looks the same as his or her peers but has to cope with the continual possibility of unpredictable seizures and other physical crises (Shakespeare 1975) than to look after a blind or deaf child whose disability is less easy to ignore or to deny and, consequently, easier to come to terms with. It is also, of course, quite possible that there is no direct causal link at all between the overall functioning of child and parent and that all such relationships are mediated by a variety of independent factors such as number of children in the family or social class.

b) Present diagnoses

One in three mothers of Ill children satisfied psychiatric diagnostic criteria at the time of the child's assessment, a higher percentage than was found among mothers of other Medical or Control children (Table 10.16). The conditions from which the Ill mothers suffered were almost exclusively anxious or depressive. This offers tentative support for the speculation in the previous section that parenting a child with diabetes or epilepsy is a particularly stressful experience, often co-existing with symptoms of anxiety and depression. Diagnostic status would appear to be related to general levels of functioning which, as already discussed, are lower for this set of mothers. This is further confirmed by the fact that fewer mothers of Disabled children, with relatively high mean GAF scores, were found to be suffering from a definite psychiatric illness. Reduction in effective functioning is, of course, part of the diagnostic criteria for many psychological conditions so, to some extent, GAF scores and diagnostic status are measuring two aspects of a single factor.

Parental personality disorder has been postulated as exposing the children to particularly high risk of psychiatric illness (Rutter 1975). It was not possible for us to disentangle all the aetiological threads in a sample of children all of whom had psychological difficulties. We did find, however, that the child’s progress seemed to be partially compromised by the presence of a
with diagnosable personality disorder exert the same influence. One possible reason for such divergent results may be that personality disorders are not a unitary assessment of pathology but vary considerably in their severity and nature. When of a comparatively mild nature they do not appear to compromise global performance much and, arguably, do not affect the children to any great extent either. There were too few cases of parental personality disorder in our sample to be able to make any definitive pronouncements but the preliminary indications of differences in impact on the children between mothers and fathers suggest that this would be worth looking at further.

c) Symptoms and treatments

The total incidence of currently-experienced anxiety in Target mothers, especially of Ill and Somatic children, was a great deal higher than in Control parents, although overall levels of past occurrences were very similar in Target and Control groups (Tables 10.17, 10.18, 10.19 and 10.20). This suggests a higher level of state anxiety in the parents of chronically unwell children at assessment. Parents of Disabled children appeared to have low trait anxiety; for the other Medical subsamples, anxiety, for a large minority of mothers, was not only a response to the current events but also an integral part of their personality make-up.

The relatively high percentage of Somatic Control mothers who had had psychoanalytic treatment is another instance of their outdoing their own Target group. The match with the Target Somatic families on variables that were controlled for (such as social class and diagnosis) appears to extend its effects to, for example, the kind of treatment sought by or offered to different kinds of parents.

d) Physical illness

The mothers of all Medical children plus the fathers of Disabled children were twice as likely to be physically ill than were comparable parents of Control children (Table 10.21). This is similar to the differences found between the Medical groups and the total Non-Medical Control and suggests that,
Medical groups and the total Non-Medical Control and suggests that, somehow, chronic illness, where present in a family, has a tendency to affect more than one member. Mothers seem to be at particular risk.

In a number of cases there was an apparent genetic link between the physical state of the child and one or both of his or her parents. For example, there were several parents of Disabled children who were themselves handicapped. In one case, both parents of a blind child were also without sight. A child with ataxia had a father suffering with the same condition, and the mother of a boy with a congenital deformity severely affecting his arms had a cleft palate. It is probable that most, perhaps all, of these cases had arisen from a familial trait. In addition there was one mother and daughter who had both lost eyes as a result of a war injury. Although there is no sense of the particular chronic illnesses and handicaps that we were studying being directly transmitted as a result of infection, there were fairly obvious links between a number of parental and child disabilities which is sufficient to account for at least some of the increased incidence of physical illness in parents of Disabled children.

Somatic states, too, sometimes seemed to have a familial aspect to them. At least three Somatic children shared their asthma or eczema with a parent. The other problems for mothers of children in all three medical groups included gynaecological difficulties, heart conditions, arthritis, rheumatism, sciatica, thyroid problems, oedema, ulcerative colitis and the after-effects of polio. Many of these could also be defined very broadly as having a possible psychosomatic basis. Fathers, too, exhibited chronic conditions such as asthma, migraines, gallstones and sinus myocarditis but to a lesser extent than their wives.

The increased physical illness demonstrated by parents, and especially mothers, of Medical children can be seen, therefore, to fall into two camps. Some of it is hereditary, passed from parent to child through the genes. This applies mostly to certain neurological disabilities and to a small number of asthmas and excemas. As very little of the illness experienced by the parents
of Medical children is solely organic (though it is difficult to know what psychoanalytically-trained commentators would allow as being wholly non-functional in origin!), we may perhaps be allowed to speculate that, in the second camp, are those parents of ill children who sometimes show their reactions to stress through physical rather than psychological symptoms. These families may be particularly oriented towards medical manifestations, given the already-existing presence of one ill member.

E) Treatment variables

a) Length of treatment

A large number of psychoanalytic adult patients drop out of treatment prematurely (Bachrach et al 1991). It is also recognised that a high proportion of children attending child guidance clinics fail to complete their therapy (Israel et al 1986, Leone et al 1986, Suzuki 1989). It is not surprising, then, that one-fifth of all Control children completed six months or less of an intensive treatment that would usually be expected to last between two and three years (Table 10.24). The Medical children were more persistent in their approach to treatment. A preliminary supposition was that this may be connected with source of referral, but this was not supported by the data. Children who had been recommended from professional agencies such as schools and hospitals did not stay in treatment longer than those who had come on their parent's initiative.

Further thought and investigation allowed us to speculate that there may be a number of interconnected reasons why chronically ill children tend not to leave treatment very precipitately in the first few weeks. The fact that they have a very definite focus for their distress may be important. Children who have separation anxiety or who wet the bed or who have school problems do not always want to acknowledge their difficulties, still less do anything about them (Rutter et al 1970). The Medical children had all these symptoms, of course but, in addition, they had their blindness or diabetes or severe asthma to contend with. This perhaps puts a more 'respectable' veneer on the idea of receiving psychological help, making it easier to accept for parents and children. 'Halo effects' (Lindemann 1981), a common attributional bias, are
widespread in the assessment of disabled and ill children. This allows most major differences between the disabled and the able-bodied in terms of, for instance, attainment and adjustment, to be ascribed to the nature of the physical disability and not to any increase in maladaptiveness (Thomas 1978).

In addition, such children and their parents are used to accepting agency assistance. Attending clinics is a familiar experience for most of them. Professional workers tend to ignore or to deny how strange and frightening it is for most families to enter the unknown world of medicine, psychiatry or psychology. Those who have had previous and, hopefully, helpful encounters with clinics will feel more comfortable about coming regularly for treatment. Linked to this is the fact that ill and handicapped children know that treatment is often gradual and long-term. Families of physically-well children may be more impatient with the intensity and slowness of psychoanalysis and take the children out of treatment before time.

There may also be cohort effects. Davis has shown how treatment for polio in the 1950s had similar characteristics to the dominating protestant work ethic of that era (Davis 1972). Slow, patient, regularly applied therapy with a long-range goal was more acceptable thirty or forty years ago than it seems to be today. Our control children came into treatment slightly later than their respective target groups (Table 7.13). The difference was not great but it is conceivable that, combined with other factors, it had a slight effect on perseverance levels and tolerance for extremely delayed gratification.

F) Termination variables

a) Reason for termination

Reason for termination (Table 10.25) is just one of many instances when the Control groups almost seem to out-do their index Targets in a particular piece of behaviour, seeming to act in line with their Medical group even in respect to factors not originally selected for. This strongly suggests that certain key factors, such as age, IQ or diagnosis, which were controlled for, exert an influence over other aspects of functioning. It may also be that personality
characteristics such as levels of motivation, persistence, sociability and so on, affect not only the kind of symptoms that will be exhibited under stress (a matched variable) but also the degree of commitment shown towards any treatment.

b) **Diagnostic category**
The higher level of anxiety in the Ill and Somatic children compared to their Disabled peers at both assessment and termination (Tables 10.7, 10.8 and 10.29a,b,c) does not allow us to identify direction of causality but does suggest an association between anxiety and all types of *illness* as opposed to handicap. Factors other than physical condition are also clearly involved in the causes and retention of anxiety but it is interesting that, by the end of treatment, the Non-Medical Control children had nearly all lost their symptoms of anxiety whereas an appreciable number of Ill and Somatic children remained diagnostically anxious. Their anxiety syndromes may have had different aetiologies from that of their matched Controls; alternatively, the chronic presence of illness may exacerbate the anxiety and make it more difficult to treat. A number of Somatic children (whose condition, by definition, includes a considerable psychological element) showed no amelioration in their presenting physical symptoms, even though general functioning had often improved.

This raises the possibility that the asthmas and eczemas that proved resistant to psychoanalysis were the result of allergic or other organic reactions rather than being psychosomatically induced. Although psychoanalysis is notoriously indifferent to manifest symptoms it is reasonable to expect that an increased ability to cope, brought about by a strengthening and expansion of the ego, would have observable effects on the psychologically-influenced aspects of the patient’s life. It is probably relevant, however, that only one patient who still displayed Somatic symptoms when therapy ended, terminated by mutual agreement with the therapist. Even bearing in mind the difficulties of identifying the most appropriate time to finish what could be an interminable process of analysis, and the temptation to classify all patients with residual symptoms as having
ended prematurely, it seems at least as likely that Somatic symptoms require a lengthy period of therapeutic intervention which many children were unwilling to allow than that all the resistant cases were in fact organically based.

Conduct disorders are recognised as being notoriously hard to influence through therapeutic means (Kazdin 1988), a finding borne out by the present study.

c) **CGAS score and CGAS change**
This is yet another area where the Controls match extremely well with their Targets (Tables 10.30 and 10.31), suggesting that the factors for which they were selected have significant implications for response to treatment and final state of functioning. The III children improved in global performance by a greater degree than their Controls but the latter group had started off with a 4-point advantage. The Index children caught them up and kept up with them so that the termination CGAS scores were virtually identical.
Chapter Eleven

The Child at Termination - Outcome Predictors
11.1 Introduction
We have already looked, on pages 280ff, at the correlations between the child’s final global assessment rating as measured by the Child’s Global Assessment Score (CGAS) and other independent variables, such as IQ and length of treatment. The other main dependent variable measuring the effectiveness of psychoanalytic treatment is the change in the child’s CGAS rating between the start and termination of therapy. This is an even more potent indicator of treatment efficacy; the extent to which the child changes, for good or ill, is more informative than a simple rating score which does not take into account the baseline of the child at start of treatment. The following section looks at some of the main outcome predictors of change in the child’s global assessment score.

11.2 Method
11.2.1 Samples
1) Total Medical Plus Control Sample
All 162 children from the Medical Index and Control groupings were studied to determine outcome predictors of CGAS change. These consisted of 81 Medical children and 81 Control children, as below:

32 Disabled Target children  32 Disabled Control children
32 Somatic Target children  32 Somatic Control children
17 III Target children 17 III Control children

2) ‘Top’ and ‘Bottom’ cases
In addition, the 20 ‘top’ and the 22 ‘bottom’ cases from the 81 Medical files were separated out. The former were children who gained more than 17 CGAS points by the end of therapy; the latter had made either zero change or a negative change. These two groups enabled comparisons to be made between patients who appeared to benefit from psychoanalysis and those for whom this form of treatment seemed counter-indicated. Approximately one-quarter of the children from all three medical samples qualified for entry into the ‘top 20’. The bottom group comprised about one in three III and Disabled children and a lesser number of Somatics (see table 11.1).
<table>
<thead>
<tr>
<th>Medical Group</th>
<th>Top 20 N (%)</th>
<th>Bottom 22 N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>7 (22% of total Disabled group)</td>
<td>11 (34%)</td>
</tr>
<tr>
<td>III</td>
<td>5 (29%)</td>
<td>6 (36%)</td>
</tr>
<tr>
<td>Somatic</td>
<td>8 (25%)</td>
<td>5 (16%)</td>
</tr>
</tbody>
</table>

*Table 11.1 Breakdown of the 20 best and 22 worst CGAS change scores*
3) Premature terminators

In order to determine which children had been most affected (either beneficially or adversely) by psychoanalytic intervention, it was felt first necessary to ascertain which of them had had sufficient exposure to it to have felt its influence. Children who came out of treatment at a very early stage were, therefore, identified. Given that the average child psychoanalysis at the Anna Freud Centre lasts between two and three years it was felt that a period of less than one-quarter of this length (i.e. 6 months or less) constituted an aborted analysis. Twenty-three (8 Target and 15 Control) children left within six months of starting.

11.2.ii Procedure

A register of variables known, or assumed, to have the potential to affect the child’s progress in treatment was assembled from the original 232 factors which had been compiled from the clinical files in the manner described in Chapter 7 and listed in Appendix C1. A few of these were not able to be analysed, either because they included too many missing values to be statistically viable or because they affected too few children to permit reliable differentiation. The remainder were run through the BMDP AM statistical software program to estimate missing data values, including missing CGAS termination ratings, from all other available variables. Preliminary investigation of the resulting information led to a decision to remove the child’s termination CGAS score and termination diagnostic status from the analysis. A high CGAS score at end of treatment is so closely associated with a high level of change (r>0.7) that the overlap between them threatened to render impotent all other possible determinants. Diagnostic status at termination was all too often simply another way of stating that the child’s level of functioning had not greatly increased during treatment.

55 These included: a) parents' religion (unknown in the majority of cases); b) number of therapists (few children had more than one), c) Anna Freud Diagnostic Category (this method of classification had not been used since 1970 and considerably less than half the children had been assessed along this dimension); d) whether the child had attended the Anna Freud Centre nursery school; e) the treatment of any relation at the Centre and f) the child's experience of Local Authority fostering. The last three categories related to very small numbers of children.
Other variables not considered from among the original 232 included all the qualitative information, usually in the form of comment fields; all data not of direct interest to our investigation, such as information on subsequent treatments; most of the data relating to siblings, and the simple recording of whether certain tests and interviews had or had not been carried out. Some of the original parameters were merged to form transformed variables. Much of the diagnostic information was treated in this way\(^{58}\) and some of the maternal and paternal variables were combined to produce parental variables. In all, 52 variables were analysed to ascertain their effect on the child's outcome at termination of treatment. A complete list can be found in Appendix C2.

These 52 factors were analysed using the BMDP 2R stepwise regression program to separate out the individual predictive power on outcome (measured by CGAS change) of each variable. There were four steps to the analysis. Firstly, all relevant variables were included (K = 52). Secondly, the analysis was re-run having taken out variables already controlled for in the matching process. This left 38. The third stage was to omit variables controlled for plus termination variables (K = 36) which were, by definition, not able to predict outcome at the time of assessment. Finally treatment variables were also removed on the same grounds to leave 33 factors for analysis. These are listed in Appendices C3, C4 and C5.

11.3 Analysis and Results

11.3.1 Descriptive Analysis

Some of the tables in this section show the data in summary descriptive form.

\(^{58}\) Diagnoses were assigned to one of 6 categories as follows: Category 1: Pervasive developmental disorders and mental retardation; Category 2: Anxieties, phobias, sleep problems, adjustment problems and somatoform complaints; Category 3: Disruptive disorders; Category 4: V codings and habit disorders; Category 5: No diagnosis - CGAS < 70; Category 6: No diagnosis - CGAS > 70.
11.3.ii Inferential Statistical Analysis
The BMDP 2R statistical software program (stepwise regression) was used to investigate the separate predictive potential of each variable. The BMDP 8D program was used to compute correlation matrices between selected variables.

11.3.iii Results
A) CGAS change
a) Total Medical plus Control Sample
All these children had been assessed on the CGAS rating scale at the start of their treatment and 96% were able to be rated when they finished therapy. There was insufficient information about the child’s overall level of functioning at termination for three Disabled subjects, two Disabled Controls and 1 Somatic child. Estimated values were used for these subjects.

Table 10.31 shows a break-down of the spread of CGAS change in the Index groups and their matched Controls. The variation was great, from the 6% of both Medical and Control children whose functioning deteriorated, through almost one in five whose global assessment showed no change from start to finish of treatment, to the remainder who improved by anything from one to 35 points. Mean CGAS change was 10 points for the Target Medical children and 9 for their Controls.

b) 'Top' and 'Bottom' cases
By definition and selection the ‘top’ 20 cases had gained at least 17 CGAS points. The spread was between 17 and 35, with a mean of 26 points. The ‘bottom’ 22 cases had made either zero change or a negative change. The spread was -13 to 0 with a mean of -2.

c) Premature terminators
Children who left treatment within 6 months showed far less improvement (mean CGAS change = 4 points) than those who remained for longer than 6 months (even if they also, eventually, terminated unilaterally). The average CGAS improvement for the ‘stayers’ among the Medical samples and their
matched Controls was 11 points. This is not to say that children who had barely established themselves in analysis never made gains. Although more than half showed either deterioration (N = 3) or no change in overall level of functioning (N = 10), ten children were rated as having shown general improvement, some of it considerable. Three made gains of 10 CGAS points and three others improved by as much as 16, 17 and 21 points respectively. However, it was felt that improvement from such short therapies would have been due to factors such as maturation, a positive relationship with the therapist, spontaneous remission etc, none of which relates to the specific attributes of classical psychoanalysis which is, of necessity, an intensive process, requiring a large time-scale for maximum effectiveness.

B) Can we predict early termination of treatment?
When the 23 extremely precipitate terminators (Prems) from the Medical and Control samples were investigated, using a stepwise regression statistical programme, no factors were found to predict reason for termination. The variable that was closest to attaining significance was the CGAS score of the child at start of treatment - which leads to the conclusion bordering on paradox that those children who were generally functioning reasonably well at assessment were those most likely to end by mutual agreement with their therapist and thus to be in treatment for, generally, the longest periods. This finding is in line with other research into psychoanalytic outcome but in this instance its effect was marginal and statistically insignificant.

The 15 medical Controls who terminated expeditiously were looked at separately from their Index subjects. This is not really a large enough sample to reach reliable conclusions but the two factors found which, rather weakly, predicted reason for termination for these Control subjects related to whether the mother had, or had ever had, psychological symptoms or treatment, and the child’s IQ score. These subjects had, on average, a higher IQ (114) than the mean of their total sample and fewer mothers with past or present psychological symptoms (29%) although the mother of one child being cared for in a institutional home, was not available for assessment. With such small numbers each case contributes disproportionately to the findings and, as
already noted, these predictive factors disappeared when the additional eight medical children were added.

When *length of treatment* was taken as the dependent variable, a *Category 4* diagnosis emerged as the main CGAS change predictive factor for the Prems (Table 11.2). This group of diagnoses included both habit disorders (primarily concerning eating, sleeping and elimination) and V-code diagnoses (conditions not attributable to a mental disorder but still a focus of attention or treatment). Children who were diagnostically rated in these categories did poorly if they left treatment very early. The only other significant factor was *social class*, the mean of which, for the early leavers, was slightly lower than for those who stayed in therapy for longer than 6 months. The control children on their own also showed a large effect of *Cat4* diagnoses. It is worth mentioning again that numbers are really too small to merit any definite conclusions being drawn.

C) Predictors of CGAS change

Having taken a brief look at the factors influencing the 14% of children from the Medical and Control samples who came out of treatment within 6 months we can return to the investigation of outcome predictors.

a) Premature terminations

The only outcome predictor for children who left treatment within 6 months of starting (apart from the premature termination itself) was the presence of *learning difficulties* (Table 11.3). These sorts of problems did not appear to weight the odds towards an early finish but they did make progress over comparatively short periods of time particularly difficult.

b) Total (Medical plus Control) sample

There are 162 children in this sample - the total Medical group of 81 plus their 81 matched Controls.

1) Initial factors - matched

Initial factors are those present for evaluation at assessment. Some of them
Table 11.2 CGAS change predictors for early terminators in Medical Target and Medical Control children (N=23)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT4 diagnosis</td>
<td>0.18*</td>
<td>0.67</td>
<td>0.32</td>
</tr>
<tr>
<td>Social class</td>
<td>0.06**</td>
<td>0.37</td>
<td>0.12</td>
</tr>
</tbody>
</table>

Intercept=0.06

Multiple R²  = 0.44†
Adjusted R²  = 0.38
Multiple R   = 0.66

†No assessment of significance can be made because of inadequate adjustment forcing a negative result when N (number of subjects) <=60 and K (number of variables) =>20. In this case, N=23, K=52 (see Cohen and Cohen 1975).

*  p<0.05
** p<0.01

Table 11.3 CGAS change predictors for Medical Target and Medical Control children who came out of treatment within 6 months (N=23)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning difficulties</td>
<td>-3.76*</td>
<td>-0.54</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Intercept=7.39

Multiple R²  = 0.29†
Adjusted R²  = 0.26
Multiple R   = 0.54

†No assessment of significance can be made because of inadequate adjustment forcing a negative result when N (number of subjects) <=60 and K (number of variables) =>20. In this case, N=23, K=52 (see Cohen and Cohen 1975).

*  p<0.05
were matched for in selecting appropriate Controls; others remained freely independent variables. By definition, no treatment or termination variables were included in the initial set of parameters.

The matched initial factors are listed in Appendix C6. Table 11.4 shows the subset of those independent variables that contributed significantly to CGAS change ratings in the total group (Medical Targets plus matched Controls). The first factor to enter into the analysis was whether the child came from an intact home or not, a variable which had been controlled for in the selection of the matched pairs for the Index children. The assumption that an undivided home may contribute to treatment outcome appears to be well-founded. Regardless of whether the break-up was due to death, separation or divorce, children from these families made fewer gains in treatment. Only 4 out of 23 of them did as well as, or better than, the mean of their particular subsample. The predictive power of this factor is statistically significant even when the premature terminations are excluded from the analysis (Table 11.5), although it should be noted that very little of the variable has actually been accounted for.

The presence of a principal or additional Cat2 Diagnosis either at assessment or, less frequently, in the past, augurs well for improvement in global functioning whether or not the child remains in treatment for at least 6 months. This diagnostic group contains mainly anxiety disorders, phobias, sleep and adjustment problems and somatoform disorders. There is a significant positive correlation between assignment to Cat2 and CGAS change ($r = .24; \text{df} = 160; p < 0.01$; two-tailed).

The child’s age at start of treatment also contributes to the likelihood of a satisfactory treatment. Younger children tended to benefit more from treatment although this difference disappeared when the premature finishers were removed.

