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## The evidence-base for psychoanalytic and psychodynamic psychotherapy with children and adolescents

An update and  
narrative synthesis

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## Foreword

On behalf of the Association of Child Psychotherapists (ACP) we are very pleased to welcome the publication of this updated systematic review of the evidence base for psychoanalytic and psychodynamic psychotherapy with children and adolescents. The ACP commissioned the review to inform important policy, service and workforce developments that are taking place in all nations of the UK and to promote awareness of contemporary developments in research in our profession. A research literate profession is better able to shape services at an individual and local level and to contribute to policy and commissioning decisions. We hope that it also contributes to similar developments in other countries.

We are very grateful to Professor Nick Midgley and his colleagues at the Anna Freud National Centre for Children and Families and University College London for their thorough and impressive work in completing this clear and accessible review. This report not only provides an update on the evidence published between January 2017 and May 2020 but also, for the first time, a narrative synthesis of all the published research to date. This valuable piece of work shows further improvements in both the quality and quantity of research evidence and will support the ACP, Child and Adolescent Psychotherapists and others involved in service improvements to provide safe and effective care and treatment across a range of mental health needs and conditions.

Mental illness in infants, children and young people is recognised as a major public health concern with evidence of rising prevalence, exacerbated recently by COVID-19<sup>1</sup>. It is widely reported that 75% of mental illnesses start before a child reaches their 18th birthday and yet, historically, child and adolescent mental health services have been under-resourced, even within the significant imbalance evident between mental health services and physical health services<sup>2</sup>. This has begun to change in recent years with far greater recognition of the extent of mental illness in infants, children and young people and the ongoing impact, through life, on their

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<sup>1</sup> NHS Digital (2020) *Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey*. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up>

<sup>2</sup> Association of Child Psychotherapists (2018) *Silent Catastrophe: Responding to the Danger Signs of Children and Young People's Mental Health Services in Trouble*. Available at: <https://childpsychotherapy.org.uk/news-media-0/acp-policy-reports/silent-catastrophe>

developmental trajectory and the necessity for effective interventions at the earliest opportunity. The NHS in all parts of the UK has committed to additional funding for child and adolescent mental health with ambitions to increase access to services for 0-25 year olds. The review has significant importance for ensuring these developments are informed by the best available evidence on the effectiveness of psychoanalytic and psychodynamic psychotherapy for children and young people.

Child and Adolescent Psychotherapists are one of the 12 core NHS Psychological Professions<sup>3</sup> and work alongside a range of other professionals in multi-disciplinary teams in many different settings. Infants, children and young people, especially where needs are severe and complex, need to be supported and enabled to access effective specialist services that can offer a range of treatments at the right time in the right place<sup>4</sup>. Such services should include professionals with a range of skills, competences and trainings working together in well-led multi-disciplinary teams. In turn these services need to be informed by evidence of effectiveness and cost-effectiveness.

Evidence-based practice is increasingly being viewed as a tripartite model in which research evidence is contextualised by service user choice and clinical experience<sup>5</sup>. The empirical evidence-base for psychoanalytic and psychodynamic psychotherapy with infants, children and young people has been slower to develop that in related fields, in part due to the relative underfunding of research in psychological therapies and on interventions with children and young people<sup>6</sup>. However, published reviews<sup>7</sup> have demonstrated a growing evidence base which suggests that psychodynamic and psychoanalytic therapies can be effective for children and young people presenting with a wide range of clinical issues. This new review adds substantially to our

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<sup>3</sup> Psychological Professions Network (2020) *Career map for the Psychological Professions*. Available at: <https://www.ppn.nhs.uk/resources/careers-map>

<sup>4</sup> Association of Child Psychotherapists (2019) *Children and Young People's Mental Health: Specialist Provision for Complex Needs*. Available at: <https://childpsychotherapy.org.uk/news-media-0/acp-policy-reports-0/specialist-provision-complex-needs>

<sup>5</sup> Psychological Professions Network (2020) *An update on our evidence-based practice project*. Available at: <https://www.ppn.nhs.uk/our-work/news/item/an-update-on-our-evidence-based-practice-project>

<sup>6</sup> MQ (2015). *MQ Landscape Analysis, April 2015. UK Mental Health Research Funding*. Available at: [https://b.3cdn.net/joinmq/1f731755e4183d5337\\_apm6b0gll.pdf](https://b.3cdn.net/joinmq/1f731755e4183d5337_apm6b0gll.pdf)

<sup>7</sup> Nick Midgley, Sally O'Keeffe, Lorna French & Eilis Kennedy (2017) *Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base*, *Journal of Child Psychotherapy*, 43:3, 307-329, DOI: 10.1080/0075417X.2017.1323945

knowledge and understanding of the range and depth of evidence now being produced.

Within the profession of child and adolescent psychotherapy there is an increasing engagement with a variety of approaches to research and the importance of these in both developing clinical practice and demonstrating its efficacy. The majority of trainings in the UK now lead to a doctoral qualification and the theses being produced are testament to the range of interests and areas where Child and Adolescent Psychotherapists are making important contributions. The profession is therefore increasingly well positioned and motivated to add to all elements of the evidence-base including research into service user experience and examining the process of psychotherapy to optimise its effectiveness with individual patients, including those from Black, Asian and minority ethnic communities. A range of research methodologies are required to better understand how services can be tailored to the needs and preferences of individuals and therefore what workforce skills, competences and trainings are required to deliver those services effectively. This updated systematic review is important contribution to these developments.

