Psychoanalytic Psychotherapy with Disturbed Adopted and Foster Children: A Single Case Follow-up Study

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ABSTRACT

This paper addresses the theme of the long-term utility of psychoanalytic psychotherapy for a child who was exposed to traumatic psychological experiences in the early years of life. He was adopted relatively late and then taken into psychoanalytic psychotherapy at the age of 11 because of unhappiness and negative self feelings, and school behavioural problems. He was comprehensively assessed when aged 10, 11 and 13. A catch-up longitudinal design was used (Robins, 1980) at the age of 15 using age- and behaviour appropriate measures. The latter allow a view of his wider adjustment to his early life experiences and his adjustment to his adoption, and also an insight into the processes of therapy in relation to outcome. This study utilizes a variation of the classical single case study method (Kazdin, 1982).

KEYWORDS

adoption, child psychotherapy, single case study

ACKNOWLEDGEMENT: We would like to thank Maritza da Costa, Lorraine Tollemache, Eve Grainger and Melanie Jones who worked with 'Paul' or his parents. Judith Morgan's fellowship was supported by an anonymous donation from a charitable foundation. We also wish to thank the Child and Family Department of the Tavistock Clinic and the Child Psychotherapy Trust for their continued support. We are very appreciative of all the secretarial work undertaken by Debbie de Wet.

Clinical Child Psychology and Psychiatry 1359–1045 (199801)3:1 Copyright © 1998 SAGE Publications (London, Thousand Oaks and New Delhi) Vol. 3(1): 51–69; 002029

A RECENT publication emphasizes that the need for post-adoption support for adoptees and their parents is becoming more widely recognized (Phillips, & McWilliam, 1996). This is particularly so in cases of later adoption where children may have had damaging early experiences and disruptions of attachments. Psychoanalytic psychotherapy is one form of help for such children. It may mitigate the effects of early life deprivation and other psychosocial adversities, and so facilitate the adjustment to a new family, thereby preventing disruptions and breakdowns of placement. This paper describes an attempt to evaluate the process of psychotherapy. The child presented with a range of chronic symptoms which in many ways were typical of this group of children, where a good adoptive family was not in itself enough. The current state of the child is assessed 1 year after completing therapy.

Since Bowlby (1951, 1965), and subsequently others, highlighted the disadvantages of institutional care for children who had suffered a breakdown of their natural families,

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there has been a steady move towards family placement as the preferred solution. However, in spite of the initial hopefulness that 'love will be enough', even for children scarred badly by their previous experiences, when a child is placed in a new family, many difficulties may arise often related to a sense of insecurity about attachments. Often re-enactment of previous problems occurs, leading to further breakdown. It was hoped that the increasing move towards adoption for emotionally damaged and unattached children, with the knowledge that placement was permanent, together with more support for adoptive parents, would enable children to settle comfortably in their new families.

However, the study by Triseliotis and Russell (1984) indicated that children placed into their adoptive families between ages 2 and 8 years, after several previous moves, tended to show higher rates of psychological problems both in childhood and adult life than the general population. There is also evidence that greater proportions of the adoptee population are referred to child psychiatric departments than would be expected (Wolkind, 1988). However, there is a rising rate of older child adoptions (Barth, & Berry, 1988). It has been shown that older children can be adopted successfully and that children whose early years have been deprived of close attachments can develop attachments later on in nurturing families (Tizard, 1977; Tizard, & Hodges, 1978; Rushton, Treseder, & Quinton, 1995). Nevertheless, some of these successfully adopted children still showed some effects of their early deprivations in adolescence, in terms of attention-seeking behaviour, poor concentration at school and difficult peer relations. Post-adoption support agencies have drawn attention to the problems which adoptive families may face and our experience in the adoption and fostering workshop at the Tavistock Clinic confirms this. It is particularly true that in the case of later adopted children who have earlier suffered trauma or abuse, there may be residual psychological scars. For these, psychotherapy may be indicated.

Triseliotis and Hill (1990) emphasized the longer term utility of adoption. They report that adoptees were functioning better in adult life than those who had been fostered or cared for in residential institutions. Even those placed later for adoption between ages 2 and 8 years after previous moves, appeared to have a stronger sense of self and to function more adequately at personal, social and economic levels.

The Tavistock study

Previous Tavistock Clinic work with severely deprived children (Boston, & Szur, 1983) had led to the hypothesis that psychoanalytic psychotherapy might facilitate permanent placement, avoiding breakdowns and further moves. The process by which this was achieved was by ameliorating the internal images of rejecting and abandoning parents which such deprived children had acquired. They tended to project the bad parental images on to new parents, thus making family relationships difficult.

The nature of psychotherapy

When children enter individual psychotherapy, the therapist offers concerned attention, within a firm and predictable, undirected setting. Small toys, drawing and modelling materials are available to facilitate communication and the therapist observes and tries to understand what the child is experiencing. Against this back-drop children can explore the full range of feelings and emotions, both positive and negative, in relation to the therapist, who in turn, can help them to understand such feelings. Such containing attention has not usually been experienced by children with disrupted backgrounds. They may gradually be helped to integrate some of their conflicting feelings, to understand their past and present situations, and to internalize more supportive and benign figures.