2) Initial factors - unmatched
Father’s GAF score (his overall level of functioning) emerged as a significant
### Table 11.4 CGAS change predictors for all Medical Target and Medical Control children (N=162)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family broken/intact</td>
<td>-5.74**</td>
<td>0.93</td>
<td>0.06</td>
</tr>
<tr>
<td>CAT2 diagnosis</td>
<td>6.70***</td>
<td>0.93</td>
<td>0.05</td>
</tr>
<tr>
<td>Age at start</td>
<td>-0.59***</td>
<td>0.94</td>
<td>0.05</td>
</tr>
<tr>
<td>Father’s GAF score</td>
<td>0.18***</td>
<td>0.92</td>
<td>0.04</td>
</tr>
<tr>
<td>Length of treatment</td>
<td>0.72***</td>
<td>0.98</td>
<td>0.03</td>
</tr>
<tr>
<td>Mother’s hospitalisation</td>
<td>10.53***</td>
<td>0.96</td>
<td>0.02</td>
</tr>
<tr>
<td>Mother’s problem now</td>
<td>-2.20***</td>
<td>0.96</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Intercept=5.01

Multiple $R^2 = 0.27**$

Adjusted $R^2 = 0.24**$

Multiple $R = 0.52$

* $p<0.05$

** $p<0.01$

***$p<0.001$

### Table 11.5 CGAS change predictors for Medical Target and Medical Control children completing a minimum of 6 months’ treatment (N=139)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT2 diagnosis</td>
<td>6.47***</td>
<td>0.31</td>
<td>0.08</td>
</tr>
<tr>
<td>Father’s GAF score</td>
<td>0.22***</td>
<td>0.20</td>
<td>0.06</td>
</tr>
<tr>
<td>Family broken/intact</td>
<td>-6.07***</td>
<td>0.98</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Intercept=-0.67

Multiple $R^2 = 0.04$

Adjusted $R^2 = 0.03$

Multiple $R = 0.20$

* $p<0.05$

** $p<0.01$

***$p<0.001$
predictor of whether or not the child was going to finish therapy with an improved CGAS score. This related equally to the Prems and to the longer-treated children, all of whom tended to do better with a relatively high-performing father. Mothers were significant predictors mainly in terms of whether or not they were currently manifesting psychiatric symptoms or undergoing psychological treatment \textit{(Mother problem now)}, and whether they had experienced any periods of hospitalisation, psychiatric or otherwise, in the child’s lifetime. Children who had mothers with present psychological profiles (often subclinical and not fulfilling sufficient criteria for diagnosis) made fewer overall gains from treatment. This did not relate to any specific maternal diagnosis nor to the mother’s GAF score. In other words, mothers might be functioning reasonably well with average or higher GAF scores but if they showed signs of anxiety, depression, personality disorder etc this was likely to attenuate the amount of improvement able to be made by their child.

The psychiatric hospitalisation statistics showed that children whose mothers had been inpatients on one or more occasions tended to do better than children who had not experienced such events. There were 31 Target and Control children whose mothers had been in hospital. CGAS scores showed a mean change of 15.2 for the Medical children and 12.3 for the Controls, higher than the comparable means for the total subsamples (table 11.6).

In later stages of the analysis in which smaller groups of variables were investigated, having removed those already controlled for and those relating to termination, two other predictive maternal factors materialised - whether or not the mother had ever made a suicidal gesture and whether or not she was, or had ever been, in psychoanalytic treatment in her own right. Less than 4% of mothers from all the Target and Control groups \((N = 6)\) had attempted suicide in the past. The children of such mothers tended to do less well in treatment.

Past or current analysands were more frequent. There were 17 mothers, mainly of Somatic children or their Controls, who had undergone analysis at some stage in their lives, sometimes both in the past and currently. This
Table 11.6  Mean CGAS change for Medical and Control groups compared with the subgroup from these samples whose mothers had been hospitalised
gave a low but significant correlation with the child’s level of improvement 
\( r = 0.15, \text{df} = 160, p < 0.05, \text{one-tailed} \).

3) Treatment and termination variables

*Length of treatment* positively affected CGAS change. On the whole, longer 
treatment resulted in a greater improvement in the child’s general functioning 
although the correlation between the two factors, albeit statistically 
significant, was not all that high \( r = 0.19; \text{df} = 160; p < .05, \text{two-tailed} \). The 
mean length of treatment for the children who improved most was 2.7 years, 
about 8 months longer than the average for the least improved children. 
Treatment duration, by definition, did not apply to the Prems for whom 
*Reason for termination* was a more important indicator of progress.

When all the matched variables were removed from the analysis, *parental 
guidance during treatment* also emerged as an important predictor. Such 
family interaction, in the nature of support, encouragement, advice and so on 
from the clinic staff was given to parents of half of the top 20 cases but to 
only 18% of the families of children who ultimately made no progress or 
whose functioning deteriorated.

Families who received help during treatment were not able to be 
differentiated from those who did not on GAF and CGAS scores, length of 
treatment, reason for termination, number of sessions per week, learning 
difficulties, the intactness of the family, parental symptoms, marital 
difficulties, social class etc. The only factor which correlated significantly 
with parental guidance during treatment was the age of the child, the parents 
of younger children being more likely to receive help \( r = -0.35, \text{df} = 70, 
p < 0.01, \text{two-tailed} \).

c) Total Medical Group

This group consists of the 81 Target children (32 Disabled, 32 Somatic and 
17 III).

1) Initial factors - matched

Among the 9 variables that predicted CGAS change among the three Medical
subgroups (Table 11.7) there were 3 which had been controlled for in the original matching of pairs - CAT2 (the diagnostic category including anxieties and adjustment problems), home status (family broken or intact) and age at start of treatment. These were the same three that applied to the total Medical-plus-Control group (see above).

Sixty-five per cent (N = 13) of the top 20 improvement scores had at least one diagnosis from category 2, compared with only 23% (N = 5) of the bottom 22 cases. As with the total Medical-plus-Control group there is a significant positive association between CGAS change and assignment to CAT2 (r = .29; df = 79; p < 0.02, two-tailed).

Similarly, all 20 children with the highest improvement ratings came from an intact home whereas the register of no change ratings and deteriorations included 5 (23%) children from broken families.

Younger children from the Medical subsamples tended to do better in therapy. The 22 Medical children who made the least gains in treatment (CGAS change ≤ 0) had an average age of 10.4 years when they began therapy, compared to the 8.2 years of the 20 highest improvers (CGAS change > 17).

2) Initial factors - unmatched
There were several parental factors with significant impact on the child’s change ratings. Once again, father’s level of global functioning (Father’s GAF score) emerged as an important contributor to the progress of his child. Well-adjusted fathers appeared to facilitate improvement significantly. This seemed to be independent of both their partner’s GAF score and the sex of the child. However, although mothers’ overall performance was not as crucial, there were facets of their life that did affect the child’s ability to change. In particular, the presence of any current maternal psychological problem or treatment (Mother problem now) was a major indicator that the child might struggle to achieve a high rate of improvement. Nearly two-thirds of the 22 least-changed children had mothers with present difficulties
<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Par guidance before t'ment</td>
<td>9.09**</td>
<td>0.24</td>
<td>0.13</td>
</tr>
<tr>
<td>Mother problem now</td>
<td>-5.26***</td>
<td>-0.33</td>
<td>0.08</td>
</tr>
<tr>
<td>CAT2 Diagnosis</td>
<td>8.76***</td>
<td>-0.39</td>
<td>0.09</td>
</tr>
<tr>
<td>Family broken/intact</td>
<td>-7.26**</td>
<td>-0.23</td>
<td>0.07</td>
</tr>
<tr>
<td>Parent ill</td>
<td>-6.29***</td>
<td>-0.29</td>
<td>0.07</td>
</tr>
<tr>
<td>Father's GAF score</td>
<td>0.36***</td>
<td>0.30</td>
<td>0.04</td>
</tr>
<tr>
<td>Marital problems</td>
<td>5.64***</td>
<td>0.23</td>
<td>0.03</td>
</tr>
<tr>
<td>Age at start</td>
<td>-0.71***</td>
<td>-0.29</td>
<td>0.03</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>2.07***</td>
<td>0.19</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Intercept = -3.33

Multiple $R^2 = 0.56^*$
Adjusted $R^2 = 0.51$
Multiple $R = 0.75^{**}$

* $p<0.05$
** $p<0.01$
***$p<0.001$

Table 11.7  CGAS change predictors for all Target Medical children (N=81)
compared to only 15% of the most-improved. A parent’s physical illness (Parent ill) also impeded CGAS change, affecting twice as many low scorers as high scorers at termination. In addition, serious marital problems between the parents had an adverse effect on the child’s ability to progress in therapy.

Learning difficulties was the last initial factor shown to make a difference to analytic outcome for the total group of Medical children. It was not so much the presence of such problems per se that affected therapeutic outcome - indeed, three out of four Medical children had at least one learning difficulty (see Table 11.1) and the lowest achievers were only slightly more likely to present with a school problem (77%) than were the highest achievers (70%) - but the type of difficulty children presented with. Children who were under-achieving were more likely to do well in treatment than children classified under ‘other’ which included attendance at special schools and ‘backwardness’. Twenty-eight per-cent of the bottom group of children had ‘other’ learning difficulties; this was true for only one child (5%) in the top group. More than half the latter sample showed serious under-achievement at school compared with less than one-third of the children who showed no change or a negative change in CGAS scores.

3) Treatment and termination variables
The first factor to enter the equation among the treatment and termination variables showed that those children whose families received parental guidance before treatment did better than those whose parents did not take advantage of, or were not offered, this resource. When the progress of the Control children was taken into account alongside the Target group it was the work done with the parents while the child was actually in analysis (Parental guidance during treatment) that was particularly influential, but for the Medical children on their own, parental support before treatment was started was the more effective. (Reason for termination also became a predictive factor of CGAS change but only when all the matching variables had been removed from the analysis. Endings by mutual agreement between child, family and therapist were associated with higher levels of change.)
d) **Disabled group**

This sample contains 32 children with chronic physical disabilities.

1) **Initial factors - matched**

The only matched factors which predicted eventual outcome for the Disabled children were related to diagnosis. *Child diagnosable*, the child’s diagnostic status at assessment - that is, whether he or she was positively diagnosable, did not fulfil diagnostic criteria or provided insufficient information to make a judgement either way - significantly predicted his or her CGAS change by the end of treatment (Table 11.8) as did an overlapping variable - assignment to *Cat5* - which applied to children without a diagnosis but with a CGAS score under 70. This implies that, even though the child did not meet specific diagnostic criteria, her or his overall level of functioning was not high.

When the Prems were taken out of the Disabled analysis, inclusion in *Cat1* (pervasive developmental disorders and/or mental retardation) also became an important factor predicting outcome. A Disabled child from diagnostic categories 5 or 1 tended to make higher-than-average gains in level of functioning. Children for whom insufficient diagnostic information was available did better (Mean CGAS change = 16) than children with positive diagnostic status (change = 10) who, in turn did better than children who fulfilled no criteria at assessment (8.4).

2) **Initial factors - unmatched**

There were initially four unmatched factors that proved good predictors for the Disabled children, plus a number of others that emerged when controlled variables and variables relating to treatment and termination were removed or when the premature terminators were excluded from the analysis.

The four that showed up in the first stage of the analysis when all the relevant variables were available for selection were: the child’s *starting CGAS; referral source;* whether or not the mother had ever (in the past or currently) had a very severe psychological problem (*M v sev prob ever*) and whether both parents of the child were still alive (*Parent dead*). The latter
Table 11.8 CGAS change predictors for all Disabled children (N=32)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Par guidance before t'ment</td>
<td>21.29**</td>
<td>0.67</td>
<td>0.27</td>
</tr>
<tr>
<td>CATS Diagnosis</td>
<td>25.39***</td>
<td>0.53</td>
<td>0.23</td>
</tr>
<tr>
<td>Referral source</td>
<td>-0.75***</td>
<td>-0.23</td>
<td>0.10</td>
</tr>
<tr>
<td>Child diagnosable</td>
<td>-4.83***</td>
<td>-0.26</td>
<td>0.07</td>
</tr>
<tr>
<td>CGAS at start</td>
<td>0.39***</td>
<td>0.34</td>
<td>0.06</td>
</tr>
<tr>
<td>Mother v sev prob ever</td>
<td>-14.39**</td>
<td>-0.22</td>
<td>0.04</td>
</tr>
<tr>
<td>Length of treatment</td>
<td>2.54**</td>
<td>0.39</td>
<td>0.04</td>
</tr>
<tr>
<td>Parent dead</td>
<td>-16.76**</td>
<td>-0.25</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Intercept = -12.80

Multiple $R^2 = 0.92$†
Adjusted $R^2 = 0.80$
Multiple $R = 0.85$

†No assessment of significance can be made because of inadequate adjustment forcing a negative result when N (number of subjects) =<60 and K (number of variables) =>20. In this case, N=32, K=52 (see Cohen and Cohen 1975).

* $p<0.05$
** $p<0.01$
***$p<0.001$
two applied, respectively, only to one child each. The mother’s ‘problem’ was a serious suicide bid but as the child’s termination CGAS was recorded as a missing value and subsequently estimated there was little information to be gleaned from this case. The parental death referred to a deaf child whose mother had died of a heart attack before the child was assessed at the clinic. His father also died during the course of treatment. The child’s condition had deteriorated by termination (after nearly 9 years of therapy) and he was transferred to a specialist hospital unit. These cases are extremely unrepresentative. When either of them were treated as outliers and removed from the analysis both factors relating to parental death and mother’s very severe problem disappeared. Mother’s problems (though not those classified as ‘very severe’) only became significant when all matched, treatment, and termination variables had been removed.

*Referral source* was a stronger predictor of eventual outcome, correlating significantly with CGAS change ($r = 0.37; \text{df} = 30, p < 0.05$, two-tailed). Disabled children referred by their parents, doctors or child guidance clinics did better, on the whole, than children coming to the clinic on the recommendation of schools and ‘other’ referral agencies including social workers and other parents.

The child’s *assessment CGAS* showed a slight positive association with the amount of change recorded during the treatment (that is, the higher the initial rating the greater the change) but this was not a robust relationship and was unable to be maintained when even single cases were removed from the equation. Many of the largest changes were realised by children whose functioning at assessment was at or below the mean for the sample (CGAS = 56) though all deteriorations also occurred only among children with low starting levels.

*Father’s* impact in terms of GAF score and whether or not he had ever suffered from a psychological problem (*F prob ever*) became apparent only when the Prems were excluded. This implied that a reasonably high level of paternal functioning was important for children who completed at least 6
months of treatment but less influential on those who terminated very early. *Parental physical illness* was a variable that became predictively important when all matched factors were removed. One-quarter of fathers and one in three mothers of Disabled children had a physical illness; their children did less well on average than the children of physically well parents.

Children with certain *learning difficulties* such as inadequate peer relations, and problems relating to their handicap (for example, poor speech, ‘backwardness’ or serious underachievement due to inability to cope with mainstream schooling) often failed to match the rating changes of other Disabled children without these particular problems.

3) Treatment and termination variables

*Parental guidance before treatment* predicted a generally good therapeutic outcome. Only 5 families were offered this service but their children recorded CGAS changes of 32, 33, 15, 29 and 10 points respectively (mean = 24). The average for the Disabled group as a whole was 10. Pre-therapy guidance for the Disabled thus had a very high correlation with outcome measures ($r=0.54$, $df = 30$, $p<0.005$, one-tailed).

*Length of treatment* was a significant predictor for the whole group of Disabled children (the longer the treatment, the better the outcome). *Reason for termination* was also indicative of changes in functioning but only for those who had completed at least 6 months of treatment, thus allowing for termination by mutual agreement with the therapist.

e) Somatic Group

This sample contains 32 children with severe psychosomatic illnesses.

1) Initial factors - matched

The only matched variable that predicted therapeutic outcome for the Somatic children was a *Cat2* diagnosis - anxieties, phobias and somatoform disorders, in the main (Table 11.9). The children from this Medical sub-group were particularly prone to anxiety and other neurotic disorders; nearly all of
### Table 11.9 CGAS change predictors for all Somatic children (N=32)

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral source</td>
<td>1.01*</td>
<td>0.29</td>
<td>0.15</td>
</tr>
<tr>
<td>Father's GAF</td>
<td>0.49**</td>
<td>0.44</td>
<td>0.19</td>
</tr>
<tr>
<td>CAT2 Diagnosis</td>
<td>9.25**</td>
<td>0.50</td>
<td>0.10</td>
</tr>
<tr>
<td>Mother prob now</td>
<td>-4.09**</td>
<td>-0.29</td>
<td>0.09</td>
</tr>
<tr>
<td>Child hospitalisation</td>
<td>-4.78**</td>
<td>-0.33</td>
<td>0.08</td>
</tr>
<tr>
<td>Parent ill</td>
<td>-4.71**</td>
<td>-0.24</td>
<td>0.05</td>
</tr>
</tbody>
</table>

**Intercept= -25.21**

- Multiple $R^2 = 0.82^\dagger$
- Adjusted $R^2 = 0.59$
- Multiple $R = 0.81$

\* No assessment of significance can be made because of inadequate adjustment forcing a negative result when N (number of subjects) \(<60\) and K (number of variables) \(\geq20\). In this case, N=32, K=52 (see Cohen and Cohen 1975).

* p<0.05
** p<0.01
*** p<0.001
them (28 out of 32) had such a diagnosis either as the principal or as an additional problem (see Tables 7.15, 9.15 and 9.16). By termination, however, only 25% were still affected, implying that the majority of neurotic conditions had remitted. A Cat2 diagnosis was associated with good outcome.

2) Initial factors - unmatched

There were initially three unmatched factors that negatively predicted outcome for the Somatic group. The child’s experience of hospitalisation tended to have an adverse effect on the benefits of therapy. One in three Somatics had had experience of hospital admission. This was considerably less than members of other Medical subgroups (Table 5.1) but, when it did occur, it appeared to have greater effect.

Secondly, children whose parent(s) were physically ill did not tend to do as well in treatment. This was specially so if it was the mother who was unwell or in cases where both parents were ill. Many parents from this group suffered with similar psychosomatic conditions (asthma and eczema, for example) as those which were affecting the child.

The third factor which adversely affected the child’s progress was the presence of current psychological problems and/or treatments affecting the mother (Mother prob now) although anxiety conditions did not have such a great effect as did depressions, marital disturbance and personality disorders, despite the fact that only a very few mothers (and, thus, children) were affected by any of these.

Two variables which had a greater impact on the Somatic child than those just mentioned were Father’s GAF score and Referral source. Somatic children, both boys and girls, did better in treatment if they had well-functioning fathers. Paternal global functioning ratings were very highly related to CGAS change ($r = 0.52; \text{df} = 30; p < 0.005$, one-tailed). This compares with a correlation of only .29 for the mother’s GAF score.
Referral source was another important predictor of ultimate improvement. Somatic children referred by their parents (N=13) did less well (mean CGAS change = 7.7) than children (N=9) referred by their GP or a hospital doctor (CGAS change = 13.3) or a Child Guidance Unit (N=5) (12.8 points). Some very high change scores were achieved by individual children referred by a nursery school teacher (+20), the Anna Freud Baby Clinic (+35) and an uncle/guardian (+19). Father’s GAF and Referral source persisted in their influence throughout the various stages of the analysis, and were equally relevant to children who finished treatment early and those who persisted for more than 6 months.

3) Treatment and termination variables
There were no treatment or termination variables that predicted outcome for the Somatic group of children.

f) Ill Group
Consisting of only 17 children, the Ill group was really too small to analyse satisfactorily using a stepwise regression technique. The list of variables that emerged as significant numbered 15. Most of these disappeared when the child with the most extreme rating in any particular parameter was removed. In fact the Ill group seemed to consist almost entirely of outliers! Certainly the children in this subsample were much less uniform than the members of the other Medical categories and this seriously affected the statistical analysis.

For example, one teenage girl (generally an inauspicious age for therapeutic success) who stayed in analysis for only 5 months made a CGAS gain of 21 points. And a boy with the least tractable of diagnoses - a pervasive developmental disorder, oppositional defiant disorder and aphasia with epilepsy, increased his CGAS rating by 33 points, despite having low-functioning parents, many hospitalisations, frequent changes of caretaker and being resident in an institutional setting. On the other hand, a girl with a high IQ, a father with a high GAF score, and a single diagnosis of encopresis partially attributable to her chronic illness made no progress at all throughout

363
2 3/4 years of treatment. Individual exceptions like these (and the III sample was rife with them), effectively sabotaged any useful statistical conclusions.

The 4 factors that had the most impact are shown in Table 11.10. The only matched initial factor that in any way predicted outcome was the sex of the child. Boys averaged change scores of 7.7 points; girls managed 9.7. The two groups were very small (10 boys and 7 girls) and, in many respects, were fairly evenly matched. Two girls and two boys failed to change at all. Two girls achieved 35 and 21 point improvements respectively; the top 3 boys recorded improvements of 33, 19 and 17 points. However the only two deteriorations within the III sample were both boys, thus depressing the average.

*Medical history* also provided some predictive indication of outcome, though not in the expected direction. All children had a history of chronic illness, of course, but leaving that aside, 11 of the 17 had no further medical history. These 11 averaged CGAS change of 3.5 points, well below the mean for the total sample. Interestingly, the children who had experienced acute illnesses and those who had had accidents did very much better, with a mean improvement rating of 18.8.

*Learning difficulties* also emerged as a significant predictive factor. Only 3 III children had no problems related to their schooling. The under-achievers tended to do particularly well in therapy; this was especially true of those who presented with a cocktail of other problems in addition!

The most significant factor related to outcome wasn’t a true ‘predictor’ at all as it wasn’t present at the start of treatment. The 5 children whose reason for termination was by mutual agreement with the therapist scored much higher at termination on the CGAS scale than the rest of the sample, averaging 20.8 points.
<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for termination</td>
<td>-4.75*</td>
<td>-0.62</td>
<td>0.34</td>
</tr>
<tr>
<td>Medical history</td>
<td>19.40**</td>
<td>0.78</td>
<td>0.23</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>5.40**</td>
<td>0.45</td>
<td>0.15</td>
</tr>
<tr>
<td>Sex</td>
<td>8.23***</td>
<td>0.33</td>
<td>0.18</td>
</tr>
</tbody>
</table>

Intercept = -4.56

Multiple R² = 1.00
Adjusted R² = 1.00
Multiple R = 1.00

†No assessment of significance can be made because of inadequate adjustment forcing a negative result when N (number of subjects) <=60 and K (number of variables) =>20. In this case, N=17, K=52 (see Cohen and Cohen 1975).

* p<0.05
** p<0.01
***p<0.001

Table 11.10  CGAS change predictors for all ill children (N=17)
11.3.iv Summary of findings

The three initial matched variables that had the most impact on outcome were family status (family broken/intact) and age at start of treatment, both of which affected the Medical-plus-Control group and the combined Index subjects on their own, though without having a significant effect on the individual subsamples, and diagnostic assignment to Cat2 which, in addition to influencing the two main groups also applied to the Somatic children.

The Disabled sample showed the impact of other diagnostic variables as well, including whether or not the child was diagnosable at all and allocation to categories 1 (PDDs or mental retardation) and 5 (no diagnosis, CGAS < 70). The sex of the child influenced the III sample, although numbers were small.

Major unmatched variables included father’s GAF which only failed to influence the small sample of III children, parents’ illness and learning difficulties - important for most of the Medical groups - and mother’s current psychological problem (Mother prob now) that affected the larger samples and the Somatics. Referral source was an important factor for Disabled and Somatic children. There were several other variables that had lesser influence on one or other of the subsamples.

The main treatment and termination variables were those relating to parental guidance and length of treatment which affected at least one of the larger groups and the Disabled children, and reason for termination which was a major influence on most of the Medical samples.