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# 1. Introduction

Psychoanalytic and psychodynamic psychotherapies<sup>8</sup> with children and adolescents are approaches to working with young people that draw on psychoanalytic ideas, whilst also integrating ideas from other disciplines, including developmental psychology, attachment theory and neuroscience (Kegerreis & Midgley, 2018; Lanyardo & Horne, 2009). Although the term 'psychodynamic therapy' covers a range of clinical models, most of them share what Kegerreis & Midgley (2018) refer to as "the central idea ... that behaviour, emotions and responses have an inherent logic and meaning – a way in which the child's problems, despite their apparent unhelpfulness, make some kind of emotional sense. Their roots lie in the internal world of the child that has been built up from his earliest experiences and relationships" (p.47)

Despite the rich theoretical and clinical history, psychodynamic child psychotherapy has been slow to engage with issues regarding the evidence base for its effectiveness. A number of reasons underlie this – including the fact that psychodynamic therapists have often been suspicious about the capacity of psychological research methods to sufficiently capture the complexity of this approach (Midgley, 2009). Debates have taken place within the field about the need to maintain the psychoanalytic approach as a research method in its own right (Rustin, 2009), or the necessity to engage with research methods used within mainstream psychology, in order to be able to appropriately judge 'what works for whom' (Fonagy & Roth, 2006). Faced by the growing necessity to demonstrate the effectiveness of psychotherapies, psychodynamic child and adolescent psychotherapists have increasingly accepted the importance of evaluating the effectiveness of their work, but often lack the skills and competencies – or the funding – to carry out the necessary research.

Although this is now beginning to change, there is still a relative lack of interest among academic researchers in investigating psychodynamic therapy with children and young people. In addition, one of the barriers to further evaluation of this approach is the relative underfunding of research both in psychological therapies generally and specifically for therapies with children and young people (MQ, 2015). Within psychological therapies research, psychodynamic psychotherapy is one the

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<sup>8</sup> This report reviews evidence in relation to both psychoanalytic and psychodynamic psychotherapy. For simplicity, and with an international audience in mind, the term 'psychodynamic therapy' will be used to cover both psychoanalytic and psychodynamic approaches, although where specific studies refer to one or the other term, we follow the authors' own terminology.

least well-funded therapies, with one recent review estimating it receives 1.96% of total funding compared to 27.55% for CBT (MQ, 2015). In the rare situation where psychodynamic psychotherapy for young people has been evaluated in a high quality, adequately powered randomised controlled trial (RCT) it has been found to be at least as clinically and cost effective as other treatments (Goodyer et al., 2016), strengthening the case for further evaluations of this modality for different clinical conditions and different age ranges. Without a robust evidence-base, the commissioning and general availability of this approach is under threat. Although a lack of research is not evidence of lack of effectiveness, over time the failure to build an evidence base within psychodynamic child psychotherapy has led to a growing perception that the approach is not sufficiently 'evidence-based'.

It is within this context that a review of the evidence base for child psychotherapy was commissioned by the North Central London Strategic Health Authority (Kennedy, 2004). This ground-breaking review identified thirty-seven papers, reporting on thirty-two distinct research studies, that set out to evaluate the effectiveness of different types of psychodynamic child and adolescent therapy for different populations. Although the findings of this review were promising, only five of the studies were RCTs– the only type of study considered sufficiently methodologically rigorous to be included by many treatment guideline developers. Nevertheless, the findings of this initial review were generally encouraging, showing beneficial effects on a variety of standardized outcome measures, including indications of sustained improvement at follow-up.

Building on the findings of this first systematic review, an update which incorporated the earlier findings was published in 2011 (Midgley & Kennedy., 2011) and a further update was published in 2017 (Midgley et al., 2017). Other reviews of the evidence-base, using slightly different inclusion criteria and search strategies, have also been carried out (e.g. Palmer, Nascimento and Fonagy, 2013; Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013). The Abbass et al. review was especially important because, for the first time, it took a meta-analytic approach, in which the authors pooled results from a range of different studies, thereby helping to address the problem of low statistical power that limits much psychotherapy research. Although including a smaller number of studies (11) and focusing only on short-term psychodynamic psychotherapy (STPP) for adolescents, all studies included were clinical trials. The meta-analysis demonstrated robust ( $g = 1.07$ , 95% CI: 0.80–1.34) within group effect sizes, suggesting the treatment may be effective. These effects increased in follow up compared to post treatment (overall,  $g = 0.24$ , 95% CI: 0.00–0.48), suggesting a tendency toward increased gains. However, in this meta-analysis



STPP did not demonstrate better outcomes than a range of robust treatment comparators, such as CBT and systemic family therapy.

Although this series of systematic reviews has played an important role in bringing together the evidence-base for psychodynamic child and adolescent psychotherapy, these earlier reviews each covered only a set period (e.g. pre-2011, or 2011-2017), or a certain sub-set of studies (such as clinical trials of short-term therapy for adolescents) and were not able to provide a synthesis of all of outcome research to date. Given the rapid developments in this field, the aim of this review is to provide an update on the evidence base for psychodynamic therapy with children and adolescents published between January 2017 and May 2020, making use of a similar methodology used in the review papers described above, including assessing the quality of research done in this area. In addition, this paper provides, for the first time, a narrative synthesis of *all* the published research to date, i.e. synthesising the findings of this new update (2017-2020) with those reported in the 2011 and 2017 reviews. In line with previous reviews, psychodynamic therapy with children aged 0-3 is not included in this review, although the evidence for this work has been reviewed elsewhere (Sleed and Bland, 2007; Barlow et al., 2016).

The findings of this narrative synthesis will be presented in relation to children and adolescents with different clinical presentations, as well as reviewing the evidence for psychodynamic therapy in 'real world' settings, when offered to children with a mix of presenting problems.