The original evaluation programme

As an increasing number of adopted and incare children were being treated, it was decided to evaluate the therapy. The working hypothesis was that psychotherapy would lead to better adjustment in the family as well as to an increase in personal integration, self-esteem and sense of identity. We would also expect general improvement in social relationships, in learning and in school adjustment. Thirteen adopted, thirteen fostered and five children in residential care were assessed at the beginning and after 2 years of psychotherapy, by means of standard questionnaires inviting open-ended responses by the therapists. Therapists were asked for details of their patients' functioning, behaviour, relationships, personality qualities, self-esteem and perception of self, types of anxiety and ability to learn, play, access to imagination and fantasy. Questions were also asked about the structure of the patients' inner world and internal parental images. Prediction of outcome was rated on a five-point scale.

At the end of therapy, a similar form was filled in with ratings on a six-point scale (from considerable progress to worse). The questionnaire has been fully described elsewhere (Lush, Boston, & Grainger, 1991). It was an experimental questionnaire and its reliability and validity have not been established formally (although there is evidence of face validity). Further, the information provided by the therapists was complemented by reviews and ratings from two of the authors (M.B. and D.L., independent of each other) and by reports from teachers, parents and other carers. On the rating scale of outcome of therapy, 26 of the 31 subjects (some 84%) were rated as improved, 22 of these considerably. In the other five cases it was doubtful whether there was any change, but none were rated worse.

Descriptive information indicated that, in most cases, the children's relationships and adjustment at home and at school had improved. Further, in most cases a considerable amount of 'inner change' was judged to have occurred, on the basis of increased trust and more realistic perceptions of carers, as well as increased concern for others. Where a predominantly suspicious attitude remained, even if there were improvements in overt behaviour, this was taken as indicative of the persisting influence of the negative internal images. While there was noticeable improvement in self-image, low self-esteem remained a problem for many children (Lush et al., 1991; Boston and Lush, 1993, 1994).

Despite limited funding, an attempt was made to devise a practical method of evaluation which could be incorporated into ordinary clinical work. However, there were several constraints (see Boston, 1989), both the financial and also the need to adapt to the therapists' ordinary procedures, rather than to introduce specific research tests for the children, which would inevitably have interfered with the transference to the therapists.

Follow-up: aims

We later proceeded to a follow-up study of some of the subjects after they had finished therapy. The objectives were to ascertain if therapy had facilitated placement and see if any changes brought about by therapy had been maintained. We were also interested in whether there would be any evidence of new positive changes, 'sleeper effects' (Kolvin, Macmillan, Nicol, & Wrate, 1988; Bell, Lyne, & Kolvin, 1989), which only became evident after the end of therapy. The assessments were based on semi-structured interviews, some standard measures of psychological functioning supplemented by open-ended general descriptions obtained from therapists and parents. The instruments used are described later. Since the children were no longer in therapy, we were able to interview them without complicating transference phenomena.

The present paper describes the progress and outcome of therapy with one subject, a boy who was adopted at 3 years into a warm and loving family, but where love alone proved insufficient to repair the damage of his traumatic early years of life. In this case, specific therapeutic help was required. Follow-up assessments made 1 year after the completion of therapy are presented.

Design of current evaluation

Design issues

The traditional single case study This consists of undertaking a baseline assessment prior to the initiation of therapy. It is followed by identical batteries of assessment at specified points in time which are known as multiple baseline assessments. These allow the monitoring of change over time. In the classical single case study, each subject acts as its own control (Peck, 1989). For such purposes, treatment is changed at some point during therapy. This can consist of stopping therapy in order to ascertain whether any positive changes continue; then after a gap, restarting therapy to see whether there is further improvement. Alternatively, therapy is interrupted by a period of no treatment to allow any treatment effects to wash out, and then another treatment is introduced (the so-called cross-over design). The latter constitutes the traditional ABAB design. These techniques are widely used in relation to behavioural therapy approaches.

Such interruptions are not considered appropriate for psychodynamic psychotherapy as they are not desirable therapeutically; nor may it be acceptable to clients that psychotherapy be discontinued and then reinstated (Kolvin, Trowell, & Berelowitz, in press). However, a variation of the above, namely the AB design, can be justified in those subjects where the problems are both severe and chronic, and hence have little expectation of change. This constitutes the rationale for the use of the AB design in this paper.

What are the implications of the above for the current study? These centre around the crucial question of whether patients can act as their own controls in psychodynamic psychotherapy. As this was a series of children, almost all of whom had suffered abuse and trauma in their early years, and whose problems were mostly both severe and chronic, it was not to be expected that much change would occur spontaneously with maturation. Hence we were of the view that any changes could validly be attributed to the therapy and thus patients could act as their own controls. Further, in the original study, the small number of 'control' subjects, where similar baseline assessments were available, but who for various reasons, had not received psychotherapy, were found to have made little or no progress during the subsequent 2-year period.

Method issues

Multiple baseline assessments allow a monitoring of changes in relation to therapy. Ideally, in the catch-up design, the assessments over time should use common measures. However, whilst the 'multiple baseline' measures which are used at designated earlier stages in development to explore short-term changes, are likely to be valid and acceptable, some such measures may prove inappropriate at longer term follow-up into adolescence or even adulthood.

