The History and Current Status of Outcome Research at the Anna Freud Centre

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Peter Fonagy & Mary Target

Introduction

Psychoanalytic treatment in psychiatry and other mental health specialisms has become extremely controversial in the last decades of the twentieth century (e.g. Detre & McDonald, 1997). The emphasis on empirically validated or empirically based treatments (EBTs) has raised the clinical trial, using randomized controlled design, to the gold standard that determines whether or not efficacy of a particular treatment has been demonstrated. Psychiatrists who ascribe to this view can now dismiss claims for therapeutic efficacy of psychoanalytic therapies in the absence of data that adhere to this standard. There have been recent attempts to offer more or less comprehensive reviews of the effectiveness of psychoanalytic methods (Fonagy et al., 2001; Gabbard, Gunderson, & Fonagy, in press; Leuzinger-Bohleber & Target, in press). These reviews take up the challenge for accountability that the EBT movement has set psychoanalytic clinicians, to align their training and practice with the current state of scientific evidence (Weisz, Hawley, Pilkonis,

[1] The studies described in this paper were carried out in close collaboration with the Yale Child Study Center, under the leadership of the late Professor Donald Cohen. We would like to dedicate this paper to his memory. He carefully guided the work described here from its inception, and gave it generous intellectual as well as material support. Other faculty members at the Yale Child Study Center have also been closely involved with the studies. In particular, we would like to acknowledge the advice and support of Professor Albert Solnit, and the warm and unstinting contributions of Dr Linda Mayes, together with the generous interest and support of Dr Robert King. We also enormously appreciated the participation and encouragement, at key phases, of Professor Alan Kazdin, of Yale University Department of Psychology. The work reported here is the result of years of effort by many leaders at the Anna Freud Centre, particularly Dr George Moran, Mrs Hansi Kennedy, Miss Rose Edgcumbe and Ms Julia Fabricius. In individual studies, major contributions were made by Mrs Anne-Marie Sandler, Dr Andrew Gerber, Dr Anthony Bateman, Dr Anna Higgitt, Dr Jill Miller, Ms Doris Fillion, Dr Daniel Barth. More recently, Ms Abby Schachter and Ms Karin Ensink have been effective project leaders of studies described. The studies described received funding from numerous sources, too numerous to mention in full, but particularly significant contributions were made by: The Anna Freud Foundation, the Mental Health Health Foundation, the Gatsby Trust, the American Psychoanalytic Association Research Fund, the International Psychoanalytic Association Research Fund, the Simenauer Trust, as well as the Board of Trustees of the Anna Freud Centre.

Woody, & Follette, 2000).

We are aware that some feel that bringing psychoanalysis into the realms of science and medicine is a serious error. While we share the anxiety felt about having the cultural frame for mental health treatment created by drug companies and economist-led government regulatory agencies, we do not think that the risks of corruption by such social and cultural forces equal the dangers of unregulated mental health care, repudiating the scientific principles commonly held in medicine. Such care “in the hands of the people”, or entirely at the discretion of professionals with vested interests, has an appalling historical record. Without systematic evaluation of effectiveness, treatments such as insulin coma therapy might still be practised. It is rarely better not to seek greater knowledge. The EBT movement is a method for the integration of the clinical knowledge base, which, if pursued with thoughtfulness and rigor, will enhance our understanding of clinical work and yield improved services for a disadvantaged and underserved group. While initially perceived as imposing alien ‘objective’ norms on a practice founded on intuition and subjectivity, the movement has the potential to liberate the scientist in the practitioner and empower clinicians to offer improved services by focusing on what they do best: offering informed individualized care to their clients in distress.

In past decades there have been impressive systematic studies of the outcome of the psychoanalysis across groups of patients and analysts (e.g. Kantrowitz, Paolitto, Sashin, & Solomon, 1987; Sandell et al., 2000; Wallerstein, 1989). However, the studies carried out to date have almost all been with adult patients. There is very little information even on the short-term outcome of psychoanalytic treatment for children. The information that does exist has largely emerged from the research tradition of the Anna Freud Centre (formerly the Hampstead Clinic), in London. We will first mention the early studies, then our current

programme of research.

While Anna Freud clearly had mixed feelings about empirical research on outcome, and did not feel at home in academic psychology (Mayes & Cohen, 1996), there is no doubt that a firm commitment to systematic observation and scientific enquiry was implicit in her work (Colonna, 1996) . For example, Lustman's evaluation (1967) of Anna Freud's scientific contribution concludes: "A review of her work reveals a consistent and scientifically sophisticated awareness of the reciprocal relationship between phenomenology and theory construction. This has resulted in a body of theoretical conceptualizations characterized by rare utility and relevance… [and] the development of her concern with and for empirical psychoanalytic research, which has evolved through categorizing efforts into a clear statement that behavior is suprastructural." (p. 825). As Mayes and Cohen note, in their careful and illuminating survey of the contemporary relevance of Anna Freud's research work, Miss Freud concluded her comments on "The Contribution of Psychoanalysis to Genetic Psychology" (1950) with the proposal that the collaborative meeting ground for academic psychology and psychoanalytic inquiry would be based not on data from the psychoanalytic consulting room but on "analytically directed observational child study" (Freud, 1951, p. 142). This is very much in line with our approach, outlined further in the current paper.

Previous work on child psychoanalytic outcome

A child psychoanalyst trained at the Anna Freud Centre, Christophe Heinicke, with Ramsey-Klee (1986), evaluated psychoanalytic treatment for latency children referred for reading retardation associated with emotional disturbances. In separate groups the frequency of treatment sessions was set at either once a week for two years, 4 times per week for two years, or once a week in the first year followed by four times a week in the second. All

patterns of treatment led to gains in self esteem, adaptation and the capacity for relationships but the gains were significantly greater, and better sustained, for the groups treated 4 times per week for one or both years. This study paved the way for later work on child psychoanalytic outcome, but - by the current standards of outcome research - is flawed by the lack of definition of disorders and treatment procedures, and the use of outcome assessments which had not been validated.

Moran and Fonagy conducted a series of studies of psychoanalytic treatment with children suffering from so-called brittle diabetes (for a detailed account, see Fonagy & Moran, 1991a). These young patients cannot maintain their blood sugar levels close to normal, and therefore their lives are constantly disrupted by life-threatening episodes of hypoglycaemia and ketoacidosis. The children in the study were referred for psychoanalysis after many other physical and psychological treatments had been shown not to be effective. Physical measures were used to circumvent the problem of measuring the outcome of psychoanalysis: a simple biochemical index of average blood glucose levels, and accurate indicators of growth.

The first study (Moran & Fonagy, 1987) explored the relationship between metabolic control and the process of psychoanalysis in a single case study of a diabetic adolescent girl. Process reports were rated for the presence of dynamic themes. The association of these themes with independently obtained measures of diabetic control was examined using time-series analysis. The study revealed a close statistical relationship between week-to-week fluctuations of metabolic control and the presence of key themes in the patient's analytic material. Most significantly, the analytic narrative predicted the child's subsequent diabetic control: the presence of conflict in the analytic material was reliably followed by an improvement in diabetic control one to three weeks later.

The second study by these authors (Moran, Fonagy, Kurtz, Bolton, & Brook, 1991) compared two equivalent groups of 11 diabetic children with grossly abnormal blood glucose profiles, requiring repeated admissions to hospital. Patients in the treatment group were offered an intensive inpatient treatment programme that included three to four times weekly psychoanalytic psychotherapy. Treatment was brief, lasting on average 15 weeks. Patients in the comparison group were offered only inpatient medical treatment. The children in the treatment group showed considerable improvements in diabetic control, maintained at one-year follow-up. The comparison group children, in contrast, returned to pre-treatment levels of metabolic control within three months of discharge from hospital. All but one of the psychotherapeutically-treated patients showed clinically-significant changes, but only three of the eleven in the comparison group did so. There was also a reduction in hospitalisation during the follow-up period in the psychoanalytically-treated group.