## 2. Methods

The search strategy and methods used in this review mostly follow those of the previous reviews (see Midgley and Kennedy 2011), with some small changes. Key psychology and psychiatry databases were searched for publications between January 2017 and May 2020. Search terms were derived using the method outlined by Schardt and colleagues (2007). For full search strategy, see appendix 1.

### Inclusion criteria

- *Language*

English Language.

- *Interventions*

Individual or dyadic (parent-child) psychodynamic and/or psychoanalytic therapy, including family or group therapy where the therapeutic intervention is described as psychodynamic or psychoanalytic. As psychodynamic treatments are based on a range of theories, this review included all studies where the researchers defined the treatment model under investigation as primarily psychodynamic or psychoanalytic.

- *Participant age*

Studies where a majority of participants were aged between 3 and 18 years old but none of the child/adolescent participants were over 25.

- *Study focus*

Studies primarily concerned with evaluating treatment outcomes, using any design involving quantitative measurement of outcomes, e.g. randomised control trials, quasi-experimental studies, and naturalistic evaluation.

- *Study outcomes*

Outcomes related to any mental health condition or problem, including sub-threshold mental health conditions and prevention of mental health difficulties.

### Exclusion criteria

- *Method*

Studies that report only on qualitative findings; single case studies; review papers; and meta-analyses.

– *Outcomes*

Studies where child outcomes are not reported (e.g. only parent outcomes reported) and studies focusing only on the process rather than outcome of therapy.

– *Interventions*

Parent-infant psychotherapy (where the intervention is primarily focused on therapeutic work with children under three years of age); studies that did not designate the model of intervention as psychodynamic or psychoanalytic, or did not use descriptive terms derived from these theoretical models

Supplementary searching was also undertaken, including contacting key researchers in the field, and hand searching the reference list of relevant papers and reviews.

## **Data extraction and quality assessment**

Studies that met inclusion criteria for this review were summarised and are presented in a data extraction table (see appendix 2). Where multiple papers described secondary analysis from the same study, papers were grouped together. Studies were sorted by methodology into four groups: randomised controlled trials, quasi-experimental studies, observational studies with a comparison control, and observational studies without a control group. Studies were also grouped by 'presenting problem', such as 'depression', 'personality disorders' or 'mixed'.

A critical appraisal of each study was then undertaken (see appendix 4). Two separate quality assessment tools, designed by the National Institute for Health, were used: one for controlled intervention studies, and one for naturalistic pre-post studies without a control group (NIHR, 2014). The two tools assess the 'internal validity' of the study, i.e. to what extent the study contain a risk of bias.

To ensure a consistent approach to the risk of bias assessment, one controlled and one non-controlled study were selected, and three authors separately rated these studies using the relevant quality assessment tools. These three authors then met together to discuss any disagreement and reach consensus on how to apply the criteria, before separately rating the remaining papers. A table of studies sorted according to internal validity rating is included in the appendix 4.

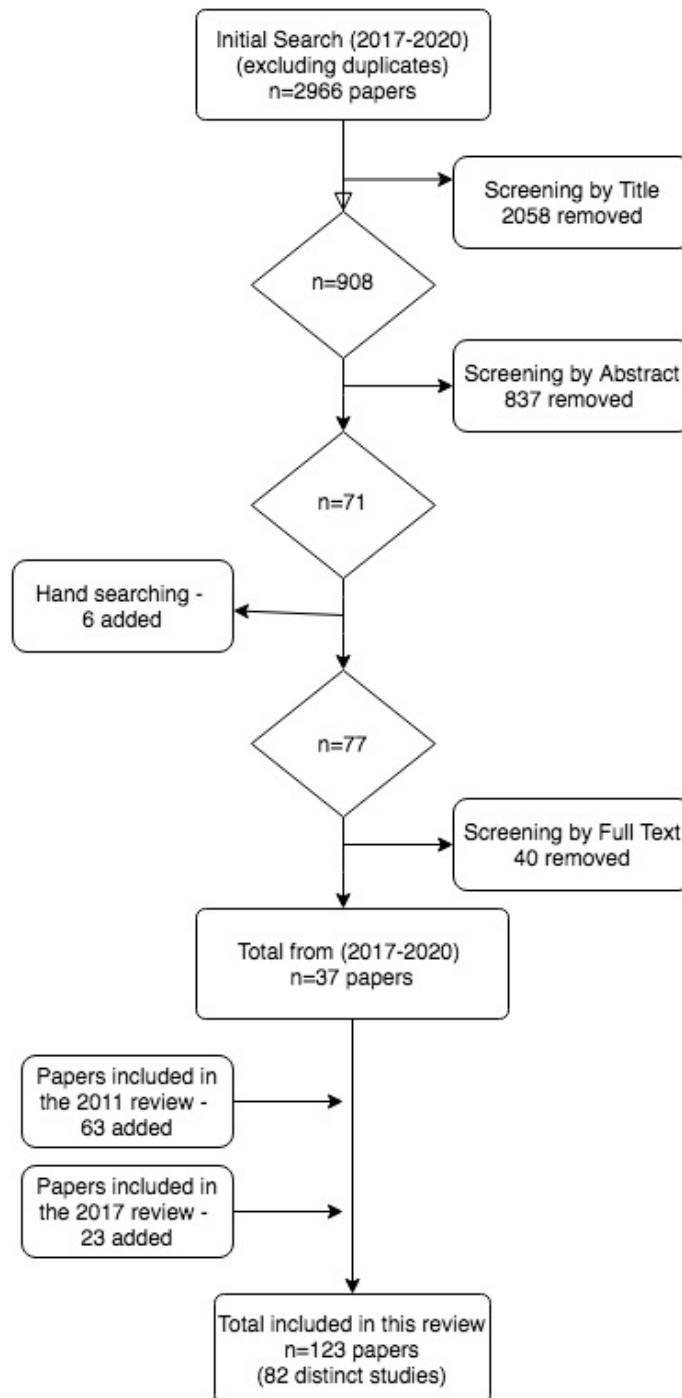
## **Data synthesis**

The data extraction table for the current review was merged with data extraction for the previous two reviews, and the full set of papers grouped by presenting problem

(see appendix 3). All papers included in previous reviews were included in this master spreadsheet, regardless of whether they met the inclusion criteria for the 2020 review. Where possible, papers describing outcomes from the same study were grouped together.