Tables 11.11, 11.12 and 11.13 show the subgroup(s) affected by each of the variables in the three categories. The early finishers (Prems) affected only the Disabled group. They are therefore shown separately, in addition to being included with the total Disabled sample. It should be borne in mind, however, that there were only two of them. The two Somatic premature terminators could not be differentiated from the rest of their group; the III sample, although containing four children who left treatment within six months, was too small to be broken down further in terms of length of treatment.
<table>
<thead>
<tr>
<th>Sample</th>
<th>All (Med + Control) N=162</th>
<th>All No Prem N=129</th>
<th>All Prem N=23</th>
<th>Total Medical N=81</th>
<th>Total Disabled N=32</th>
<th>Total No Prem Disabled N=30</th>
<th>Total Somatic N=32</th>
<th>Total III N=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family broken/intact</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child diagnosable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT1 diag</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT2 diag</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT5 diag</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Table 11.11 Matched initial factors affecting outcome, by sample*
<table>
<thead>
<tr>
<th>Sample</th>
<th>All (Med+ Control) N=192</th>
<th>All No Prem N=129</th>
<th>All Prem N=23</th>
<th>Total Medial N=81</th>
<th>Total Disabled N=32</th>
<th>No Prem Disabled N=30</th>
<th>Total Somatic N=32</th>
<th>Total III N=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral source</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Learn diffs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child hosp</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child's CGAS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child's past diag</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Med Hist</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent ill</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent dead</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Marital probs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>M's hosp</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>M prob now</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>M prob ever</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>M's suicide attempt</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>M's analysis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>F prob ever</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>F's GAF</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 11.12 Unmatched initial factors affecting outcome, by sample
<table>
<thead>
<tr>
<th>Sample</th>
<th>All (Med + Control) N=182</th>
<th>All No Prem N=129</th>
<th>All Prem N=23</th>
<th>Total Medical N=81</th>
<th>Total Disabled N=32</th>
<th>No Prem Disabled N=30</th>
<th>Total Somatic N=32</th>
<th>Total III N=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>Parental guidance before treatment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parental guidance during treatment</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Length treatment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Term reason</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11.13  Treatment and termination variables affecting outcome, by sample
11.4 Discussion

'The most pessimistic prognosis is disproved as regularly as the most optimistic one'
Maud Mannoni (1970)

11.4.i Early terminators

Children who left treatment within 6 months of commencement generally did less well on CGAS measures than those who remained in therapy for longer periods, although there was a great deal of variation and some early finishers did very well indeed. There were no major unifying factors linking children who came out of analysis very precipitately. Reason for termination, of course, covers a wide spectrum. Children left therapy early at their own request, at their parents' wishes, because of external circumstances and because the therapist saw the case as unlikely to make progress. None of these reasons was unique to the premature finishers. Many children who were in analysis for a number of years also finally left on the same grounds. We do not really know why certain families feel unable to remain for long periods of treatment - though it is equally legitimate to ask why other children and their parents are willing to commit themselves to several years of daily analysis with all the disturbance and inconvenience that that entails and with no firm guarantee of substantial improvement at the end.

A number of children did improve immensely in just a few months and perhaps decided that their treatment goals had been fulfilled and therapy could be terminated. This would almost certainly necessitate overriding the wishes of the therapist and the treating institution and requires a decisive and assertive attitude from the family and/or child. It was noted that premature terminators did tend to have high IQs and well-functioning parents.

Others never settled into the intensive routine of analysis at all and left within days or weeks of starting, with the presenting problem untouched. The inherently middle-class ethos of talking about and working through problems makes analysis a culturally-alien process for most people and social
class rating did indeed emerge as a significant predictor of treatment length although it must be said that the nature of psychoanalytic treatment - its intensity, duration and expense - makes premature termination extremely common even among highly selected patients. There are very high rates of deflection among adult analysands (Aronson and Weintraub 1969, Hamburg 1967), one study reporting 52% of patients terminating unilaterally (Bachrach et al 1991). Most of these were assessed as unimproved or worse (op cit).

There are no previous studies of child analysands but child guidance units generally report heavy attrition (Suzuki 1989, Leone et al 1986, Israel et al 1986). The 14% of early leavers among the Medical and Control children in the present study is, therefore, not high. The fact that some of them made considerable gains despite the paucity of treatment is a useful reminder that the ‘non-specific’ factors (Frank 1972) of therapy such as expectation of benefit and the importance of the patient-therapist relationship are active ingredients in the outcome equation. In addition, children are particularly prone to developmental disturbances which clear up spontaneously. In the process of maturation 4 or 5 months can be a long time.

Diagnostic assignment to Cat4 (habit disorders and ‘V’ codes) signified a less favourable outcome for the Prems. Because elimination and feeding patterns have frequently been acquired under stress (Herbert 1974) they are extremely vulnerable to breakdown. Such habit disorders are common and are often resistant to modification (Shepherd et al 1971, Richman et al 1982). Even when successfully treated, relapse under stress is frequent (Yates 1970). These conditions do, of course, usually clear up over time but once they are firmly established they are not easy to shift quickly. Furthermore they are often used by both the child and the parent as a battleground on which parent-child conflicts (one of the most common ‘V’ code diagnoses) are fought out. The complexities, phantasies and regressive aspects of such behaviours are often intricately entangled and require time to sort out. It is not surprising that children and their parents who were
impatient of such delay and who left treatment early before the disturbances had been addressed recorded low levels of CGAS change.

11.4.ii Predictors of CGAS change

11.4.ii a Initial factors - matched

*Family broken or intact*

Previous research has shown that children who are not brought up by two natural parents show more anti-social and neurotic behaviour (Wadsworth et al 1985, Rutter 1972) and are more likely to suffer psychiatric disorder (Rutter et al 1970). This does not necessarily imply that such children will not respond as well to treatment as their peers from intact backgrounds. Nevertheless, this is precisely what we did find in the present study. Children from broken homes generally made fewer gains from psychoanalytic treatment, even if they stayed in therapy for more than 6 months, than did children from intact families.

However, no risk factor occurs on its own, interacting instead with a host of other potential contributors (Quinton et al 1990, Steinberg 1987). Children from broken homes in our sample were in institutions, had alcoholic or violent parents, had been abandoned by mother at birth, had seen their mother murdered by their schizophrenic father, had parents who were dead or in a long-stay psychiatric hospital, had witnessed the whole family killed under the Nazi régime and so on. These are grossly abnormal situations and far more obstructive to the child’s level of functioning than a broken family *per se*.

Even where the breakdown was less dramatic nearly all the children involved lived with a parent who was anxious, depressed or had other psychiatric symptoms; parental personality disorders in broken families were common. It is probable, then, that the lack of response to treatment shown by children from broken homes in our study was not directly attributable to not having both mother and father at home but was a result of a combination of factors such as adverse past experiences and the parents’ depressed functioning.
Family status only became significant when all the Medical subsamples were combined or when both the Target and Control cases were looked at; as individual groups neither the Disabled, Somatic or Ill children showed significant effects from this variable.

**Age**
Younger children tended to make more gains in treatment. This confirms the findings from other investigations that pre-adolescents respond better than teenagers to psychological intervention (Kazdin 1988, Miller et al 1972, Weisz et al 1987). The regressions and transferences of *psychoanalysis*, in particular, which put the patient in touch with earlier patterns of behaviour, are specially hard for older children to deal with (A. Freud 1966) at that time in their life where they are rejecting the restrictions of childhood for a new independence from parental figures. Many practitioners, including Anna Freud, have felt that psychoanalysis, with its inherent intensity and introspection, is counter-indicated as the treatment of choice for most adolescents (A. Freud 1965).

In addition, the chronically ill and handicapped face their own unique problems as they enter the teenage years. Davis (1972) has pointed out that physical impairment only becomes *socially* significant when the child attempts to assimilate it into an adolescent body-image. The difficulties that the tasks of maturation demand of the ill child help to explain the finding that the older the child at start of treatment the less likely are significant positive changes in her or his level of functioning although, like the previous factor discussed, the age of the child at start of treatment was only significant for the larger groups and not for the separate Medical subsamples.

The impact of age on outcome was particularly noticeable in shorter treatments when the patient terminated early. This suggests that very young children may sometimes make quite rapid improvements, perhaps as the result of maturation. A number of studies have observed that, although the young child typically has higher rates of incidence for most symptoms than his older sibling (Shakespeare 1975, King et al 1990, Rutter et al 1970,
Rutter 1975) most of these anxieties, habit disorders and other behavioural
disturbances do disappear spontaneously within two or three years
(Shakespeare 1975).

Sex
It is generally recognised that girls tend to do better in treatment than boys
(Kazdin 1988, Kolvin et al 1981, Weisz et al 1987a) and our total Medical
sample supported this by finding a negative correlation between sex and
CGAS change of \( r = -0.1, \text{ df } = 79 \). Although not statistically significant this
did indicate greater improvement among the girls than among the boys.
When the controls were added the correlation decreased to \(-0.05\) but was
still in the expected direction. Sex emerged as a significant predictor only
among the small III sample.

Child’s Diagnostic Status and Category
The Disabled group of children differentiated themselves from the other
Medical subsamples and from the main Control groups by the relationship to
outcome of their original diagnostic status and by the types of diagnosis that
proved predictive of termination ratings. All other groups (apart from the III
sample which contained too many unrepresentative cases to be reliably
evaluated) found neurotic and somatic conditions to be important predictors
of CGAS change. Only for the Disabled children were other diagnostic
categories significant.

This group was also the only one to show the influence of the diagnostic
rating (‘Diagnosable’, ‘Criteria Not Fulfilled’ or ‘Insufficient Information’) to
which the child had been assigned at his or her original assessment. Counter-
intuitively, the children who fulfilled no clinical criteria did less well than
those with a positive diagnosis. This should be seen in conjunction with the
parallel finding that children without a diagnosis (criteria not fulfilled) but
with a CGAS under 70 did well in treatment. These children are not regarded
as functioning optimally although it is difficult to specify particular problems.
They are not ‘ill’ as such but may be unhappy and low-achieving. As these
Cat5 ratings were not made for any III child and for only 2 Somatic children,
the possibility exists that restrictions inevitable in the life of the young blind or deaf child might have artificially lowered CGAS rating scores even though every effort was made to avoid this source of bias. It is known that ego development for the blind, and probably for other major handicaps, deviates from ‘normal’ rates (Burlingham 1965) and it is difficult to avoid making comparisons to his detriment between the handicapped child and his physically-able age-mates.

On the other hand, severe physical disabilities do lead to a lowering of self-esteem (Harvey and Greenway 1984) and other difficulties such as the failure to adequately internalise appropriate sex roles (Thomas 1978). The daily sessions and long time-scale of psychoanalysis might be expected, more than any other psychological treatment, to offer children who have no specific psychiatric profile but whose development is adversely skewed, the time and environment in which to make sense of their frustration and unhappiness and begin to assimilate the problematic aspects of their life.

This could explain why non-diagnosable children with low CGAS scores did well in therapy but it still leaves unanswered the conundrum of why other children, also with no diagnostic profile and with the additional advantage of higher CGAS scores, improved less than children with a diagnostic status or for whom information was unavailable. The answer may lie in a combination of small numbers and ceiling effects. The small numbers refer to the ‘insufficient information’ children, of whom there were only 4, one of whose termination CGAS was unknown. Of the remaining 3, one outlier who notched up a 28 point improvement severely skewed the mean.

The ceiling effects relate to the high CGAS scorers, two of whom started at 80 and thus had very little room for manoeuvre. One did manage an ‘average’ improvement of 10 points which lifted him near the top of the scale; the other was recorded as showing zero change - a misleading rating as a termination score of 80 is still extremely high. Low initial ratings allow for considerable activity; movement from a depressed baseline is, therefore, less significant than improvement higher up the scale (Wallerstein 1989).
Conversely, lack of movement in the very high ranges does not indicate an *impasse* in the same way as it would for much lower scores.

The other diagnostic category which applied only to the Disabled group was Cat1, pervasive developmental disorders and mental retardation. Children in this category had a very good prognosis. This is unexpected as PDDs, by definition, refer only to gross developmental difficulties which, generally, do not improve very much with time. Autism and childhood schizophrenia are examples of conditions which fall into this category. There are several remarks to make about this apparent anomaly. Firstly, there were only four Disabled children who came into this diagnostic category so numbers were, as usual, small. This was still significantly higher, however, than among the Somatic or larger groupings and this may provide a clue to the mystery of why these children did much better than expected.

It is possible that at least some of them were misdiagnosed, that their severe physical condition was wrongly attributed to permanent organic or developmental deviance. A three-year-old child with orthopaedic deformity, for example, lost his diagnosis of PDD and improved his CGAS score by 33 points (from 50 to 83) after two years of treatment. It seems more likely that his extreme youth and physical disability led to an unreliable diagnosis at assessment than that extreme pervasive dysfunction was eliminated through treatment. As far back as 1959 Hollinshead reported that an apparent surplus of emotional difficulties in handicapped, compared to able-bodied, children was *not* due to increased maladjustment in the former group but to the nature of their physical difficulties. Considerable psychoanalytic research among blind babies and young children, in particular, has also underscored the point that developmental lags and unevenness in maturation are *normal* in these circumstances and should be expected (Wills 1979, Nagera & Colonna 1965). Autoerotic activities such as rocking behaviours, for example, are merely the attempt of the sensory-deprived child to increase the stimulation that other children receive effortlessly (Burlingham 1979).
Secondly, mental retardation should probably not have been combined with PDD. A blind child with an IQ of 66, and therefore inevitably classifiable as suffering from mild mental retardation, retained this diagnosis but improved her CGAS score by 30 points as her many other diagnoses succumbed to therapy. Taking into account her limited ability, she was functioning at a very high level by the end of treatment. (It is comforting to note that it is not just the Anna Freud researchers who may have been guilty of the occasional misclassification; this particular child was referred to the clinic by the Royal National Institute for the Blind who had designated her as 'ineducable').

These two children showed very high change scores and made assignment to this category seem particularly auspicious. Another child, who really was pervasively disordered, did not improve at all; a fourth had a CGAS change of 10 points (the mean for the Disabled group) but still only reached 40 points, which is very low and well below ‘normal’ functioning.

Favourable prognosis for the Somatic, total Medical and total Medical-plus-Control groups was associated with placement in Cat2 which contained mainly anxiety, somatoform and adjustment disorders. Neurotic and somatic complaints are generally recognised as being more responsive than conduct disorders and social problems to psychological intervention (Kolvin et al 1981, Kazdin 1988) and our results confirmed this finding. The claims of psychoanalysis to be more effective for the neuroses than for other psychiatric conditions (Bachrach et al 1991) seem justifiable. A high initial level of anxiety in adult psychoanalytic patients is strongly related to eventual global improvement (Bachrach et al 1991, Kernberg 1976). When dealing with children, however, it should be remembered that fears, phobias and anxieties are so widespread as to be practically inevitable (Herbert 1974, Lapouse and Monk 1958) and that maturational effects are largely responsible for the remission of much emotional distress (Kazdin 1988).

Having said that, the incidence of anxiety for the Somatic children was more than twice the rate among Non-Medical children suggesting the presence of repressed or suppressed emotion which was partly responsible for their
psychogenic illnesses (Bastiaans 1977). These children did well in treatment, perhaps because of the opportunity afforded them to express previously defended-against hostilities and aggressions. A number of psychoanalytic clinicians have also recorded this alleviation of somatic symptoms as soon as patients begin to respond to the psychoanalytic context (Bastiaans 1977, Knapp 1977, French and Alexander 1941). And, spontaneous remission notwithstanding, the treatment of the anxieties that feed psychosomatic conditions before the latter are allowed to become permanent structures of adult life (Gaddini 1977) has to be worthwhile.

11.4.iii Initial factors - unmatched

Referral Source

The Disabled and Somatic children showed outcome scores which were partially dependent on the original source of referral. For the Disabled group, referring parents predicted a favourable outcome but this was not so for the Somatics and the number of parents referring Disabled children was actually quite small (16% - considerably less than all other samples). For both Somatics and the Disabled, GPs, hospital doctors and Child Guidance Units made appropriate referrals who generally benefited from the treatment offered. Schools were not so successful in identifying children who needed, and could make use of, psychoanalytic treatment. Nor, in the case of the Disabled children, were ‘other’ agencies with which they were involved, such as the RNIB and social workers. Medical and psychological units obviously have a great deal of expertise in assessing disturbed children and it is not surprising that their recommendations are generally helpful. The other referral sources may suffer from lack of experience and, in the case of Somatic parents in particular, from excess anxiety which hinders the ability to make a clear judgement. It is notable from the tables of psychiatric symptoms (9.25, 9.26, 9.27 and 9.28) that mothers of Somatic children have a higher tendency to anxiety than other mothers. This may be counter-productive when it comes to deciding what sort of treatment, if any, the child needs.

Learning difficulties

School-age children are very likely to have at least one difficulty related to
school (Rutter 1975, Rutter 1974), regardless of whether or not they are otherwise regarded as emotionally or behaviourally disturbed. Well over half the children in our sample were noted as having some educational difficulty, this percentage rising to 74% among the Medical children. For those children who terminated within the first 6 months, both Targets and Controls, the presence of learning difficulties made improvement less likely.

School is a major component of a child’s life, comprising his or her social life and work environment, the place where he or she succeeds or fails, develops self-esteem or feels inadequate and helpless. At school the child discovers whether or not she can make friends and is liked by others; whether or not he can learn to concentrate and pay attention; whether or not they can read and write easily (major social handicaps for those who struggle with these skills). The additional problems of the physically disordered child may necessitate frequent absences from school, difficulty in keeping up with the teaching, problems in forming friendships. School is, in short, a complete microcosm of life. Dealing with the problems associated with it is an important prerequisite for improved functioning.

Children who left treatment within 6 months made fewer gains if they still had learning difficulties. In fact, the very concept of global assessment is highly dependent on a child’s performance socially, academically and behaviourally in his own world - that is, at school. For children who had not managed to address their school-related problems CGAS scores were, almost inevitably, lower than they otherwise might have been.

The Medical children in general showed a predictive effect on outcome of learning difficulties. For the group as a whole the miscellaneous ‘other’ category was a particularly aversive influence. This was used to note such problems as repeated absences due to the illness or disability (a common occurrence for children with chronic physical conditions - Shakespeare 1975), lack of concentration, attendance at ‘special’ schools and so on. These are mostly external events which it is difficult to address in treatment. Therapy is unlikely to be able to modify rates of hospitalisation (and, thus,
absence from school) or the need to attend a school for the blind or deaf or mentally impaired. In these cases children often made little progress.

In contrast, children from the total sample of Target children - and the Ill group in particular - did well if they came into treatment specifically as ‘underachievers’. This goes against the findings of previous research which has linked underachievement to conduct disorders and antisocial behaviour and seen it as a marker of a poor outcome for the child (Rutter 1974, Bachman et al 1978). Our Ill children seemed to do better if they were not only underachieving but also displaying other problems such as poor social interactions and disruptive behaviour but this should probably be put down to a small and unusual sample!

The good prognosis of inadequate school achievement for the Medical children in toto cannot be dismissed so easily. Serious underachievement affected more than one in three Target children, with or without other problems, and most of them did very well in treatment. It is more common among the Medical group than among their Controls and seems, therefore, to be linked to the child’s physical condition and to be something that can be effectively tackled, and remedied, in psychoanalytic therapy. Although, in the general population, underachievement is linked with externalising behaviours, which are often resistant to treatment, recent research has shown that, for chronically ill children, behavioural problems are more liable to be internalised than expressed overtly (Thompson et al 1990). This suggests that underachievement in these cases is a consequence of lowered self-esteem and feelings of damage that, preoccupying the child, lead to loss of concentration in class (Garner 1981). Determinants of this kind can be suitably addressed in treatment, leading to a better than normal response in ‘Medical’ underachievers.

For the separate group of Disabled children, poor peer relations at school (predictive of general maladjustment - Rutter et al 1970) and problems secondary to the physical handicap both emerged as indicators of a disappointing outcome. These often occurred in parallel, suggesting an
overlap. Loss of sight or hearing adds considerable difficulty to social interaction (Thomas 1978, Nagera and Colonna 1965, Burlingham 1965). Deafness and blindness are not always well tolerated by the general public (Davis 1972, Lindemann 1981, Abrams and Kodera 1979) and the problems are legion for children with partial visual, motor or auditory deficits trying to cope in mainstream schooling. The totally handicapped tend to fare better than those who can ‘pass as normal’ in certain circumstances (Shakespeare 1975) though, as we have already observed, attendance at a ‘special’ school is also associated with difficulties for the child. Socially, he or she is excluded to a considerable extent from the larger world of the physically well; emotionally, depression can result from being surrounded by peers with permanent and life-restricting disabilities (Minde et al 1972).

Child’s Assessment CGAS
The Disabled children showed a slight positive influence on outcome of the child’s global rating assessment at start of treatment. Higher initial scores tended to improve more than lower starting assessments but this was rather a weak effect. It is more interesting to note that, for all other groups and subsamples, the child’s level of functioning at the beginning was not related at all to how well or badly he or she did in treatment. Even children with quite low functioning could, and often did, improve immensely throughout their treatment.

The statistical phenomenon of regression towards the mean would anticipate that children with lower starting scores would improve more (thus moving towards the mean of their sample) than would children with initial scores elevated well above the mean. However, the relationship between initial and termination ratings that we have here is apparently random, suggesting that this may be at least partly due to the characteristically dynamic and fluctuating nature of childhood functioning. Children can show very rapid deteriorations and improvements over relatively short periods of time. Behavioural and emotional disturbances can manifest with alarming rapidity and severity without necessarily running the risk of being consolidated into a more permanent character trait. Level of functioning sampled at one point of
time only (assessment or start of treatment, for instance) may indicate a nadir from which the child is about to emerge, with or without treatment. Absolute global functioning scores are, thus, generally less useful as an indicator of potential change than knowledge about the chronicity of the presenting symptoms; unfortunately, the latter information was not often available.

Child’s Hospitalisations and Medical History

Somatic children who had experienced at least one hospital admission tended to do less well in treatment.

Hospitalisation in childhood is one of the commonest causes of parent-child separation (Wolkind and Rutter 1985) and separations are, indeed, potentially damaging for a child (Rutter 1975). However, hospitalisation for the Disabled and Ill children, which had happened much more frequently than for the Somatics, appeared to have no effect on the child’s change score after therapy.

Other research has indicated that separations of less than one month carry little risk (Rutter 1971) although longer stays may lead to increased disturbance (Shepherd et al 1971). Length of stay was not always recorded on the child’s file but short stays were common and it is unlikely that a protracted hospitalisation would have gone unmentioned. The most likely reason for adverse reactions relates to the age and sex of the child involved. It is known that the worst effects of separation through hospitalisation are felt between 7 months and 4 years (Rutter 1975) and that boys generally fare worse (Herbert 1974). It was indeed the Somatic boys who were most affected and most of these had been in hospital, often undergoing routine operations or treatment for their psychosomatic complaint, between the ages of 2 and 4, although it was not always possible to determine age from the retrospective evidence on file. The Ill and Disabled children had often had their first hospital stay earlier, as babies, usually in response to their physical condition, and repeated hospitalisations thereafter appeared to affect them less.
Hospitalisation for treatment of a chronic condition carries no more threat of disturbance than treatment for an acute complaint (Shepherd et al 1971). A successful negotiation of, say, an operation, can be a constructive experience for a child (Jessner et al 1952). This appears to be borne out by the Ill children in our study. Those who had had acute illnesses or accidents did very much better in treatment than the others in the sample. We know that the sample is small and skewed but all four children who had suffered accidents severe enough to make hospitalisation necessary subsequently made large gains in treatment, recording CGAS changes of 33, 35, 17 and 8 points. The latter indicated a gain for an autistic boy from 30 to 38 points, which represents a certain degree of success from such a poor baseline.

It is impossible to tell whether the Ill child’s medical history is really a significant positive factor in determining subsequent levels of functioning. All children had had substantial treatments of various kinds and perhaps those who made progress did so in spite of all the medicalisation of their lives. But perhaps success in coping with, and overcoming, temporary acute and accidental conditions gives the child with diabetes, epilepsy or other chronic illnesses some sense of control over his or her otherwise unpredictable medical condition.

An alternative, psychoanalytical, explanation is proposed by Jessner et al who found that a mother’s ambivalent or negative attitude towards her child sometimes changed for the better when the child underwent hospital treatment. Jessner concluded that ‘unconscious wishes to punish the child were fulfilled and the child responded positively’ (Jessner et al 1952).

**Parental physical illness**

Many more Medical children than their physically-well peers had ill parents. Mothers were twice as likely to have a physical illness; for fathers the difference was not as marked but was still present. The total Medical group and the Somatic children were particularly affected; for the Disabled, parental illness only emerged as a predictive variable after matched variables had been removed. The Ill children had lower rates of parental illness and their
therapeutic outcome was not affected by this parameter. For the others, the presence of parental illness, especially if suffered by the mother or by both parents, was negatively associated with change scores.