The third of these studies (Fonagy & Moran, 1991a) was an independent series of experimental single case studies. This assessed the impact of treatment on growth rate (measured by changes in height and bone age) in three children whose height had fallen below the 5th percentile for age. Charts of the children's heights over 2-3 years prior to their treatment indicated that medical intervention had been of little value. In order to illustrate the causal relationship between the psychoanalytic therapy and their growth measures, changes in three indicators were recorded for six-month periods before, during and after treatment. For all three children, treatment was associated with an acceleration of growth and a substantial increase in predicted adult height (in the case of one boy, an increase of over 10 centimetres). As might be expected, growth rate improvements were more marked in children who were younger at the time of undertaking psychotherapy.

Taken together, these studies of diabetic children illustrated one important method of

assessing the effectiveness of psychoanalysis. The crucial components of this approach were: 1) a client group who responded poorly to alternative treatments; 2) an outcome variable independent of the treatment process; 3) process studies which offered pointers to the effective component of the treatment. These studies illustrate that as well as producing evidence of efficacy which was "hard" enough to convince the sceptical medical carers of these patients, and to be published in major psychiatric journals, an empirical study could yield data of clinical psychoanalytic interest, probably extending to other patients engaging in self-harming behaviour and perhaps well beyond.

This promising series of studies suffers from an absence of replication. The samples are small, the length of hospitalisation is not matched, with the psychotherapeutically-treated group having significantly longer admissions, and the absence of psychological measures of change leaves open the question of whether psychological or physical changes were responsible for the effects observed. Comparison with a no-treatment control group is also less compelling than effectiveness relative to an alternative treatment, e.g. CBT. Nevertheless, the importance of the studies is enhanced by the well-known long-term complications associated with this condition, and the relatively poor outcome associated with other treatment methods.

The ongoing programme of work on outcome at the Anna Freud Centre

Identifying predictors of therapeutic outcome

The first of our studies to be described used retrospective chart review methodology: 763 cases already treated at the Anna Freud Centre in either 4-5 times per week psychoanalysis or 1-3 times per week psychodynamic therapy were systematically reviewed. The procedures and results of this study have been more fully described elsewhere (Fonagy

& Target, 1994; 1996; Target & Fonagy, 1994a, 1994b). In approaching this vast collection of clinical material (many case records covering hundreds of pages), we decided to use standardised psychological and psychiatric, as well as psychoanalytic, descriptions of the children treated. This allowed much easier comparison between these children and those who were offered other forms of psychiatric treatment, and therefore readier acceptance of the findings in the wider psychiatric community. The sacrifice initially was accepted within psychoanalysis, but this we hope is being rectified by our further studies, to be mentioned later.

Three main studies of the closed case records were reported:

(a) Emotional disorders (Target & Fonagy, 1994a).

This study examined the effectiveness of psychoanalysis for children and adolescents with DSM-III-R diagnoses of anxiety or depressive disorders. 352 charts were reviewed and independently rated for a wide range of demographic, clinical, process and outcome measures. The study showed that: (i) 72% of those treated for at least 6 months showed reliable, clinically significant improvement in adaptation, and only 24% had a diagnosable disorder at termination; (ii) phobic disorders were most likely to remit, and depressed children least likely; (iii) children under 11 years were significantly more likely to be well at the end of treatment; (iv) while longer treatment was predictably associated with good outcome, more frequent sessions also led to greater improvements independently of the child's age and length of treatment; (v) intensive treatment was significantly more helpful for children who presented with more severe disturbance, in terms of a psychoanalytic diagnosis of atypical personality development, multiple psychiatric diagnoses or pervasive impairment, usually affecting social, emotional and cognitive functioning.

A number of demographic and clinical variables helped to identify the children who

were most likely to improve. These included higher IQ, younger age, longer treatment, good peer relations, poor overall adjustment of the mother, the presence of anxiety symptoms in the mother, concurrent treatment of the mother, and absence of a history of maternal antisocial behaviour. Groups of children with depressive, overanxious and specific anxiety disorders had different predictors of favourable outcome, underscoring the heterogeneity of this group, and the different processes at work in their psychotherapeutic treatment.

(b) Disruptive disorders (Fonagy & Target, 1994) .

Here 135 children with disruptive disorders were matched on demographic, clinical and treatment variables with children presenting with emotional disorders. Overall improvement rates were lower for disruptive disorders, and nearly one third of the children treated terminated within one year of starting treatment. Premature termination was associated with older age, non-intensive treatment, less well-functioning mother, fewer learning difficulties at school and lack of concurrent parental guidance. Of those disruptive children who remained in treatment, 69% were no longer diagnosable on termination. Predictors of improvement included the presence of an anxiety disorder, absence of other disorders, younger age, intensive treatment, longer treatment, maternal anxiety disorder, child having been in foster care, and psychotherapeutic treatment of mother.

(c) Developmental considerations (Target & Fonagy, 1994b).

This third report examined the way in which the age of a child or adolescent when treated in psychoanalytic psychotherapy related to the outcome of that treatment. 127 children were selected from each of three age bands (under 6, 6-12, and adolescents); they were matched on broad diagnostic grouping, gender, socio-economic status, global adaptation and frequency of sessions. Outcome was indicated by diagnostic change and clinically significant change in adaptation. Younger children generally improved to a greater

extent. Children under 12 benefited from intensive treatment more than from non-intensive treatment, but this was not true of adolescents. Division into age groups improved the accuracy of prediction of improvement. This study suggested that in psychodynamic treatment, younger age is an advantage, and that developmental factors considerably affect the outcome of this form of therapy.

Evaluation

A number of themes ran through the various analyses of this data. Younger children appeared to improve more during psychodynamic treatment. Anxiety disorders, particularly specific rather than pervasive symptoms, were associated with a good prognosis, even if the primary diagnosis was of a different type, e.g. disruptive. Children with severe pervasive developmental disorders (particularly autism) did not do well, even with prolonged, intensive treatment. However, among children with emotional disorders, there was evidence that severe or complex symptomatology did respond well to intensive treatment, but did not show satisfactory rates of improvement in non-intensive psychotherapy.

However, we need to acknowledge some substantial limitations of retrospective studies, which have prompted our further work to be reported below. The comparison groups are drawn from the same, treated population, so improvements do not reflect superiority over an untreated control group. The sample is unrepresentative, and is heterogeneous over a historically long period, during which referral criteria changed. The treatments also varied across time and were not manualised. Data acquisition depended on the quality of the records which was variable, and there may have been unknown confoundings between different types of case and the quality of reporting. The very simple measure of outcome inevitably obscures the subtle differences between changes in individual cases.

A change of perspective on outcomes generated by this study

Outcome studies should always be carried out within a theoretical context. Anna Freud's work formed the backbone of our research, and of our understanding of the findings. The Anna Freud Centre's mission has always been to provide psychoanalysis for children, with a view to restoring them as far as possible to the path of normal development (Kennedy & Moran, 1991). While recognising the place of less intensive therapy, which was indeed confirmed and clarified by some of our chart review findings, clinical experience supported by other results of the above study suggests that intensive treatment may sometimes be essential to influence pathological developmental processes.