In the current study, the original assessments were never intended to 'travel' into later adolescence and thus were not necessarily relevant at the catch-up stage. It was therefore decided to use age-relevant questionnaires and self-rating scales which reflected adolescent and young adult social adjustment within the family. Hence, for the purpose

of this study, the change of measures to more appropriate ones, was considered a strength rather than a weakness.

The current evaluation

This paper addresses one case in some detail using a catch-up longitudinal design (Robins, 1980). Data points for investigation were the assessments at the start (A) and end of therapy (B), and finally at 1 year follow-up (C).

(A) The assessments at the start of the therapy included:

- Routine psychological tests for the patients (see Educational Psychological Assessment).
- Questionnaires for the therapist.
- Open discussion to achieve best estimates of where to place the subjects' behaviour and functioning on a rating scale. These measures had face validity but there were no formal checks on reliability. They were intended for short term follow-up (Lush et al., 1991).

(B) The assessments at the end of therapy involved similar procedures to A but no repeat psychological tests.

(C) The assessments at follow-up employed semi-structured open-ended questionnaires for gathering family and psychosocial information (Kolvin, Miller, Scott, Gatzanis, & Fleeting, 1990). These had satisfactory reliability and had both face and discriminate validity. The measures used are described in more detail in the appendix. They include:

- *A measure of self-esteem* (Battle, 1981).
- *Parker's Parental Bonding Instrument (PBI)* (Parker 1979, 1990; Parker, Tupling, & Brown, 1979).
- *Weissman and Paykel Social Adjustment Scale* (Weissman & Paykel, 1974).
- *Children's Global Assessment Scale* (Shaffer et al., 1983).
- *Newcastle Recent Life Events Schedule* (Berney et al., 1991).
- *Behaviour Checklist.*

It should be noted that different sources of data were available when compared with the original study. Previously only the therapists had been interviewed and at follow-up the subject and parents were seen as well. As explained earlier, the former was in order not to interfere with ordinary clinical practice and to avoid introducing new people to the patients while in therapy.

The case study

We shall now proceed to the case study which examines our original working hypothesis that a stable, loving family may not be sufficient to undo the damage caused by early traumatic experience. Hence, such a placement may need to be complemented by psychotherapy.

Paul

An unhappy, confused and underachieving 10-year-old boy, adopted at age 3 into a loving family, presented with diverse problems, which had changed little over the years.

Like most of the children in our study, Paul was adopted relatively late (at around 3 years). His early history was traumatic; his biological mother was a drug addict and his father was absent. He was first taken into care when he was 9 months old, and was placed

in a residential nursery but was snatched from there by his mother's co-habitee and disappeared for several months. Mother, her partner, Paul and a new baby of 6 weeks disappeared for 6 months during which time his baby brother died in rather dubious circumstances. When Paul was found he was placed with a foster family where he stayed for over a year. By this time he was $2^1/_2$ years old and he was placed with the L family with whom he has been ever since. He was finally adopted by them after an initial period of anxiety and uncertainty. The Ls have also adopted a girl, 3 years younger than Paul. The adoptive parents, henceforth called the parents, had a stated aim of doing the best for their children. Father works in local government and mother is a part-time nurse.

Referral

Paul was referred to the Tavistock Clinic by his mother, at the suggestion of the head teacher. His parents were worried about his unhappiness and negative feelings about himself and felt his long-standing sense of insecurity and low self-esteem were becoming worse. These are not unusual symptoms found in children who have experienced deprivation in their early years. Paul also had frequent aches and pains. Furthermore, the school reported that his achievements were poor and his behaviour disruptive. He was restless and anxious, found it difficult to concentrate and distracted his class mates. Both teacher and parents felt he might be underachieving. All these problems were long lasting and showed no signs of improvement. While not always severe, they were handicapping in the sense that they gave rise to impairment – educationally, psychologically, socially with peers, and in relationships within the family. His insightful parents appreciated that both they and he needed help.

Initial clinical assessment at Tavistock Clinic (Data Point A)

Paul and his parents were seen by an educational psychologist, a child psychotherapist and a social worker.

Educational psychological assessment

Paul was observed in the classroom and seen individually on three occasions during which a number of cognitive and projective tests were undertaken:

- Revised Wechsler Intelligence Scale for Children (Kaufman, 1979).
- British Ability Scale (Rotation of Letter Like Forms) (Elliot, 1983).
- Children's Apperception Test (Bellak, & Bellak, 1950).

The educational psychologist concluded that Paul's cognitive functioning was within average range, but the sub-test results were very variable. He proved eager to learn and read and could verbalize his thoughts and ideas well, but he found spatial awareness, together with planning and co-ordinating tasks, difficult and his pencil control was poor. He tended to respond impulsively, without thought, and was easily distracted and frustrated. He was highly self-critical and tended to feel inadequate. He became quite involved with the tests, but could pay attention only for short periods, and sometimes he refused to stay with the tasks presented. His behaviour during the tests, and particularly in the classroom, was observed to be agitated, fidgety, with tapping, kicking and difficulty in concentrating. He seemed to test the limits, leaving his seat or the room without permission.