Physical illness alone is likely to make the task of parenting more onerous. The sufferer may have chronic pain and fatigue and/or considerable restriction of movement. The parents in our sample had conditions such as heart disease, arthritis, thyroid problems, motor disorders and blindness. In addition to the physical problems there are psychological correlates of illness, such as anxiety and depression (Wallerstein 1986) and increased stress (Graham 1985), which, again make it more difficult to adequately fulfil parental duties (Bond and McMahon 1984, Forehand et al 1986). The potential adverse effects of parental psychopathology on children are well-documented (eg Herbert 1974, Bond and McMahon 1984). Mothers (and fathers to a lesser extent) who are themselves unwell and anxious and who have the care of chronically-disordered children will find it difficult to supply the kind of environment in which the child might function to full capacity.

In addition, Somatic children often shared psychosomatic symptoms with their parents - a common finding (Minuchin et al 1975). In families where this was the case (and, indeed, even where it was not) the illness(es) of both parents and child may play a functional rôle within the family which cannot easily be given up (op cit). The child may not be ‘allowed’ to develop to his or her full potential and, thus, CGAS change may remain artificially depressed. This ties in with one psychoanalytic view of bodily symptoms as early forms of mother-child communication (Gaddini 1977, McDougall 1974). The unconscious message that the child must remain dysfunctional in some way in order to retain the interest and care of the parent may be emphatically reinforced by illness seen in parental rôle-models.

**Marital problems**

Serious marital problems were fairly common, affecting one family in five although only in the total Medical group was this related to a poorer final outcome for the child. Bond and McMahon (1984) have shown an
association between maritally-distressed mothers and behaviourally-disturbed children, especially boys, but this does not help to explain why the Medical children should be apparently more vulnerable than children without chronic physical disorders. There was no significant difference in terms of the sex of their offspring between the numbers of parents with marital problems in the Control and Target groups, which makes it impossible to argue that the difference in effect lay with a predominance of boys in the Medical sample. It was certainly true that twice as many Medical boys (N = 11) had parents with marital problems than girls (N = 5) but this was only very slightly more than expected given the 63:37 gender breakdown in the Medical referral population and the girls in our sample actually did much less well in terms of CGAS change than their male peers (mean change 1.4 compared with the boys’ 8 or, when one outlier who scored 33 change points was removed, 5.5).

One possible explanation for the severe effects of the state of the marriage on the child’s well-being is the association with father’s psychological functioning. For some reason there is a much less significant relationship between marital problems and father’s own psychological problems and level of functioning for the fathers of matched Control children than for the Target sample or for the total Non-Medical sample (N = 688) as can be seen from Table 11.14. We know that Father’s GAF is a very potent predictor of outcome for the child. Fathers whose psychological stability remains relatively independent of the state of their marriage (eg the matched Control fathers) can probably help their child contend with the vicissitudes of his or her environment, including tensions between the parents. For most fathers, though, problems in the marriage are strongly associated with poorer overall functioning (direction of causality debatable), making it unlikely that they would be able to protect the child from the stresses and strains of the home situation. It is not known why the Control fathers were different in this respect from other fathers in the sample.

Father’s GAF Rating
Father’s overall level of functioning emerged as a significant predictor of
<table>
<thead>
<tr>
<th>Variable</th>
<th>Medical Target (df 79) 2-tailed</th>
<th>Medical Control (df 79) 2-tailed</th>
<th>Non-Medical (df 686) 2-tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father's GAF score</td>
<td>-0.49***</td>
<td>-0.24*</td>
<td>-0.23 ***</td>
</tr>
<tr>
<td>Father Problem Ever</td>
<td>0.40***</td>
<td>0.19 ns</td>
<td>0.27 ***</td>
</tr>
<tr>
<td>Father Severe Prob Ever</td>
<td>0.40***</td>
<td>0.06 ns</td>
<td>0.23 ***</td>
</tr>
</tbody>
</table>

* p<0.05  
** p<0.01  
***p<0.001

Table 11.14 Correlation of marital problems with other variables for a number of samples

<table>
<thead>
<tr>
<th>Variable</th>
<th>Corr. with Father's GAF (df 160)</th>
<th>Corr. with Mother's GAF (df 160)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat2</td>
<td>-0.19*</td>
<td>0.05 n.s</td>
</tr>
<tr>
<td>Disruptive behaviour at school</td>
<td>-0.19*</td>
<td>-0.07 n.s</td>
</tr>
<tr>
<td>CGAS at start</td>
<td>0.25**</td>
<td>0.17*</td>
</tr>
<tr>
<td>CGAS at finish</td>
<td>0.32***</td>
<td>0.20*</td>
</tr>
<tr>
<td>Termination reason</td>
<td>-0.17*</td>
<td>0.09 n.s</td>
</tr>
<tr>
<td>Marital problems</td>
<td>-0.35***</td>
<td>-0.20*</td>
</tr>
</tbody>
</table>

* p<0.05  
** p<0.01  
***p<0.001

Table 11.15 Correlation of Father's GAF with selected child variables and comparison with Mother's GAF correlation
outcome for nearly all the samples looked at (the Ill children and the 2
Disabled Prems were the only exceptions). Despite previous research which
has found fathers to become important to their child’s development only in
the later years of childhood (Thomas 1978), our study found no interaction
between the predictive nature of father’s GAF and the age of the child. Good
paternal functioning was equally beneficial for children of all ages. Children
who had high GAF fathers were more likely to end therapy satisfactorily, by
mutual agreement with their therapist, to have a relatively high CGAS both at
assessment and at the end of treatment. Their diagnoses tended to be the
phobias, anxiety conditions and somatoform disorders which fitted into
Cat2, the category which was associated with the best outcome of all
diagnostic groups and they were less likely to be disruptive at school. A high
GAF score for father is more closely associated with lack of marital problems
than is an equivalent level of functioning for the mother.

Table 11.15 shows the correlations for all these variables and compares
them with the associations with mother’s GAF which did not emerge as a
significant predictor of outcome.

The recorded religion variable showed no relationship with Father’s GAF and
CGAS change, thus failing to support the possibility that the viricentric
nature of much religious commitment, or the close family structures
associated with, for example, Judaism, might have contributed to the
importance for the child of level of paternal functioning.

Mother’s and Father’s Psychological Problems and Treatments
In line with previous research associating psychiatric disturbance in children
with emotional problems in their parents (Rutter et al 1970) we also found
that parental psychological problems tended to have negative consequences
for the children. The Ill group was too small and diverse to register any
uniform influence from the parents’ emotional status but all other samples
showed a clear effect. The most potent impact was made by mother’s
current psychological problems (Mother problem now) which affected the
total Medical-plus-Control group, the total Medical group and the Somatic
The Disabled children showed a clear relationship to parental problems in either mother or father (the only subsample to register influence from paternal symptoms) occurring either currently or in the past (Mother problem ever and Father problem ever). It is not entirely clear why this should have been the case only for the Disabled children except that fewer of their mothers registered symptoms than was true for the other groups (Table 9.23) and the percentage of either parent showing any current problems was probably too low to have a significant impact (Table 10.20) without the added impetus of past pathology, but it does offer some support to other researchers who have suggested that parental psychiatric illness, even when no longer current, may continue to exert an adverse effect on children (Cohen et al 1990).

Rutter and Quinton (1984) contend that parental psychopathology is of little consequence unless it co-exists with what they call ‘family discord and disruption’. A subsequent investigation by Shepherd et al (1971) supported this thesis by demonstrating that ‘family stress’ has a marked association with a functional lack of improvement in the child at follow-up. Our sample groups also showed significant correlation between the presence of parental symptoms and serious marital difficulties and/or breakdown of the marriage, which would seem to indicate a measure of ‘family discord and disruption’.

It could be that it was this that affected the child rather than the mere presence of just any old parental symptom although there were other symptomatologies and treatments which also were closely related to the presence of parental problems. Mother’s anxiety and mother’s out-patient psychiatric referral, for example, correlated very strongly with current and/or past problems in either parent. Highly anxious mothers were generally unhelpful for the child.\(^{57}\) We also noticed a tendency for both parents of a child to manifest symptoms in tandem, a phenomenon also observed by

\(^{57}\) Not all parents showing ‘symptoms’ in the present investigation were clinical psychiatric cases but most of the problems were severe enough to interrupt and distort the parenting function in some way.
Rutter and Quinton (1984), who explain this as a form of ‘contagion’ and point out that this leads to increased likelihood of family disruption.

Many of the effects of parental symptomatology on the child have been found to be indirect (Rutter and Quinton 1984, Cohen et al 1990, Quinton et al 1990, Herbert 1974). From the present data it does indeed seem likely that the more oblique effects of parental psychiatric illness are the more powerful influences, affecting, *inter alia*, the marriage and the child’s ability to function well at school (recorded as Learning Difficulties), both of which influence the progress the child is able to make through therapy. On the whole this is mediated through the presence of maternal problems but, as we have seen, father’s GAF score is also a highly significant factor. Parental GAF scores and the presence of psychological problems are very highly correlated. Other work has shown childhood problems to be associated more with psychiatric illness in the mother than in the father (Shepherd et al 1971) although the sequelae of paternal pathology (such as increased hostility towards the child) has important effects, especially on sons (Rutter and Quinton 1984).

Although the symptomatology recorded under our categories of ‘Problem Now’ and ‘Problem Ever’ did not always indicate psychiatric caseness, our data offer some support to the research just cited in that the mother’s impact is particularly directed through *specific* symptomatology in contrast to father whose *general* functioning has the greater influence. It may be that mothers’ problems are often a reactive response to the child and, as such, manifest more in specific symptomatology than in overall functioning. GAF scores may be the more robust, indicating intrinsic ability to cope with life while problems and symptoms may be more sensitive to current events, in the same way as Verbal and Performance components of the IQ test vary in their reliability though not, necessarily, in validity. A possible relationship and directions of influence between the GAF scores and symptomatology of both parents and the way this impedes or facilitates the child’s development is diagrammatically illustrated below.
For the total Medical-plus-Control groups, suicide attempts made by mother, and mother's psychoanalytic treatment also showed themselves to be influential on the child's final outcome. Only 6 children (4%) had had mothers who had tried to kill themselves; not surprisingly, this was not a positive advantage for the child. On the whole, having a mother who had had, or was currently having, psychoanalytic treatment for herself, was of benefit to the child, presumably because such mothers were emotionally oriented towards intensive treatments and had already acknowledged the value of analytic therapy. They would also have been more understanding of the negative phases of the child's treatment and less likely to remove him or her from treatment when the going got tough. In the early days of her own child psychoanalytic practice, Anna Freud (1974), in an attempt to preclude any 'playing-off between analysis and the home, premature terminations etc', restricted child analysis to those whose parents had themselves been
analysed. Although this was criticised by other child analysts and proved too restrictive to be easily implemented into general clinical practice, our results indicate that she may have had good reasons for such a stringent point of view.

Mother’s hospitalisation

Table 11.6 shows a higher mean CGAS change over all groups for children whose mothers have been hospitalised. This is counter-intuitive, going against the vast literature that predicts dire consequences for children who undergo mother-child separations (Rutter 1971, Rutter 1975, Shepherd et al 1971, Herbert 1974) and may, of course, simply be a type 1 error, not always easy to avoid with such small samples. It was also not possible to determine in every case the length of the mother’s stay and the reason for it. Rutter (1975) has pointed out that short separations carry very little risk for the child - though he didn’t go so far as to say they could be positively beneficial! - and many of the mothers’ hospitalisations were probably relatively untraumatic. However, some of the stays lasted at least several weeks. One mother spent 13 weeks in a TB unit when the child was about 18 months old; there were also psychiatric admissions and a mastectomy as well as an operation for detached retinas and hospitalisations for childbirth and miscarriages. Bearing in mind that the anamnestic details collected at assessment were not primarily dealing with the mother, it is reasonable to suppose that hospitalisations mentioned would have tended to be significant episodes for mother and/or child. Very short, routine admissions would have been more likely to have been omitted from the history-taking. In other words, the hospitalisations that have been recorded are probably not entirely insignificant. This makes it even more remarkable that children whose mothers had been in hospital on at least one occasion tended to make larger CGAS changes.

56Maud Mannoni (1970) claimed that this simply demonstrated Anna Freud’s own need to be understood by those parents whose child she was (mis)appropriating through treatment.
For some of the children, of course, hospitals would have been fairly familiar places which may possibly have attenuated the separation difficulties to an extent. Nevertheless, Table 11.6 shows that Control children whose mothers had been hospitalised were also able to benefit considerably from their analysis. Perhaps separation from mother lead to symptomatology of a kind which is particularly effectively treated by psychoanalysis? The relevant children in our sample did not bear out this possible explanation. Their symptoms and diagnoses ranged across the board, from neuroses to psychoses, from developmental problems to conduct difficulties. They could not be differentiated in this respect from the children with unhospitalised mothers. We are more inclined to suppose that a mother’s admission to hospital provided the child with a developmental challenge which, if confronted and coped with successfully, allowed for ego growth and an increased capacity to deal with other vicissitudes of life.

This is, admittedly, mere speculation but we do know that the successful undergoing of an operation can be a positive experience for a child (Jessner et al 1952). It is entirely possible that the anticipation of separation, for most children, feeds heavily on phantasies of rejection, deprivation and so on. When the reality comes to pass it is found to be easier to cope with and, as with the child’s own hospitalisations and operations, offers the opportunity for increased self-confidence if it has been negotiated adequately. Jessner’s comments, cited above, that child hospitalisations may fulfil unconscious parental wishes of harm towards the child (Jessner et al 1952) may also operate in reverse. That is, the child’s death wishes towards his mother (and the consequent guilt and anxiety that these occasion) may find partial fulfilment (and relief) when the mother is sacrificially offered up to a dangerous situation and returns unharmed.

We also know that some chronic conditions, such as asthma, are alleviated when the parents are away from the house (Steiner et al 1982, Purcell and Weiss 1970) which suggests that the parents’ constant presence may be a mixed blessing for many children and that they might benefit from the
occasional temporary separation - provided, of course, that adequate substitute caretaking is provided (Rutter 1975).

11.4.iii c Treatment and termination variables

Parental guidance

Parental guidance before treatment is offered to a small percentage of families as an additional component of the very detailed assessment process before the actual treatment gets under way. The child may be observed and the parents advised and counselled in their dealings with him or her. This ‘dressage’ phase of analysis in which the child is motivated to enter into a therapeutic relationship (Smirnoff 1971) was recommended by Anna Freud in her early writings but, by the time the Hampstead Clinic began its work in 1950, expediency had severely reduced the number of families offered this pre-treatment resource. In fact, from the total sample of 769 children only 54 (7%) of families were given this extra help.

The Non-Medical children whose parents received pre-treatment guidance did not make significantly more progress than their peers (mean CGAS change = 12 points) but the Medical children whose parents had been supported in this way recorded substantial positive changes in functioning between the start and end of treatment. Unfortunately there were very few of them, only 7 in all. One III child showed an improvement of 17 points and a Somatic child was given a 23 point improvement. The other 5 were Disabled children who showed a mean change of 24 points (range 10 to 33).

We have seen that parents, especially mothers, of Disabled children are generally less anxious and with fewer psychiatric problems than other clinic mothers (chapter 9) and we speculated that this might be due to the possibility of attributing the emotional and behavioural difficulties of their children to the frustrations and restraints of the handicap rather than to the familiar theories of disturbed parent-child interactions. This would free the mother from the guilt, resentment and anxiety which so many clinic mothers experience (Rutter 1975, Shepherd et al 1971) and may make them more open to receiving advice and help on handling the child. It is felt as no great
Shame to need extra help in learning how to parent a blind or deaf child whereas, for some inexplicable reason, mothers are expected to know ‘naturally’ how to cope with able-bodied children. Mothers of Disabled children, then, may have less need to feel defensive about receiving guidance. Perhaps it is this more relaxed attitude, or the relief at sharing the parenting burden with professionals, that, in turn, frees the child from the anxieties of the parents and enables him or her to use the therapy to great advantage.

The apparently good effects of early parental guidance for the families of medical children must also, however, take into account the problem of generalising from an unrepresentative sample to the whole population. These families may have been highly selected. Indeed, all the children involved were very young (and, as we have already seen, age can be an important determinant of outcome). The oldest of the Disabled children whose parents received pre-treatment guidance was only 6½. Some of them were already members of the Anna Freud nursery school and were referred by staff who would have had a fairly good idea of the indications and counter-signs for psychoanalytic treatment. Such children, despite their medical condition, may have been perceived not only as needing help but also as remediable, and treatment would have been suggested by the clinic on that basis.

Having said that, it should not be supposed that these children did not really need therapy in the first place. Independent assessors, for the purpose of the present investigation, rated the majority of them as very definitely diagnosable with pervasive or other disruptive conditions and as having made substantial improvement by the end of their analysis.

By explaining the idiosyncrasies of psychoanalytic treatment to parents whose assumptions may be at odds with the reality, and by giving reasons

---

59 Although one little girl with a pervasive developmental disorder and a very low level of functioning had, later, to be transferred to more specialist treatment. She managed a CGAS gain of 10 points, the lowest change score in the parentally-guided group but compatible with the average for the whole sample.
for the duration and intensity of therapy and making clear the basic postulates and principles on which it is based, guidance prior to the start of treatment may give parents a clearer understanding of the importance of regular and punctual attendance and of the priority which the therapist expects to be accorded to the child’s sessions. This may help in pre-empting disappointment and unreal expectations and in maintaining the child in treatment.

Parental guidance during treatment has similar aims of ‘holding’ parents, thus enabling them in turn to ‘hold’ the child to better enable him or her to successfully complete the course of treatment. Forty-four per cent of the total Medical-plus-Control sample were offered this resource during the course of therapy. The 72 members of the group who received parental guidance during treatment achieved a mean CGAS change of 11.8 compared to the average change rating of 8.2 realised by the 90 for whom guidance was not offered.

The possibility of a conscious or unconscious selecting of families of patients who are going to do well in any case, thus constituting a self-fulfilling prophecy, does not arise as it may possibly do with families who were offered guidance before treatment began. The age of the child was the only variable that distinguished families receiving help in the course of their child’s analysis from those who did not. And this is probably only because older children would have been treated, as far as was possible, as independent of their parents, in the true tradition of psychoanalysis which does not usually solicit interviews from families and friends of the patient. However, younger children do do better in therapy and this may have contributed to the better results of those whose parents were seen throughout the treatment process.

Despite this lack of direct correlation with specific factors, it seems reasonable to conclude that the extra support and encouragement given via regular parental interviews does seem to exert genuine benefit on the child.
Length of treatment

Adult outcome studies of psychotherapy have described a 'dose-effect' relationship (Newman and Howard 1986), with improvement linearly related to the number of sessions received. Similarly, in specific investigations of adult psychoanalysis, length of treatment has been found to be the only independently measured factor to regularly relate to what is called in the literature 'substantial therapeutic benefit' (Bachrach et al 1991). However, for children, the results are much less conclusive. On the whole, shorter therapies have been found to be as effective as longer treatments for most children (Rosenthal and Levine 1971) and follow-up assessments have reported no consistent relationship between the child's level of post-treatment functioning and the number of sessions he or she received (Shepherd et al 1971). In fact, Casey and Berman (1985), in a review of 75 studies of child psychotherapy outcome, found that length of treatment was negatively related to outcome although they do point out that shorter treatments tended to use outcome measures that produced larger effect size. Kazdin (1988) asserts that, for children, factors such as age, sex, developmental stage and diagnostic problem have more impact on the efficacy of the intervention than does the length of treatment.

However, child outcome research to date has concentrated almost exclusively on treatments that are completed within, perhaps, six or twelve sessions (Shepherd et al 1971). This has very little to do with intensive psychotherapy such as psychoanalysis where children may receive 500 sessions or more. As already noted, children remaining in therapy for under 6 months (less than, approximately, 100 sessions) were reclassified as having terminated prematurely, whatever their improvement status. We have very little knowledge of the effects of length of treatment on outcome. Heinicke (1965) and Heinicke and Ramsey-Klee (1986) have shown that four sessions a week lead to greater improvement than once-weekly therapy and other, non-analytic clinicians, such as Lovaas, working with autistic children, have also recorded positive effects of high-dose contact with the child (in Kazdin 1988) but intensity of treatment is not the same as duration.
The number of sessions per week had no significant predictive effect on outcome for any of our samples (probably because most children were taken into intensive 4- or 5-times weekly analysis and few received less than three sessions a week), but length of treatment did have a consequence, small but statistically significant, for the total subsample of Medical children and their Controls, and the sub-group of Disabled children. The effect was not great and raises a number of potentially confounding issues. The longer the child remains in therapy the more likelihood there is of his or her problems remitting spontaneously or through maturation or with a change in environmental contingencies—many children improve when they change schools, for example (Shepherd et al 1971). Further investigation is needed to disentangle the many variables that interact over time and to determine the true relationship of length of treatment to outcome. It may be that optimal duration describes a ‘U’ curve; the mean length of treatment for the Disabled children was midway between the Somatics (shorter) and the Ill group (longer), neither of whom showed a significant effect. Some meta-analytic studies of adult treatments have also suggested this possibility (Smith et al 1980).

**Reason for termination**

Reason for termination was significantly related to outcome for members of all groups (provided they had not terminated precipitately) with the lone exception of the Somatic children. Children who finished by mutual agreement with the therapist tended to do better than those who terminated for other reasons. Rachman and Wilson (1980), sceptical commentators on psychoanalytic treatment and its effects, point out that very high rates of improvement can be calculated by the simple expedient of not regarding a treatment as finished until substantial improvement has been recorded. As psychoanalytic treatment is open-ended and of typically long duration, there is ample opportunity to yield to this particular temptation and we cannot rule it out as the major explanation for this finding.
Chapter Twelve

Conclusion
12.1 Summary of main findings

12.1.1 Factors exerting influence on outcome

A) Child variables

Age
Younger children tended to do rather better in treatment, especially if they remained in therapy for at least 6 months. This applied only to the larger groups studied (the Target-plus-Control sample and the combined Medical sample).

IQ
Although the child’s IQ rating did not exert a predictive influence over the change in global assessment recorded between the start and finish of treatment (our main dependent variable), it did correlate rather interestingly with the CGAS rating at termination (which may or may not have changed significantly from the CGAS at start of treatment). For the Non-Medical children (N = 688) there was an expected low, positive association between both Verbal and Performance scores and final level of functioning. For the Disabled and Somatic children Verbal scores correlated rather better than Performance scores with termination CGAS but for brain-disordered children, suffering with epilepsy and other organic conditions, of which there were several among the Ill group, performance IQ gave a better prediction of the level they would eventually be able to reach.

Children vary greatly in their resilience to cope and it is often rather too simplistic to assign improvement or deterioration to one particular factor or set of factors. One child, a five year-old girl who acted as one of the Disabled controls, illustrates this rather well. She came into treatment suffering with Post-Traumatic Stress Disorder as a result of having witnessed the murder of her mother by the father in a fit of delusional jealousy. At the time of his child’s assessment he had been diagnosed as a paranoid schizophrenic and was restrained in a top-security hospital unit. The child had been fostered and moved around from one relation to another. Nevertheless, despite her appalling circumstances she was able to use her year and two months of intensive analysis to advantage and terminated without any obvious symptoms and with a CGAS of 80, an increase of 15 points. Although it is possible that systematic follow-up would have uncovered later manifestations of disturbance, so far as we know, she continued to function well throughout her childhood.
Learning difficulties
The mere presence of learning difficulties was not found to affect the child’s potential for therapeutic change although the type of difficulty experienced had more specific effects. In general, children with learning difficulties needed time to work through them and those who terminated within 6 months tended to make little progress. School refusers, in particular, were unlikely to stay in treatment until a satisfactory ending had been achieved and their potential for change was therefore not able to be fully exploited. Children who had learning difficulties directly related to their handicap or illness also did not do well in treatment. However, underachievement in school was a good prognostic sign for the Medical children and was able to be effectively addressed in therapy.