Anna Freud's model assumed that emotional disorders of childhood arose in association with the arrest or distortion of lines of normal development for which the child may find maladaptive solutions. Anna Freud therefore conceived developmental anomalies as risk factors for neurotic disorders. Our work with case records in conjunction with other research has led a group working at the Anna Freud Centre to extend psychoanalytic assumptions about psychic change in child analysis (Fonagy & Moran, 1991b; Fonagy, Moran, Edgcumbe, Kennedy, & Target, 1993). We delineated two models of the psychoanalytic treatment of emotional disturbance in children. The first (the classical model) involves the patient recovering threatening ideas and feelings, which have been repressed or distorted as a result of conflict and defence. Non-intensive and intensive treatments seem to be equally effective for this group, although for younger children intensive treatment may have an added advantage. The second model (the mental process model) draws attention to inhibited, fundamental mental processes. The gradual engagement of these in treatment occurs primarily through patient and analyst focusing on the thoughts and feelings of each person, and how the child understands these. Patients with disorders that involve the

inhibition or decoupling of essential mental processes, such as reflective capacities, or aspects of awareness of the mental states of others, show more pervasive (though not necessarily more severe) psychopathology, and require intensive psychoanalytic intervention. This distinction roughly corresponds to the traditional psychoanalytic distinction of neurotic vs developmental disorder. On the basis of the retrospective study, we have reached a clearer definition of such disorders in diagnostic terms, and we have been able to confirm the theoretical expectation that these patients really do need long-term and intensive intervention.

This retrospective study is now being followed by a group of further research initiatives, which aim to extend the findings considerably. The main ongoing studies are outlined below.

The groundwork for a prospective study of the efficacy of child psychoanalysis

The only method of evaluation of therapeutic outcome that meets strict scientific requirements in the wider mental health community is the randomised controlled trial (RCT). There are great practical and ethical difficulties in using RCTs to evaluate intensive, long-term therapies. These include the identification of outcome measures appropriate to psychoanalytic treatment, the need for very long term follow-up to demonstrate subtle changes in personality functioning, difficulties in describing complex treatment procedures sufficiently clearly for others to be able in principle to replicate the study, and the very great expense of mounting an investigation with sufficient statistical power to produce conclusive results. We have been working for some years to overcome these problems.

(a) Measurement of outcome.

Measures applied in the evaluation of other therapies, such as change in symptoms, must be included when assessing the outcome of psychoanalytic treatment. However, if one

is to test our belief that analysis does much more than reduce observable symptoms, then an attempt must be made to measure parameters identified by analysts as relevant (especially intrapsychic functioning). Some such measures are: the quality of object relationships, adaptiveness of defences, the range and regulation of the child's emotional responses, the development of morality, and social understanding. This posed a formidable challenge, in that normative data were not yet available on many measures, and relevant measures had in some areas not even been developed. The approach we took was to make use of recent progress in developmental psychology, and develop a battery of measures devised to chart the cognitive and social development of children, and then collect normative data on these measures.

The core measures included in the battery are: 1) The Hampstead Child Adaptation Measure (HCAM) (Schneider, 1999; Target, 1993), which is a measure of social and emotional adaptation (conceptually based on Anna Freud's developmental lines) scored for 14 different domains, using different norms for five developmental levels; 2) The Child Behaviour Checklist (CBCL) (Achenbach & Edelbrock, 1983), the Teacher's Report Form (TRF) (Achenbach & Edelbrock, 1986), and Harter's Self Perception Profile and Social Support Scale for Children (Harter, 1985); these three measures are widely-used indices of symptomatology and self-esteem, which we used in their own right and as validating measures for our new scales; 3) MacArthur Story Stem Battery (Oppenheim, Emde, & Warren, 1997), an assessment of the internal world and representations of self and other, using a doll-play story completion paradigm, and which we adapted and manualised for school-aged children; 4) Mean and Nice Interaction Scale: Peers (Fischer, Handke, & Hand, 1998), this is an assessment of moral development using doll figures, which we similarly adapted for school-aged children; 5) State-Trait Anxiety Inventory for Children (STAI-C)

(Spielberger, 1973) and the Child Depression Inventory (CDI) (Kovacs, 1992), two widely-used self-report measures of mood in children over 8 years, which we used in their own right and as validating measures for our new scales; 6) Weschler Intelligence Scale for Children; (WISCIII-R); 7) The Child Attachment Interview (CAI) (Target, Shmueli-Goetz, Fonagy, & Datta, in preparation); 8) the Family Adaptability and Cohesion Evaluation Scale (FACES) (Olson, 1994), and 9) the Affect Task, an existing measure of emotion attribution and understanding, developed for preschool children by Miriam Steele, Peter Fonagy and Howard Steele, and adapted and extended in this project for children of elementary school age.

Measures were selected to 1) Cover four outcome domains: symptomatology, adaptation, inter-personal (family and peer relations), intra-personal (affect regulation, understanding of emotions in self and others, cognitive-affective representational structures); 2) Provide data obtained from children themselves, their parents, as well as teachers; and 3) Use multiple methods of assessment. Three new measures, the HCAM (Target, Fonagy, Schneider, Ensink, & Janes, 2000), the CAI and the Affect Task for School-Age Children (Fonagy et al., 1999) were developed and validated. New coding systems for measures such as the Happe Strange Stories and MacArthur Narrative Completion Task were also developed, as well as validated. To validate this battery on a clinical sample, 80 children aged 6-11 were recruited from referrals to Child and Adolescent Mental Health Consultation Services and compared with 80 normal controls.

The results indicate that the test-retest and inter-rater reliability data of the measures was good. Further objectives were to determine whether new and existing measures distinguish between referred and non-referred children, whether the measures and procedure were acceptable to a clinical population, and ultimately to reduce the battery in a rational manner. The results indicate that there were significant differences in the performance of

referred and non-referred children on all the measures, and that the measures and procedure were acceptable to a clinical population.

The HCAM provides a systematic method of assessing a child's adaptation to his or her psychosocial environment across a range of domains, making it possible to identify areas of impairment and strengths. This measure may fill an important gap when a more detailed profile of the child's strengths and difficulties is required, and has the particular advantage of providing data related to resilience, as well as deficits. As far as the other parent report measure is concerned, parents of non-referred children reported significantly more family cohesion on the Family Adaptability and Cohesion Scales (FACES), but it would seem that one year after referral, parents of referred children reported that their families had become more balanced. This is an interesting finding, and it would be crucial to determine whether this happens as a result of, or independently from intervention.

The CAI has shown inter-rater reliability, stability, discriminant validity, convergent validity and predictive validity. The successful development and validation of this measure of attachment in middle childhood fills a significant gap. It will undoubtedly contribute to research and a systematic understanding of attachment and the factors which facilitate and impede secure attachment during the primary school years.

Preliminary results suggest that the Affect Task is sensitive to difficulties in emotional understanding which are associated with emotional and behavioural difficulties. While its sensitivity to small changes requires further exploration, it is a potentially valuable instrument for assessing child psychotherapy outcome. Considering the paucity of child measures of emotional understanding, it may also fill an important gap as a reliable measure in this area of developmental psychology. Preliminary analysis of the MacArthur Narrative Completion Task data suggests that when used with the new coding system this measure adds

to our understanding of the narrative styles and internal working models of children who have emotional and behavioural difficulties, when compared with those without. The results suggest that there are interesting differences between the narratives of normal children, and those referred with internalising and externalising symptoms; referred children produced narratives which lacked coherence and a sense of intentional and effective action, and which reflected their difficulties with affect regulation. It was also clear from the narratives of externalising children that they used denial and avoidance much more than the other groups. The results of the theory of mind tasks, the Happe Strange Stories, and the Mean-and-Nice Stories show significant differences between referred and non-referred children. Children with behavioural and emotional difficulties were significantly less able to explain the Happe Strange Stories in mental state terms. The results suggest that this task, which was initially developed for use with autistic children, might also contribute to our understanding of the theory of mind of children in this age range more generally. The results looking at change over a one year period also suggest that development of a theory of mind is inhibited in referred children and children with behavioural and emotional difficulties, when compared with children who are developing normally. The sensitivity of this task to developmental changes and blocks is likely to be an advantage when studying the impact of psychosocial interventions. Differences between the referred and non-referred groups were also found on the Mean-and-Nice Stories. Non-referred children were significantly better at taking intentions into account when judging “mean” and “nice” actions, a capacity believed to underlie moral development. The task did not identify changes over a one year period, suggesting that it does not match the Happe Strange Stories’s sensitivity to developmental trends.

