Final Outcomes Report:
Evaluation of School-based Treatment for
Abused and Neglected Children

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Executive Summary

While considerable research has examined the effectiveness of psychological interventions with children, little research has been conducted on long-term psychodynamic therapy for children, particularly in schools (Mishna & Muskat, 2004). Although some research suggests psychodynamic treatment may be beneficial with certain high-risk, multi-problem children (Fonagy & Target, 1994, 1997; Kantrowitz, 1997), there remains a dearth of research exploring this form of intervention with maltreated children. The purpose of this evaluation was to examine a unique intervention for maltreated children informed by psychodynamic theory and rooted in an ecological school-based approach. Ecologically informed practice, comprising extensive engagement with parents and teachers, requires particular attention given its potential to holistically transform both individuals and their environments.

The evaluation was conducted for recipients of the school-based intervention, comprising children who had been chronically abused or neglected. Thirty-three interviews were conducted six and twelve months after the commencement of therapy with parents, therapists, and teachers of the six children originally enrolled in the intervention. The respondents all observed significant and positive changes in children, which they attributed to the intervention. Most children were identified as: improving academically; engaging more socially; gaining confidence; and increasing their ability to identify, express, and regulate their feelings. The centrality of the therapist’s involvement with the parents created opportunities for: parents to develop supportive dyadic relationships with therapists; therapists to serve as an ally and liaison for parents with school and community systems; and therapists to better understand the family dynamics, which informed the child psychotherapy. The fact that the therapy took place in the children’s schools allowed therapists to learn about the child from teachers, to more holistically understand the child by watching them interact in school, and to provide support and guidance to the teachers.
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**Purpose of Evaluation**

The purpose of the evaluation was to increase understanding of the effectiveness of school-based psychodynamic treatment for severely traumatized high-risk multi-problem children, under the age of 12 years. In addition to increasing our understanding of the impact of child maltreatment on children’s emotional, psychological, social and behavioural functioning, this evaluation addresses a gap in the outcome research literature on the effectiveness of long-term psychodynamic therapy with children. Additionally, this evaluation explored the lived experience of therapists, parents, and teachers, in ecologically-informed school-based interventions.

**Research Goals**

The purpose of this evaluation was to:

1. understand the impact of ecologically informed school-based therapy on children who have been severely maltreated;
2. identify the influence of an ecological informed intervention on the connection between families and schools;
3. contribute to evidence-based practice knowledge regarding long-term child psychotherapy; and
4. utilize the findings to modify and strengthen the program for the children and families currently served.

**Description of Program**

The mandate of the *Child Psychotherapy Foundation of Canada* (CPF) is to raise funds for the treatment of abused and traumatized children. In March 2005 “Hedge Funds Care Foundation” awarded the CPF $60,000 to provide psychodynamic psychotherapy for eight maltreated children less than 12 years of age. Therapists who are members of the *Canadian Association of Psychoanalytic Child Therapists* (CAPCT) provide the treatment. CAPCT is a professional association of child psychoanalytic therapists. Its mandate is to foster the growth of the profession in Canada, promote awareness of the value of dynamic psychotherapy with children, provide educational and networking opportunities for members and help maintain ongoing research in child psychotherapy. The CAPCT has a Code of Ethics and a Standards Committee to ensure professional and ethical practice on the part of its members and provides malpractice insurance. Therapists in the association may be graduates or candidates in supervision within the *Toronto Child Psychoanalytic Program*.

The treatment provided through the CPF takes place in the children’s schools in the nurse’s office or another private room. Sessions occur 2 to 3 times a week and are 50 minutes in length. The therapists also regularly meet with the children’s parents/caregivers and teachers. The aims
of the treatment are to 1) provide a therapeutic relationship in order to improve the child’s emotional, social and academic functioning; 2) work closely with parents and teachers in order to effect change within the environments in which the child functions and lives; and 3) facilitate communication and cooperation between the children’s parents/caregivers and the school community.

Program Target Population

The Criteria for the children to be treated in this program by the Child Psychotherapy Foundation are as follows:

1. Children must be between 2 and 13 years of age.
2. Children must have been maltreated – physically or sexually abused or neglected – as determined by a court or a children’s aid society or a mental health agency.
3. Children may be living with a parent or relative or be in the care of a children’s aid society, but caregivers must participate in the treatment process. Caregivers are expected to meet weekly with the therapist, participate in an interview with the president of the Child Psychotherapy Foundation twice per year and fill out the Child Behaviour Checklist.
4. Children must reside in the GTA.
5. Children must be referred by a mental health agency, a school board or a children’s aid society.
6. Children must attend a school or daycare which has space to accommodate the treatment.
7. Children must have teachers who are willing to participate in the treatment process, who are willing to meet with the therapist on a regular basis and agree to fill out the Teacher Report Form as well as participate in an interview with the president of the CPF twice per year.
8. Children’s caregivers and teachers must agree to sign consent forms for the treatment, and parents must agree to allow the Child Psychotherapy Foundation to use information about the treatment in a disguised form in order to fulfill the reporting obligations to the funders and for general fund raising purposes.
9. Parents are informed if the therapist is a candidate in the TCPP. Parents may object on that basis or may object on another basis and if they do, they will be provided with another therapist.