Sex
No consistent effects were found which related to the sex of the child.

Medical history
There was no notable effect of medical history on CGAS change.

B) Family variables

Family size
Despite previous research findings (Rutter et al 1970) we found no association between treatment outcome and family size.

Family broken or intact
Children from intact families did better in treatment. All three Medical groups had higher rates of family intactness and lower incidences of parental divorce, separation and severe marital problems than did the Non-Medical families, with the Somatic group differing significantly from the main samples. Information relating to the child’s primary caretakers and significant experiences of loss overlapped with this category.
Social class
There was no direct effect of social class on outcome although it is likely that it interacts with other variables with higher predictive strength, such as IQ, intensity and length of treatment, reason for termination, the likelihood of a parent having had previous psychoanalytic treatment and so on.

Assessed on occupation, the Anna Freud clientèle is essentially middle-class and professional, belonging almost exclusively to the top 3 classes in the Registrar-General’s Classification system. The III children were of a significantly lower SES rating (mean 2.9) than the Somatic group (mean 1.9).

Maternal employment
There was no clear relationship between the employment status of the mother and the outcome of the child but III children whose mothers were employed, especially on a part-time basis, showed generally high CGAS at termination.

C) Referral and diagnostic variables

Primary referral source
General practitioners, hospital consultants and other child guidance units were good sources of referrals, tending to recommend children who stayed in treatment and did well. School and special agencies were much less successful in selecting suitable referrals. Parents were indifferent sources of referral. When they were not too entangled in the general atmosphere of apprehension, guilt and parent-child conflict surrounding their child’s difficulties, their desire for psychological intervention was appropriate and able to be supported and followed through by them. For some children, however, especially those with psychosomatic symptoms, parental involvement appeared to be too anxiety-ridden to be able clearly to determine what the child needed and whether that could be matched by what psychoanalytic therapy could offer.
**CGAS at assessment**

There was very little evidence to show a clear link between the level of functioning shown by the child at the start of treatment and final outcome measured by CGAS change. There was a tendency for high CGAS scores at assessment to pre-empt premature termination and it might be argued that this increases the probability that the child will improve his or her level of functioning by the end of treatment by either developmental or therapeutic means.

**Child Diagnosis**

Anxiety, phobic, somatoform and sleep disorders had a generally good prognosis and had usually either completely remitted or been substantially alleviated by the end of treatment. Children classified principally in this diagnostic group tended to make considerable improvement. Most conduct disorders manifested by the Medical children also improved or disappeared during therapy. Habit disorders such as enuresis were less common but more resistant to therapy as were specific or pervasive developmental disorders. Children who presented with these problems did less well on the whole.

**D) Parental variables**

**Parental illness**

Having a parent with a physical illness was a negative indicator for outcome. This mainly applied to the Medical children whose parents (especially the mothers) were significantly more likely to be physically ill.

**Serious marital problems**

Parents' marital problems appeared to correlate highly with father’s and, to a lesser extent, with mother’s, psychological dysfunction, acting to the detriment of the child’s potential for change. This was not observable with the matched Controls but was so for the Medical children (N = 81), for the total group minus the Medical children (N = 688) and for the original full sample (N = 769).
Maternal psychological characteristics
Mother’s overall level of functioning (her GAF score) had little impact on the child’s final outcome; specific symptomatology was, however, a significant predictor. Mothers who displayed symptoms, or who were undergoing hospital psychiatric treatment, at the time of the child’s assessment, were indicators of children who were, on average, not going to improve as much as their peers. Excessively anxious mothers were generally unhelpful as were the less common suicidal gestures or a diagnosis of personality disorder. Maternal involvement with psychoanalysis in her own right, either historically or in the present, was a good predictor of change in the child.

Paternal psychological characteristics
Father’s GAF score was very highly correlated with the child’s termination CGAS and emerged as a highly significant predictor of CGAS change.

E) Treatment variables

Type of therapist
No effect was found for type of therapist. Staff and student analysts produced equally good results (though staff often had the more difficult cases to treat).

Intensity of treatment
No effect was found for intensive versus non-intensive treatment.

Length of treatment
Children who left treatment within 6 months of starting generally did less well than their peers. There were, however, notable exceptions to this which suggest that, for some children, substantial change can be effected after only short periods of treatment. On the whole, length of treatment had only a slight, though significant, effect on outcome for the Medical children. There was also a small association between treatment length and termination CGAS for the total group of Non-Medical children.
Parental guidance

Parental guidance before and/or during treatment facilitates CGAS change, especially for the Medical child.

F) Termination variables

Reason for termination

Children who ended by mutual agreement with their therapist tended, tautologically, to have higher change scores. For the total Non-Medical sample (N = 688) there was a slight association between reason for termination, length of treatment and final CGAS score but this was not observable for any of the Medical samples.

Diagnostic status at termination

Eighty-three per cent of children were judged to be definitely clinically diagnosable at start of treatment. More than half of these (58%) improved sufficiently to be undiagnosable by the time their therapy had terminated, leaving 35% of children still psychiatrically classifiable, though comorbidity, severity and certainty of diagnosis were all greatly reduced. This percentage dropped to 25% when the children who terminated within 6 months were excluded. Forty per cent of children who terminated unilaterally were diagnosable; 20% of those who finished by agreement with the therapist were also still diagnostically classifiable. There were almost no diagnoses present at termination that had not been present at assessment.

Neurotic diagnoses were much more likely to remit than were psychotic or conduct disorders.

Termination CGAS

Three-quarters of the Medical and Control children had improved their CGAS rating by the end of therapy. This was very slightly higher than the rate for the total Non-Medical group. Most of the remainder made no change at all. Only 6% deteriorated over the course of their therapy. The mean change in
CGAS was +10 points. Thirty-eight per cent of the chronically disordered children scored 70 points or more (the arbitrary cut-off point denoting psychological health), an increase of 32% over the number of psychologically healthy children at assessment.

A list of good and poor prognostic indicators can be found in Appendix G and a pilot test of the predictive efficacy of these indicators follows.

12.2 A preliminary investigation to test the prognostic ability of variables identified retrospectively as having good or poor influence on outcome

‘What follows is speculation ... an attempt to follow out an idea consistently, out of curiosity to see where it will lead’ Sigmund Freud (1920)

12.2.i Introduction

The adult psychoanalytic outcome literature is quite clear that it is not possible to effectively predict outcome from the patient’s characteristics at assessment (Bachrach et al 1991). Wallerstein’s ‘if ... then’ contingencies were seldom met (Wallerstein 1989). The only variable that relates to outcome for adult analysands is length of treatment: diagnostic and demographic variables have no predictive power (Bachrach et al 1991).

Despite Mannoni’s sceptical comment, quoted on page 370 we suggest that this is not necessarily the case with children and that it may be possible to predict those who will benefit from a psychoanalytic treatment from those who do less well. We made a brief and preliminary, but successful, attempt to do this, as described below.

12.2.ii Method

12.2.i.a Samples

Twenty-two cases (4 Somatic Targets; 4 Somatic Controls; 4 Disabled Targets; 4 Disabled Controls; 3 III Targets; 3 III Controls) were selected at random from the 162 cases that comprised the three Medical subsamples and their Controls. The cases selected are listed in Appendix H.
12.2.i.b Procedure

Each case was checked for good and poor outcome indicators as described above and listed in Appendix G. Treatment enhancers, such as parental guidance, were excluded. Each good indicator was assigned a value of +1; each poor indicator was assigned a value of -1.

A total positive summation was assumed to indicate a good prognosis (+10 CGAS change points or more). A total zero or negative summation indicated little or no progress or deterioration.

12.2.i.c Results

Using this extremely rough and ready measurement the bipolar change status (10 or more plus points; less than 10 plus points) accurately predicted the actual change status of 20 out of the 22 children. The two exceptions were a Somatic child with positive points who scored 0 CGAS change and an III child with negative points who scored 10. A third child was taken out because, although his CGAS score didn’t change between assessment and termination as his indicators predicted it should, he scored 80 points at both ratings which is unusually high and doesn’t allow much room for manoeuvre.

12.2.i.d Discussion and Conclusion

This is obviously a very crude way of indicating suitable children for psychoanalytic treatment and is weighted against over-inclusion (in true psychoanalytic tradition!) by defining fewer good indicators than poor but nevertheless demanding that the former outweigh the latter. However early success suggests that this could be further refined. Perhaps differential weighting for items could be worked out. In addition, parental guidance might be used more readily, especially before treatment and in cases which comprise several poor indicators. It is possible that such extra parental help could then be counted as an additional good indicator, increasing the probability of success.
12.3 Associations between Target and Control groups

In addition to the inevitable differences between Target and Control groups in terms of medical histories and hospitalisation, Target children were more likely to have parents who were physically ill, and they more often retained diagnosable anxiety conditions after the end of treatment. Certain groups of Target children also showed higher rates of learning difficulties than did their Controls and there were differences in their primary source of referral although both of these variables were at least partly attributable to the physical status of the child. Learning difficulties in Control subjects were more often accounted for by poor peer relationships. An unexpected finding was the extremely high rate of school refusal among the Control groups, especially the Disabled Control sample.

All in all, though, there were very few significant differences between Target and Control groups, even on parameters not originally selected for. In terms of, for example, past diagnostic status (Table 10.10), Anna Freud Diagnostic category (Table 10.11) and CGAS ratings (Table 10.12) the Controls matched their Index patients fairly accurately despite the fact that these variables had not been selected for matching. A complete list of factors similar to both sets of matched-pairs subjects can be found in Appendix L.

This implies that correct pairing of, for example, age and current diagnostic status and category, relates to the possibility of having reached psychiatric caseness in the past and also to overall level of functioning. Similar degrees of psychological vulnerability seem to link children who may differ on other parameters including chronic physical illness or disability. Previous research that has found children with medical conditions to show a higher degree of emotional disorder than children without medical problems (Shepherd et al 1971, Wallender et al 1989) are looking at general populations in which psychiatric morbidity can be correlated with, inter alia, physical status. In clinic populations where all members of the samples are psychologically disturbed, the presence or absence of physical illness and/or handicap does not appear to be a particularly strong determinant. There are diverse and multi-determined routes to the appearance of emotional and behavioural
difficulties. Physical condition may well affect predisposition to neurotic and conduct disorders, but parental and other characteristics seem to be equally potent psychogenic factors for other, physically healthy, children.

12.4 Discussion of issues and questions raised earlier
In the introductory section to this thesis a number of questions and problems relating to psychoanalytic treatment were identified. Most of these had not been satisfactorily acknowledged, let alone answered, by psychoanalytic practitioners. It is now time to return to these areas of concern to determine what progress, if any, has been made by the current investigation.

12.4.1 Methodological Concerns
Psychoanalysts have consistently rejected the methodological frameworks which have been used to evaluate other psychological treatments. And, reassuringly for them, these concerns have amassed a certain amount of support from outside the analytic community. Gene Glass, for example, one of the foremost meta-analytic investigators into therapeutic outcome, admits the lack of adequate processes for measuring effect size for psychoanalysis. The standard procedure of subjecting all forms of psychological treatment, regardless of theoretical assumptions and ecological demands, to precisely the same evaluative techniques, works satisfactorily with therapies based on rigorous, objective sets of principles that can be applied across the board to case after case. Symptoms can be counted; frequency and length of specified behavioural incidents (such as hand-washing or temper tantrums) can be recorded; the patient’s cognitive distortions (such as ‘Everything I do goes wrong’) can be identified and acknowledged. Such treatments impress favourably in meta-analytic studies.

Psychoanalysis is another kettle of fish altogether. It finds its raison d’être in the investigation of hypothetical constructs which, by their very nature, cannot easily be either identified or acknowledged. Manifest symptoms and behaviours are assumed to be merely superficial expressions of latent (hence, by definition, hidden), occult, repressed, guilt-ridden, shaming conflicts and
phantasies. Accessing these murky psychic depths is complex and time-consuming. Moreover, although psychoanalysts do work according to theoretical precepts which could be operationalised, they also take seriously less easily-definable concepts like affects, intuitions, dreams - and not solely the affects, intuitions and dreams of the patient but, frequently, those of the analyst as well.

Each case has its own context and its own momentum. There may be universalities in the human condition (as Freud strongly believed there were) but the details are of the patient’s own manufacture. It is these creations that interest the psychoanalyst so much. These unconscious, phantastic, defended-against wishes and conflicts cannot justifiably be forced to adhere to the same criteria as overt, measurable behaviours.

This present investigation has taken seriously these psychoanalytic complaints of unfair treatment at the hands of analytic research. The small effect sizes which psychoanalysis has shown in comparison with other therapies are, we claim, the consequence of poor outcome measures with respect to psychoanalysis, rather than to the intrinsic limitations and ineffectiveness of psychoanalytic treatment.

That said, we have also conceded that psychoanalysis has made little attempt to investigate the validity and efficacy of its theories and therapies. Grünbaum’s call for a ‘spirit of controlled enquiry’ (1984) into the workings of psychoanalysis is one to which we wholeheartedly respond.

While recognising that what psychoanalysis offers is unique (thorough and radical modification to the relationship between the main psychic components of id, ego and superego) and cannot therefore be entirely evaluated according to psychometric criteria designed to reflect more quantitative change, we have tried to identify those indications of therapeutic benefit which might be reliably and validly operationalised on partially-quantitative scales. The measures used, such as the GAF, the CGAS and the diagnostic classifications, combine all the rigour of rating scales with the
flexibility of skilled clinical expertise and understanding. This, we believe, meets the stringent demands of scientific procedures without compromising the essential individuality of the psychanalytic approach to treatment.

This is only a preliminary investigation and it is to be hoped that our methods will be refined and made ever more appropriate to what we see as the much-to-be-desired working relationship between psychoanalysis and systematic, unbiased research.

12.4.ii Criteria offering evidence for therapeutic efficacy

Symptom removal _per se_ has traditionally been little regarded by psychoanalysts who talk disparagingly of 'symptom substitution', implying that, while the target symptom may remit, others will appear unless the underlying cause is tackled (by psychoanalysis, naturally!) Our attitude has been that, while not the main focus of therapeutic effectiveness, diagnostic status at the end of treatment is important. It is difficult to see how claims for widespread (and beneficial) personality revision can be substantiated if the initial cause of distress remains untouched. Decline in presence and/or severity of symptoms has been included in a wider outcome measure - that of global functioning - which has looked at the child at home, school and play; by him/herself and in relationship with parents, teachers, friends and siblings; at hobbies and abilities and the use made of them; and at general levels of confidence, self-esteem, lack of excess anxiety etc. This was felt to be a more realistic rating than simply counting symptoms though, of course, the continued presence of initial psychological or psychosomatic conditions inevitably tend to mitigate substantial improvement in functioning, and thus is an indirect outcome measure.

12.4.iii The disadvantages of the individual case study

Ideally, experiments to determine the difference between two conditions (for example, psychoanalytic treatment and no psychoanalytic treatment) should endeavour to hold constant as many factors as possible, manipulating only the variable of interest in order that a degree of certainty might attach to the causality of significant differences in outcome measures. Subjects who
match the targets in all relevant factors bar the one under immediate investigation, act as controls against the possibility of the results being confounded by non-anticipated variables.

Our investigation, in common with most psychoanalytic research, used only individual cases: referrals and acceptances for treatment that were completely independent of one another and had not been selected with research criteria in mind. Many years (and many different therapists and diagnosticians) separated the treatments. There were points in common between subgroups that differentiated their members from those belonging to other subgroups, and matchings on a number of factors between children with and without chronic medical conditions was, on the whole, satisfactorily achieved, but the prime focus of interest - whether psychoanalytic treatment for emotional and behavioural disturbance does or does not have significant effect - was commonly present in all cases. We did not have a control group in which such treatment had not taken place.

We earlier listed (pages 46-47) Alan Kazdin’s objections to the case study as acceptable research methodology. We can now consider to what extent, if at all, we managed to circumvent these acknowledged disadvantages of single case samples.

Kazdin claims that case studies rely too heavily on anecdotal evidence to be scientifically useful. It is true that our cases were originally treated and written up as individual samples but the common assessment, diagnostic, and treatment threads running through each case have allowed us to pull together a very large number of otherwise disparate cases and to unify them along a number of parameters, according to standard psychometric procedures. This has permitted a certain degree of objectivity without in any way detracting from the psychoanalytic validity of the in-depth case history.

We do plead guilty, however, to Kazdin’s second point of contention - that case studies rely too heavily on ‘one- or two-shot assessments’. We evaluated each of our subjects on two occasions, at assessment and at
termination, so we did at least have a baseline record with which to compare the final state. This was, indeed, our major evaluative means of measuring the usefulness of the mediating treatment. But, as Kazdin has observed, this is insufficient to rule out the testing itself (or, more germane to our sample, the diagnostic procedures) as the instigator of change. All clinicians recognise the therapeutic value that may sometimes be gained by patients from an initial interview - or even from simply making contact with the clinic or being on a waiting-list. The Anna Freud Centre has such an elaborate and thorough assessment process that as much quality time and attention may be offered to the child and family at this stage as over a complete treatment elsewhere. And, certainly, some children did show remarkable improvement by the time of their premature termination in the first weeks of analysis.

The significant positive correlation between improvement and length of treatment may have been partially compromised by our psychoanalytically-informed assumption that, in the absence of information to the contrary, children withdrawing very early had made no gains and were, therefore, identically evaluated as at start of treatment. This was an unsubstantiated conclusion to have reached. In our defence we can offer the observation that children who did improve rapidly appear to have fuller case-notes than those who never really settled into analysis and just slid away, not having been helped. It is this latter group for whom there was no information and about whom we therefore assumed no change.

The main confounding factor, however, in assessing the significance of length of treatment for children is always going to be maturation effects. The longer the therapy, the higher the probability of the child 'growing out of' the symptoms and behaviours of concern.

Treatment length also plays a part in Kazdin’s further arguments against the use of case studies. He points out that acute or episodic conditions will, by definition, modify themselves over time. They may return later but a termination at an auspicious moment can always be recorded as a successful treatment and, without adequate follow-up, it is difficult to challenge this.
The widely-recognised occurrence of spontaneous remission applies to chronic conditions as well. Opponents of dynamic therapy quote figures that show that about two out of every three disturbed patients get better on their own, without professional intervention (Eysenck 1985). This is where control groups would have been useful because, indeed, our figures do hover around the two-thirds improvement mark, depending on the criteria used to determine success. Fifty-eight per cent of children had lost diagnostic status by the end of treatment; about three-quarters of the total sample had improved their global functioning score. Besides, documentary evidence for the chronicity of our subjects’ symptoms was not always available. In some cases their problems may have been acute manifestations of a disturbance that would have died down with or without therapy.

The ‘single subject’ drawback of the case study can be partly overcome, as it was in our investigation, by the use of many ‘single’ subjects who form a sample, albeit a rather amorphous one much less rigidly selected than the typical experimental group of subjects.

We believe that we have gone some way to dispelling Kazdin’s (and others) justifiable criticisms of the case study as a valid methodological approach, but that it is nowhere near far enough. Control groups, inter-treatment evaluations and follow-up assessments would all be useful and would add greatly to scientific rigour, helping to disentangle alternative explanations from the treatment effects.

**12.4.iv Is child psychoanalysis beneficial to the patient?**

Our outcome data suggest that, by and large, the psychoanalytic treatment offered to the child at the Anna Freud Centre is beneficial - or, at least, it is not often detrimental. Three out of four children improved in terms of global functioning over the course of their treatment. While this may reflect remissions, maturations, external events and other factors, and may not be wholly or even partially attributable to the analysis, it does indicate that the majority of children gained in some way over the treatment period.
Moreover, most of the remainder did not actually lose ground as a result of their treatment. Only 6% of Medical children deteriorated (6% of Controls also; 8% of Non-Medical children). Some of these children were ‘heroic indications’ for analysis - children with pervasive developmental disorders, autism, and other severe, possibly organically-based, pathology who, but for research and humanitarian interests (frequently, alas, in that order) would not have been taken into treatment at all. For these, deterioration was often a consequence of their condition and there is no knowing whether their intensive treatment may not have slowed down the inevitable.

However, taking this line brings us very nearly to the point of negating any effect, be it for good or ill, of child psychoanalysis, with both improvements and deteriorations put down to biological and environmental factors rather than to psychological change. If this is the true explanation of our results a lot of time and money could be saved by dispensing with analytic treatment altogether. At present we are just not able to extricate the effects of therapy from the other factors in the child’s life. We need untreated control subjects who grow up along with our index patients, who share similar symptoms and syndromes and who are prone to the same possibilities of regression and development as their treated pairs. Change between these two groups would indicate therapeutic effects much more clearly than change in our case-study sample has been able to do.

To summarise: we can certainly claim that psychoanalytic therapy is seldom, if ever, harmful to the child, but to go further and point to positive advantages is difficult without the use of control groups and follow-up procedures.

12.4. v  Is depth analysis the best possible intervention? Can shorter and/or less intensive régimes be as effective?
We have already discussed the almost insurmountable problems of making valid comparisons between psychoanalysis and other treatment interventions. We are able only to take a preliminary look at these crucial questions. From the present investigation we have learned that some childhood problems, for
example school-related difficulties, take time to work through, and that children who terminate treatment within 6 months generally find that any such problems remain unalleviated. This suggests that a relatively lengthy therapy may be the best available means of addressing certain issues. Indeed, length of treatment showed a slight positive association with change scores, though we fully acknowledge the general adage about the healing properties of time, with or without therapeutic expertise. Intensity (or depth) of treatment is obviously related to, though not synonymous with, length. But, although there were no significant differences in outcome between those children treated intensively (4 or 5 times a week) and those treated ‘non-intensively’ (1-3 times a week), the number of session hours for all our children would have been considerably more than they would have been offered almost anywhere else. Intensity is, therefore, a relative term. It may well be, however, that once-weekly sessions are as effective as daily visits to the analyst, for most children. This would certainly be more acceptable to many families.

Early cases in the history of psychoanalysis were often not treated at length as they are today. Some patients saw their analyst only during the summer holiday months when they could travel to his consulting-room. Many others had treatments of 2 or 3 months only. It may be that, especially in the case of children, we could advantageously return to such procedures. (D. W. Winnicott’s account of ‘The Piggle’ (1977) shows what we might call ‘substantial therapeutic benefit’ from a very small number of irregular sessions, generally at the child’s express request.)

12.4.vi Can current analytic processes be improved?
Undoubtedly. One of the most important things that psychoanalysis can do to improve its therapeutic benefits to patients is to try to determine whether any of the features of other treatments with relatively high proven success rates might conceivably be added into the psychoanalytic treatment of children without doing too much damage to the latter’s integrity. We have seen from the present study that parental guidance before and/or during treatment is a good predictor of successful outcome. In recent years
(and, again, this was not necessarily the case in the early days),
psychoanalysis, in sharp contrast to, say, family therapy or behaviour
therapy, has isolated patients from their environment and has taken little or
no account of parents, family and friends. With children, of course, this strict
attitude has had to be modified to some extent. Our evidence suggests that
this could be further relaxed to good effect.

Less intensive and shorter treatments should also be further investigated.

12.4.vii How do physically ill children respond to psychoanalytic treatment?
Prior to this study very little was known about the way in which children
with chronic medical conditions in addition to their psychological difficulties
would respond to psychoanalytic intervention. We found that, in our sample,
medical history had no notable effect on CGAS change. Overall, the Medical
children did as well as children without handicap or illness. The Somatic
group of children had a marginally better outcome than all other groups, but
not significantly so. Factors which were important in predicting outcome,
such as diagnosis, parental level of functioning, and age were important
across all samples.