His responses on the projection test, the Children's Apperception Test (C.A.T.), were not altogether typical of the severely deprived child in that he was able to imagine and

to tell stories about the pictures, and there was some sense of ordinary family relations (Williams, 1961; Holmes, 1990). But there were glimpses of deprivation in the fear of starvation, the absence of a mother figure where one is usually seen, and in not describing parents available to help cope with night-time anxieties. The C.A.T. record suggests that in spite of the good family care Paul was receiving, psychological scars of earlier traumatic experiences remained. Interestingly, in view of his adoption, he described a 'pretend' kangaroo carrying the baby because 'the mother is tired'.

Child psychotherapist's assessment

When he was first assessed, he spoke at such great speed – often about dangerous things in stories – that the psychotherapist found it hard to absorb and consider what Paul was telling her. His play showed aggression, confusion and low self-esteem. However, he also showed longing for help and understanding. He seemed well motivated for therapy. Some of the above features were reminiscent of that shown by many of the children in the research group.

Recommendation

For clarification purposes, one of the authors (I.K.) has offered a retrospective diagnosis that Paul was suffering from a long-standing depressive condition complicated by an attention deficit disorder with hyperactivity. On the basis of the educational psychologist's report and the child psychotherapist's observations, the history, and the strong motivation which both the child and parents showed, individual psychotherapy was recommended, complemented by regular work with the parents. Previous experience of children with such chronic problems and disrupted histories indicated that three times weekly was more likely to be effective, and the parents agreed to this. As no therapist was immediately available, the assessing child psychotherapist saw him monthly on a holding basis for the year's waiting period. She also saw the parents, as well as the sister, but it was some time before the parents agreed to weekly work for themselves.

Subsequent assessment prior to start of therapy

This was a form designed specifically for the research, allowing therapists to record their observations and clinical judgements in as systematic a way as possible.

The form was completed by the new child psychotherapist at the start of therapy. Paul was now 11 years old. Paul had changed very little during the year's wait, his motivation was still good, he was eager to communicate, and he had good verbal ability. He was still finding it very difficult to settle at home or at school and his parents were unable to contain him emotionally or set boundaries for him. He was jealous of his adopted sister and was rivalrous with other children. His behaviour which included overt sexual play, was more that of a young child than an 11-year-old. In spite of his good imagination and capacity to symbolize, he was judged to have little capacity to think, learn or play appropriately.

The therapist considered Paul to be confused, with anxieties of a predominantly persecutory nature, that is he tended to attribute uncaring or malign motives to ordinary events such as ends of sessions. He was particularly anxious about separations, which was hardly surprising in view of his early history, but he tended to deny his vulnerable feelings by putting on an air of bravado. Under this exterior he was insecure, uncontained and showed little concern for others. In general he was thought to be operating at an immature level, acting on impulse, rather than reflection.

Paul's inner world was described as fluid and chaotic, with no boundaries between inside and outside, between fantasy and reality, and with much confusion of identity. The therapist thought Paul had the potential for developing a good internal supporting figure but no stored experience of one – despite his having had good quality parental care over the previous 8 years.

Aims of therapy and prediction of progress

The therapist hoped Paul could become more self-confident, more able to concentrate, think, learn to accept limits and behave more appropriately for his age.

At an internal level, the aim was for the development of the capacity to make deeper relationships and for reflective thought, with a sense of boundaries and less need to act on impulse. A modification of his highly self-critical attitude was hoped for so that Paul would be able to like himself better.

This implies the establishment of more benign and supporting figures in his inner world. The therapist predicted considerable progress because of Paul's emotional accessibility and eagerness to communicate.

Assessment 2 years after start of therapy (aged 13) (Data Point B)

A similar form, to the one completed at the beginning of therapy, was completed by the therapist after 2 years of therapy. This was intended to assess progress and to establish to what extent the specified aims had been achieved. Paul was rated as showing considerable progress with improvement in most areas. The rating was confirmed by two researchers who had examined the material independently.

This general improvement was also confirmed by the parents – Paul had 'improved beyond all expectations'. He was easier at home, better settled at school and more accepting of limits. He had transferred successfully to secondary school and was doing well.

The therapist said that Paul showed great improvement in his ability to learn and could think more clearly. His behaviour and play were now more age appropriate, with less overt sexual behaviour. He had a period of violence and aggression in the early part of therapy but was now more controlled. As with many other children in our study, Paul's perception of himself was still unfavourable as he saw himself as naughty and inadequate. However his parents no longer spoke of his low self-esteem; his relationships had improved and he generally seemed more secure and contained, though he was still lacking in self-confidence.

Thus it was considered that the aims of therapy had largely been achieved. There were quite a lot of internal world changes, but the therapist thought there was need for further psychotherapeutic work. Paul still felt suspicious at times but was more in touch with reality, with a stronger sense of his own identity. He was functioning in a more consistent and integrated way. He was more in touch with his feelings and was beginning to show concern for others, for example his sister and the therapist. Separation was still a problem. Further, Paul frequently wanted to reject others before being rejected himself, but his tolerance of emotional pain was greater than it had been.

He now seemed to have much better internal figures, particularly a more protective and nurturing mother and some concept of a father or internal limit-setting capacity, even though this aroused feelings of rivalry. He still appeared to be persecuted by internal fantasy figures, perhaps residues of past relationships.

Therapy continued for a further year after the 2-year assessment, when Paul, his parents and the therapist agreed the therapy should end. All agreed there had been a satisfactory outcome.