### 3. Findings

In total, 37 papers, published after January 2017, were identified in this updated review for the period from 2017 to 2020, comprising 28 distinct studies.



When screening papers, it was not always made explicit whether the intervention should be considered primarily psychodynamic or psychoanalytic. Where this remained unclear having reviewed the full published text, first authors were contacted, and were asked to clarify whether they considered the treatment being evaluated to be primarily psychodynamic/psychoanalytic.

Having completed the data extraction and quality assessment of these new studies, the findings were then combined with the findings of the previous review studies published in 2011 and 2017 (see Diagram 1). This led to a total of 123 papers, comprising 82 distinct studies. The key findings from this total number are presented here, organised in relation to the primary presenting problems of the children in the studies. As not all studies were focused on children and young people with specific psychiatric disorders, findings are presented under the broad categories, e.g. of 'emotional' or 'behavioural' disorders, with sub-sections detailing the evidence-base in relation to more specific clinical presentations within each of these three groups. The most significant and/or more recent studies are described, with full details about all studies to be found in Appendix X and Y. Although each study included slightly different age groups, we have used the term 'children' to refer primarily to those aged 3-11, and 'adolescents' to refer to those aged 12-25 (although in nearly all cases the maximum age was 18).

### **3.1 Emotional disorders**

Emotional disorders are the most common reason for children and young people to access mental health services, and are relatively common in children. For example, in the UK a 2018 paper reports that one in twelve (8.1%) 5 to 19 year olds had an emotional disorder, with rates higher in girls (10.0%) than boys (6.2%). Anxiety disorders (7.2%) were more common than depressive disorders (2.1%) (Sadler et al. 2018).

This review identified 24 studies evaluating the psychodynamic treatment of children with a range of emotional disorders: 5 studies focused on mixed emotional disorders, 4 on depression, 2 on self-harm, 6 on anxiety disorders, and 5 on feeding and eating disorders. Additionally, one paper reports secondary analyses from the Anna Freud Retrospective study of a mixed population, focusing on those children diagnosed with emotional disorders.

A number of the earliest evaluations of psychodynamic therapy for children focused on the treatment of emotional disorders (e.g. Smyrniotis and Kirby, 1993; Sinha and

Kapur, 1999). For example, an Italian quasi-randomised trial (Muratori et al., 2002, 2003, 2005) of time-limited psychodynamic psychotherapy for children aged 6-11 years with emotional disorders demonstrated the potential effectiveness of this treatment for internalising problems, although externalising problems also improved. The overall effect size for those treated with psychodynamic psychotherapy was 0.72. The outcome was better for those children with 'pure' emotional disorders (ICD-10) as opposed to 'mixed' emotional disorders (ICD-10). Although both the experimental treatment group and the control group improved on measures of global functioning in the first six months, only the experimental group showed evidence of a shift to a non-clinical range maintained at two year follow-up. This finding suggests the possibility of some kind of 'sleeper effect', as has been identified more clearly in some studies of psychoanalytic psychotherapy with adults (e.g. Falkenstrom et al., 2007).

One study using an RCT design to examine the effectiveness of psychodynamic therapy with adolescents with emotional disorders was carried out in Germany (Salzer et al., 2014). The study examined the effects of psychodynamic treatment in an inpatient setting, in adolescents who met criteria for emotional disorder comorbid with conduct disorders at baseline. 68 adolescents (14–19 years old) were randomised to receive psychodynamic treatment in an inpatient setting or to the waitlist group, after which they received inpatient treatment (Salzer et al., 2014; Cropp et al., 2019). The treatment group had a significantly higher rate of remission, and significantly better outcomes on a range of internalizing and externalizing symptoms, as well as reflective functioning, but not on psychological distress. These effects were maintained at six-month follow-up. This was the first controlled study providing preliminary evidence for the use of psychodynamic treatment in young people experiencing emotional disorders with significant comorbidity.

The largest naturalistic evaluation of psychodynamic therapies for children with emotional disorders was the Anna Freud Centre retrospective study (Fonagy and Target, 1996), which identified that children with emotional disorders responded well to psychoanalytic treatment. The findings showed that the vast majority of the 299 children (85%) showed a favourable response (Target and Fonagy, 1994a). In general those children diagnosed with emotional disorders did better than those with behavioural disorders. This finding is supported by other studies of mixed diagnostic groups, discussed elsewhere in this review, which also appeared to show that psychodynamic psychotherapy is particularly effective in reducing internalizing symptoms (Deakin & Nunes, 2009; Krischer et al. 2013; Baruch, 1995; Ryyänen et al., 2015; Kronmüller et al., 2005).

On the basis of the findings of the Anna Freud Centre retrospective study, a pilot study was set up (Target et al., 2002) which aimed to evaluate the treatment of

children aged 6-12 with severe and complex emotional disorders. Extensive data were collected on four children receiving psychoanalytic/psychodynamic treatment (Haslam, 2008). Detailed analysis of these four cases indicated that significant change took place in the behavioural domain, with mean decreases in internalising problems and total scores on the CBCL, and decreased levels of anxiety and depression; however no change was found in attachment status. This study was of course limited by the small sample and the lack of a control group, but benefits from the fact that the small number of cases were analysed intensively, using multiple measures, video-recorded treatments and clear entry criteria to the study.