Research Stakeholders

Research stakeholders include children’s service organizations, particularly Children’s Aid Societies and School Boards. Social workers and teachers, especially special education teachers, are also an important audience for this work. More broadly, policy makers in the Ministries of Community and Social Services, Education, as well as Health and Long-Term Care are also an audience of interest with a stake in the results.
Review of Related Research

The Canadian Incidence Study of Reported Child Abuse and Neglect (2001) estimates that in 1998, 61,201 child maltreatment investigations involving children less than 16 years of age, were substantiated by the investigating worker. An estimated 31% of all child investigations involved physical abuse as the main reason for investigation; 10% involved sexual abuse; 40% neglect and 19% emotional maltreatment (Trocmé et al., 2001). Incidence rates from substantiated cases indicate that roughly 10 children per 1000 experience some form or combination of physical abuse, sexual abuse, neglect and emotional maltreatment perpetrated by their parents, step-parents and common-law partners. It is important to remember that the rates of child maltreatment reported in this national study may significantly underestimate the actual prevalence of child maltreatment since the study did not include: 1) cases investigated only by the police; 2) unreported cases known to professionals; 3) unreported cases known to community members; and 4) unknown cases (Trocmé et al., 2001).

In a study conducted by the Law Commission of Canada, the direct and indirect costs to society of child maltreatment in Canada in 1998 were estimated to be a staggering $15,705,910,047 (Bowlus, McKenna, Day, & Wright, 2003). Another study reported that in 1998 costs (direct and indirect) associated with depression and psychological distress were just over $6 billion in Canada but that less than $150 million was spent on services provided by psychologists (Hunsley, 2002). Given that there is evidence to indicate that the effectiveness of psychotherapy is comparable or greater than antidepressant medication (DeRubeis, Gelfand, Tang, & Simmons, 1999) and that it is more cost-effective than antidepressant medication (Antonuccio, Thomas, & Danton, 1997), the lack of funding available for psychotherapeutic intervention with victims of child maltreatment is troubling (Hunsley, 2002).

Maltreated children are at substantial risk to experience social, psychological and emotional difficulties. A lengthy delay before these children are provided with treatment only prolongs the treatment and increases its cost. Research examining the effectiveness of early psychotherapeutic intervention programs for families and young children at risk for physical abuse and neglect found that interventions generally resulted in positive social, emotional, and psychological outcomes (Geeraert, Van den Noortgate, Grietens, & Onghena, 2004).

Given the enormous direct and indirect costs associated with child maltreatment, as well as the high level of pain and suffering that victims experience as a result of being severely traumatized, the need for treatment as well as prevention is clear – the direct and indirect costs of inadequate levels of effective treatment are much greater than the costs of providing effective treatment (National Clearing House on Child Abuse and Neglect, 2003). A growing body of empirical research has demonstrated that children who experience childhood abuse or neglect are at risk for developing a range of emotional, behavioural and health problems in childhood, adolescence and adulthood (Avery, Massat, & Lundy, 2000; Cohen, Brown, & Smailes, 2001; Meyerson, Long, Miranda Jr., & Marx, 2002; Runyon, Faust, & Orvaschel, 2002; Tenney-Soeiro & Wilson, 2004). Studies have established the effects of child maltreatment on many areas of children’s lives – academic, social, emotional, and physical health (Cohen et al., 2001; Kendall-Tackett, 2000; Rodgers, Lang, Laffaye, Satz, Dresselhaus, & Stein, 2004; Springer, Sheridan, Kuo, & Carnes, 2003; Ystgaard, Hestetun, Løeb, & Mehlum, 2003). A number of studies consistently report that
children who are victims of child abuse are more likely to experience elevated rates of Major Depressive Disorder, Anxiety Disorder, Disruptive Behaviour Disorder, Substance Abuse, Personality Disorders and Post Traumatic Stress Disorder, as well as higher levels of suicidal ideation, depression and lower levels of school functioning (Avery et al., 2000; Cohen et al., 2001; Springer et al., 2003; Ystgaard et al., 2003).

Research has investigated the additive impact of exposure to different types of abuse. According to one study, adolescents diagnosed with Major Depressive Disorder (MDE) who also exhibited behavioural problems were more likely to have been exposed to a combination of sexual abuse, physical abuse and neglect than other adolescents with MDE (Westenberg & Garnefski, 2003). Findings from another study concluded that participants who had been exposed to multiple forms of abuse were more prone to experience problems with substance abuse and risky sexual behaviours in adulthood (Rodgers et al., 2004).

Given the seriousness and complexity of the risk factors and symptomatology associated with child maltreatment, an important aim of treatment outcome research is to establish what treatments are effective in helping maltreated children overcome these abuse-related traumas (Saunders, Berliner & Hanson, 2003).

The majority of child psychotherapy outcome studies have examined cognitive-behavioural treatments. These treatments have been shown to be effective in modifying behaviour and ameliorating such disorders in young people as conduct disorder, Attention Deficit Disorder with Hyperactivity (ADHD), eating disorders, anxious and aggressive behaviours, and self-mutilating and self-stimulating behaviours (Hendron, 1993). These treatments have also proven to be effective with sexually abused children and their families (Ross & O’Carroll, 2004). However, weaknesses of cognitive and behavioural treatments have been identified in the literature. Hendron (1993) has acknowledged that, “behavioural and cognitive treatments have limited ability to deal with patients with complex personality disorders or those whose difficulties stem from early childhood” (p. 334). Furthermore, Brandell (2001) critiqued therapies such as cognitive and behavioural treatments, for being symptom-based, time-limited and not sufficiently focused on the therapeutic relationship.