We have identified some of the individual, family, diagnostic and therapeutic
factors which lead to particular treatment outcomes but these are not
peculiar to any particular sub-sample.

12.5 Discussion of possible limitations of the current investigation

12.5.i Treatment integrity
Was every child in this study given roughly similar therapeutic treatment or
were there vast differences between therapist styles, relationships with
patients, theoretical perspectives and so on? If each therapist-patient dyad is
essentially dissimilar in important therapeutic respects from all others, no
valid generalisations about treatment efficacy can possibly be made.
The difficulty with psychoanalysis is that it possesses few treatment manuals or other means of enhancing the consistency of individual treatments (Bachrach et al 1991). We don’t know what goes on in analytic sessions. They are not observed or systematically and objectively recorded. Process notes are written by therapists but these are inevitably highly selected. What therapists actually do and what they say they do in a formal report are two very different entities (Wallerstein 1989). In addition, most of the analysts were students, only part-way through their training. Because analysis is such a protracted and intensive treatment even ‘experienced’ analysts have only seen a fraction of the number of clients that practitioners of other approaches will have dealt with. Many of the children in this investigation were the first or, at most, second or third patient of their treating therapist.

However, these difficulties, when recognised and placed in perspective, should probably not be regarded as irreparably damaging to treatment integrity. The vast majority of psychoanalytic treatments are conducted by student analysts in training (Garfield & Bergin 1986); this is part of the essential ecology of psychoanalytic therapy. To investigate the efficacy of psychoanalysis *qua* therapy means accepting and recognising this. In our study we found no differences in outcome between children treated by staff and student therapists, though staff very often undertook the more complicated or atypical cases. Similarly, Wallerstein (1986) found that very ill patients (an unusual intake for ‘insight’-oriented therapies) did better with experienced analysts. There is no evidence, however, that for the average patient, student analysts confer a disadvantage.

Moreover, the term ‘student’ in this context is misleading, implying merely that the therapist in question has not completed her or his training with respect to psychoanalysis. *All* ‘student’ candidates are mature, experienced in other branches of child care such as psychiatry, social work or psychology, are undergoing a personal analysis and have had at least a year of child analytic training before taking their first patient - a carefully selected case and treated under strict supervision. By this stage the trainee has been well grounded in the theory and practical implications of psychoanalysis and
is not far from becoming a fully-fledged adherent of the psychoanalytic community. (This might be a drawback in terms of objectivity but, so far as treatment integrity is concerned, it probably guarantees as much uniformity as could reasonably be expected from such an amorphous intricately-woven theoretical basis).

No attempt was made to look at personality factors in the treating therapists. Evidence that these may be important to treatment outcome is balanced by other work which denies their importance (Marks and Gelder 1966, Morris and Suckerman 1974a, 1974b).

**12.5 ii Controls**

Control subjects or groups are a *sine qua non* of experimental outcome research but such laboratory-based investigations, although methodologically irreproachable, do not always produce results that are generalisable to actual treatment-room therapy. Carefully controlled studies tend to produce larger effect sizes than clinic-based studies (Weisz and Weiss 1989) where, as in real life, a mishmash of factors entangle, intermix, confound and generally spoil the neat theoretical compartmentalisations of the researchers. Naturalistic designs make a virtue of necessity by forgoing the experimental advantages of untreated controls for increased ecological validity. In the present investigation, some use was made of the serendipitous controls of early terminations. The target groups of children with chronic medical conditions were also able to be matched along certain parameters with interpatient controls which permitted the variability of other, uncontrolled, factors to be measured. We were not, however, able to make comparisons between children treated with psychoanalytic therapy and those with similar profiles who remained untreated or who were treated with different psychological interventions. We do not know whether children treated with psychoanalytic techniques would have made more, less, or equal progress with, say, behavioural techniques or family therapy.

**12.5.iii Retrospective evidence**

In addition to having to sacrifice the usual research exigencies of control and
manipulation of variables, the process of setting up and testing hypotheses was also severely affected. All our data was retrospective and, consequently, all our assessments and predictions were also post hoc. Fonagy and Moran (1993) have suggested that this may be an inescapable aspect of research into a Zeitgeist which is so at odds with the basic assumptions of experimental and cognitive psychology.

The temptation of assuming post hoc ergo propter hoc must, of course, be firmly resisted (Schaffner 1983) but this is not best done by backing away from the difficulties altogether and attempting to investigate psychoanalytic efficacy by transposing it into a setting for which it was not designed. As with most aspects of life, causal relationships between psychoanalytic factors are the exception rather than the rule. Clear-cut directions of cause and effect are muddied by confounds and a multiply-deterministic framework. For the most part, only correlational inferences can be made.

Our primary data was retrospective twice over. Firstly, information was not observed and recorded as it arose but anamnestically recalled by parents in diagnostic interviews. There is evidence to show that such memories become modified over time, even over a period as short as 2 weeks (Steele et al. 1980), particularly if parents are asked about adverse experiences. Systematic biases in retrospective recall affect the correct sequencing of events and accurate recall of child-rearing practices (Cox and Rutter 1985). Not unnaturally, there is a strong tendency to distort accounts of past events such as toilet training and parent-child separations, in line with more current attitudes (Yarrow et al. 1970).

Secondly, this retrospectively-gleaned material was, itself, not used in research until some years after it had been gathered. In addition, it had been collected for clinical and not research purposes. Although the requirements of the Diagnostic Profile encouraged a fairly methodical data collection, much of the quantitative material (psychiatric diagnoses, CGAS and GAF scores etc) was inferred, often many years later, from accounts which, having been
recorded by a large number of individuals, inevitably varied in quality, quantity and rigour.

12.5.iv Matched variables

Nine variables were matched between the Target Medical children and a Control child without a chronic physical condition. We had a limited and fixed population from which to draw these matches; 81 children had to be paired on 9 parameters from a pool of 608 children. A great deal of care was taken to select the best-possible overall match for each child but correspondence was seldom as close as would have been liked. We did not match on variables such as chronicity, severity and age of onset of emotional problem. Had we done so we might have had an indication of which emotional difficulties were long-standing and which were transitory and more likely to remit naturally with or without therapeutic intervention. However, information on these issues was often not available (another disadvantage of retrospective evidence) and, even when it was, it was not possible to match on more factors than the nine already selected. Although such data was not matched between Targets and Controls, it was not ignored altogether. When available it was subsumed under the diagnostic label(s) which allowed us to qualify the actual diagnosis with one of three levels of certainty. To be ‘definite’ often required the clear presence of target symptoms for a certain, specified, minimum period of time. Comorbidity also received less attention than it deserved, children being matched primarily on principal diagnosis. Additional problems were only taken into account in the rare instances where there was a choice of possible match. No parental variables were controlled for.

12.5.v Sample

Our sub-samples were really too small to happily accommodate all the variables we were trying to manipulate. Cohen and Cohen (1975) show that some statistical analyses become unreliable when N is less than 60 and the number of independent variables are more than 20. The three Medical groups contained 32, 32 and 17 subjects, respectively. The original 232 variables
Comparisons between Target and Control groups and between combined Target and the main Non-Medical sample were possible, and the three Target samples showed some interesting differences. By no means all the results were rendered invalid because of small numbers. Nevertheless, there were numerous occasions on which no satisfactory conclusions could be reached because of the low sample size. Our subjects were not very representative of the usual clientele of child guidance units, being predominantly middle-class and with high IQs but it is probable that patients at other child psychoanalytic centres have similar profiles.

12.5.vi Long-term studies

A problem with long-term investigations is that the field itself moves over the time studied (Wallerstein 1986). Child rearing practices, attitudes to psychological treatments, hospitalisation procedures, the implications of certain chronic illnesses and disabilities, and much more, have all changed since the 1950s and continue to do so. We know, for instance, that changes in medical training have made modern GPs more attune to, and sympathetic with, emotional dysfunction (Rutter et al 1970). This may well have an effect on referral patterns to specialist centres such as ours.

12.5.vii Follow-up

Workers in the field of therapy outcome are divided between those who claim follow-up studies to be unnecessary, adding no further information to that available at termination (Nicholson and Berman 1983, Frank 1972) and those who believe termination measures may either underestimate subsequent gains (Kolvin et al 1981) - the so-called 'sleeper effect' - or may show immediate benefits which are not maintained over time (Kazdin 1988). Shepherd found that improvement at follow-up was not related to treatment at all but was consequent on environmental changes (Shepherd et al 1971).
Outcome research on psychoanalysis (adult treatments only) suggests that no original measure predicts level of functioning at follow-up, 5-10 years after termination. But such studies also assert that outcome cannot be predicted from assessment (Bachrach et al 1991); we have shown that, with children, this may not be so. Our lack of follow-up seems regrettable, despite the conclusions of some of those cited above. Claims for therapeutic effectiveness are hollow if improvement made during treatment does not generalise to life outside the clinic or if gains are not able to be consolidated and maintained. Psychoanalyst Robert Wallerstein points out that medical research acknowledges minimum time periods (for example, 5 years in much cancer research) before claims for treatment efficacy are recognised. Psychoanalysis makes wider-sweeping claims than any other treatment about its potential to restructure personality. We might, therefore, expect a successful psychoanalytic treatment to have far-reaching effects for the analysand. For a child, we need to know whether these effects stretch into adult life.

No systematic effort has yet been made to follow-up the child patients in this present study, though it is not impossible that attempts to do so might be made as part of a future investigation. The difficulties of finding children who were in analysis ten, twenty, forty years ago are, obviously, legion. Many will not want to be reminded of their long-term, intensive analysis; they may never have told the people around them of their childhood bedwetting or phobias or antisocial behaviour. They may have forgotten (genuinely or for good psychoanalytic reasons!) what took place, perhaps when they were only 6 or 7 years old. Do we have the right to disturb their current life with our research inquiries?

There are additional ethical problems to be addressed. Few of the children themselves gave informed consent to either treatment or to use of such treatment in research. This was done by their parents or guardians. Furthermore, although the nature of future research for which any child’s case-history might be used was never specified (because unknown), such large-scale investigations as this were certainly not envisaged by either staff.
or parents. To be included in an occasional paper for a psychoanalytic conference or journal is not the same as the realisation that, two decades on, one’s personal treatment files and all the intimate knowledge they contain, have been combed by researchers who now want to ask intrusive follow-up questions. These are very real dilemmas. The research is incomplete unless we have some knowledge of how our child patients progressed, but we do not have the right to open old wounds or discuss forgotten histories. We would need to offer comprehensive debriefing and support resources for those who needed additional counselling after being informed that they had taken part, involuntarily, in this piece of retrospective research.

12.5.viii Research instruments

A) The Anna Freud Diagnostic Profile

Critics of the Profile have put forward two major objections. Firstly, that the subheadings are ordered according to metapsychological concerns which not only makes difficulties in relating it to other conceptual systems but, more importantly, places its claims *hors de combat* with regard to objective verification. The second complaint is that literature relating to the Profile has concentrated almost entirely on case illustrations (e.g. Yorke 1980) and has not attempted to assess validity or reliability (Achenbach 1988).

The first criticism is only partially justified. The Profile was developed for use within a psychoanalytic treatment setting and it is therefore understandably concerned with issues of central interest to psychoanalytic practitioners. Nevertheless, Anna Freud, together with other ego psychologists such as Hartmann and Kris (1945) promoted a genetic account of development as opposed to the strictly classical dynamic viewpoint (see pages 57-58). Whilst not disputing the importance of the traditionally understood psychic conflict as a manifestation of the interaction of internal forces, the genetic stand observes the child, not as an isolated combatant with his internal struggles, but as a subject with an environment. His difficulties, historically rooted in his specific past, are accessed to a large extent from interpretation of the anamnestic data of the Social History. The focus of interest is in how a certain conflict has grown out of a particular set of experiences and why it
persists (Smirnoff 1971). The Profile is not, therefore, as exclusively ‘meta-
psychological’ as it is sometimes assumed to be. The traditional
psychoanalytic concerns of libidinal development and dynamic and structural
conflict are certainly addressed but are explicitly related to environmental
influences. In addition, there are sections on genetic assessment, family
background and personal history.

This relative emphasis on historical data over metapsychological issues
should facilitate making good the shortcomings which are the subject of the
other criticism raised above, namely, that the Profile has not been subjected
to validation checks. This is true, but there is no evident reason why such
checks could not be made. Indeed, the present research study makes a small
and preliminary contribution to this by making it possible to relate a child's
original diagnostic status on a variety of measures, including the Profile's
diagnostic categories, its one quantifiable section, to outcome.

Whatever its limitations, the Profile has at least two strengths:

1) The information on each child has to be ordered under a series on
non-variant headings. Systematic data collection throughout the referral
process is therefore a prime requirement, making omission to record
information concerning any aspect of the child's personality assumed to
possess developmental significance less likely. (This still begs the question of
what these important facets of character might be. The empirical verification
of psychoanalytic concepts is still a major research question. Nevertheless,
data collection in the structured context of the Diagnostic Profile is reliable
even if its validity is not yet assured. In fact, although interviews can
sometimes be relatively poor methods of assessment, the structure of the
Profile probably gives the Anna Freud diagnostic process higher reliability
than most interview schedules.)

2) A fact which seems to have escaped the notice of critics is that
profiles are essentially provisional (A. Freud 1962), as all diagnostic
procedures should be, and are not written only at assessment but can be
modified throughout the course of treatment and Terminal Profiles compiled as the child finishes his analysis. These interim and termination records can be compared with the original evaluation. Recorded change may be attributed to the treatment or, alternatively, to incorrect interpretation of the data at referral. This provides a useful check on the reliability of the Profile as a diagnostic tool.

B) The DSM classification

DSM-III is, in principle, basically atheoretical, not prioritising any disease model or aetiological assumption (except in the few instances where this is intrinsic in the category description. Adjustment Disorder, for example, implies a disturbed reaction to a psychosocial stressor.) However, some prognostic assumption is implied by the substantial structural revision to Axis II (Rutter 1988) which has added mental retardation and the pervasive developmental disorders to the existent personality disorders (which may be diagnosed before age 18 in cases where the disturbance is pervasive and unlikely to be limited to a developmental stage) and specific developmental disorders. This has grouped, for the first time, all those syndromes which remain relatively stable into adulthood (McConville and Steichen-Asch 1990), which suggests that all the Axis I diagnoses, such as child and adolescent conduct disorder, avoidant disorders and all the identity disorders, would not be expected to persist past childhood. This is an as-yet unproven assumption (op cit).

There are other objections to certain diagnostic procedures in DSM-III-R. Cantwell and Baker (in McConville and Steichen-Asch 1990) criticise the criteria for pervasive developmental disorders which allow severely retarded autistic children to be placed in the same category as high functioning children with atypical personality development. In addition, in moving towards the development of broader categories of polythetic disorders for which any combination of a certain number of symptoms from a list is sufficient for a positive diagnosis, DSM-III-R has made it easier to pick up cases of, for example, Attention Deficit Hyperactivity Disorder and Conduct Disorder, than former versions did. Conversely it is now less easy to
diagnose Oppositional Defiant Disorder and it is not even known whether this is a valid diagnostic entity and how far it overlaps with the conduct disorders. Nevertheless, despite these reservations, DSM-III-R is seen, overall, as a positive step towards more adequate diagnosis and treatment for child and adolescent psychiatric disorders (McConville and Steichen-Asch 1990).

12.6 Conclusions and suggestions for further research

The children in this study improved during treatment by an average of 10 points on a measurement scale of global functioning. Children with long-term physical conditions tended to do at least as well in psychoanalysis and, in the case of Somatic children, rather better than, their physically well peers. This was not due solely to maturation effects as CGAS scores were assessed according to age norms. A 7-year old would not be permitted to show an improved rating after two years of treatment simply because he was now 9 and had developed skills he had not previously possessed. To show improvement he would have to be ranked higher pro rata among 9 year-olds than he had been, compared to 7 year-olds, at the beginning of therapy.

Neither, however, is it possible to claim that all gains came about as a result of the psychoanalytic treatment. Kolvin lists a number of factors in addition to the clinical work itself which are potentially able to facilitate a positive response to child therapy. These include historical events, carry-over effects from previous treatments, suggestion, and regression to the mean (Kolvin et al 1981). It is difficult to disentangle these various determinants. Anna Freud herself admitted that 'where pathology is not too severe, the child analyst will often query after the successful conclusion of a treatment how much of the improvement he [sic] can claim as the outcome of his therapeutic measures and how much he must ascribe to maturation and to spontaneous developmental moves' (A. Freud 1965).

The mean 10 point improvement was the 'average therapeutic effect' (Bergin 1966) across large numbers of subjects. As in other treatment outcome
studies, the percentage of children showing gains was little better than spontaneous remission rates (Eysenck 1969) and only just over half our cases showed complete remission of symptoms. If the one in four children who did not improve with psychoanalytic treatment could be reliably identified and referred to more appropriate treatment modalities for their particular needs improvement rates might be substantially higher. A first attempt to describe such children was made on page 405.

For example, a suggestion was made earlier that school refusers from colluding families may be better helped in family therapy where the parent-child interactions assumed to be responsible for both the presenting symptom and the lack of persistence in treatment might be confronted directly. Psychoanalysis is not as well suited as some other forms of therapy to work simultaneously with parents and children. Referral of certain children to other therapies must be done for positive, child-centred reasons, however, and not as a way of ‘dumping’ the negative statistics. Rutter has come to the conclusion that psychoanalytic clinics ‘will provide valuable help for some families, but for others they have little to offer and their failure to recognise that may prevent the families from getting the kind of treatment they need’ (Rutter 1975). A better alternative to labelling some cases intractable would be to look at the shortcomings of what we are offering in the way of treatment and to see whether modifications to technique, theory or practise might give better results.

Psychoanalysis is more ambitious than other therapies requiring immense ‘therapeutic effort’ (Newman and Howard 1986) in costs, duration and intensity. Wallerstein doubts whether it achieves any more than other forms of treatment. If intervention can be made at the moment when development is first under threat, analysis may be the best means of preventing vulnerability from becoming a full-blown illness. The main goal of child analysis is to facilitate and strengthen the child’s natural tendency to grow and develop normally (A. Freud 1965, Fonagy and Moran 1990). This study has not, and could not possibly, validate psychoanalysis as the only or best method of treatment for children, but it does suggest that large numbers of
children did receive ‘substantial therapeutic benefit’ (Wallerstein 1986) from their analyses, and certain factors which particularly impede or facilitate progress have been identified. It seems likely that analytic treatments for children could be reduced in length without adverse effects. It is also possible that non-intensive psychoanalytic therapy may be as effective for many children as daily sessions.

It remains to try to work out a reliable and valid predictive system to select those children who are most likely to benefit from analysis. We should attempt to operationalise the expert clinical judgements of experienced analysts and to test this empirically with well-designed, methodologically-sophisticated studies. The duration of treatments needs to be singled out from other factors to determine whether shorter therapies are of equal benefit. There are also a number of smaller areas of research to be looked at, including the effects of maternal employment on treatment outcome, the implications of maternal personality disorder and the consequences of state versus trait anxiety in parents and the child on developmental progress.

Freud once wrote, in uncharacteristically modest tone, ‘Psychoanalysis is really a method of treatment like others. It has its triumphs and defeats, its difficulties, its limitations, its indications’ (1933). We have carried out a preliminary investigation to identify the main factors predicting these various outcomes. It is to be hoped that research into the effectiveness of psychoanalytic therapy, especially for children, will continue in ever more-refined studies.
References


Auden WH (1940) ‘In Memory of Sigmund Freud’ Another Time Faber & Faber, London


Balint Michael (1971) The Doctor, the Patient and the Illness London: Pitman Medical


Brook Peter and Cooper Brian (1975) ‘Community Mental Health Care: Primary Team and Specialist Services’ J Royal Coll GPs 25, 93-110


Burlingham Dorothy (1979) ‘To be Blind in a Sighted World’ Psychoanalytic Study of the Child 34, 5-30


Casey Rita J and Berman Jeffrey S (1985) ‘The Outcome of Psychotherapy with Children’ Psychological Bulletin 98 2 388-400


Caws Peter (1986) ‘The Scaffolding of Psychoanalysis’ Open Peer Commentary on Grünbaum (q.v) The Behavioural and Brain Sciences 9, 217-284


431


French TM and Alexander F (1941) ‘Psychogenic Factors in Bronchial Asthma’ *Psychosomatic Medicine* 4, 2-94


Freud Anna (1954b) ‘Problems of Infantile Neurosis’ *The Psychoanalytic Study of the Child* 9, 16-71

Freud Anna (1962) ‘Assessment of Childhood Disturbances’ *The Psychoanalytic Study of the Child* 17, 149-158


Freud Anna (1965) *Normality and Pathology in Childhood* Penguin Books Ltd


Freud Sigmund (1905b) *Fragment of an Analysis of a Case of Hysteria* Penguin Freud Library Vol 8 Penguin Books Ltd


Freud Sigmund (1909a) *Notes upon a Case of Obsessional Neurosis* Pelican Freud Library Vol 9 Penguin Books Ltd

Freud Sigmund (1909b) *Analysis of a Phobia in a Five-year-old Boy* Pelican Freud Library Vol 8 Penguin Books Ltd


Freud Sigmund (1915) *A Case of Paranoia Running Counter to the Psychoanalytic Theory of the Disease* Pelican Freud Library Vol 10 Penguin Books Ltd


Freud Sigmund (1925a) *Some Psychical Consequences of the Anatomical Distinction between the Sexes* Penguin Freud Library Vol 7 Penguin Books Ltd


Freud Sigmund (1925c) *An Autobiographical Study* Pelican Freud Library Vol 15 Penguin Books Ltd


Gesell A and Ilg FL (1943) Infant and Child in the Culture of Today New York: Harper


Glover Edward (1954) ‘The Indications of Psychoanalysis’ J Mental Science 100, 393-401


Habermas J (1971) Knowledge and Human Interests Beacon Press


Hollinshead MT (1959) ‘The Social Psychology of Exceptional Children (Part 1)’ *Exceptional Children* 26, 137-140


Israel Allen C, Silverman Wendy K and Solotar Lauren C (1986) ‘An Investigation of Family Influences on Initial Weight Status, Attrition and Therapeutic Outcome in a Childhood Obesity Programme’ *Behaviour Therapy* 17, 2, 131-143


Jersild AT, Markety FV, Jersild CL (1933) *Children’s Fears, Dreams, Wishes, Daydreams, Likes, Dislikes, Pleasant and Unpleasant Memories* New York: Columbia Univesity Press


King Neville J, Guillone Eleonara and Ollendick Thomas H (1990) ‘Fears in Children and Adolescents with Chronic Medical Conditions’ J Clinical Child Psychology 19, 2, 173-177


Lask B and Matthew D (1979) ‘Childhood Asthma - a Controlled Trial of Family Psychotherapy’ Arch Dis Child 54, 116-119


437

Nisbett R and Wilson T (1977) ‘Telling more than we can know’ Psychological Review 84 231-259


Parsons Talcott (1964) Social Structure and Personality Glencoe Ill: The Free Press


Pollock George (1986) ‘Is there a “Two-Cultures” Model for Psychoanalysis? The Behavioural and Brain Sciences 9, 253-254


Shaffer D et al (1983) ‘Children's Global Assessment Scale (CGAS)’ *Arch Gen Psychiatry* 40, 1228-1231


Shepherd Michael, Oppenheim Bram, Mitchell Sheila (1971) *Childhood Behaviour and Mental Health* Univ. London Press Ltd


Task Force on Intervention Research (1988) *Research on Child and Adolescent Disorders*

Tattersall RB (1977) 'Brittle Diabetes' *Clinics in Endocrinology and Metabolism* 6, 403-419


Vaillant George E and Schnurr Paula (1987) 'What is a Case?' *Arch Gen Psychiatry* 45, 313-319

Vas Dias Susan (1990) 'Paediatric Psychotherapy: the Development of a Technique for a Service in a General Paediatric Outpatient Clinic' *J Child Psychotherapy* 16, 2, 7-20

Verhulst FC, Koot JM, and Berden G (1990) 'Four-year follow-up of problem behaviour in an epidemiological sample.' *J Am Acad Child and Adolescent Psychiatry* 29, 440-448

Wadsworth Jane, Burnell Ionna, Taylor Brent, and Butler Neville (1985) 'The Influence of Family Type on Children's Behaviour and Development at Five Years' *J Child Psychology and Psychiatry* 26, 2, 245-254


Watson Johanna (1986) 'Parental Attributes of Emotional Disturbance and their Relation to the Outcome of Therapy' *Australian Psychologist* 21, 2, 271-282


Williams P & Clare A (ed) (1979) Psychosocial Disorders in General Practice Academic Press

Wills Doris M (1979) ‘The Ordinary Devoted Mother’ and her Blind Baby’ Psychoanalytic Study of the Child 34, 31-49

Winkley Linda (1990) ‘Living with Chronic Illness: Consultation to a Children’s Renal Dialysis Unit’ J Child Psychotherapy 16, 2, 49-62

Winnicott DW (1958) Through Pediatrics to Psychoanalysis London: Tavistock

Winnicott DW (1971) Playing and Reality Tavistock Publications

Winnicott DW (1977) The Piggle The Hogarth Press Ltd


Yule W (1973) ‘Differential Prognosis of Reading Backwardness and Specific Reading Retardation’ British J Educational Psychology 43, 244
Appendices
Pro-forma for Anna Freud Centre Files

Patient Details

Name ___________________________ Index No. ______
Sex M / F Date of Birth day month year
Address: London District ________, or County ____________

Patient living with:
- natural parents
- father
- M + step-father
- F + Step-mother
- adoptive parents
- relatives
- foster parents
- other ______

Siblings, at beginning of treatment:

<table>
<thead>
<tr>
<th>T / A / S / H</th>
<th>M / F</th>
<th>yrs/mths. Same home? Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths. Same home? Y / N</td>
</tr>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths. Same home? Y / N</td>
</tr>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths. Same home? Y / N</td>
</tr>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths. Same home? Y / N</td>
</tr>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths. Same home? Y / N</td>
</tr>
</tbody>
</table>

Dead siblings (including stillbirths, but not miscarriages):

<table>
<thead>
<tr>
<th>T / A / S / H</th>
<th>M / F</th>
<th>yrs/mths at death. Age of patient yrs/mths. not yet born.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T / A / S / H</td>
<td>M / F</td>
<td>yrs/mths at death. Age of patient yrs/mths. not yet born.</td>
</tr>
</tbody>
</table>
**Parents (natural or adoptive)**

**Country of origin:**
- UX / Eire
- Continental Europe - West
- Continental Europe - East
- N. America
- S. America
- Asia
- S. Africa / Zimbabwe
- Rest of Africa
- Australia / NZ
- Other (state) _______________________
- Not known

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Religious background:**
- Jewish
- C of E
- Other Protestant
- RC
- Unspecified Christian
- Atheist / Agnostic
- Muslim
- Sikh
- Hindu
- Other (state) _______________________
- Not known

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[447]
Father's Occupation (highest level) ___________________________ / N.K.