Work with parents

The considerable work undertaken with the parents, both before and during the course of Paul's therapy, was thought to have contributed to the successful outcome. This is in line with the general findings in the study. Wherever possible, regular help was offered to parents, in conjunction with the child's therapy. However, our experience has been that it is sometimes more difficult to engage adoptive and foster than natural parents. Adoptive parents may feel less secure in their parenting, more anxious to show they are 'good' parents and may, therefore, be more reluctant to acknowledge difficulties, even when desperate for help. Clinical referral may seem like a repetition of the original assessment process for adoption – their suitability again on the line. Paul's parents were enthusiastic about the support they received from weekly sessions with their own worker, particularly when things were difficult. They emphasized how much extra they felt adoptive parents had to accept, especially anxiety, disappointment and guilt. They felt that Paul had improved in therapy beyond their expectations.

The parents had to work through their feelings of disappointment, sadness and anger about their inability to have birth children and also about the prolonged adoption process. Counselling was undertaken in relation to their sense of failure because Paul (and later his adoptive sister) needed therapy. They realized their feelings were part of the insecurity common to many adoptive parents and came to understand that Paul's problems stemmed from his early history. They were then able to look at their parenting more realistically. As the work continued, they became more open and relaxed in sessions as well as with the children.

Therapeutic processes leading to change

At the beginning of therapy, Paul behaved and related to the therapist in a manner more characteristic of a young child, making an immediate, passionate and idealized relationship to her, almost as if she were a long lost mother. His imagined ideas about her were expressed very openly in a way unusual for an 11 year old. But there was an indiscriminate, as well as a somewhat 'promiscuous' quality to his contact, implying that the therapist was just one of his many 'ladies'. He was also observed chatting to all and sundry in the waiting room. His way of relating had some of the qualities of an institutionally reared child, latching on to any visitor or stranger who comes, appearing needy of attention and affection but usually relating quite superficially. Such behaviours have been well described by Tizard in her study of children who spent their early years in a residential nursery (Tizard, & Rees, 1975; Tizard, 1977).

Paul lived in a constant state of confusion about many things – what went on in his mind and what occurred in the outside world. He lived in a world he found incomprehensible and puzzling. He believed that his eyes were all powerful and that he could make things 'gone' (Paul's word) – possibly he felt he had done this with his original parents. He was particularly confused about family relationships and showed this in his play with the animals as well as in his questions. However, in therapy, he was able to express his anxieties and unconscious ideas about his adoption and about his biological parents. For example, the orphaned chimps were adopted by the kangaroo family which reflects his feelings about his own circumstances (compare the C.A.T record in which he

described the kangaroo mother in the picture, as 'a pretend mother carrying the baby because the mother is tired').

The impulsive, restless behaviour observed by the psychologist and the teacher was demonstrated in the therapy sessions where its meaning could be unravelled. Paul often seemed to identify more with animals, especially monkeys, than human beings. He also identified with a pop singer who 'looked like a monkey'. His birthdays occasioned upsurges of anxieties about his 'real' parents. He maintained that he was not born but 'hatched'. He appeared to see strangers as potential relatives and he was preoccupied with who the therapist's husband might be, suggesting various well known figures with whom he himself was identified. His cuddly toy was said to feel strange because it was 'adopted' and he wanted to clear the strange feelings out of his own head by immersion in cold water. The therapist wondered if this behaviour represented an endless attempt to identify his lost parents and siblings, particularly his unknown father. He was preoccupied with what others had, feeling something was withheld from him. At the beginning of therapy, Paul expected to die young.

Paul's behaviour in therapy threw much light on the reasons for his restlessness and referral problems. With all this inner turmoil he could hardly be expected to concentrate on school work. His superficial and impulsive way of relating, together with his insecurity and confusion about family relations and his own identity, would be bound to make it difficult for his adoptive parents to get through to him and to feel their care was adequate. Fortunately they were insightful enough to realize that they and Paul needed help. There was no evidence that without therapy Paul would have been able to make progress. Little seemed to have changed since his adoption aged 3 until his referral aged 10, nor in the waiting period till he started treatment aged 11.

The therapy provided a predictable setting in which his inner turmoil could be considered. In particular, the therapist offered a space for Paul's chaotic feelings to be understood, before being returned to Paul in a more meaningful, and therefore more bearable, form (Bion, 1962). The various figures in Paul's inner world were projected into the therapist as the relationship with her developed, possibly suggesting unconscious memories of his biological mother. At first contact the therapist became the idealized long lost mother, but it was not long before she was felt by Paul to be the abandoning, promiscuous, drunk and selfish mother. A variety of father figures were attributed to her or her husband and sometimes she was treated more like a sister or brother. The therapist's task of tolerating and clarifying Paul's unconscious projections on to her, while at the same time demonstrating a different reality by her consistent care and attention, gradually enabled Paul to develop a more realistic relation to her. Confusions were clarified and as a result of this work, Paul became able to identify with more caring, attentive and also limit-setting adult figures. This enabled him to establish a better and more realistic relationship with his adoptive parents and others.

This process took place gradually during the course of Paul's 3 year therapy and suggests that the reported externally observed improvements in behaviour were related to the inner changes which were taking place in the therapy.