There is a lack of systematic outcome research on psychodynamic, long-term therapy for children. Two reasons for this gap include a) the complexities of conducting systematic research on psychodynamic therapy (Kantrowitz, 1997; Kazdin, 1991), and b) the expense of long-term psychotherapy (Fonagy & Target, 1997). There has been little outcome research on psychodynamic therapy with children. Several studies have demonstrated the effectiveness of psychotherapy (James & Mennen, 2001) and psychodynamic therapy (Osofsky, 2003) as a treatment modality. More specifically, findings from studies of psychodynamic therapy with children consistently indicate that psychodynamic treatment with children is more effective than no treatment (Kazdin, 1991; Weiss, Catron, & Harris, 2000). Results also suggest that this treatment modality can be beneficial with certain high-risk, multi-problem children (Fonagy & Target, 1994, 1997; Kantrowitz, 1997).

The literature has revealed that the effectiveness of treatment varies based on the length and intensity of treatment, as well as the participant’s age. Several articles highlight the effectiveness
of longer and more intensive psychodynamic treatment in working with children (Fonagy & Target, 1994, 1997, Heinicke & Ramsey-Klee, 1986), and the more positive response of younger children than older children to therapy (Fonagy & Target, 1997; Weisz & Weiss, 1993). However, Smyrnios and Kirby (1993) report that their study comparing the long-term effectiveness of time-limited (12 sessions within a period of 15 weeks), and time-unlimited (within a range of 3 to 62 sessions) psychodynamically-based therapies with children did not reveal a significant difference in outcome, based on treatment length. Further research is required to examine how treatment length and intensity, as well as the child’s age, influence the effectiveness of psychodynamic therapy.

Child psychodynamic therapy is at an increasing disadvantage in the struggle for credibility and resources within the medical system and wider society. The literature reveals increasing unease about the time and expense involved in psychodynamic treatment, particularly for children (Fonagy & Target, 1997). Treatments such as cognitive-behavioural treatment, are often preferred due to the fact that they are time-limited (Fonagy & Target, 1997; Skowron & Reinemann, 2005), and considered to be less expensive (Fonagy & Target, 1997).

The relative absence of outcome studies on psychodynamic treatments is also apparent in the literature on the effectiveness of school-based interventions. Most studies on school-based interventions focus primarily on cognitive and behavioural treatments for anxiety, aggression, disruptive behaviour and ADHD (Evans, Axelrod, & Langberg, 2004; Fisher, Masia-Warner, & Klein, 2004; Wilson, Lipsey, & Derzon, 2003). More research addressing the effectiveness of school-based psychodynamic intervention is needed in order to fill this gap in the literature.

Research examining the effectiveness of psychotherapy for children must include questions related to which children, at what age, with what problems, and in what kind of family circumstances, respond best to which treatments (Kazdin, 1991). At this point in time, the answers to these questions are not clear. Further research, such as this evaluation, is required to answer these questions.
Methodology

Participants

The children involved in this project have been maltreated—physically or sexually abused or neglected—as determined by a court, a children’s aid society or a children’s agency. Their emotional, psychosocial, and cognitive development has been severely compromised. These children and their families have ongoing and complex needs and are typically inadequately served by social services, contributing to problem escalation and ever costlier interventions.

The sample thus far comprises eight children, three girls and five boys. At the time of referral, two children were four years old, three were five, six, and seven respectively, two were nine years old and one was ten. Three of the children live with their biological mother, one child lives with their biological father and another lives with their biological grandmother. Two children are adopted and live with their adoptive families and one child lives with a foster family. The children’s family backgrounds are quite diverse: two of the children’s biological parents were born in the Caribbean, and one each in Africa and Israel. One of the adopted child’s biological parents was born in Romania and the adoptive parents are Canadian, whereas the other adopted child’s birth parents were born in Russia and the adoptive mother was born in England. The parents of two children, one of whom was adopted and the other of whom lives with her father, were born in Canada. Despite the complex and difficult lives of these children and their families, the only attrition in this project was a result of the deportation.

All of the children in the sample experienced early and sustained abuse, trauma, and emotional neglect. Poverty, transience, substance abuse and violence have been evident in six of the families. These families have had long standing difficulties spanning generations, and are not well connected to or supported by their communities, including the communities of their children’s schools. Two children were sexually abused over a long period of time (one by the child’s mother’s partner and one by a family friend). One child was severely physically abused by her mother. Two children resided in East European orphanages until late in their second year of life and were malnourished, under-stimulated and behind in all their milestones.

Research Design

With parental, teacher and therapist consent, demographic, quantitative and qualitative data that the Child Psychotherapy Foundation routinely collects as part of the child’s treatment was examined for the purposes of this evaluation. Qualitative data was collected through interviews, while quantitative data was collected with standardized instruments including the Child Behaviour Checklist (CBCL) and the Teacher Report Form (TRF). Qualitative data was utilized to obtain perspectives about the experience of therapists, teachers, and parents/caregivers in this program as well as to gain a rich understanding of the impact of the therapy for the child’s emotional, social, and academic well-being, from the perspectives of their parents, teachers and therapists. Quantitative data was intended to inform evidence-based practice in this area.
Grounded theory was utilized to support trustworthiness, as the data analysis was rooted in constant comparison between the data and the emerging themes (Creswell, 1998; Strauss & Corbin, 1990, 1998). Negative cases were highlighted and analyzed to challenge the examination and creation of themes. Further, an additional researcher and the original interviewer, both highly knowledgeable regarding this therapeutic intervention, reviewed the resultant codes and themes to ensure the findings were valid and relevant.