Reg. General's Classification ______ / not assignable / not known

At assessment: □ employed □ employed intermittently
□ unemployed □ not known

Mother's Occupation (highest level) ___________________________ / N.K.

Reg. General's Classification ______ / not assignable / not known

At assessment: □ employed full-time □ employed part-time
□ no paid work □ employed intermittently
□ not known

Family constitution: □ intact □ broken

If broken: □ separation / divorce, patient □ yrs
□ mother's death, patient □ yrs
□ father's death, patient □ yrs
□ single parent (father left before patient's birth)
□ other__________________________

Other significant separations:

<table>
<thead>
<tr>
<th>Hospitalisation of</th>
<th>absence</th>
<th>patient's age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>wks</td>
<td>yrs</td>
</tr>
<tr>
<td></td>
<td>wks</td>
<td>yrs</td>
</tr>
<tr>
<td></td>
<td>wks</td>
<td>yrs</td>
</tr>
<tr>
<td></td>
<td>wks</td>
<td>yrs</td>
</tr>
<tr>
<td>Event</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Death / departure of important figure, child under 5 yrs</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Boarding school, child under 10 yrs</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Taken into Local Authority Care, or other fostering</td>
<td></td>
</tr>
</tbody>
</table>

**Age of child**

- yrs / mths. No. of placements

**Reason for removal**

**Length of separation from natural/adoptive family**

- yrs / wks.

**Parental holidays / business trips, both absent, child under 3 yrs.**

**Other significant separations**

**Frequent changes of primary caretaker (nanny, au pairs, etc., in sole charge)**

- when child under 4 yrs? Yes / no / not known.

**Serious physical illness in family:**

- Father
- Mother
- Siblings
Referral source:

- Parents
- Patient
- GP
- CGC
- Other doctor / hospital
- Therapist treating other member of family
- School / education authority
- AFC Nursery
- AFC Baby Clinic
- Other

Previous treatment for presenting problems:

- Hospital psychiatric treatment
- Paediatric advice
- Tavistock Clinic
- (Other) CGC
- Special schooling / remedial teaching
- Psychotherapy / psychoanalysis
- Other

School / learning difficulties:

- School refusal
- Specific learning difficulty
- Serious underachievement
- Poor peer relationships
- Disruptive behaviour
- Disabling anxiety symptoms (e.g. compulsions)
Problems secondary to physical handicap (e.g., partial sight)

Other

Significant medical history:
- Accidents
- Operations
- Chronic conditions
- Serious acute illnesses
- Other

Diagnostic statement at assessment? Y/N  Category

Treatment

Year treatment began

Age at beginning of treatment

Length of treatment, if known

If not known, length of recorded treatment

Sessions per week initially

Year treatment began

Age at beginning of treatment

Length of treatment, if known

If not known, length of recorded treatment

Sessions per week initially

Recorded treatment

4.5
Therapist: staff / student. Name _______________________

'Sex: M / F.

Change of therapist? Y / N. Yr. of treatment __

Reason:

1. Change to staff.
2. Departure of first therapist
3. Death of first therapist
4. Change to therapist of other sex
5. Other ______________________

Changes in frequency? Y / N.

(1) Year of treatment New frequency per week / month

Reason

(2) Year of treatment New frequency per week / month

Reason

(3) Year of treatment New frequency per week / month

Reason

Code reasons: 1. Need for more intensive work
2. Preparation for agreed termination
3. Major practical problems in bringing child
4. Parents' wish to reduce frequency, other than 3.
5. Child's wish to reduce frequency
6. Admission to hospital (physical illness)
7. Admission to hospital (psychiatric reasons)
8. Move to residential school / community (therapeutic reasons)
9. Other (specify)
### Information on termination

<table>
<thead>
<tr>
<th>Good</th>
<th>Scanty</th>
<th>From inference</th>
<th>None</th>
</tr>
</thead>
</table>

### Information on outcome

<table>
<thead>
<tr>
<th>Good</th>
<th>Scanty</th>
<th>From inference</th>
<th>None</th>
</tr>
</thead>
</table>

### Reason for termination, if known

- By agreement (completed)
- Premature, by parents
- Premature, by patient
- By therapist, not progressing
- By therapist, ext. circs, e.g. departure
- By patient / parents, ext. circs.
- Transferred to other treatment
- Other

### Subsequent treatment at Centre?

- Treatment Recommended? Y/N
- Consultation? Y/N

### If yes:

- Age treatment began
  - [ ] yrs
  - [ ] months
- Length of treatment
  - [ ] yrs
  - [ ] months
- Sessions per week / month

### Reason for further treatment

---

### Change of therapist?

- Y/N

### Reason

---

### Subsequent treatment elsewhere?

- Y/N/not known

### If yes: Before age 18?

- Y/N

### Arranged through Centre?

- Y/N

### Further details

---

453
**Reports available**

Referrer's report

Social history

Psychological testing

IQ

Projective

Diagnostic interviews with child

Diagnostic interviews with parents

Diagnostic profile

Minutes of diagnostic conference

Weekly reports

All / most / some / none

Bimonthly reports

All / most / some / none

Number of biannual reports

Number of Wednesday papers

Published report

Indexing

School reports

Reported interviews with parents during treatment

Nursery records

Closing summary

Terminal profile

Follow-up reports

Quality of weekly reports

Especially clear and informative

Average

Vague, rambling or very brief

Average length of weeklies: less than half a page / half - 1 page / 1 - 2 pages / over 2 pages

454
PSYCHIATRIC DIAGNOSIS OF PARENT

Mother diagnosable in past?
(up to 3 months before assessment)  Yes
Criteria not fulfilled
Insufficient information

Mother diagnosable at assessment?
(including preceding 3 months)  Yes
Criteria not fulfilled
Insufficient information

GAF score at assessment  /N.K.

Father diagnosable in past?
(up to 3 months before assessment)  Yes
Criteria not fulfilled
Insufficient information

Father diagnosable at assessment?
(including preceding 3 months)  Yes
Criteria not fulfilled
Insufficient information

GAF score at assessment  /N.K.
FORM FOR PSYCHIATRIC DIAGNOSIS OF PARENT

Person diagnosed: Mother/Father
Material used: Past / at assessment
Diagnosis: Principal / Additional / N.K.

Category: 

Severity: Mild / Moderate / Severe

List numbered symptoms present:

Criteria:
Y/N A
Y/N B
Y/N C
Y/N D
Y/N E

(Cross out letters not applicable for given category.)

Certainty of Diagnosis: Definite / Probable / Possible

Definite: all required criteria specifically described in material.

Probable: all but one or two criteria described, remaining features very likely to be present (e.g. specific developmental disorder where sufficient impairment is clear, but required tests not administered; mood disorder in parent, where treatment is described but individual symptoms not listed.)

Possible: clear suggestion of disorder, e.g. report that relative was depressed, but no details. Or possibility that another disorder underlies manifest symptoms, e.g. depressive state in case of solitary conduct disorder and poor self-esteem.
**Psychiatric symptoms or treatment in family:**

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
</table>

- Psychosis
- Bipolar affective disorder
- Puerperal depression following birth of patient
- Other depressive episodes
- Obsessional illness
- Other anxiety symptoms
- Personality disorder
- Drug/alcohol addiction
- Sexual dysfunction
- Violence/extreme aggressiveness within family
- Antisocial behaviour outside family
- Suicide attempts
- Mental subnormality
- Inpatient psychiatric treatment
- Outpatient psychiatric treatment
- Psychotherapy
- Psychoanalysis

Further details

Major: [Insert details here]
PSYCHIATRIC DIAGNOSIS OF CHILD (PATIENT)

Child diagnosable in past?
(Improved at least 3 months before assessment)  
Yes  
Criteria not fulfilled  
Insufficient information

Child diagnosable at assessment?  
Yes  
Criteria not fulfilled  
Insufficient information

CGAS score at assessment  
/N.K.

Child diagnosable at termination?  
Yes  
Criteria not fulfilled  
Insufficient information

CGAS score  
/N.K.

AFC category

Index no.  

458
FORM FOR PSYCHIATRIC DIAGNOSIS OF CHILD

Material used: Past / at assessment / at termination

Diagnosis: Principal / Additional / N.K.

Code: [Blank]

Category: .................

Severity: Mild / Moderate / Severe

List numbered symptoms present:

Criteria: Y/N A ..................................................

Y/N B ..................................................

Y/N C ..................................................

Y/N D ..................................................

Y/N E ..................................................

(Cross out letters not applicable for given category.)

Certainty of Diagnosis: Definite / Probable / Possible

Definite: all required criteria specifically described in material.

Probable: all but one or two criteria described, remaining features very likely to be present (e.g. specific developmental disorder where sufficient impairment is clear, but required tests not administered; mood disorder in parent, where treatment is described but individual symptoms not listed.)

Possible: clear suggestion of disorder, e.g. report that relative was depressed, but no details. Or possibility that another disorder underlies manifest symptoms, e.g depressive state in case of solitary conduct disorder and poor self-esteem.

Age at onset [Blank] yrs / NOT KNOWN


Treatment [Blank] ________________________________
CHILD BEHAVIOR CHECKLIST FOR AGES 2-3

**CHILD'S NAME**

**SEX** □ Boy □ Girl

**DATE OF BIRTH**

**AGE**

**ETHNIC GROUP OR RACE**

**GROUP** □ African □ Asian □ Native American

**TYPE OF WORK**

**FATHER'S NAME**

**MOTHER'S NAME**

**THIS FORM FILLED OUT BY**

**CHILD'S BIRTHDATE**

Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2.

Below is a list of items that describe children. For each item that describes the child now or within the past 2 months, please circle the 2 if the item is very true or often true of the child. Circle the 0 if the item is somewhat or sometimes true of the child; if the item is not true of the child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to the child.

<table>
<thead>
<tr>
<th>Item</th>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please see other side
Does your child have any illness, physical disability, or mental handicap? ☐ No ☐ Yes – Please describe

What concerns you most about your child?

Please describe the best things about your child:
**THE CHILD BEHAVIOR CHECKLIST**

<table>
<thead>
<tr>
<th>Item</th>
<th>Question</th>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 1</td>
<td>Fears the horse might bite or do something bad</td>
<td>0 1 2 31.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2</td>
<td>Allergy (describe)</td>
<td>0 1 2 32.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 3</td>
<td>Argues a lot</td>
<td>0 1 2 33.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 4</td>
<td>Talks to strangers</td>
<td>0 1 2 34.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 5</td>
<td>Feels others are not like you</td>
<td>0 1 2 35.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 6</td>
<td>Acted too young for his/her age</td>
<td>0 1 2 36.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 7</td>
<td>Brags, boasting</td>
<td>0 1 2 37.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 8</td>
<td>Can't concentrate, can't pay attention to long</td>
<td>0 1 2 38.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 9</td>
<td>Can't get nervous mind off certain thoughts, obsessions (describe)</td>
<td>0 1 2 39.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 10</td>
<td>Slaps self, table, or hyperactive</td>
<td>0 1 2 40.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 11</td>
<td>Conga to adults too dependent</td>
<td>0 1 2 41.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 12</td>
<td>Complains of loneliness</td>
<td>0 1 2 42.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 13</td>
<td>Confused or seems to be in a fog</td>
<td>0 1 2 43.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 14</td>
<td>Cruel to animals</td>
<td>0 1 2 44.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 15</td>
<td>Cruel, bullying, or meanness to others</td>
<td>0 1 2 45.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 16</td>
<td>Daydreams or gets lost in his/her thoughts</td>
<td>0 1 2 46.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 17</td>
<td>Deliberately harms self or attempts suicide</td>
<td>0 1 2 47.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 18</td>
<td>Demands a lot of attention</td>
<td>0 1 2 48.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 19</td>
<td>Destroys his/her own things</td>
<td>0 1 2 49.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 20</td>
<td>Destroys things belonging to his/her family or other children</td>
<td>0 1 2 50.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 21</td>
<td>Disobedient at home</td>
<td>0 1 2 51.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 22</td>
<td>Disobedient at school</td>
<td>0 1 2 52.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 23</td>
<td>Disobedient at school</td>
<td>0 1 2 53.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 24</td>
<td>Doesn't eat well</td>
<td>0 1 2 54.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 25</td>
<td>Doesn't get along with other children</td>
<td>0 1 2 55.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 26</td>
<td>Doesn't seem to feel guilty after misbehaving</td>
<td>0 1 2 56.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 27</td>
<td>Easily excited</td>
<td>0 1 2 57.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 28</td>
<td>Eats or drinks things that are not food</td>
<td>0 1 2 58.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 29</td>
<td>Fears certain animals, situations, or places, other than school (describe)</td>
<td>0 1 2 59.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 30</td>
<td>Fears going to school</td>
<td>0 1 2 60.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 1-1. Behavior problem Items 1-56h of the Child Behavior Checklist.**

---

**THE CHILD BEHAVIOR CHECKLIST**

<table>
<thead>
<tr>
<th>Item</th>
<th>Question</th>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 1</td>
<td>Physically attacks people</td>
<td>0 1 2 57.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 2</td>
<td>Picks nose, snout, or other parts of body (describe)</td>
<td>0 1 2 58.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 3</td>
<td>Plays with own sex parts in public</td>
<td>0 1 2 59.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 4</td>
<td>Plays with own sex parts too much</td>
<td>0 1 2 60.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 5</td>
<td>Poor school work</td>
<td>0 1 2 61.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 6</td>
<td>Poorly coordinated or clumsy</td>
<td>0 1 2 62.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 7</td>
<td>Pretends playing with older children</td>
<td>0 1 2 63.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 8</td>
<td>Pretends playing with younger children</td>
<td>0 1 2 64.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 9</td>
<td>Refuses to talk</td>
<td>0 1 2 65.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 10</td>
<td>Repeats certain acts over and over, compulsions (describe)</td>
<td>0 1 2 66.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 11</td>
<td>Runs away from home</td>
<td>0 1 2 67.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 12</td>
<td>Screams a lot</td>
<td>0 1 2 68.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 13</td>
<td>Self-conceited or easily embarrassed</td>
<td>0 1 2 69.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 14</td>
<td>Sees things that aren't there (describe)</td>
<td>0 1 2 70.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 15</td>
<td>Shows off or clowning</td>
<td>0 1 2 71.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 16</td>
<td>Shows injury or less than most children</td>
<td>0 1 2 72.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 17</td>
<td>Sneaks more than most children during day and night (describe)</td>
<td>0 1 2 73.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 18</td>
<td>Sneaks or plays with bowels movements</td>
<td>0 1 2 74.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 19</td>
<td>Sleeps too guilty</td>
<td>0 1 2 75.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 20</td>
<td>Sleeps less than most children</td>
<td>0 1 2 76.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 21</td>
<td>Sleeps more than most children during day and night (describe)</td>
<td>0 1 2 77.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 22</td>
<td>Sleeps more than most children during day and night (describe)</td>
<td>0 1 2 78.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 23</td>
<td>Sleeps more than most children during day and night (describe)</td>
<td>0 1 2 79.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 24</td>
<td>Sleeps more than most children during day and night (describe)</td>
<td>0 1 2 80.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 25</td>
<td>Sleeps more than most children during day and night (describe)</td>
<td>0 1 2 81.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 26</td>
<td>Sleeps outside the home</td>
<td>0 1 2 82.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 1 27</td>
<td>Sleeps up things his/hers doesn't need (describe)</td>
<td>0 1 2 83.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 1-2. Behavior problem Items 57-113 of the Child Behavior Checklist.**

---

Please see other side.

---

Please be sure you have answered all items. Underline any you are concerned about.
Index no.  

Number of tests done at AFC  

Number of tests done elsewhere  

**IQ scores at AFC assessment (beginning of treatment):**

<table>
<thead>
<tr>
<th>WISC-R or equivalent</th>
<th>Verbal IQ</th>
<th>Performance IQ</th>
<th>Full Scale IQ</th>
</tr>
</thead>
</table>

Test administered: WISC / WISC-R / Stanford Binet / Kohs / Merril Palmer / other  

Reading age:  

Arith. age:  

Chron. age:  

**IQ scores at other assessments:**

1.  

<table>
<thead>
<tr>
<th>WISC-R or equivalent</th>
<th>Verbal IQ</th>
<th>Performance IQ</th>
<th>Full Scale IQ</th>
</tr>
</thead>
</table>

Test administered: WISC / WISC-R / Stanford Binet / Kohs / Merril Palmer / other  

Reading age:  

Arith. age:  

Chron. age:  

2.  

<table>
<thead>
<tr>
<th>WISC-R or equivalent</th>
<th>Verbal IQ</th>
<th>Performance IQ</th>
<th>Full Scale IQ</th>
</tr>
</thead>
</table>

Test administered: WISC / WISC-R / Stanford Binet / Kohs / Merril Palmer / other  

Reading age:  

Arith. age:  

Chron. age:  

463
### 3. WISC-R or Equivalent

<table>
<thead>
<tr>
<th>Test administered:</th>
<th>Verbal IQ</th>
<th>Performance IQ</th>
<th>Full Scale IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
<tr>
<td>Arith. age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
<tr>
<td>Chron. age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
</tbody>
</table>

### 4. WISC-R or Equivalent

<table>
<thead>
<tr>
<th>Test administered:</th>
<th>Verbal IQ</th>
<th>Performance IQ</th>
<th>Full Scale IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
<tr>
<td>Arith. age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
<tr>
<td>Chron. age:</td>
<td>years</td>
<td>months (mths)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Criteria for rating parental psychiatric symptoms or treatment.
Also see Page 457, Appendix A.