Overall, the majority of the research shows that children with emotional disorders respond well to psychodynamic therapy; indeed, this kind of therapy is often shown to be more effective for internalizing than externalizing disorders. Findings also show that young people with more severe disorders including complex comorbidities can benefit from psychodynamic therapy in an inpatient setting. Some studies demonstrate evidence of a 'sleeper effect' beyond the end of treatment; this could be investigated further with more longitudinal research. Notably, the majority of the research conducted on young people with emotional disorders has focused on children of primary school age. As the following sub-sections suggest, this may be because, on reaching adolescence there is a greater likelihood that diagnosis of a specific type of emotional disorder will be made.

### *3.1.1 Depressive disorders*

Depression is one of the most common reasons for young people to seek mental health support in the UK. Figures suggest that 2.1% of young people aged 5-19 are diagnosed with depression, with rates of depression increasingly significantly after the age of 12 (Sadler et al 2018). Depression is a debilitating condition with high risk of recurrence and is associated with both intentional self-harm and suicidal ideation (Callahan et al. 2012).

Psychoanalytic understanding of depression has a long history, and there is now an extensive evidence base for the effectiveness of a range of psychodynamic treatments for depression in adults (Driessen et al., 2010; Fonagy 2015). Depression is also one of the few areas where there has been a clear progression in research evaluating the evidence-base for psychodynamic child and adolescent psychotherapy. In the 1990s and early 2000s, both the Anna Freud Centre retrospective study (Target and Fonagy, 1994a) and the Heidelberg study (Horn et al., 2005) carried out retrospective analyses of children meeting the criteria for a depressive disorder. In the case of the Anna Freud Centre study looking at 65 children and adolescents with dysthymia or



major depression (Target and Fonagy, 1994a), 75% showed reliable improvement and no depressive symptoms at the end of treatment, with intensive treatment appearing to be more helpful than once weekly psychotherapy. The study by Horn *et al.*, (2005) identified 20 children and adolescents fulfilling diagnosis of major depression or dysthymia among the larger sample. In contrast to the treatment group, where 20% of the children showed clinically significant and reliable improvement, no subject in the waiting-list control group met this criterion.

These early naturalistic evaluations were followed by a multi-centre randomised trial by Trowell *et al.* (2003, 2007, 2009, 2010), which focused on childhood and early adolescent depression. The study compared time-limited individual psychodynamic therapy (with parallel parent work) and systems integrative family therapy (Trowell *et al.*, 2007) for depressed young people aged 10 to 14 years. The trial was undertaken in London, Athens and Helsinki. At the end of treatment significant reductions in disorder rates were seen for both groups (Trowell *et al.*, 2007). A total of 74.3% of cases were no longer clinically depressed following individual psychotherapy and 75.7% of cases were no longer clinically depressed following family therapy. There was also an overall reduction in co-morbid conditions across the study, and improvements in family functioning, self-esteem and social adjustment (Garoff *et al.*, 2012, Kolaitis *et al.*, 2014). In the psychodynamic group, there were no relapses in the six months following the end of treatment. Furthermore, all cases of depression had resolved at follow up, again suggestive of a 'sleeper effect' (i.e. an ongoing response to therapy following completion).

Similarly encouraging findings were found in a study published in 2014 which reported on the outcomes of 53 children and young people (3-21 years old) who took part in a quasi-randomised study (Weitkamp *et al.*, 2014). Participants were allocated to either a psychoanalytic psychotherapy or a waitlist condition. At the end of therapy, there was a reduction in depressive symptoms in the treatment group, with a large effect size based on child ( $d = 0.81$ ) and parent-report ( $d = 1.09$ ). A significant reduction in depressive pathology was also found in the waitlist group based on parent report ( $d = 0.64$ ), but not based on child report. In the treatment group, an improvement in quality of life was also found with moderate to large effect sizes (child report  $d = 0.56$ ; parent report  $d = 0.83$ ). At one-year follow-up, 53% of the treatment group did not have any psychiatric disorder, suggesting potential sustained long-term effects of psychoanalytic psychotherapy. However, data was not available on quality of life or long-term psychiatric diagnoses in the waitlist group.

Building on these earlier findings, the IMPACT study was the largest and best-designed RCT study of psychoanalytic psychotherapy to date. It aimed to compare the effectiveness of two specialist therapies, Short-Term Psychoanalytic

Psychotherapy (STPP) and Cognitive-Behavioural Therapy (CBT), with a brief psychosocial intervention (BPI), in the treatment of adolescent depression (Goodyer et al., 2011, 2016). The study sample includes 465 adolescents (aged 11-17) who met criteria for moderate to severe depression. Participants were clinically referred and therefore reflect clients routinely referred into NHS services in the UK, with 47% of the young people receiving STPP having one or more co-occurring psychiatric diagnosis (most frequently generalised anxiety disorder, social phobia, post-traumatic stress disorder and oppositional defiant disorder), 35% having a recorded lifetime suicide attempt and 54% reporting non-suicidal self-injury episodes.