**Sample**

As the evaluated program is small, all clients were included in the evaluation. Full pre and post quantitative data was collected for six children, with one parent/guardian and one teacher assessment for each child. Preliminary quantitative data was collected on an additional two children who became involved in the program at a later date.

Qualitative data for the original sample of six children were collected six months and again twelve months after therapy commenced. Qualitative data were additionally captured six months after therapy began for the two children who become involved with the CPF at a later date. One child among the original cohort was lost to attrition as his family moved out of the country. As such, qualitative data collected at six months for all eight children consist of twenty-four interviews and qualitative data at twelve months after therapy for five children consist of fifteen interviews.

**Data Sources and Data Collection**

Quantitative data were collected with the use of standardized checklists administered to parents/caregivers and teachers, including the *Child Behaviour Checklist* (CBCL; Achenbach, 2001a) and the *Teacher Report Form* (TRF; Achenbach, 2001b). These are very well established measures utilized to determine the effects of a treatment intervention, and they assess internalizing and externalizing child behaviour. Copies of these checklists are attached (see Appendix I).

Qualitative data were collected through semi-structured interviews conducted by the president of the Child Psychotherapy Foundation with parents/caregivers, teachers, and therapists of the children receiving treatment. These interviews were conducted at six-month intervals after therapy commenced to examine the child’s progress in therapy as well as at home and at school. Interviews additionally examined the role of the therapist in both family and academic spheres and examined parents’, teachers’, and therapists’ perceptions of the long-term and school-based orientation of the program. The interview guide for these interviews is attached (see Appendix II).

**Evaluation Limitations**

There were several limitations associated with the quantitative analysis. Quantitative data analysis was completed with a paired-sample t-test, as the data were too minimal (in both sample size and number of observations) to allow for additional statistical tests. The small sample size was a barrier to successful statistical analysis, as the initial round of intervention included only
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six children. Of these six, five have fully completed pre- and post-CBCL forms (the sixth child and his family were deported from the country prior to completion of the post-CBCL), and only four have fully completed TRFs. The lack of completed TRFs reflects the difficulty receiving successfully completed forms; one teacher mistakenly completed a CBCL form, and another did not answer enough items for the TRF to be scored and included. We do not yet have the data of two children who began treatment several months later.

In addition to the small sample size, other concerns regarding the manner in which the completed CBCL and TRF forms reflect children’s experiences became apparent in the analysis and further impeded in-depth quantitative analysis. Parent and teacher ratings of the children did not agree, which compromised analysis of the quantitative data. This phenomenon has been documented in the literature, as studies have found agreement between parents and teachers to be low to moderate (Achenbach, McConaughy, & Howell, 1987; Mitsis, McKay, Schulz, Newcorn, & Halperin, 2000; Spiker, Kraemer, Constantine, & Bryant, 1992; Stanger & Lewis, 1993).

While various factors may explain this difference, the most salient factors for this evaluation include informant characteristics (Cai, Kaiser, Hancock, & Lipsey, 2004; Offord, Boyle, & Racine, 1991; Offord, Boyle, Racine, Szatmari, Fleming, & Sanford, 1996; Richters, 1992; Youngstrom, Loeber, & Stouthamer-Loeber, 2000), and socioeconomic factors (Gagnon, Viatro, & Tremblay, 1992; Youngstrom et al., 2000). Given the marginalization and trauma experienced by many of the children’s parents, it follows that parental assessments may be further impacted by the context of the parent and family life, thereby creating disparate findings between the CBCL and TRF for each child.
Results

Quantitative Results

Overall, there was little agreement pre- and post-test between teachers and parents, with teachers generally – but not consistently – scoring children higher than parents on internalizing and externalizing behaviour. Further, given the wide range of scores between informants and the small sample size (n=5), no specific trend is identifiable in changes to internalizing, externalizing and total problem scores before and six months into psychotherapy. For more detail regarding the limitations of the quantitative results, please see the evaluation limitations section.

Qualitative Results: Six Months

A number of significant themes were identified in the analysis of interviews conducted after six months of therapy.

Therapists’ Perceptions of Changes Made by the Child in Therapy

All of the children’s therapists observed significant changes in the children within the therapy sessions. With the exception of one child, who was initially enthusiastic about therapy, the children showed various degrees of reluctance at the beginning of therapy. The therapists described the ways children acted when the therapy began as follows: “controlling the play” and “trying to control the endings of the sessions;” being “hyper vigilant;” “uncommunicative;” “engaging in repetitive activities;” showing “lack of symbolic play;” and acting in ways that suggested uncertainty about whether the therapist could be trusted or would abandon the child. All of the therapists observed that, in time, the children became more spontaneous and creative in their play, as well as more expressive and introspective. For example, one younger child, who was physically timid and appeared fearful of rebuke, spent much of the time in early sessions sitting in one spot fiddling with a small doll. Her teacher reported that this child was “overly compliant with rules and requests.” Several months into the therapy, this girl began to engage in ever more expansive physical pursuits such as skipping, singing and dancing. Her teacher reported that the child had begun, at times, to challenge rules. For instance, on one occasion this child engaged in forbidden water play, which the teacher felt, illustrated, her growing sense of adventure and ability to take risks.