<table>
<thead>
<tr>
<th>Symptom/treatment</th>
<th>Criteria for severity rating 1</th>
<th>Criteria for severity rating 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis; Bipolar affective disorder; Puerperal depression; Other depressive episodes; Obsessional illness; Other anxiety symptoms; Drug/alcohol addiction</td>
<td>Manageable in the community but requiring out-patient care or of sufficient severity to justify such treatment (e.g. clearly requiring but refusing treatment, or manageable with support and medication from GP)</td>
<td>Requiring inpatient treatment or of sufficient severity to justify such treatment (e.g. life-threatening actions, only managed at home with intensive support or because patient refused admission)</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>Mild/moderate impairment of occupational, family or social functioning (e.g. narcissistic individual has series of relationships clearly dominated by demands for attention; has shallow egocentric relationships with children)</td>
<td>Severe impairment of occupational, family or social functioning (e.g. borderline individual cannot work, frequent changes of partner, attacks self or others, has been imprisoned)</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>Limiting and probably destructive to relationship but containable (e.g. long-term impotence, paedophilia restricted to pornography; transvestism)</td>
<td>Not likely to be tolerated by normal partner (e.g. incestuous relationship with child, impotent unless causing pain to partner etc)</td>
</tr>
<tr>
<td>Violence/extreme aggressiveness within family; Antisocial behaviour outside family</td>
<td>Likely to lead to conviction but not imprisonment if prosecuted (e.g. minor assault within or outside family; petty thefts; minor fraud)</td>
<td>Likely to lead to imprisonment if prosecuted (e.g. repeated attacks on adults requiring hospital treatment; single such attack on child; sexual assault of children; repeated or large-scale theft, fraud etc)</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>Relatively minor repeated attempts without injury, or single attempt requiring hospital treatment</td>
<td>Life-threatening or fatal, or requiring physical treatment on at least 2 occasions</td>
</tr>
<tr>
<td>Mental subnormality; Inpatient psychiatric treatment; Outpatient psychiatric treatment; Psychotherapy; Psychoanalysis</td>
<td>Present or absent</td>
<td></td>
</tr>
<tr>
<td>Major marital problems</td>
<td>Moderate (separation of between 1 week and 2 months; rows involving minor violence, not injury; or enough misery for outside help to be sought)</td>
<td>Severe (marriage ended, or separation over 2 months; or very destructive on-going situation - e.g. serious assaults, legal injunction, children openly used as ‘pawns’)</td>
</tr>
</tbody>
</table>
Appendix C1

Initial variables selected from case notes

1. First name
2. Surname
3. Case number
4. Sex
5. Date of birth
6. Lives in London?
7. London district/County
8. Primary caretakers
9. Adopted
10. Adopted age in years
11. Adopted age in months
12. Sibling number
13. Sibling type (Twin, half, adopted etc)
14. Sibling sex
15. Sibling age years
16. Sibling age months
17. Child’s age when sib born
18. Sibling in same home?
19. Dead sibling
20. Dead sibling type
21. Dead sibling sex
22. Dead sibling age at death in years
23. Months
24. Dead sibling age of index child at death in years
25. Months
26. Father’s country of birth
27. Mother’s country of birth
28. Father’s religion
29. Mother’s religion
30. Registrar-General’s Classification for Father
31. Father’s employment status
32. Father’s occupation
33. Registrar-General’s Classification for Mother
34. Mother’s employment status
35. Mother’s occupation
36. Family broken or intact
37. Separations in family number
38. Type of family break
39. Child’s age at time of break
40. Comment
41. Hospitalisation number
42. Who was hospitalised
43. Length of absence from caretaker
44. Child’s age at time of absence in years
45. Months
46. Reason for hospitalisation
47. Comment on hospitalisation
48. Father’s illness (Yes/No)
49. Father’s illness 1
50. Father’s illness 2
51. Mother’s illness (Yes/No)
52. Mother’s illness 1
53. Mother’s illness 2
54. Sibling’s illness (Yes/No)
55. Sibling’s illness 1
56. Sibling’s illness 2
57. Number of presenting symptom (on Achenbach checklist)
58. Achenbach number
59. Score (Somewhat true/Very true)
60. Comment
61. Entry diagnosis number
62. Diagnosable in past (Yes/No)
63. Axis/Classification
64. Diagnosis
65. Confidence rating
66. Diagnosis status (Principal/additional)
67. Diagnosis severity
68. Age at diagnosis
69. Duration of illness
70. Complete/continues
71. Number of treatments
72. Diagnosable at assessment (Yes/No)
73. Axis/Classification
74. Diagnosis
75. Confidence rating
76. Diagnostic status (Principal/ additional)
77. Diagnosis severity
78. CGAS score at assessment
79. Previous treatment number
80. Type of previous treatment
81. Child’s age at previous treatment
82. Comment
83. Treatment for which diagnosis
84. Learning difficulties number
85. Type of learning difficulty
86. Child’s age at time of difficulty
87. Comment
88. Significant medical history number
89. Type of medical problem
90. Child’s age at time of problem
91. Comment
92. Diagnostic statement at assessment (Yes/No)
93. First referral source
94. Comment
95. Second referral source
96. Comment
97. Primary Anna Freud Category
98. Secondary Anna Freud Category
99. Comment
100. Year treatment began
101. Initial sessions per week
102. Maximum sessions per week
103. Age at start of treatment in years
104. Age at start of treatment in months
105. Length of treatment (if known)
106. Length of recorded treatment
107. Therapist number
108. Therapist type (staff / trainee)
109. Therapist name
110. Therapist sex
111. Therapist change
112. Reason for change of therapist
113. Which year of treatment did this therapist start
114. Comment
115. Frequency number
116. Year of treatment for change of frequency
117. New frequency
118. Reason for increase/decrease
119. Comment
120. Information on termination
121. Information on outcome
122. Primary reason for termination
123. Secondary reason for termination
124. Comment
125. Diagnosable at termination (Yes/No)
126. Diagnosis number
127. Diagnosis status (Principal/Additional)
128. Diagnosis severity
129. Axis/Classification system
130. Diagnosis
131. Confidence rating
132. CGAS score at termination
133. CGAS change
134. Mother diagnosed in past
135. Mother diagnosed at referral
136. Mother diagnosis
137. Comment
138. Confidence of diagnosis
139. Severity of diagnosis
140. Status of diagnosis
141. Mother GAF score
142. Father diagnosed in past
143. Father diagnosed at referral
144. Father diagnosis
145. Comment
146. Confidence of diagnosis
147. Severity of diagnosis
148. Status of diagnosis
149. Father GAF score
150. Sibling diagnosed at referral
151. Sibling GAF score
152. Family diagnosis
153. Family physical illness
154. Subsequent treatment at AFC
155. Subsequent consultation at AFC
156. Subsequent AFC treatment recommended
157. Subsequent treatment - age began
158. Subsequent treatment - length
159. Subsequent treatment - sessions per week
160. Subsequent treatment - same therapist (Yes/No)
161. Subsequent treatment - reason for change
162. Subsequent treatment - reason
163. Subsequent treatment - comment
164. Subsequent treatment elsewhere (Yes/No)
165. Type of subsequent treatment elsewhere
166. If yes, before age 18?
167. Arranged through AFC?
168. Type of subsequent treatment
169. Age at subsequent treatment
170. Reason
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>171</td>
<td>Comment</td>
</tr>
<tr>
<td>172</td>
<td>Name of agency</td>
</tr>
<tr>
<td>173</td>
<td>Number AFC IQ tests</td>
</tr>
<tr>
<td>174</td>
<td>Number IQ tests elsewhere</td>
</tr>
<tr>
<td>175</td>
<td>Referrer’s report</td>
</tr>
<tr>
<td>176</td>
<td>Social history</td>
</tr>
<tr>
<td>177</td>
<td>Psych test (Yes/No)</td>
</tr>
<tr>
<td>178</td>
<td>Intelligence tests (Yes/No)</td>
</tr>
<tr>
<td>179</td>
<td>Projective tests (Yes/No)</td>
</tr>
<tr>
<td>180</td>
<td>Number of diagnostic interviews - child</td>
</tr>
<tr>
<td>181</td>
<td>Number of diagnostic interviews - parents</td>
</tr>
<tr>
<td>182</td>
<td>Diagnostic Profile</td>
</tr>
<tr>
<td>183</td>
<td>Minutes of Diagnostic Profile</td>
</tr>
<tr>
<td>184</td>
<td>Number of weeklies</td>
</tr>
<tr>
<td>185</td>
<td>Number Bimonthlies</td>
</tr>
<tr>
<td>186</td>
<td>Number Wednesday case reports</td>
</tr>
<tr>
<td>187</td>
<td>Published report</td>
</tr>
<tr>
<td>188</td>
<td>Indexing (Yes/No)</td>
</tr>
<tr>
<td>189</td>
<td>School reports</td>
</tr>
<tr>
<td>190</td>
<td>Interviews with parents during treatment</td>
</tr>
<tr>
<td>191</td>
<td>Many unreported?</td>
</tr>
<tr>
<td>192</td>
<td>Nursery records</td>
</tr>
<tr>
<td>193</td>
<td>Closing summary</td>
</tr>
<tr>
<td>194</td>
<td>Termination Profile</td>
</tr>
<tr>
<td>195</td>
<td>Follow-up reports</td>
</tr>
<tr>
<td>196</td>
<td>Quality of weeklies</td>
</tr>
<tr>
<td>197</td>
<td>Average length of weeklies</td>
</tr>
<tr>
<td>198</td>
<td>baby observation</td>
</tr>
<tr>
<td>199</td>
<td>Baby clinic</td>
</tr>
<tr>
<td>200</td>
<td>Toddler group</td>
</tr>
<tr>
<td>201</td>
<td>Nursery</td>
</tr>
<tr>
<td>202</td>
<td>Parental guidance before treatment</td>
</tr>
<tr>
<td>203</td>
<td>Parental guidance during treatment</td>
</tr>
<tr>
<td>204</td>
<td>Parent in simultaneous analysis</td>
</tr>
<tr>
<td>205</td>
<td>Mother in simultaneous analysis</td>
</tr>
<tr>
<td>206</td>
<td>Father in simultaneous analysis</td>
</tr>
<tr>
<td>207</td>
<td>Close relation treated</td>
</tr>
<tr>
<td>208</td>
<td>Other relationships with staff</td>
</tr>
<tr>
<td>209</td>
<td>Other contact</td>
</tr>
<tr>
<td>210</td>
<td>Full diagnosis (Yes/No)</td>
</tr>
<tr>
<td>211</td>
<td>IQ tests number</td>
</tr>
<tr>
<td>212</td>
<td>Time of tests (before/during/after treatment)</td>
</tr>
<tr>
<td>213</td>
<td>Verbal IQ</td>
</tr>
<tr>
<td>214</td>
<td>Performance IQ</td>
</tr>
<tr>
<td>215</td>
<td>Full scale IQ</td>
</tr>
<tr>
<td>216</td>
<td>Test type</td>
</tr>
<tr>
<td>217</td>
<td>Comment on test</td>
</tr>
<tr>
<td>218</td>
<td>Reading age</td>
</tr>
<tr>
<td>219</td>
<td>Reading test used</td>
</tr>
<tr>
<td>220</td>
<td>Arithmetic age</td>
</tr>
<tr>
<td>221</td>
<td>Arithmetic test used</td>
</tr>
<tr>
<td>222</td>
<td>Chronological age</td>
</tr>
<tr>
<td>223</td>
<td>Comment on all tests</td>
</tr>
<tr>
<td>224</td>
<td>Achenbach symptom number</td>
</tr>
<tr>
<td>225</td>
<td>Achenbach severity/ frequency score</td>
</tr>
<tr>
<td>226</td>
<td>Comment</td>
</tr>
<tr>
<td>227</td>
<td>Type of symptom</td>
</tr>
</tbody>
</table>
228. Which parent
229. Current/past
230. Comment
231. Frequent changes of primary caretaker
232. Case in sample
Appendix C2
Revised list of 52 variables used for analysis in the present investigation (some transformed from a merging of two or more initial variables)

Diagnostic category 1  (Pervasive developmental disorders/mental retardation)
Diagnostic category 2 (Anxieties, phobias, sleep, adjustment, somatoform)
Diagnostic category 3 (Disruptive, conduct disorders, mixed emotional and conduct)
Diagnostic category 4 (V code and habit disorders)
Diagnostic category 5 (No diagnosis - CGAS under 70)
Diagnostic category 6 (No diagnosis - CGAS over 70)
Sex of child
Age at start of treatment
Family broken/intact
Therapist type
Father’s GAF
Mother’s GAF
Parent physically ill
Learning difficulties
Parental guidance before treatment
Parental guidance during treatment
Primary caretakers
Mother’s employment status
Mother’s past diagnostic status
Mother’s present diagnostic status
Father’s past diagnostic status
Father’s present diagnostic status
Child’s past diagnostic status
Child’s current diagnostic status
Child’s CGAS at start
Referral source
Initial number of weekly sessions
Maximum number of weekly sessions
Reason for termination
Length of treatment
Social class
Number of sibs
Child’s disruptive behaviour
IQ
Medical history
Experience of loss
Experience of insecurity
Child hospitalisation
Mother hospitalization
Parent dead
Mother problem now
Mother problem ever
Father problem ever
Mother severe problem ever
Father severe problem ever
Mother very severe problem ever
Mother anxiety problem
Mother problem with violence
Mother suicide attempt
Mother outpatient treatment
Mother psychoanalysis
Marital problems
Appendix C3

List of 38 variables used in the second stage of the statistical analysis after variables matched between Target and Control groups have been excluded.

Father’s GAF
Mother’s GAF
Parent physically ill
Learning difficulties
Parental guidance before treatment
Parental guidance during treatment
Primary caretakers
Mother’s employment status
Mother’s past diagnostic status
Mother’s present diagnostic status
Father’s past diagnostic status
Father’s present diagnostic status
Child’s past diagnostic status
Child’s CGAS at start
Referral source
Maximum number of weekly sessions
Reason for termination
Length of treatment
Number of sibs
Child’s disruptive behaviour
Medical history
Experience of loss
Experience of insecurity
Child hospitalisation
Mother hospitalization
Parent dead
Mother problem now
Mother problem ever
Father problem ever
Mother severe problem ever
Father severe problem ever
Mother very severe problem ever
Mother anxiety problem
Mother problem with violence
Mother suicide attempt
Mother outpatient treatment
Mother psychoanalysis
Marital problems
Appendix C4

List of 36 variables used in the third stage of the statistical analysis after variables matched between Target and Control groups and termination variables have been excluded.

Father's GAF
Mother's GAF
Parent physically ill
Learning difficulties
Parental guidance before treatment
Parental guidance during treatment
Primary caretakers
Mother's employment status
Mother's past diagnostic status
Mother's present diagnostic status
Father's past diagnostic status
Father's present diagnostic status
Child's past diagnostic status
Child's CGAS at start
Referral source
Maximum number of weekly sessions
Number of sibs
Child's disruptive behaviour
Medical history
Experience of loss
Experience of insecurity
Child hospitalisation
Mother hospitalization
Parent dead
Mother problem now
Mother problem ever
Father problem ever
Mother severe problem ever
Father severe problem ever
Mother very severe problem ever
Mother anxiety problem
Mother problem with violence
Mother suicide attempt
Mother outpatient treatment
Mother psychoanalysis
Marital problems
Appendix C5

List of 33 variables used in the fourth stage of the statistical analysis after variables matched between Target and Control groups, termination variables and treatment variables have been excluded.

Father’s GAF
Mother’s GAF
Parent physically ill
Learning difficulties
Primary caretakers
Mother’s employment status
Mother’s past diagnostic status
Mother’s present diagnostic status
Father’s past diagnostic status
Father’s present diagnostic status
Child’s past diagnostic status
Child’s CGAS at start
Referral source
Number of sibs
Child’s disruptive behaviour
Medical history
Experience of loss
Experience of insecurity
Child hospitalisation
Mother hospitalization
Parent dead
Mother problem now
Mother problem ever
Father problem ever
Mother severe problem ever
Father severe problem ever
Mother very severe problem ever
Mother anxiety problem
Mother problem with violence
Mother suicide attempt
Mother outpatient treatment
Mother psychoanalysis
Marital problems
Appendix C6

Matched initial factors

Diagnostic category 1 (Pervasive developmental disorders/mental retardation)
Diagnostic category 2 (Anxieties, phobias, sleep, adjustment, somatoform)
Diagnostic category 3 (Disruptive, conduct disorders, mixed emotional and conduct)
Diagnostic category 4 (V code and habit disorders)
Diagnostic category 5 (No diagnosis - CGAS under 70)
Diagnostic category 6 (No diagnosis - CGAS over 70)
Sex of child
Age at start of treatment
Family broken/intact
Therapist type
Child's current diagnostic status
Initial number of weekly sessions
Social class
IQ
Appendix D

Children's Global Assessment Scale
(for children 4 to 16 years of age)  Schaffer et al 1983

Rate actual functioning regardless of treatment or prognosis. The examples of behaviour provided are only illustrative and are not required for a particular rating.

100-91  **Superior functioning in all areas** (at home, at school, and with peers); involved in a wide range of activities and has many interests (eg has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts etc); likeable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms.

90-81  **Good functioning in all areas**; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (eg mild anxiety associated with an important exam, occasional "blowups" with siblings, parents or peers).

80-71  **No more than slight impairment in functioning** at home, at school or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (eg parental separations, deaths, birth of a sib), but these are brief, and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61  **Some difficulty in a single area but generally functioning pretty well** (eg sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51  **Variable functioning with sporadic difficulties or symptoms in several but not all social areas**; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41  **Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area**, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.

40-31  **Major impairment of functioning in several areas and unable to function in one of these areas** (disturbed at home, at school, with peers, or in society at large, eg persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21  **Unable to function in almost all areas**, eg stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (eg sometimes incoherent or inappropriate).

20-11  **Needs considerable supervision** to prevent hurting others or self (eg frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, eg severe abnormalities in verbal and gestural communication, marked social aloofness, stupor etc.

10-1  **Needs constant supervision** (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.
Appendix E

Global Assessment of Functioning Scale (GAF Scale)

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health/illness. Do not include impairment in functioning due to physical (or environmental) limitations.

90-81 Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).

80-71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work).

70-61 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60-51 Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with co-workers).

50-41 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

40-31 Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30-21 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day; no job, home or friends).

20-11 Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears faeces) OR gross impairment in communication (e.g. largely incoherent or mute).

10-1 Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information.
Appendix F

Examples of individual cases in each of the Medical categories:

Case # 1: (Sample number 039)

Boy aged 13:0
He had drank poison accidentally and injured his stomach at the age of 2½. He had suffered hepatitis at ages 5 and 7. He had broken his arm at 6½ and was operated on for this. His sight was very poor, with a high probability that he would become totally blind, and he had developed symptoms of ulcers in response to stress.

Codings:
Chronic disability: Sight. Single, major.
Acute illnesses: Two bouts of hepatitis at ages 5 and 7. Details unknown so classed as multiple, minor.

Grouping:
Chronic Disability Group.

Comments:
Many codings and almost all ratings are debatable. It is not known from the files whether the ulcer-like symptoms are a true chronic condition or an acute flare-up. Nor can we really discriminate their severity. In this case the child is rated under both categories of chronicity but would be regarded as being more adequately described as suffering from a chronic disability. On the whole disabilities 'trump' over illnesses, but every case is taken on its own merits.

Case # 2: (Sample number 139)

Boy aged 3:2
At the age of 1 year he had suffered severe burns which resulted in one month's stay in hospital where he was nursed in isolation. Also at age 1 he had had an attack of measles that required a 2-week hospital stay. Asthma and petit mal epilepsy had been present from birth.

Codings:
Operations None.
Chronic disabilities: None
Chronic illness: Epilepsy with petit mal attacks. Asthma. Rating: Multiple, major.

Grouping:
Chronic Illness Group.
Comments:
Measles would not normally be ratable but because this case was serious enough to require admission to hospital, it fell within the criteria for noting. This means, of course, that the severity of acute illnesses demands a relatively high threshold to rate inclusion. This seems reasonable, as all children will have a certain number of acute illnesses while far fewer will suffer accidents, operations, and chronic conditions. This boy is eligible for entry under either the ill or the psychosomatic groupings; in the absence of any information on the severity of the asthma it is assumed that the epilepsy is a more severe condition. This child is very young and it is possible that the petit mal and the asthma may diminish or stop altogether as he gets older. Had he come to our Centre ten years later he might not have been codifiable under a significant current medical history.

Of course, a child with no significant current medical history could have suffered considerably, and with implications reaching into the present, from past conditions that no longer obtained. We made the decision that our target groups should be made up only of children with current disabilities and illnesses because of the greater likelihood that ongoing problems would have been noted during the diagnostic process. Those remaining under the chronic sections were selected out before matching for controls, to avoid any confounding of past chronic episodes.

Case # 3: (Sample number 591)
Girl aged 8:11
This child suffered from an eczema which had caused her to miss a whole year of schooling and which also led to considerable self-mutilation through scratching. Shortly before referral she had spent 6 months in hospital with a ‘traumatic and painful’ skin infection, assumed to be another manifestation of the eczema. This was her second hospitalisation in connection with eczema and on this second visit she also developed asthma.

Codings:
Accidents: None
Operations: None
Chronic disabilities: None
Acute illnesses: None
Chronic illnesses: Eczema and asthma. Multiple, severe.

Grouping:
Chronic Psychosomatic Group.

Comments:
There is no indication that the asthma is particularly severe and, on its own it would have been coded as minor. However, the more or most severe of the entries in each category dictates the rating and the eczema in this case is undoubtedly extremely severe indeed.
Appendix G

Generally poor prognostic indicators:

1. School refusal
2. 'Other' learning difficulties esp if related to physical handicap or illness
3. Low performance IQs, especially for children with brain dysfunction
4. Habit disorders
5. Pervasive or specific developmental disorders
6. Mother's current psychological problems
7. Mother's diagnosis of personality disorder
8. Suicidal gestures from mother
9. Parental physical illness
10. Serious marital problems

Good prognostic indicators:

1. Younger age range, especially pre-school
2. Underachievement at school (medical children only)
3. Family intact
4. Child anxiety diagnosis
5. High level of functioning from father (GAF = >70)
6. Mother's psychoanalysis
7. Mother's hospitalisation

To optimise treatment effects:

1. Parental guidance before and during treatment which, in turn
2. Decreases premature terminations

School refusers tend to withdraw early from treatment. Because both school refusal and premature termination may be partly due to parental collusion, such children may be more effectively treated with family therapy or behavioural techniques than with psychoanalysis.
Appendix H

Cases used for investigative study into the reliability of good and bad prognostic indicators

039
081
109
112
118
140
188
222
228
291
311
346
356
418
427
448
501
579
701
729
734
740
Appendix J

Summary profiles of subgroups

Disabled
1. Significantly more learning difficulties than controls.
2. More likely to have poor peer relationships at school.
3. Significantly more accidents than controls.
4. More likely than other groups to be referred by special agencies and other miscellaneous sources.
5. Mothers tend to have higher GAF scores than in other medical samples.
6. Mothers less likely to be diagnosable than many other groups.
7. Mothers less likely than all other groups to have current symptoms.
8. Mothers much less likely to have ever had psychological problems than all other groups.
9. Mothers less likely to be anxious or depressed than in other target groups.
10. Unemployed mothers less likely to suffer with depression.
11. More likely than other groups to end treatment by being transferred elsewhere.

Ill
1. Slightly older than other samples.
2. Significantly more learning difficulties than controls.
3. Significantly more hospitalisations than controls, especially multiple admissions.
4. More acute illnesses than controls.
5. Lower social class than other samples; significantly lower than the Somatic group.
6. More likely to be referred by doctors.
8. Mothers more anxious than in most other groups.
9. Mothers significantly more likely to have current symptoms than in most other groups.
10. More likely to have a physically ill father than controls.
11. Significantly more likely to have a physically ill mother than controls or non-medical groups.
12. More likely to leave treatment prematurely or be terminated by the therapist for lack of progress than other groups.
13. Conversely, also more likely to be ‘heroic indications’ and to stay in treatment for many years.
14. Significantly more likely to have termination anxiety diagnosis than controls.

Somatic
1. Slightly higher social class.
2. Significantly higher family intactness than non-medical group.
3. Child significantly more likely to have an anxiety diagnosis at assessment and at termination than most other groups.
4. Mothers more likely to be anxious than most other groups.
5. Mothers more likely to have current symptoms than most other groups.
6. Slightly better outcome than all other groups.
Overall Medical profile
1. Significantly more children with learning disabilities (Disabled and III) than controls.
2. More likely than non-medical groups to do better if underachieving at school.
3. Significantly more likely than controls to have had in-patient hospital treatment, including significantly more multiple admissions.
4. Higher family intactness.
5. Lower rates of divorce and parental separation.
7. Parents less likely to have past psychiatric diagnoses.
8. Parents less likely to attain positive current diagnostic status.
9. Mothers less diagnosable (Disabled and Somatic).
10. Fathers significantly less likely to be diagnosable than control groups.
11. Mothers significantly more likely to be physically ill.
12. Fathers more likely to be physically ill (especially Disabled and III).
13. Children significantly less likely to have mood disorders (eg depression) than in nonmedical sample.
14. Children more likely to have conduct and pervasive developmental disorders (Disabled and III).
15. Children more likely to have anxiety disorders, significantly so at termination (III and Somatic).
Appendix K

There is a debate in the literature, which we referred to on pages 180ff, on the validity of separating chronic conditions of assumed functional (psychosomatic) origin from the organic illnesses. The following summarises the major differences and similarities uncovered in this investigation between the two groups.

Somatic versus Ill

Differences:
1. Somatics younger than Ill children.
2. Somatic families significantly higher social class.
3. Somatics much more likely to have anxiety diagnoses at assessment.
4. Ill more likely to have conduct and pervasive disorders.
5. Ill mothers have a preponderance of current symptoms, especially anxiety.
6. Somatic mothers have more past symptoms.
7. Somatic mothers more likely to have had psychoanalytic treatment.
8. Ill significantly less likely to be offered intensive treatment.
9. Somatics much more likely to end by mutual agreement.

Similarities:
1. High rates of maternal anxiety.
2. High rates of current symptoms for mother.
3. High rates of child anxiety at termination.
Appendix L

Targets and controls

The nine matched factors were not the only variables uniting each target medical group with its control. The following variables were not matched but, possibly because of the influence of those factors that were controlled for, showed considerable similarity between target and control group.

1. AFC categories.
2. All family variables including separations and losses (only family broken/intact matched for) and mother’s employment status.
4. CGAS ratings at start.
5. Parental illness (Somatic targets and controls).
6. Mother’s use of psychoanalysis.
7. Reason for termination (especially Somatics).
8. Psychiatric status at termination.
9. CGAS rating at termination.
10. CGAS change.