Young people in all three arms of the study were found to have sustained reduced depressive symptoms. STPP was found to be equally effective as CBT and BPI in maintaining reduced depressive symptoms a year after the end of treatment, with an average of 49-52% reduction in depressive symptoms one year after the end of treatment. There were no significant differences in total costs between the three treatment groups by the end of study. Although no superiority effects for STPP at long-term follow up were found, 85% of adolescents receiving STPP no longer met diagnostic criteria for depression one year after the end of treatment. Further improvements were observed with regard to anxiety, sleep impairment and obsessive-compulsive symptoms, as well as general psychopathology (Aitken et al., 2020; Reynolds et al., 2020). Important patterns were also identified in the trajectories of change (Davies et al., 2020), with the majority of young people (84%) being 'continued improvers' (rapid improvement, followed by further, slower improvements), and a smaller group (16%) being 'halted improvers' (rapid improvement, followed by no improvement or worsening). Presence of baseline comorbidity somewhat increased membership to the halted-improvers class. Interestingly, ending therapy prematurely was not associated with poorer outcomes in the IMPACT study (O'Keeffe et al., 2019), although it appears that certain sub-groups of those who dropped out may have poorer outcomes, possibly associated with unresolved ruptures in the therapeutic alliance (O'Keeffe et al., 2020).

The findings of the IMPACT study are the strongest support to date for the long-term effectiveness of psychoanalytic psychotherapy in the treatment of adolescent depression, which can be observed across a range of symptoms. The strengths of this study were the large sample, long-term follow up, the use of standardised outcome measures, the fact that outcome assessors were blind to treatment allocation, and that treatment fidelity was assessed by independent raters (Midgley et al., 2018). Because the study was mixed-methods (Midgley, Ansaldo and Target, 2014), and included the audio-recording of treatment sessions, it has also allowed the possibility

of examining a whole range of different therapy processes which are outside the scope of this review.

An interesting addition to the evidence-base for psychodynamic therapy with depressed adolescents comes with the study by Lindqvist et al. (2020), whose ERICA study examined the effectiveness of Internet-based psychodynamic therapy (IPDT). IPDT consisted of eight therapist-supported self-help modules delivered over 8 weeks on a secure online platform. Modules consisted of texts and videos followed by exercises that participants completed and sent to their therapist upon which they received feedback. In addition, the treatment included one 30-minute chat session between participants and their therapist each week. 76 young people (aged 15-18) with unipolar depression, were randomized to either IPDT or a control condition involving online therapist support with weekly monitoring of symptoms and well-being. The study demonstrated a statistically significant additional weekly decrease in symptoms for patients in the IPDT group compared to the control group, and the between-group effect size at the post-treatment assessment point was large ( $d=0.82$ , 95% CI 0.5-1.29) and in favor of IPDT. Improvements on all secondary measures were also significantly greater in the treatment group. Treatment gains for depression and anxiety symptoms were maintained at the 6-month follow-up. However, findings were based on a relatively small sample size, and the intervention is now being tested in a large-scale RCT, where IPDT will be directly compared to an internet-based CBT programme (Mechler et al., 2020).

Taken together, the substantial evidence-base described here supports the view that young people with moderate to severe depression have at least equally good outcomes in psychodynamic therapy as in other well-supported approaches, such as CBT and family therapy. This supports the guidance of the National Institute of Clinical Health and Excellence (NICE) in the UK that STPP should be offered as one of a range of treatment options for children and young people with depression (NICE, 2019). There are also promising indications that novel adaptations of psychodynamic therapy, including internet-based treatment, may also be effective.

### *3.1.2 Self-harm*

Self-harm (which in ICD 10 is referred to as 'intentional self-harm' and in DSM 5 is referred to as 'non-suicidal self-injury disorder' (NSSID) and may also be referred to as 'self-injurious behaviour') is common in young people, especially adolescents, and often co-occurs with a range of other difficulties, including depression, anxiety and emerging personality disorder.

Two studies have specifically evaluated psychodynamic treatments for reducing self-harm. The first (Rossouw & Fonagy, 2012) compared Mentalization-Based Treatment for Adolescents (MBT-A) with Treatment As Usual (TAU), which included a range of specialist therapies usually offered in a child and adolescent mental health service. MBT-A was a year-long, manualized, psychodynamic treatment, comprising weekly individual sessions and monthly family sessions. 80 participants were recruited into this pragmatic RCT. The study found significant reductions in self-harm and risk-taking behaviours in both groups. These reductions were significantly greater for the MBT-A group, with a 44% recovery rate compared to 17% in the TAU group. Overall the study found modest effect sizes within a relatively small sample, but this does suggest potential in this treatment for reducing self-harm in this very hard-to-treat group of young people, who often present with complex difficulties.

The second study to investigate treatment for reducing self-harm also evaluated a mentalization based intervention (Griffiths et al. 2019). This study was a randomised controlled feasibility trial, comparing combined MBT-A and treatment as usual (TAU) (n=26), to TAU alone (n=27). MBT-A was delivered to adolescents in a group format, up to 12 sessions. This study recruited from a UK mental health service (tier 3 and tier 4 CAMHS) where patients might be experiencing a number of difficulties in addition to self-harm, therefore, TAU varied from case to case, involving medication, psychotherapy, psychosocial treatments, and other interventions. The findings showed that self-reported self-harm and emergency department presentation for self-harm significantly decreased over time in both groups, though there were no between group differences. Social anxiety, emotion regulation, and borderline traits also significantly decreased over time in both groups. Mentalization emerged as a significant predictor of change over time in self-reported self-harm and hospital presentation for self-harm. Notably, however, individuals in the TAU group may have received interventions that also drew on mentalization principles. Therefore, there may not have been a clear distinction between the two treatment arms in terms of treatment received, which perhaps explains the lack of between group differences.

Overall, the findings of both these studies suggest that a contemporary psychodynamic therapy such as mentalization based treatment may be effective for treating self-harm, but further research is required, perhaps comparing treatment to a waitlist control, or to a specific alternative psychotherapy, such as CBT.