Thus, we have gone some way towards filling gaps in the previously available set of

measures appropriate for testing the outcome of psychoanalytic child psychotherapy.

(b) The specification of treatment technique, or manualisation.

Although there is a vast literature on technique in adult and child psychoanalytic treatment, this is not written in the explicit, 'operational' terms that are required to define a treatment approach in studies of efficacy. Paulina Kernberg and her colleagues prepared an excellent manual on supportive-expressive psychotherapy for children with moderate to severe conduct disorders (Kernberg & Chazan, 1991). In some respects, this manual is appropriate for other childhood disorders, and incorporates a distinction between insight-oriented treatment and developmental help which is very like the one we propose. We have, however, prepared a Manual of the approach adopted at the Anna Freud Centre, to be applied to the full range of developmental and neurotic disorder in latency children (Fonagy, Edgcumbe, Target, Miller, & Moran, Unpublished manuscript)2. Of its 17 chapters, 5 provide historical and theoretical background, and 12 take an important aspect of technique, offering a definition, the aims the analyst would have in mind in using that form of intervention, the ways in which it is implemented, and finally situations in which it is not likely to be helpful. The Manual drew extensively on the many years of work to systematise child psychoanalytic treatment at the Centre, for instance the Hampstead Index Project (Sandler, 1962; Sandler, Kennedy, & Tyson, 1980). Validation of the Manual was carried out by subjecting individual chapters of the manual to formal assessments of comprehensibility, accuracy and comprehensiveness with current senior and junior clinicians at the Centre (Miller, 1993).

(c) Monitoring of treatment integrity.

As well as specifying the technique involved in this treatment, it was necessary to

[2] This manuscript is available from the Anna Freud Centre.

devise measures of the content and technique of analytic sessions in order to learn to what extent the technique described in the manual was in fact being used. This involved developing scales for recording the process of treatment. We developed a measure named the Session Rating Scale (Fonagy, Phipps-Buchan, & Target, 1996), which attempts to quantify the psychoanalytic experience of children treated at the Centre. The scale provides a measure of the content and quality of the work with each patient, which may help to identify what type of treatment was most successful in which sort of case. It also offers a way of excluding cases where the therapeutic work, for whatever reason, was not within the range of accepted psychoanalytic technique as defined in the manual.

The implementation of a prospective study of child psychoanalysis

We have not yet succeeded in obtaining the scale of funding which would allow us to start a full randomised controlled study of the outcome of child analysis, comparing it to both the best-validated alternative treatment (CBT) and a 'treatment-as-usual' control (ordinary clinic practice, which is usually short-term family work). We are currently designing a scaled-down efficacy study, less ambitious in scope than that we originally prepared these instruments to support, and which can be carried out using existing clinical resources rather than extensive research staffing. This means using a very reduced version of the outcome measures referred to above, and no active control group.

A second line of work that we have begun is the development of a treatment manual for a briefer, more specific psychotherapy (based on our theoretical work over some years), a manualisation of psychotherapy explicitly aimed at enhancing reflective functioning in the child (Bleiberg, Fonagy, & Target, 1997). We hope through this to be able to offer a briefer and more focussed but still psychoanalytic therapy, which might be more viable as an evidence-based treatment for the future, for children who would benefit from this approach.

The Psychoanalytic and Psychotherapeutic Treatment of Young Adults

This was a prospective study led by Mrs Anne-Marie Sandler, established under the Directorship of Dr George Moran, where two groups matched for age, socio-economic status and DSM diagnosis were sequentially assigned to five-times weekly or once weekly psychoanalytic treatment with experienced psychoanalysts. Assessments were made at 18-month intervals by independent raters. The study is still underway and is likely to be completed in 2002. The sample consisted of 30 young adults (aged 18-24) referred to the Anna Freud Centre who were assigned to psychoanalysis or psychotherapy according to available vacancies. They were predominantly middle class, and 2/3 were women. Two experienced psychiatrists independent of the treatment made diagnostic assessments using structured interviews (SADS-L and SCID-II). All patients in the study had at least one Axis II diagnosis with the average number of diagnoses on this axis being two, and dependent, avoidant/paranoid, borderline and narcissistic personality disorder being the most common. All patients also had at least one Axis I diagnosis (mostly mood disorders) and the average number of Axis I diagnosis was 3.5. No patient had a diagnosis of psychosis and less than half the sample (40%) were on psychotropic medication. A significant number of the patients had histories of violent episodes or self harm. About a quarter had previous psychiatric hospitalisations. The psychiatric and psychosocial assessments were repeated at 18-month intervals.

Treatments

The treatments were open ended with a mean length of 3.5 years. The intensive (5 times weekly) treatments lasted an average of 4.6 years with a range of 1-8 years. Non-intensive (once weekly) treatments were somewhat shorter, ranging between 6 months and 4 years with an average of 2.1 years. There were substantial numbers of premature

terminations: 8 in the intensive group, 7 in the non-intensive. Not surprisingly, given the age and diagnoses of the group, attendance at sessions was far from perfect: an average of 76% in the intensive group, with a very large standard deviation (17.6) vs 66% in the non-intensive group (s.d. 18.3).

Treatments were delivered by 15 qualified psychoanalysts (all Members of the British Psychoanalytical Society) trained in the Contemporary Freudian tradition with an average of 3.8 years of post-qualification experience at the start of the project3. The treatments were strongly transference focused, within the developmental framework elaborated by Anna Freud. All analysts participating in the study attended a once-monthly supervision meeting chaired by Anne-Marie Sandler. The supervision concerned both the intensive and the non-intensive cases. Analysts had to provide a full narrative account of one session per month that was circulated to the research group and formed the basis of the group supervision. Analysts also completed a weekly rating scale which was a 500 item checklist where they reported the main themes of the treatment and their interpretive work. There was no tape-recording of sessions.

Measures

At entry to the study all patients completed the SCL-90, the Beck Depression Inventory, the Spielberger State and Trait Anxiety Inventory, the Social Adjustment Scale, the National Adult Reading Test and the Eysenck Personality Questionnaire. They were also administered a number of structured interviews, including the Adult Attachment Interview, the Schedule of Affective Disorders and Schizophrenia-Lifetime Version (SADS-L) and the Structured Clinical Interview for DSM-III-R, Axis II (SCID-II). The battery was repeated at

[3] The Anna Freud Centre Young Adults Research Group included: Ms Julia Fabricius, Dr Luigi Caparotta, Miss Rose Edgcumbe, Mrs Hansi Kennedy, Mrs Rosemary Davies, Dr Rosine Perelberg, Dr Duncan McLean, Mrs Anne Harrison, Dr Anne Zachary, Mrs Marion Burgner, Professor Maria Tallandini, Dr Sally Weintrobe and Dr

18-month intervals. The assessment interviews were carried out by Anthony Bateman MD and Anna Higgitt MD. Patients who showed significant improvement on at least three measures were regarded as having improved. The systematic reports completed by the psychoanalysts participating in the study were of greater analytic interest.