Particularly significant were Paul's reactions to holiday breaks and the inevitable interruptions during the course of treatment. These reawakened his earlier experiences of rejection and abandonment and aroused aggressive, destructive and sometimes violent behaviour. A temporary loss seemed like a death to Paul. The therapist was then perceived as a bad, abandoning, hardly human parent whom he hated and suspected. Firm limits were needed but, as Paul and his therapist weathered and contained these turbulent emotions, more genuine trust developed, and a more realistic concept of caring parental figures emerged. However, he remained for quite some time preoccupied with

his unknown father, feeling himself to be a 'bastard'. At times he identified his father with Jesus Christ but at others he feared that his father was in prison for some dreadful crime. His destructive behaviour in the therapy sessions could also be seen as a re-enactment of disturbing events of his early years. The therapist's ability to contain all this pain and trauma in therapy enabled Paul to behave more appropriately and he was able to transfer successfully to secondary school.

Working through these violent emotions and experiences, within firm limits, gradually enabled Paul to gain more control and to become more thoughtful and reflective. But with this, came great sadness and awareness of the pain of what he had lost. He was able to come to a more realistic acceptance and understanding of his adoption – in his play the cow found the baby kangaroo that was about to fall off a cliff. The conflicts became more ordinary and age appropriate, to do with family rivalries, and he was much better and happier at home. As he approached adolescence he was tormented by thoughts of growing up and ending therapy. Termination was agreed, with the possibility of returning in later adolescence if required.

The follow-up assessments

Routine follow-up interview, 6 months after termination: therapist's impressions (Paul now 14.5 years)

For the purposes of this follow-up, the therapist was asked to complete the checklist described in the Appendix. While the therapist could only offer answers relevant to her experience with Paul, the general impression was favourable. Paul's relationships were satisfactory except with his sister. Paul was seen as happy and neither anxious, aggressive, restless, nor disobedient. The only negative comments were that he sometimes had temper tantrums, still needed much adult attention and was competitive and rivalrous. There was also improvement in his ability to concentrate and his self-esteem.

As to changes since Paul first came to the clinic, the therapist thought he had improved in all aspects – emotionally, socially, academically and generally. She now saw Paul as much more mature, calmer and more in touch with reality.

She thought improvement had continued since the end of therapy, both emotionally and generally. This suggested that improvement can continue to occur after cessation of therapy (Bell et al., 1989).

Follow-up assessments 1 year after termination (Paul now 15 years) (Data Point C)

Paul and his mother attended the interviews. Father was invited but could not come.

Interview with Paul The researcher (J.M.) established good rapport with Paul. She noted he was relaxed and self-contained. He smiled appropriately and, occasionally showed off slightly by using rather sophisticated words in a slightly self-conscious but good humoured way. He immediately ascertained the researcher was from Africa and then went on to enunciate his own anti-racist views. Generally, the interviewer was impressed with Paul's composure and the inner strength she thought he displayed. She judged him to be well-adjusted and mature. The following assessments were undertaken:

(a) *Battle Self Esteem Questionnaire*

Paul's response included a high degree of confidence and good self-esteem. The only negative responses concerned a poor ability to express views and feelings and that he was not always successful with school assignments.

(b) *Parker's Parental Bonding Instrument (PBI)*

Father: Paul's comments about his father were nearly all positive. He was seen as warm, helpful and affectionate; but there were some discrepancies regarding how much freedom and independence Paul felt father allowed him. The scores for father fell into categories of high care and low control, which places Paul's view of his father in the category of optimal parenting.

Mother: Paul's comments of his mother were again mostly positive. Overall, he viewed his mother as showing relatively lower levels of care and affection and high levels of protection – this combination veered towards the Parker category of affectionless control. However, the scores were not extreme and, merely suggest some ambivalence about maternal care. An alternative explanation of this pattern might be that the experience with his biological mother and feelings about her still affected his relationship with his adoptive mother.

(c) *Weissman and Paykel Social Adjustment Interview*

Most of Paul's responses suggested reasonably good social adjustment. According to his responses, he had only missed a few days of school over the last year. He could do the work but sometimes felt inadequate. Paul found some of the subjects at school boring. He reported a little friction with some teachers and with one friend. Nevertheless, he said he had friends, usually trusted them and confided in them. He had several hobbies, mainly sports and collecting things. No friction was reported with friends outside school. He enjoyed being with people and did not usually feel lonely, isolated or bored.

Family themes related to Paul's adoptive family. Family relationships were good and he reported he could be open with both parents but especially father, although he quarrelled with his sister. He showed reasonable concern for the family and there was no sense of guilt that he might have let them down or that they had let him down. His school adjustment was found to be adequate and so too were his social and leisure adjustment. The conclusion was that his overall social adjustment was satisfactory.

(d) *Paul's view of therapy*

When Paul was asked whether he thought therapy had helped him, he said it had allowed him to be more in touch with his feelings. This is certainly a positive response and is broadly consistent with the psychotherapist's and mother's view and also that of the research workers.

Interview with Paul's adoptive mother

(a) *Personality and Behaviour Checklist*

The same checklist completed by the therapist was then completed by Paul's mother. She thought his general relationships were good – with the possible exception that he experienced moderate difficulty with strangers. Many answers suggested positive adjustment; he was usually happy and co-operative, not destructive, unafraid of new situations, and not confused. However, sometimes he was discontented, lacked confidence, needed a lot of adult attention and approval, had temper tantrums, was competitive, on occasions was depressed, had low self-esteem, was restless and had some aches and pains.