### *3.1.3 Anxiety disorders*

Anxiety disorders are one of the most common reasons for referral to child and adolescent mental health services. However only a small number of studies (4) have

specifically evaluated the effectiveness of psychodynamic therapy with this clinical population, with only one of these being a RCT (Salzer et al. 2018). Of these four, two focussed on anxiety disorders in general, one focused specifically on Social Anxiety Disorder (Salzer et al., 2018), and one focused on Obsessive Compulsive Disorder (Apter et al., 1984). Additionally, two papers report a re-analysis of a subset of data taken from a larger study, in one case the re-analysis focuses specifically on Separation Anxiety Disorder (Muratori et al. 2005).

Milrod and colleagues (2013) conducted a small pilot study which investigated the effect of manualized psychodynamic psychotherapy delivered twice weekly over a 12-week in a sample of 10 young people with anxiety disorders. Nine participants completed treatment and by the end of treatment no longer met criteria for their primary diagnosis, and showed clinically significant improvements across outcome measures, including anxiety symptoms and general functioning. These gains were maintained at six-month follow up. Although the study was limited by a very small sample size and lack of control group, it demonstrated the potential efficacy of a short-term, manualized psychodynamic approach with this group of children.

In a study based in Germany, 30 children aged 4-10 years old with anxiety disorder were recruited. 18 were allocated to receive 20-25 sessions of Psychoanalytic Child Therapy (PaCT), and 12 were allocated to a waitlist control group (based on therapist availability), after which they also received PaCT (Göttken et al. 2014). Based on intent-to-treat analyses, 60% of the treatment group no longer met diagnostic criteria for any anxiety disorder, whereas in the waitlist group, no participants had remitted by the end of the waitlist. Improvements were also seen on a range of standardized parent- and teacher-reported measures. At six-month follow-up, the effects of treatment were maintained on parent and teacher-report, although the child report did not show significant effects of treatment.

In another study conducted in Germany, Weitkamp and colleagues (2018) used a quasi-experimental design. The authors compared outcomes of a group of children and adolescents aged 4-21 years receiving psychodynamic therapy (n=86), with those of a waitlist control group (n=35) who received 'minimal supportive treatment'. As treatments were open-ended in length, the first 25 sessions were classified as 'the first treatment period', at which point comparison was made with the waitlist control group. Overall, the findings suggest that in the first treatment period, psychoanalytic therapy had no advantage over minimal supportive treatment, as both groups improved with small effect sizes and no significant group differences. However, across the whole long-term therapy period, anxiety symptoms were significantly reduced, and this remained stable at 12 month follow up. The authors note a number of

limitations to the study design, including relatively high dropout rates and missing follow up data, which could increase the risk of bias in these findings.

The only study specifically focussing on Obsessive Compulsive Disorder was conducted in Israel (Apter et al., 1984). This small study had a sample of 8 young people, all of whom had previously failed to comply with behavioural treatment. The treatment provided was integrative, but took place in a unit with a broadly psychodynamic approach. Overall, results were good; with seven out of the eight participants were 'much improved' by the end of treatment. However, the small study size, non-randomised design, and non-specificity of the psychodynamic therapy model, limit the conclusions that can be drawn.

The best designed study of psychodynamic therapy for children with anxiety disorders was carried out by Salzer et al. (2018). This study included 107 adolescent patients, aged 14-20, diagnosed with Social Anxiety Disorder (SAD): randomized to CBT (n = 34), PDT (n = 34), or Wait List (n = 39). In both CBT and PDT, an identical dosage of 25 individual 50-minute treatment sessions was offered (with some twice-weekly sessions at the start of treatment); therapy sessions were recorded and assessed for treatment fidelity. Both active treatments were superior to the waitlist condition with regard to reducing anxiety symptoms, with medium-to-large effects for CBT and medium effects for PDT; these effects were stable at the 12-month follow-up. Response rates and remission rates were slightly better for CBT than for PDT, but both were better than waitlist.

Some naturalistic evaluations have retrospectively separated out the children with anxiety disorders from other difficulties in order to assess the effectiveness of psychodynamic therapy for this group. For example, Muratori and colleagues (2005) looked at data for participants who met the criteria for separation anxiety disorder, and found that children receiving short-term psychodynamic psychotherapy had significantly better outcomes in terms of an overall global assessment than those who had received 'usual care'. Moreover, improvements continued during the two-year follow-up period as the superiority of outcome for children receiving psychodynamic psychotherapy compared to the control group became greater. Likewise, the Heidelberg Study of psychodynamic therapy (Kronmüller et al., 2010) showed that children with anxiety disorders did better than children with either depression or disruptive disorders (Horn et al., 2005; Winkelmann et al., 2000). Whereas 62% of the anxious children in the treatment group showed clinically significant and reliable improvement at the end of therapy, this was the case for only 8% of the subjects in the waiting list condition.

Overall, the evidence to date suggests that psychodynamic therapy, even when relatively short-term (<30 sessions) is effective in the treatment of anxiety disorders, and that these outcomes are maintained at a 6-month follow-up period. However one quasi-experimental study seems to suggest that longer-term therapy might be required to see improvements beyond those also seen in a 'minimally supportive' waitlist control. In the only RCT study identified here, psychodynamic treatment was shown to be slightly *less* effective than CBT in the treatment of Social Anxiety Disorder, though participants in both treatment groups had good outcomes. Future research could consider the relative benefits of long and short-term therapy, utilizing experimental designs with larger samples of young people, with a focus on common yet under-researched conditions such as OCD.