1) Session reports. We decided to sample psychoanalytic process by asking analysts to provide reports of one session per month allocated randomly using guidelines adopted from the Committee on Scientific Activities of the APA (Klumpner & Frank, 1991). The guidelines involve relatively simple supplements to normal reporting. We recommended that session reports include nearly verbatim process notes presented in a standard format that clearly identifies speaker and referent. We asked that the analyst should indicate unverbalised thoughts, affects and non-verbal behaviour separate from approximate or exact wording of speech. We also asked analysts to identify their annotations and thoughts using an alternative format.

Such standard data samples are easier to compare, both within the same analysis and across analyses. We were able to assess, for example, the clinical belief that neurotic defences are centred on repression or reaction formation, isolation, intellectualisation, but that borderline and psychotic patients are characterised by a predominance of primitive defensive operations (i.e. splitting). Daily reports yielded information concerning qualitative aspects of the analyst-patient interaction, dominant themes in the transference and the analyst's style in handling these. We were also able to look at the pattern of change in these parameters and the extent to which such change patterns are determined by the nature of the patient's pathology seen from a psychoanalytic or a psychiatric perspective.

2) Weekly reports. We tried and abandoned the use of the traditional weekly record

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Brian Martindale.

in use at the Centre, not because it lacked psychoanalytic interest, but rather because it weighted somewhat excessively the current focus of the clinician, and was subject to severe memory recall biases. In particular, it was difficult to see whether themes not evident in any particular week were entirely absent or simply took a secondary place in the clinician's mind in relation to more recent developments.

In place of weeklies we adopted a new instrument, the Anna Freud Centre Weekly Rating Scale (Fonagy, Gerber, & Young Adults Research Group, 1993). This is a 537 item instrument which covers four areas: 1) the patient's general stance towards the analysis during the week; 2) the major manifest themes and quality of the patient's ideational, affective and behavioural content; 3) the analyst's understanding of these themes; 4) the major themes of the analyst's interventions, both interpretative and non-interpretative. The analyst also provides a narrative summary of the week in answer to five specific questions: 1) the patients primary concern; 2) the nature of the transference; 3) the main theme of the analyst's interpretation; 4) the most prominent affects encountered; and 5) the forms of resistance and defence encountered by the analyst including acting out.

Results

The follow up assessments of this group of patients are still ongoing. The intended comparison between the outcome of intensively and non-intensively treated patients awaits the follow-up of a number of psychotherapy cases. The coordination of data collection, and the data analysis, have been carried out by Andrew Gerber MD.

The psychometric assessments confirmed that the sample was a relatively disturbed group, with all the subjects falling within the clinical range on two or three measures. All but two had clinically significant levels of anxiety, and all but five fell within the clinical range on the Social Adjustment Scale. Improvements were marked on all measures. In order to

investigate what was associated with relatively large improvements, the sample was divided into two groups, those who achieved and maintained clinically significant improvements on at least three out of the six measures, and those who did not. Clinically significant improvement was defined following the criteria of Jacobson and Truax (1991). 50% of the sample reached this criterion, slightly more (two-thirds) in the intensively treated group. Women were much more likely to improve than men (87.5 % vs 25%). Improvement was somewhat more common in cases who were more disturbed at the beginning of treatment (this may have reflected no more than regression to the mean).

The Adult Attachment Interview yielded particularly challenging results. Interestingly, insecure classifications (mostly preoccupied attachment) increased with continuing treatment. The proportion of secure classifications only returned to baseline levels at follow-up. This is partly accounted for by psychoanalytic therapy creating the appearance of lack of resolution of loss or trauma. The data analysis performed by Andrew Gerber suggests that the tendency to follow the pattern of security-preoccupation-security is more likely to occur in those who were most improved by the therapy. Initial security was not associated with large improvements unless the patient moved through this preoccupied-entangled period. In line with this, passivity (speaking in confusing or vague ways, e.g. unfinished ideas, or mixing up self and other) increased in the improved group during the course of treatment, but declined before termination. In the less improved group, passivity did not increase during treatment but increased at the end. The coherence of the transcripts declined for both groups over the course of treatment, but more markedly so for the improvers, who also recovered coherence at the end of treatment.

The process data collected from the Weekly Rating Scales also interacted with improvement status in challenging ways. A factor analysis yielded two major dimensions for

this instrument. One, which we labelled ‘resistance’, loaded on items which indicated the patient’s negative attitude, immaturity of mental functioning, lack of good analytic material, enactments, negative and primitive transferences, primitive defences, lack of specific affect, negative countertransference, and an absence of clearly object-related transference (Cronbach’s alpha 0.94). The second factor, which we labelled ‘expression of unconscious content’, loaded on items which indicated the patient’s expression of aggression, sexuality, low self-esteem, concerns with the body, gender, age or race, the presence of transference with anxiety, preconscious anger, and the absence of isolation and externalisation as defences. These two dimensions showed different patterns across the treatment for improvers and non-improvers. Whereas the second factor, ‘unconscious content’, started out being substantially higher in the non-improved than in the improved group, the means converged over the course of the treatment, declining somewhat in the less improved group and increasing substantially in the improved group. ‘Resistance’ was substantially higher in the non-improved group at the beginning and declined towards the middle of treatment, only to increase again towards the end. In the improved group, resistance was much lower at the beginning and although it increased steadily it never reached the general level of the non-improved group. There is evidence that these patterns were established from the first year of treatment.

Further analysis of these data indicates that improvers in terms of the psychiatric measures could be differentiated from non-improvers on the basis of aspects of the analytic process, particularly analyst's reports of aggression taken up in the transference and the extent and diversity of emotional reactions reported by patients. Transference in successful treatments is characterized by anxiety, guilt, fear of rejection, idealisation and projected aggression. By contrast, failed treatments are typically associated with shame, humiliation,

existential anxiety in the patient, and a sense of boredom and 'cut-offness' on the part of the analyst. Of great importance was the observation that less successful treatments showed differing trends as the treatment unfolded. For example, in relatively poor outcome treatments, the quality of the analytic material gradually deteriorated, affects decreased in intensity, immature mental functions increased together with primitive transferences, and the use of sexual fantasy to support identity. Sadly, there was evidence for the analyst responding by increased disengagement by, for instance, failing to comment on timekeeping problems and concentrating on extra-analytic issues.

Evaluation

This study represents several important achievements, particularly in the systematic follow-along of a relatively large number of analytic treatments that can be compared with psychotherapeutic treatments. The study generated a great deal of data, which have taken some time to analyse. Initial findings of particular interest include evidence, from the AAI data, for the notion of “regression in the service of the ego” as part of successful treatment (Kris, 1952). There is also evidence that early unconscious material, particularly when the analyst indicates that he or she is interpreting the material, is associated with poorer outcome. There are some unanswered questions, including the massive gender difference found, and the lack of a very marked difference in outcome between intensive and non-intensive treatment. However, on the whole, the initial set of analyses confirm what is generally believed to be good analytic technique, including the taking up of indications of negative transference.

This study has a number of major weaknesses including the small sample, non-random assignment of patients, lack of an untreated control group, lack of tape-recording of therapeutic sessions, lack of manualisation of treatment and unequal treatment lengths.

However, it has a number of strengths such as the independent assessment of outcome, the use of standardised instruments and the attempt to integrate process and outcome measures.

The very long-term outcome of child psychoanalysis

A further research study we have undertaken is to follow up a group of people who were treated at the Anna Freud Centre as children, their siblings, and a further group of untreated, referred children with apparently similar psychopathology in childhood. Our theoretical stance leads us to predict, amongst other things, that there will have been clear differences in technique, levels of change, and rates of change depending on the depth of personality disturbance in a child. In the context of the present study, we have predicted that those children who appeared to be suffering from pervasive and deep-seated psychopathology would show substantial impairment of emotional and social adjustment as adults, unless they had received long-term and intensive psychoanalytic intervention, whereas differences between intensive and non-intensive treatment outcome would be much narrower in the treated children with less severe pathology. We therefore expect considerable differences in outcome between the groups in the sample, to the extent that different types of pathology in childhood can be assessed, and we have looked to test the hypothesis that the differences in immediate outcome observed in our chart review study would persist into adult adjustment and functioning. This is the prediction on which we will focus in what follows.