These accounts suggest residual difficulties but Paul's mother was emphatic that generally they were much less evident than previously. She was certain he was much better emotionally, socially and generally than when he first attended. However, in the academic sphere she thought there had been little change. She also did not think there had been much change in Paul since therapy ended.

Paul's mother was mostly very positive about him and hence on the basis of the information from mother, the therapist's rating of improvement appeared supported.

(b) *Newcastle Recent Life Events Schedule: interview with mother*

The only events of consequence in the last year were as follows:

Illness: Paul's father was taken to hospital for a day and his sister had a minor operation and was home for a few weeks. Both these events had a slight impact on him. Paul himself had cut himself with a knife bought illicitly when on a school trip abroad. He was not upset because he had cut himself but rather because he was not allowed to go on the next school trip. There were no new major problems at school.

Legal: Paul was caught stealing from a shop during the year – parents were called but not the police – the incident did not appear to upset him.

Family: There had been more arguments at home between Paul and his parents and this had upset him – these were thought not unusual at his age.

Social: Paul's mother thought there had been some deterioration in the way he was accepted by his peers and this had affected him.

Other events: An important event in the last year was the stopping of therapy. While he did not wish to return to therapy his mother thought he looked back on it positively.

Children's Global Assessment Scale (CGAS) The three evaluators independently offered clinical judgments of Paul's overall level of functioning, based on the interview with mother, her checklist answers and the profile on the Weissmann and Paykel Social Adjustment Scale. The CGAS ratings fell in the 70–80 range which indicated generally good functioning with no more than slight impairment of functioning at home, school or with peers. According to the CGAS description this indicates that some disturbance of behaviour or emotional distress may be present in response to life stresses 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.

Discussion

Outcome

The assessments of Paul 6 months and 1 year after ending therapy, gave a generally encouraging picture and there was a sense of optimism about the future. The therapist, who saw Paul at 6 months after the end of therapy, was pleased with his progress and thought improvement had continued after therapy had stopped. There were no major difficulties. Paul did not wish to re-enter therapy and this can be viewed as a favourable sign as the ending had been planned. The Social Adjustment Scale suggested good adjustment in most fields, although there was evidence of some friction with teachers and minor difficulties with school work. His relationships with his adopted family appeared good and his confidence and self-esteem had improved.

Paul's mother was also happy about his progress. There had been a couple of disquieting incidents, but she regarded these as isolated events and had few complaints and overall she was satisfied with his functioning and progress. At the interview with the researcher, the basic picture proved similar. She was impressed with his composure and evidence of inner strength. She considered he had matured and had adjusted well. There was evidence of good social adjustment in most domains. While there was some evidence of residual friction with teachers and some difficulties with school work, this was not substantial. His relationship with his adoptive family appeared good. The Parental Bonding Instrument responses indicate memories and feelings about inadequate maternal care in the preschool years. However, these should not necessarily be attributed entirely to care received from his adoptive mother and her reactions, they may have been confounded by memories of care received from his biological mother.

Two other researchers (D.L. and M.B.), who reviewed the test results and interview material independently, considered Paul to be basically managing well, though sometimes lacking in confidence and needing more adult approval than is usual in adolescence. The therapist's view, at her 6-month follow-up, that he had continued to improve, was thus confirmed.

Paul and therapy – a vignette

Paul's therapy was often tumultuous especially in the first year and the pain and anger projected onto the therapist were often difficult for her to bear. It seemed necessary for the therapy to be reasonably frequent. These sessions enabled Paul to explore his confused inner world with its predominantly perverse, aggressive and uncaring parent figures. In the therapy, changes in Paul's inner world occurred relatively quickly. This was helped by his good current family situation. The therapist described how she changed in the transference from being seen as a perverse mother/wife in the early months of therapy to being thought of as a loving, nurturing mother. Breaks in the therapy were still difficult for Paul probably re-awakening his feeling of having been rejected by his biological parents and then his foster parents when he was so young. He was able to work through these feelings with the help of the skilled, sensitive and patient therapist.

Was the improvement due to therapy?

Mid-adolescence can be a time of turmoil for many, if not most, youngsters and this is particularly true for adoptees who have had earlier traumatic and disruptive experiences. However, adolescence can be a time of crisis when earlier problems can re-emerge and threaten disruption. Paul had made progress with his loving adoptive family when he was younger, but by the age of 10 he was unhappy with significant disruptive problems at school and inappropriate social behaviour. These difficulties had not improved by the age of 11; in fact, the reverse was true. The fact that at 15 he was managing quite well suggests that the changes in Paul were in response to the therapy that both he and his parents received, and was unlikely to have been achieved by good parenting alone. There were indications that change had continued after the end of therapy and so grounds for hope that the progress would continue.

Does improvement reach a plateau at the end of therapy?

Not only has change been demonstrated, but this has continued after the end of therapy. This suggests that the therapeutic processes had given rise to a different outcome trajectory (Bell et al., 1989).