All the therapists also reported that, over time, the children engaged with them in a manner that suggested increasing trust in the therapists. One child, who was overweight, relied on food to soothe himself, insisting on bringing his own to the sessions. After several months he stopped doing so and informed the therapist that he thought she could look after him if he became upset.

The therapists believed that the children benefited from the long duration of therapy. Many therapists commented on the extensive length of time required to create an environment and develop a relationship in which the child felt comfortable and willing and able to open up and to play.
Although most of the children displayed initial hesitation about therapy, all of them seemed open to sessions and many expressed excitement about attending. None of the children appeared concerned about attending therapy during the school day. The children’s parents and teachers commented on the children’s positive feelings after sessions. Indeed, none of the teachers complained of any disruption to the classroom or the other students.

**Parents’ and Teachers’ Perceptions of Changes Made by Children**

All of the parents and teachers believed that the children were in need of treatment, and all but one found the school-based treatment to be worthwhile and helpful for the children. Even the one parent who did not find the treatment helpful acknowledged that the child “loves” the therapist “to pieces, looks forward to seeing her” and “loves playing with her.”

The parents and teachers all found that the children made noticeable changes during the six months in which they participated in therapy, including becoming calmer, less rigid, and seeming happier, more focused and patient. The children were also described as better able to withstand school pressures, and as gaining in maturity and independence. For example, a child who had been described as withdrawn became more outspoken and more able to “stand up” for herself.

In general, the boys were portrayed as becoming calmer and “acting out less,” whereas the girls were typically seen as gaining confidence and becoming more able to “test boundaries,” take risks, and express their emotions. Finally, most of the parents and teachers described the children as becoming more resilient; that is, more able to re-stabilize after becoming upset. For instance, before therapy, an altercation with a peer would cause one child to remain upset for the remainder of the school day; he was unable to settle, concentrate or learn. Six months later, this child was described as being soothed within an hour of such an altercation and as then able to settle down and follow school routines. The teacher reported that this change was helpful not only for the boy, but also freed the teacher to concentrate on the classroom, benefiting the class as a whole.

**Parental Perceptions of Therapy and Relationship with the Therapist**

With respect to their overall views of the therapy, the parents varied considerably. Some parents were portrayed by the therapist, or reported themselves, to be unresponsive or unsupportive of the therapy; whereas others were described, and depicted themselves, as very committed and engaged. One parent, for example, viewed the therapist as an extension of Children’s Aid Society, which clearly influenced her responses. Other parents considered the therapist to be an ally and support. While some parents felt supported by suggestions offered by the therapists, with one parent even requesting more concrete advice from the therapist, one parent felt offended by some of the parenting suggestions that the therapist put forward. Another parent perceived the therapist and child as a “little unit” which she could not understand or access. Not surprisingly, this parent did not feel the therapist provided her with enough information or input as “the mother.” In contrast, another parent who termed the therapy “extremely positive,” felt quite supported by the therapist and believed the therapist’s input enhanced her parenting skills.
and helped her increase her ability to engage with her child. It appeared that the mothers of the most disruptive children felt they learned less about their children and tended to think the school needed more support to accommodate their children than they themselves did.

The frequency with which parents met with the therapists varied, as did their proclivity towards being late for or cancelling appointments. The parents all expressed various degrees of anxiety related to the therapists, similar to their expressed anxieties about contact with school personnel. They reported having rarely, if ever, receiving positive reports about their children. Some parents commented that their conversations with the therapists were the only positive remarks they had heard, from professionals, about their children. For example, one parent said that her child’s teacher and principal had always had her on “speed dial” and that the call was “never good news.” One child was described as concerned about the relationship between his parents and the therapist, worrying that they were discussing negative things.

**Therapists’ Perception of Parents and Relationship with Parents**

A striking finding was that all of the therapists consistently reported that building relationships with the children’s parents proved to be the most challenging aspect of the treatment. With the exception of one parent, the therapists described the parents as “difficult to engage.” They elaborated that the parents were “hard to contact,” often did not return their calls and frequently cancelled, failed to show up for or arrived late for appointments. Prior to their involvement in this project, these parents did not typically attend school meetings or functions or have regular contact with the school. As they came to know the therapists, the parents disclosed that they did not find the school particularly helpful, and a number of parents felt the school only added to their burdens and problems. As noted, these parents were used to being contacted when their children displayed academic or behavioural problems.

The therapists’ responses varied significantly in respect to their perceptions of the children’s parents and to the nature of the connections/relationships. Two therapists found the parents “unresponsive” to their overtures. However, with time, the reasons for this “unresponsiveness” became clear and were understandable and compelling. The other therapists all described difficulties at the outset in developing positive relationships with the children’s parents, but most felt they had made substantial progress by the time of the six-month interview. In one case, it took many months for the therapist to meet the mother, and then three meetings took place within three weeks. In another case, it took several months before a parent would answer calls from the therapist on the parent’s cell phone; she then began to answer immediately and warmly. At the time of the interview, one therapist identified her relationship with the mother as in need of “repair.” A tentative finding was that the mothers of the most disruptive children were harder to engage, whereas the teachers of the most disruptive children were particularly engaged with the therapists.

All of the therapists reported gaining an increased appreciation of the need to validate parenting choices, provide parents with positive anecdotes about their children, and encourage parents to understand their child more and communicate differently. Importantly, the therapists increasingly recognized the need to de-emphasize their role as “expert” and, rather, to collaborate as a “team” with the parents. One therapist said, “Even though I like her and I think
she really cares, it’s hard for her to allow other people to fill needs that she can’t or take helpful hints. But if I tell her to just relax and not worry, then she relaxes and it’s not so much of a problem anymore.”