Using the empirically validated distinction between neurotic and developmental disorder described in the context of the retrospective studies above, we assume that social adversity and psychiatric difficulties are especially likely to persist where developmental delays and distortions were not addressed through intensive psychotherapy. Amongst those who did not meet our criteria for probable process disturbance, we expect non-intensive treatment to have had some effect in restoring the individual to a normal path of

development. Furthermore, we anticipate that improvements in the psychosocial environment might have improved the adaptation of children with representational (neurotic) disorders, whereas this would not have been sufficient for those with mental process disorders.

In this study, we predict that those children who suffered from pervasive and deep-seated psychopathology will show substantial impairment of emotional and social adjustment as adults, unless they received long-term and intensive psychoanalytic intervention, whereas differences between intensive and non-intensive treatment outcome will be narrower (but still evident) in the treated children who had shown less deep-seated pathology. We would therefore expect considerable differences in outcome between the groups in the sample, to the extent that different types of pathology in childhood can be assessed. The present study aimed to test the hypothesis that benefits seen at the end of treatment will still have a discernible impact at long term follow-up, in comparison with the outcomes of untreated children with similar problems.

This ongoing follow-up study aims to evaluate two contrasting expectations about the long-term outcome of child psychoanalysis. The cautious view sometimes expressed by Anna Freud (and of course by her father, Freud, 1937), was that psychoanalysis could resolve current conflictual difficulties but would not protect the analysand from later neurotic illness. It was Anna Freud's (1978) view that analytic help could provide a vital bridge back to a normal developmental path, removing both developmental and neurotic obstacles. However, she did not believe that the child was then any less vulnerable than other normal children to the later vicissitudes of life events, relationships, etc., which might cause a breakdown in adolescence or adulthood. In contrast to this view, we have suggested that psychoanalytic therapy might enhance resilience in the face of later events, enabling the child to understand, predict and plan for his own and others' responses, particularly within relationships, through

for instance facilitating the capacity for mentalisation, or reflection on mental states, and through enhancing the security and autonomy of internal working models of attachment relationships (Fonagy & Target, 1996). It is our ambitious suggestion that early psychoanalytic treatment is justified in terms of effort and cost since it may actually enhance psychological resilience to later stress and conflict, though the strengthening of key ego functions (Fonagy, Steele, Steele, Higgitt, & Target, 1994; Fonagy & Target, 1997; 1998). These contrasting predictions might reflect the development in psychoanalytic technique that occurred over the intervening time (e.g. Freud, 1965; 1974; 1981), gradually incorporating the technique of developmental help into the theory and practice of child psychoanalysis. This changing of technique at the Hampstead Clinic, now the Anna Freud Centre, provides a natural experiment, in that we can explore the hypothesis that those analyses that involved a substantial developmental component might have a greater resilience-enhancing function.

The quantitative study

We are using 3 types of measures. First, and perhaps most central, in-depth interview-based objective measures of life-events, transitions and plans, current personality functioning, and memories of childhood experiences of care and maltreatments as well as retrospective psychiatric and personality disorder diagnosis. A battery of validated interviews was devised to assess adult functioning as far as this is possible independent of psychopathology and psychiatric disturbance, across a wide range of domains. Many of the measures came from a family of psychometric instruments pioneered in the United Kingdom by research groups around Professors Michael Rutter and George Brown. These instruments are often referred to as interviewer-based semi-structured interviews. While largely structured, the interviews permit a specially trained interviewer to make judgements about the material being provided by the subject as the interview progresses. Thus, the coding and

data gathering phases are in a sense overlapping. Despite some subjectivity, these instruments have high levels of reliability, and the track record of the research groups that have used these instruments shows that they can lead to significant advances in connecting environmental influences and psychopathology.

Ours is a comprehensive battery of interviewer-led instruments where highly trained interviewers elicit information from participants about life history and current experiences to enable the reliable coding of complex aspects of functioning such as the quality of an individual's friendships, their success at work (Hill, Fudge, Harrington, Pickles, & Rutter, 1995; Hill, Harrington, Fudge, Rutter, & Pickles, 1989) or the success of their transitions from adolescence to adulthood (Bifulco, Brown, & Harris, 1994, 1996). The measures brought together in this study are unique and give a very rich picture of an individual's development from early in life until the present day. First, in-depth interview-based objective measures of life-events, transitions and plans, current personality functioning, psychiatric and personality disorder diagnosis from childhood onwards. Second, self-report measures of symptomatology (SCL-90), physical health (SF-36), IQ, personality (SCID-II) etc. And third, psychodynamic measures of attachment and internal representations of object relationships which provide relatively reliable data on the quality of object relationships, the coherence of object representations, expectations concerning other's behaviour, morality, perspective taking, hostility and mentalizing capacity (George, Kaplan, & Main, 1985; Main & Goldwyn, 1998; Westen, 1991; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997).

To summarise the scope of the assessment measures, the following areas are included, sometimes from different perspectives in more than one interview protocol:

- Psychiatric history through childhood, adolescence and adult life.
- Social adversity through childhood, adolescence and adult life (including

exposure to abuse and neglect).

- Physical health status.
- Estimate of IQ.
- Current and early-adult personality functioning (in relatively superficial terms: capacity for work and success in career, quality of friendships and love relationships, etc).
- Current personality disorder, in psychiatric and psychoanalytic terms.
- Attachment classification and reflective function.
- Memories of psychoanalytic treatment, where applicable.
- Life events and external difficulties, over last five years.
- Social support.
- Coping strategies and effectiveness.

Preliminary results

The number of cases we were able to trace and interview has limited the conclusions we have been able to draw, and we are still completing coding and quantitative analyses. Thus, the results are preliminary, and in particular, the difficulties in recruiting untreated subjects means that quantitative comparisons are invalid for this group (the small number of untreated cases are, however, included in the qualitative study, below). We feel more confident, though, of the comparisons between treated and untreated siblings, and between treated subjects who were rated in our earlier study as having achieved a clinically significant change in their child therapy, and those whose outcome was at the time considered poor.

We found evidence that whilst in childhood most treated subjects suffered more adversity than their siblings, in adulthood the siblings were more likely to experience negative life events than the treated subjects. In terms of personality functioning, in the work

domain all of our sample with the exception of those whose childhood outcome was poor are doing well. In the love relationship domain, individuals with successfully treated psychiatric disorders in childhood appeared to be doing somewhat better than both their siblings and the untreated controls. None of those unsuccessfully treated in childhood appears to have an adequate love relationship. In terms of friendships, even those successfully treated appear to be somewhat disadvantaged relative to their siblings.

In terms of attachment security, those children whose outcome was relatively good appear to do as well as their siblings in terms of the likelihood of secure attachment. Those unsuccessfully treated appear to be predominantly 'preoccupied/entangled', whereas those untreated appear to be predominantly 'dismissing'. In terms of the capacity to mentalise, to reflect on mental states, as predicted, the group rated in childhood as successfully treated does somewhat better than all the others, whereas those whose outcome was considered poor in childhood remain unable to conceive of mental states accurately. In brief, successful childhood treatment does appear to be something of a protective factor. However, it is possible that unsuccessfully treated individuals are even worse off than those whose disorders were untreated. We should bear clearly in mind that the samples are small.