Processes

An aim of this paper was to illustrate the links between the therapeutic processes and observed changes in behaviour. Case reports have greater potential for identifying processes than large series outcome studies. This study illustrated the crucial importance of modifying the internal world of the child if changes in the external relationships and behaviour are to be achieved. It demonstrates that it is likely to be inner world changes that affect the perceptions of the bonding and attachment experiences. This coincides, to a certain extent, with the original therapy hypothesis but these findings merit being replicated in other single case studies. Variations of the traditional single case design, as exemplified in this study, provide rich psychodynamic material which provides some insights into the relevant processes and mechanisms.

Methodological deficiencies

The methodological difficulties of this work are due to the way the project gradually evolved. It was a planned longitudinal study with interval assessments during the course of therapy. Further, the original intention was to encourage therapists to evaluate their work by making their assessments and case reports more systematic and comparable, and thus open to scrutiny by external researchers. There was also the philosophy of not 'interfering' with the relationship between a therapist and a patient by direct contact of a researcher with the patient. However, after psychotherapy had ended this was no longer a requirement. At that point, additional resources in the shape of two extra team members (J.M. and I.K.) enabled a more systematic follow-up to be undertaken, using the standardized measures previously described, with both patients and parents. Furthermore, age-appropriate measures, relevant to adolescents, could now be employed. Some of these would not have been appropriate at the younger age. As asserted earlier, the change of to age-relevant measures, was considered a strength rather than a weakness.

Conclusion

This single case study, with data points through to follow-up, certainly suggests that the changes in Paul were in response to the therapy both he and his parents received.

In many cases of later adoption, where the residual psychological scars of earlier traumatic experiences are continuing to present problems in family life, something more than good loving care may be needed. Psychotherapy for the child, with concurrent help for the parents, is one form of intervention in which there was evidence of success in the case described. It is likely that the help the parents received contributed substantially to the outcome, but we cannot prove this. However, there is no evidence that the converse applies, that is, that psychotherapy for the child would have worked without parental counselling.

We cannot prove that this intervention was more successful than others would have been, but it is unlikely that sufficient inner change would have occurred without psychotherapy. Every case is unique but our experience has been that psychoanalytic psychotherapy, although often not easy, has effected change in similar cases when other interventions have failed. Further evaluation studies including single case studies, naturalistic or controlled research programmes with longer term follow-up are required, and clinicians should be encouraged to undertake more research of this nature.

Rationale is offered for the use of a single-case design when undertaking psychoanalytic psychotherapy for severe and chronic psychological disturbance.

Appendix

Further description of instruments used in follow-up

A measure of Self-esteem (Battle, 1981) This consists of 40 self-rating questions relating to the subject's self-esteem and confidence. The questionnaire contains 40 questions in a yes/no format. The sub-scales are: the social factors: emotional state; acceptance of self regarding intelligence, gender, appearance; success/failure on tasks etc. test–retest reliability is satisfactory with correlations between 0.86 and 0.9.

Parker's Parental Bonding Instrument (PBI) (Parker 1979, 1990; Parker et al., 1979) The PBI is a self-report scale measuring the subjects' perception of parenting he/she had received in childhood, that is, the perceptions of parent's display of care and affection

on the one hand and over-control on the other. The scores can be categorized into four categories according to high or low care and high or low control. The focus of the assessment is on the subjects perceptions of the parent's attitude rather than actual behaviour. The instrument has satisfactory reliability and validity (Parker et al., 1990).

Weissman and Paykel Social Adjustment Scale (Weissman, & Paykel, 1974) This is a semi-structure interview. The scale covers the following major areas of functioning: work or study, social and leisure activities, relationships and the family. The themes in childhood fall into four shorter domains – the subject's performance at expected tasks, the amount of friction s/he has with people, aspects of his/her interpersonal relations and his/her feelings and satisfactions. The categories deal with the subject's overt behaviour and also his/her inner feelings.

Global ratings related to each domain are also completed at the end of the interview. For the purpose of this research we focused on the last 2 months as well as the past year. This provides a view of the subject's current social adjustment and more long standing adjustment. The inter-rater reliability is satisfactory ($r = 0.76$).

Newcastle Recent Life Events Schedule This is a modified version of the questionnaire developed by Goodyer and colleagues (Goodyer, Kolvin, & Gatzanis, 1985). It was abbreviated by Kolvin for subsequent research (Berney et al., 1991). It provides information about recent life events and the psychological impact of these on the child. The sub-scales include: illness events; accidents; entrance events, for example birth of baby, new parental partner etc.; exit events, for example death; school events; threatened exit events, for example arguments between members; home events, for example family mobility; social events; finance events. It was included because any changes which have occurred in the period between the initial baseline and the final follow-up could be influenced by recent life events especially those which might have had a significant negative impact on the subject. Thus we have attempted to make appropriate allowance for such relevant experiences.

Behaviour Checklist This is a list of questions devised by the researchers partly based on Rutter and Graham Scale (Rutter, Tizard, & Whitmore, 1970). The items covered aspects of behaviour, personality and relationships scored on three point scale – 'yes', 'sometimes', 'no', and comments were invited on whether changes of better, no change or worse had occurred in the following domains; emotional, social, academic and general since the child was first referred to the clinic and also since he finished therapy.

Children's Global Assessment Scale This well-known scale was developed by Endicott et al. (1976) and modified by Shaffer et al. (1983) for use with children to provide a measure of overall severity of psychiatric disturbances during a specified time period. There are equal intervals of 10 from 1 to 100 with high scores representing positive mental health and low scores representing psychopathology.

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