School as the Location of Therapy

There was overwhelming agreement that it was appropriate and important that the therapy take place in the child’s school. Indeed, all of the respondents—parents, teachers and therapists—were quite certain that the therapy would not have occurred had it not been located in school. The parents all explained that they would not have been able to take their children to appointments located outside the school. A number of the therapists found that seeing the child in the school environment contributed to their viewing the child as a “whole person,” particularly as some therapists saw the students over recess or lunch and thus observed their interactions with peers. In addition, when a session was preceded by a particularly positive or negative school incident the therapist could observe and assess the influence of that event on the child’s play. A few teachers commented that as a result of other children seeing the therapist with a student, the other children became more accepting and supportive of the student involved in therapy. In addition, some teachers noted that holding therapy in the school allowed them to develop positive relationship with the child’s therapist. One parent commented on the improved therapist-teacher-parent connection, because this parent and the therapist regularly discussed how best to communicate with the teacher.

It is striking that the parents, teachers and therapists all reported that none of these children was able to play before their involvement in therapy. The children were described in such terms as “preoccupied,” “distressed,” “hyper vigilant” and “unable to self-regulate,” to such an extent that play was impossible. A number of the respondents believed that the sessions represented the first time the child began to truly engage in play. Moreover, many of the teachers and parents observed the children’s increasing capacity to play both at home and at school, alone and, in some cases, with peers and siblings.

Despite the overwhelming positive views of school as a location for therapy, many therapists experienced difficulties because the school was unable or unwilling to find adequate space, leading to privacy concerns. Since this posed an issue for many of the children, the President of the Foundation became involved with the school boards’ administrations and, as already noted, in one case developed a formal agreement which resulted in a welcoming attitude on the school board’s part.

Teacher-therapist Relationship

By and large, the teachers and therapists described their relationships as positive and mutually supportive. They found that their close proximity facilitated moment-to-moment exchange of information and consultation and felt that the relationship created an opportunity to discuss progress of the child, for both parties to learn more about the child and become more responsive to the child’s needs. Both teachers and therapists were surprised at how useful and positive their relationships were. All the teachers felt that they learned something new from their interactions with the therapists. Many commented that they became more able to understand and respond to
the children’s needs as a result of conversations with the therapists. Moreover, teachers reported that what they learned was helpful in relating with other children who required extra assistance. The teachers described themselves as becoming more mindful of student needs and more able to understand the child’s behavioural concerns as rooted in their traumatic experiences, rather than viewing the child as merely “needy” or “disruptive.” The teachers attributed this increased awareness to their contact with the therapist. A number of the teachers commented that they often asked therapists for advice regarding the child in therapy, and felt supported by the therapist. Some tentative themes emerged, including the finding that teachers of the little girls who were subdued rather than disruptive required less support and had less contact with the therapists. Some of the girls’ teachers noted that through discussion with the therapist they began to pay more attention to the unique needs of these children, who were otherwise so accommodating in class they were not on the teacher’s radar.

Most of the teachers and therapists remarked on the frequency of their meetings, every week or two and, in some cases, as often as twice a week. One teacher, who met only monthly with the therapist, still felt very positive about the relationship. Another teacher wished the therapist had provided more information about the child’s progress. Interestingly, that therapist believed that this teacher felt usurped by the therapist in the child’s life and that this teacher was ambivalent about the therapy.

Child’s Academic Status

A number of teachers suggested that the child either had a learning disability (LD) or might have an undiagnosed LD. Only two children were described as having average-to-high academic status. One teacher wondered whether the trauma experienced by the child “blocked” the child from learning. This teacher felt more able to identify and respond to the child’s learning problems because contact with the therapist resulted in a better understanding of the child.

Qualitative Results – Twelve Months

Family Lives

Several families continue to cope with difficulties that impact the child. One family is coping with the mother’s severe illness, which has created considerable stress and has fostered a largely unstructured family environment. One child’s mother travels for long stretches at a time, and another child’s father and step-mother are in a relationship depicted as “tension-filled and strained.”

Therapist Relationship with Parent/Caregiver

Parents were described as opening up more to therapists with time. Various explanations for this increased engagement included: the therapist proved their commitment to the child through the prolonged length of time as the parent may have expected the therapist to leave as previous support providers had; the therapist was able to provide something the family perceived as a concrete benefit, such as educational testing or volunteer tutors; and the therapist was able to
engage more as the family grew more comfortable with her over time. The increased engagement was seen as pivotal to parents’ perceptions of therapy, as one family-therapist relationship changed dramatically once the therapist engaged the mother more; they now meet frequently, share information and the mother feels the therapist is very helpful and accessible, in contrast to her previous ambivalent feelings about the therapist.

This increased engagement was found to be beneficial to the entire family unit as the parents enjoy their own time to talk to the therapist and perceived this time to reflect as calming and rewarding in contrast to the tension that marked their initial time with the therapist. One single mother noted that the therapist had been witness to her development as a parent and the development of she and her child as a unit, as no one else had. Therapists also noted that their improved relationship with the family contributed to the therapeutic work with the child, as the therapist was better able to understand and speak to the family dynamics.