We have made a number of other preliminary observations. For example, we were able to compare the information about childhood gained from these retrospective interviews with the original observations carefully recorded by clinicians under Anna Freud's supervision. It seems that the agreement in recall between case-files and adult recollection was relatively high, particularly for physical abuse and discord in the parental relationship. Ratings also matched case-files in terms of the extent to which childhood experiences were regarded as loving, rejecting, pressuring or involving. Thus we may conclude, with respect to the current controversy concerning the accuracy of childhood memories, that these are

broadly reliable. Is there evidence that the forgetting (repression) of adverse experience is associated with psychopathology or poor personality functioning? The answer seems to be no. It seems that individuals who are better functioning remember somewhat less well: their recollections are very coherent but definitely tinged with idealisation. They appear to smooth over or forget adverse experiences noted at the time of their assessment, even quite objective events, for example the prolonged psychiatric hospital admission of the mother when the subject was 12 years old, or parental divorce in the patient's adolescence. These idealizing subjects were much less likely to come from the treated group, even from those with successful outcome. The good-outcome cases, as adults, seemed to have retained an accurate and balanced, though still inevitably more painful memory than their siblings.

The qualitative follow-up study

The collection of data for the quantitative long term follow-up study demonstrated to us, that no matter how complex and time consuming the quantitative measures are, they inevitably fail to represent some of the richness of personal lives that makes the psychoanalytic study of subjectivity uniquely valuable scientifically. The limited number of cases that could be traced and interviewed also reduced the scope of quantitative analysis. We consequently decided to carry out a parallel qualitative study of long-term outcome with sub-samples of participants. The aim of this study, which is ongoing, is to explore the long-term outcome of child analysis through an intensive examination of life histories and treatment records. The study uses case-control methodology to identify individuals comparable on demographic and clinical variables in childhood, and map relevant aspects of their subsequent life-course. We wish to explore differences in long-term outcome, in relation to differences in therapeutic experience. The study makes use of case records in the Anna Freud Centre archive, most of which are already coded for research purposes as part of the

retrospective study described above, and relates these to follow-up interviews collected from individuals who were previously treated at the Centre, now adults. The general hypothesis we are focussing on here (others can also be addressed, as will be mentioned later) concerns the importance of developmental considerations in psychoanalytic treatment, if the positive outcome is to last.

There is a rich tradition of the study of individual lives from a psychoanalytic perspective (e.g. Cohen & Cohler, 2000). Much has been learnt about determinants of more and less adaptive outcomes through prospective, longitudinal studies of individuals who, in childhood or adolescence, had contact with mental health services (Hauser, Powers, Noan, & Jacobson, 1984; Vaillant, 1977). While these studies are enormously valuable in teaching us about the determinants of development, they cannot tell us much about how psychoanalytic treatment might have modified the later life course.

We are carrying out a series of studies, all with ‘small n’ case-control design, with qualitative, narrative analysis of chart and interview data.. The studies do not use inferential statistics to compare groups, but we will use qualitative analysis of systematically collected data (psychoanalytic and interview). Clearly, this can only be meaningfully done if the subjects are sufficiently matched, and thus we are limited in which qualitative studies are actually feasible, by the details of the cases which could be traced later. The studies we list below are examples of those which we have begun to investigate. For each study, different contrast groups are identified, and both the treatment records and the interview data are reviewed. Content themes, once identified, are confirmed by independent assessment by one of us, or a trained RA. The material available for review is as follows:

Psychoanalytic data

The childhood records inevitably vary in the amount of detail available, but as a rule

they give a good picture of the referral situation in the child and family, and of the psychoanalytic process. All information generally available has been systematically coded and entered into a database as part of the retrospective study of case records. In addition, we have begun to develop ways of coding more subtle aspects of psychopathology (particularly developmental disturbances) and treatment process.

Interview data

As part of the quantitative phase of this follow-up project, we have collected comprehensive information about childhood, adolescence and adulthood on over 75 subjects. Subjects treated at the Anna Freud Centre have been traced and approached, together with a random sample of their siblings, and an untreated group of children referred to the Anna Freud Centre. The untreated group have been matched where possible for symptomatology on the basis of both records and retrospective recall (RECAP interview), as well as age at time of referral, gender, and socio-economic status.

Individual studies

Six individual, small studies are under way, as follows. Wherever possible, the single matched pairs will be extended as two or more matched pairs, as the sample permits:

A. The comparison of one treated and one untreated person, matched for: presenting problems in childhood (diagnostic grouping and comorbidity), age at presentation (within one and a half years), same gender, year of referral (within one decade), social class (same class or difference of no more than one), psychiatric functioning of parents (presence/absence of disorder at time of referral, likely to meet diagnostic criteria). The hypothesis to be explored is that psychoanalytic treatment will be associated with greater resilience in adolescent and adult personality functioning and mental health.

B. The comparison of one treated and one untreated person from the same family, i.e.

siblings brought up together. The study will examine different memories of and long-term responses to the ‘same’ psychosocial environment.

C. The comparison of one successfully vs. one unsuccessfully treated person (‘success’ judged on the basis of childhood outcome, already rated for the retrospective study). The two cases will be matched for: presenting problems in childhood (diagnostic grouping and extent of comorbidity), severity rating in childhood (CGAS within 8 points), age at presentation (within one and a half years), same gender, year of referral (within one decade), social class (same class or difference no more than one), psychiatric functioning of parents (presence/absence of disorder at time of referral, likely to meet diagnostic criteria), intensity of treatment (both intensive), and if possible identity of analyst (i.e. two cases treated by the same person). The study will test the hypothesis that more favourable childhood outcome will be associated with superior adjustment and functioning (resilience) in later life.

D. The comparison of one intensively and one non-intensively treated person, matched for: presenting problems in childhood (diagnostic grouping and extent of comorbidity), severity rating in childhood (CGAS within 8 points), age at presentation (within one and a half years, both children under 11 yrs), same gender, year of referral (within one decade), social class (same class or difference no more than one), psychiatric functioning of parents (presence/absence of disorder at time of referral, likely to meet diagnostic criteria), and if possible identity of analyst (i.e. two cases treated by the same person). The hypothesis to be explored is that intensive treatment will have a more beneficial long-term effect. This hypothesis has been strengthened by the findings of Sandell in the Stockholm study, where long-term analytic treatments were followed up for some years (Sandell, 1999; Sandell, Blomberg, & Lazar, 1997; Sandell et al., 2000).

E. The comparison of one person with healthy adult functioning (personality and social adjustment at follow-up), with another whose functioning is poor. The two cases will be matched for: presenting problems in childhood (diagnostic grouping and extent of comorbidity), severity rating in childhood (CGAS within 8 points), age at presentation (within one and a half years), same gender, year of referral (within one decade), social class (same class or difference no more than one), psychiatric functioning of parents (presence/absence of disorder at time of referral, likely to meet diagnostic criteria), intensity of treatment (both intensive), and if possible identity of analyst (i.e. two cases treated by the same person). The study will compare the treatment process and associated factors (e.g. work with parents, support from attending Hampstead nursery during analysis) to try to discern what differences might be related to the later outcome.

Qualitative data analysis

Methods of qualitative data analysis have only recently emerged, and are not as well agreed-upon as quantitative methods in the scientific literature. However, our planned methodology is similar to a number of other psychoanalytic investigations, such as that used in the DPV follow-up study (Leuzinger-Bohleber, Beutel, Stuhr, & Rüger, 2000). We are also being intensively trained in the relevant method of Interpretative Protocol Analysis, suitable for analysis of narratives of the kind we have collected, by the developer of the method, Dr Jonathan Smith. The methods are systematic and have a number of steps:

A. Child treatment records

Open review of narrative psychoanalytic data, to identify key themes. This refers to the analytic treatment, and may be themes related to the therapeutic relationship, the nature of the child's behaviour in the therapy session, the techniques used. This information will be organised using the Anna Freud Centre Weekly Rating Scale (Fonagy et al., 1996), which

was specifically developed to study the content of weekly reports at the Anna Freud Centre. A Young Adult version of the same measure has already been shown to be reliable and valid in the Centre's study of psychoanalysis and psychotherapy with young adult patients.

Once the major content themes have been identified, the relevant process records will be 'blinded', made unidentifiable in terms of the group and hypothesis being studied. An independent rater will then review the same material using the content themes, plus control themes, on which differences between the matched groups are not anticipated.

Reliability will be established by obtaining at least two ratings on a subset of the material to be rated for each study, separately, with samples of material being selected according to the major variables of interest for the hypothesis under investigation in each study.

B. Follow-up interview data

The 12-hour interview narratives will be formally coded in two ways: (i) using the coding schemes written by the original authors, which allow one to examine aspects of ego strength, object relationships and mental processes and capacities (such as reflective function) hypothesised to underlie resilience; (ii) more globally, on Wallerstein's 17 Scales of Psychological Capacities (Sundin, Armelius, & Nilsson, 1994; Wallerstein, 1988) which are psychoanalytically-based ratings, grouped into Attributes of Self, Regulation of Self, and Relations with Others. For these formal ratings, 'good outcome' will be considered as scoring above the population mean on a majority of relevant scales, 'bad outcome' as being below the population mean by at least 1 standard deviation, on a majority of scales. Subjects falling between these groupings will be characterised as showing 'mixed outcome'.

In addition, all interview material will be reviewed qualitatively through content analysis of the taped material for clinically important themes across all interviews, e.g.

running through from memories of childhood to the patterns of adult defences, interpretations of experience and quality of object-relations. These judgements will all be made independently of the child data.

The interview material will be analysed using the method of Interpretative Protocol Analysis, to discern themes emerging across small groups of cases.

Apart from the studies above, designed to test our hypothesis about the relationship between outcome and different types of disorder (neurotic vs developmental) and therapeutic process (classical vs developmental help), we are in a position to look qualitatively at other aspects of the interview data. This includes examining the inter-relationships between attachment classification and indices of disordered personality functioning, particularly as seen in the interview on current relationships, devised by Drew Westen, the relationship between memories of therapy and the outcome of that therapy, and other aspects of childhood and adult functioning. Another area of study is to focus on particular disorders. For instance Dr Robert King and the authors will be examining the long-term outcome of patients with clear-cut obsessive-compulsive disorder, in comparison with non-obsessional anxious patients with a comparable level of overall disturbance.

The long-term follow-up interviews offer a rich archive of material, which in conjunction with the rich archive of treatment records, offer many possibilities of study for years to come.

Conclusion

This paper has reviewed fifteen years of work on the outcomes of psychoanalytic therapy at the Anna Freud Centre. This is an ambitious, ongoing program of work, aimed ultimately at establishing analysis and psychotherapy as evidence-based treatments for particular groups of young people. There are limitations to outcome studies of psychoanalytic

treatment inherent to this intervention. It is evidently easier to evaluate brief therapy or pharmacotherapy than a complex and long-term treatment with wide-ranging aims differing in each case. Initially, we also needed to take into account the opposition of many clinicians who were understandably sceptical about this approach to evaluating their work. Over the last decade there has been a noticeable culture shift, and therapists at the Centre have increasingly accepted the need for monitoring of the process and outcome of their work. For example, as part of the pilot study for the prospective investigation, several therapists agreed to have their sessions videotaped, and discussed in a study group of clinicians and research staff. This change would not have been possible without the support of successive generations of leaders of the Centre. Gradually it has been accepted that the debate over the effectiveness of psychoanalysis must be pragmatic in relation to external realities, while also needing to respect ethical principles. There is a clear danger that the therapy that is "without substantial evidence" will be generally thought to be without substantial value. Once this idea is allowed to flourish, as it has already shown worrying signs of doing, a cultural change becomes inevitable, a change which at least temporarily has the power to stop the development of our discipline - through rejection of psychoanalysis as a therapeutic choice, through discouraging young people from entering the profession and through bringing psychoanalytic contributions to mental health disciplines and other subjects into disrepute.

Our work at the Anna Freud Centre is but a small fragment of what needs to be done, and can be done, to demonstrate to others the value of our approach. Continued international collaboration will be essential to provide funders with compelling evidence for the value of our clinical intervention. Psychoanalysts have been shy of public exposure, fearing intrusion and humiliation. While psychoanalysis may not be a panacea, the emerging evidence underscores that we have nothing to be ashamed of and that our theory and technique may

well be uniquely helpful in assisting those whose life experience and perhaps constitutional make-up has put them at greatest disadvantage. The reasons for evaluation studies may not be the ones which clinicians desire but doing them will teach us more about our patients, our work and ourselves.

When we started we had little definite evidence about what we may expect to be the outcome of psychoanalysis for children, adolescents or young adults. Although some pioneering studies showed the usefulness of psychoanalytic treatment for special groups of children (with a specific learning disorder – reading retardation, or a chronic physical illness - brittle diabetes), its effectiveness across the spectrum of commonly-presenting disorders still remains to be convincingly demonstrated. From our retrospective study, we have some data (limited, by the normal standards of psychotherapy research) suggesting the specific groups of children and adolescents for whom intensive treatment can be argued to be an effective intervention even if not clearly the treatment of choice. Paradoxically, it seems that this group is not that which analysts most frequently identify as the "good analytic case". The follow-up study is consistent with the long term good outcome of the early treatment of these relatively seriously disturbed children. We were again and again surprised to meet individuals who as children manifested serious and to many 'hopeless' conditions yet in adulthood, following successful treatment, were relatively high achieving individuals with stable social circumstances and no history of further psychiatric problems. This is a heartening picture but it should be tempered by the fact that currently many children we see with similar problems appear to come from far greater levels of deprivation. It is possible that our treatments focused predominantly on the child will be less effective in the current environment of far greater family disturbance and higher levels of background deprivation. With the increase of social inequality between the most and least privileged in our society

since the clinical work we reported on was carried out (e.g. Wilkinson, 2000) it is possible that child therapy alone may no longer be sufficient for the most underprivileged in our society. It should be remembered however that treatments at the Anna Freud Centre have always included as much work with the family as the family would accept, and that the families treated have always included a sizeable minority with major social and psychiatric problems.

The relatively good outcomes that we observed across studies of patient groups that, on the grounds of natural history or received clinical wisdom, would be expected to do poorly, is an indication of the opportunity for 'surprise' which scientific investigations can provide. Clinical experience is undoubtedly the most valuable source of knowledge that any of us can hope to have; it guides our intuitions in our daily work and we rightly depend on it in most important decision-making contexts. However, as one would expect, it is vulnerable to the same limitations as all human thinking, in particular the bias towards finding what was expected, which Freud himself recognised as the pleasure of identifying the familiar in the unfamiliar (Freud, 1919). Without the input of data collected sufficiently systematically to correct the danger of self-fulfilling prophecies, if not independently then at least with a different set of implicit expectations than the clinical, the danger is of relatively slow progress in the context of other disciplines which can draw on the energy generated by the challenge of the unexpected. In the past we have been surrounded by scientific disciplines that were hostile to psychoanalytic ideas and clearly lacking in sufficient subtlety to enable discourse across disciplines, so we might have been correct in maintaining some isolation. However, in the light of the rapid advances in both biological and social science methodology, this isolation can no longer be justified. This programme of work has benefited enormously from developments in social science methodology as well as sophistication in

medical evaluation strategies. Future progress in these fields, for example the use of brain imaging as a measure of therapeutic change, is likely to benefit our discipline as long as we have maintained a sufficient presence in the therapeutic and scientific fields to be offered funding and opportunities for collaboration.

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