The relationship-building also facilitated further communication, and therapists were able to update the family about the child in school and also about the child in general, for example providing information that the child told the therapist but not the parents, while keeping confidentiality in mind. Increased communication also provided opportunities for the therapist to offer guidance to the family, and promoted discussion that was no longer tentative and impeded by concerns of misunderstanding or hurt feelings. This engagement further allowed the therapist to serve as an ally to the family regarding the broader system, and several parents and therapists noted new roles for the therapist in engaging with the school, social workers, and daycare staff on behalf of the family.

One negative case was identified, as a therapist indicated that the family with whom she works has become less engaged and more difficult to contact unless they need the therapist, in which case she feels they become “rather demanding.” The therapist finds work with the family to be “very draining.” This family is also described as not engaged with the school unless the parents are upset.

**Child’s Academic Status**

Almost all the teachers noted that the children were improving, though several were still far from meeting their grade requirements. Several teachers and therapists indicated that restrictions on child academic support within schools impeded progress. For example, if a child was receiving one form of academic support, such as a reading group, it was often difficult to attain additional support for them. Some therapists were able to advocate for academic testing and support.

Many teachers and parents were of the opinion that the children would do better with more support, with teachers suggesting the benefit of further work at home and parents indicating they felt the schools should be doing more for their children. Many students were described as doing better when provided with one-on-one support but as getting “lost” among more vocal or advanced students in groups, and one student was seen as particularly responsive when the project was hands-on, such as in science class.
There was one negative case identified, as one student was depicted as becoming “worse” behaviourally and academically at school. At the time of the interview, the situation had escalated to the point at which the school identified the desire to transfer the child to a behavioural class. This particular child has been identified as “extremely low functioning,” and the child’s academic success as impeded by his low IQ.

**Influence of Teacher in Family and Therapy**

Several students had a different teacher in this second year, which is an obstacle to drawing conclusions about child improvement from the perspectives of the teachers.

Teachers reiterated the themes evident after six months, including: the therapist and teacher acting as a team; the teacher providing the therapist with information about the child’s experiences in school; and the therapist providing the teacher with guidance and support in teaching the child and other similar children. Several teachers who did not have a relationship with the child’s family indicated that the therapist helped the teacher problem-solve about the child in the absence of parental involvement. The therapist was characterized as a sort of liaison who shared information between school and parents/caregivers. This was especially useful for teachers and parents who had differing opinions about child, particularly regarding behavioural or academic concerns such as teachers encouraging more academic work at home or parents expressing frustration with the school’s inability to manage the child.

All teachers commented that they saw benefit to therapy for the child. Some felt that the therapy provided an outlet for rambunctious play and discussion of feelings which would allow the child to focus more in class. For students whose behaviour had greatly disrupted the class, teachers noted an increasing ability to calm down when upset, which benefited the entire class. Other teachers noted that the child needed someone to talk to, and felt the child benefited greatly from the one-on-one interaction.

One teacher indicated that she would like to have meetings with both the therapist and parents to touch base about the child’s progress, and another teacher indicated that time with the therapist allowed for reflexivity around the role as teacher and how their manner of engaging with a student may ameliorate or trigger difficulties for child.

**Therapist Efforts during Play**

Therapists actively attempted to mimic real life situations in therapy by reflecting situations children noted concern about (such as being bullied) or situations they had watched children confront on the playground (such as losing a game), allowing the child to practice a difficult situation with the therapist and to then apply skills outside of therapy.

Therapists also focussed on providing gestures to show the child they thought about them between sessions, by such things as bringing an apple to each session. One therapist created a little more “space” each week through play to discuss the child’s sexual abuse. After several months, the child utilized this space and discussed trauma and her ongoing related fears.
Changes made by Child in Therapy

As therapy progressed, therapists identified that the children became more open with their emotions, and more able to identify and work through negative feelings of self. Children became more active in play and more verbal overall. Children were described as becoming more able to focus in therapy, and increasingly able to identify and articulate their needs. Children also became more relaxed in therapy.

The therapeutic environment also helped children learn more about how various places have different rules about behaviour. One child became far more aware about the rules of school, daycare, and therapy and was more able to “play by the rules” of each place.

Therapists also noted that many of the significant breakthroughs regarding the trauma the children had experienced came after extensive engagement. One child in particular was only able to discuss the abuse after approximately nine months in therapy.

Perceptions of Changes Made by Children at School and Home

Almost all of the children were described as better able to engage with others, and several students were noted as becoming quite popular. Families stated that the children were “exploring,” “blossoming,” and generally “happier.” Many were also described as interacting better with family members, and more able to express their emotions.

Teachers indicated that several children were more open to new people, and more able to express themselves in class. A number of teachers noted that the children appeared more eager to learn and read. Teachers also identified some children as better able to recognize when their actions were coming close to “crossing the line” and to then show restraint, particularly regarding making noise and disrupting the class. Children were also seen to be more able to recognize and communicate their personal limits regarding class dynamics. For example, one student became able to verbalize an inability to sit quietly any longer and the need to “do something else.” Students were also observed to be more alert and “present” in the classroom.

Lingering Concerns Regarding Child Behaviour

One child was described as not showing advances that were comparable to those made by the other children. He was depicted as exhibiting defiance, as having poor impulse control, as not interacting well with his sibling, as not seeing consequences to his behaviour, as bullying other students, and as unable to verbally express emotions. Some of the boys were described as continuing to engage in much milder forms of disruptive behaviour.

Some of the girls were described as continuing to appear more connected to adults than to other children, as appearing very concerned about belonging, as seeming to be quite afraid to act independently, as appearing wary of expressing anger, and as having little confidence in friendships.
**Barriers to Progress**

Several barriers to progress were identified during the interviews, including an identified lack of support from the parents or the teacher. Some parents were observed as not addressing the child’s emotional needs or providing the structure needed to provide stability in a child’s life. One teacher was identified as unresponsive regarding the therapeutic process, and was not engaged with the therapist or family.

Some families are experiencing significant stress, such as terminal illness or parental relationship tension, which impacts on the child’s sense of stability or belonging.

One child was identified as “very low-functioning,” and therapy was not seen to be creating intended outcomes because of the child’s low IQ and significant learning issues.

**School as the Location of Therapy**

Most teachers were not concerned about the academic impact of missing classes for therapy, as these missed classes were either not “content-heavy” or the students were able to catch up. A few teachers indicated that missing class may pose a greater problem as students move into higher grade levels. Teachers did not identify any stigma or class disruption associated with therapy.

One negative case was identified, as one child was described as occasionally having a difficult time making the transition into class after therapy, because he seemed to be “energized” after spending time imagining and playing. After the teacher spoke to the therapist about this, the therapist incorporated more calm time at the end of each session to help the child return to class routine when therapy is over.
Conclusion

The respondents all observed significant and positive changes in children, which they attributed to the intervention. Most children were identified as: improving academically; engaging more socially; gaining confidence; and increasing their ability to identify, express, and regulate with their feelings. The centrality of the therapist’s involvement with the parents created opportunities for: parents to develop supportive dyadic relationships with therapists; therapists to serve as an ally and liaison for parents with school and community systems; and therapists to better understand the family dynamics, which informed the child psychotherapy. The fact that the therapy took place in the children’s schools allowed therapists to learn about the child from teachers, to more holistically understand the child by watching them interact in school, and to provide support and guidance to the teachers.

The parents, therapists and teachers all identified positive outcomes, which they attributed to the long-term and school-based nature of the therapy. In particular, the intervention allowed: parents to feel more included, often for the first time, in the school system; teachers to shift from being sceptical to becoming firmly supportive of the therapy; and therapists to increase their commitment to working to engage parents for therapeutic gains. The community-oriented nature of the intervention and the depth of information gathered regarding the key factors influencing change enhance opportunities for knowledge transfer.

Recommendations

These insights learned throughout this research project have led to the following recommendations:

- That this complex and high needs population be recognized as having unique needs that requires an ecologically informed school-based intervention that engages families and schools.
- That practice principles be developed to guide psychodynamic interventions with this complex and high-needs population, for example the importance of reaching out and engaging with the parents in a collaborative manner.
- That more research, particularly longitudinal research is necessary to examine the long term implications of this form of intervention for the social and academic outcomes of the child. Additionally, long term research could identify the potential social, health and justice sector cost-savings associated with intensive therapy at a young age.
Lessons Learned

The research team identified several pivotal lessons from the process of evaluation, including:

- That the role of the coordinator in a complex intervention and research project is pivotal to the success of the program and evaluation. The coordinator role assured a feedback loop to connect parents, therapists and teachers (where the connection was less solidified) in order to address concerns identified through interviews but not addressed by therapists. As such, it is important that the coordinator have a clinical background to understand the therapy and the needs amongst groups.
- That the ecological component of this intervention be a core component of the work of the therapists, especially for parents who are initially resistant. It was pivotal that therapists recognize that it was their job to work to break down barriers to engage with families and teachers.
- That supervisors involved in this therapy be aware of this client population and their specific individual needs. It also became evident that supervisors needed to be skilled in case management in order to communicate with involved professionals and services and to contribute to progress by the therapist and their clients.
- That quantitative data collection, particularly the CBCL, may not reflect the manner and process of change experienced by high-needs children. As such, the contributions of qualitative data collection should be highlighted for the evaluation of complex interventions.

Next Steps

Given the promising results of this evaluation, the research team plans to further program and research development. In particular, there are plans to:

- Develop and evaluate practice principles to guide work with this high-needs and complex population, with a focus on ecologically informed principles.
- Pursue additional research opportunities, particularly of a longitudinal and quasi-experimental nature, to more precisely determine the optimal length and format of this therapeutic intervention. Specifically, we intend to integrate the concrete practice principles into treatment to ensure fidelity in a future research project to examine the long-term outcomes associated with this intervention.
Knowledge Exchange Plan

Knowledge exchange and dissemination will be facilitated for psychotherapists by the extensive networks of the Child Psychotherapy Foundation. Results will be synthesized into a fact sheet by the Institute for Evidence Based Social Work at the University of Toronto for dissemination to all Faculty of Social Work community partners, School Boards, and Children’s Aid Agencies.

Results will also be disseminated nationally to agencies that support and protect children through our partnership with the Centre for Excellence in Child Welfare (CECW) at the Faculty of Social Work, University of Toronto. We will further distribute the evaluation results to media sources such as TV, radio, newsprint and the U of Toronto website.

In addition to community knowledge exchange, the results will be disseminated through scholarly papers and publications. One paper on the findings has already been accepted for publication (Mishna, in press), and two additional publications on the process and results are planned. Two conference abstracts on the project have also been submitted for presentation at the Society for Social Work and Research annual conference.
References


Canadian Psychological Association.
Mishna, F. (in press). Meeting them where they are: Intensive school-based psychotherapy for children who have been maltreated. *Psychoanalytic Social Work, 14*(2).
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