### *3.1.4 Eating disorders*

The diagnostic group 'feeding and eating disorders' comprises a number of related conditions, including Anorexia Nervosa and Bulimia Nervosa, which most frequently affect adolescents. Other eating disorders – including avoidant/restrictive food intake disorder – are more commonly diagnosed in childhood. Feeding and eating disorders are less common than depressive or anxiety disorders; an NHS 2017 report states that 0.4% of 5-19 year-olds experience an eating disorder (Sadler et al. 2018). However, the long-term consequences of eating disorders can be severe, with studies suggesting that 20% of young people with an eating disorder may have chronic symptoms that persist into adulthood (Wonderlich et al. 2012). Further, anorexia nervosa has one of the highest mortality rates of any psychiatric disorder (Birmingham et al., 2005)

In this review, five studies were identified evaluating psychodynamic therapy for eating disorders: 3 focus on Anorexia; one on Bulimia; one on eating disorders with co-occurring Addictive and/or Impulse Control Disorder; and one on children's 'Feeding and Evacuation disorders'. The latter is the only study to examine a population of pre-school aged children.

Three studies have looked at the effectiveness of psychodynamic psychotherapeutic treatment for anorexia nervosa. Building on the promising findings of a small-scale study (Vilvisk & Vaglum, 1990), two studies of Adolescent Focused Psychotherapy (AFT) have been carried out, evaluating this approach in comparison to behavioural family systems therapy (Robin et al., 1995, 1999) and to Family Based Treatment (FBT, Lock et al., 2010). Both of these studies found that both treatments being compared led to considerable improvement and were similarly effective in producing full remission (defined as 95% of normal weight as expected for sex, age and height)

at the end of treatment. In Lock et al. (2010) rates of improvement remained good at both six- and 12-month follow-up, although levels of full remission were higher in the FBT group. A more recent study of year-long psychodynamic psychotherapy for patients diagnosed with eating disorders also found significant improvements post-therapy (Strangio et al., 2017). In this study, abuse history was found to be a negative prognostic factor for patients with eating disorders undergoing dynamic psychotherapy, as may be the case for treatment with other types of therapy as well.

Only one study has focused specifically on Bulimia Nervosa. Stefani and colleagues (2017) conducted an RCT comparing the effect of psychodynamic psychotherapy (PDT) and cognitive behavioural therapy (CBT) in a sample of 81 female adolescents with bulimia. Patients received therapy for one year (approximately 60 sessions). Findings showed positive results that were broadly similar across the two treatments. A third of participants in both groups fully recovered. Both groups showed significant reductions in binge and purge behavior, and general pathology, and results were stable at 12-month follow up. Overall these findings indicate equal efficacy of both types of therapies in treating binge eating disorders.

In the only study of eating disorders in younger children, Chirico et al. (2019) investigated the efficacy of focal play therapy (FPT) for 17 children aged 2-5 experiencing 'eating and evacuation' disorders. The treatment involved weekly alternate play sessions with the child and his/her parents together, and sessions with parents only. Findings showed that the first 6 sessions were effective in promoting a positive parent-therapist alliance; however changes in parental levels of distress and parent-child relationships post-treatment did not reach statistical significance. The authors speculate that more sessions were needed to obtain a remission of child symptoms. This study had a relatively small sample and no control group, which limits the conclusions that can be drawn.

Overall, the evidence suggests that psychodynamic therapy can be effective in the treatment of eating disorders, with most research to date focused on anorexia and bulimia. Three RCTs have been conducted, comparing forms of psychodynamic therapy to CBT and Behavioural Family Systems Therapy. In all three trials, both treatment arms were shown to be similarly effective, suggesting that psychodynamic psychotherapy is one of a number of effective psychotherapies. There is some evidence to suggest that young people with a history of childhood abuse may make less progress in therapy, and further research needs to be done to ensure there are evidence-based treatments for this sub-group of patients.



### 3.2 Behavioural disorders

Behavioural disorders (also called 'externalizing' or 'disruptive' disorders) are relatively common in children and young people, affecting about 4.6% of 5-19 year olds (Sadler et al. 2018), and are more common in boys than in girls (Samek & Hicks, 2014). Behavioral disorders are characterized by aggressive, inattentive, and impulsive behaviours. These disorders can have long-term negative consequences including impaired academic progress, substance use problems, and higher rates of involvement with criminal justice services in adulthood (Erskine et al 2016).

Although disruptive disorders are a common reason for referral to child mental health services, only six studies have specifically studied the efficacy of psychodynamic psychotherapy for these children. Three of these examine a mixed population including children diagnosed with Oppositional Defiant Disorder (ODD), Disruptive Disorder, Conduct Disorder (CD) and Attention Deficit Hyperactivity Disorder (ADHD) (Weitkamp et al. 2017; Eresund 2007; Laezer 2015). One study looks at children and young people specifically diagnosed with CD (Edginton et al 2018), and one on children diagnosed with ODD (Prout 2019). One study of hyperactive children was too poorly designed to draw conclusions (Jordy & Gorodscy 1996). In addition to these studies, two papers have reported secondary analyses of larger studies of mixed populations, with the secondary analyses focusing on outcomes for those children with a range of externalizing disorders (Fonagy & Target 1994; Winkelmann et al. 2000).

Weitkamp et al. (2017) conducted a partly controlled, dual-perspective effectiveness study in a naturalistic setting, evaluating the effectiveness of psychoanalytic psychotherapy for children and adolescents with 'severe' externalizing problems including CD, hyperkinetic disorders, and social functioning disorders. Similar to their 2018 study (reported above), the authors compared outcomes of a group of children and young people aged 4-21 years receiving psychodynamic therapy (n=65), with those of a waitlist control group (n=28) who received 'minimal supportive treatment' after the first 25 sessions. Results showed that both groups improved with small effect sizes and no significant group differences. Hence, psychoanalytic therapy had no advantage over minimal supportive treatment after the first therapy interval. However, at the one-year follow-up, significant improvements were reported, with higher levels of improvement were reported in patients with depressive status. More than half of the patients either fully recovered or improved at the end of therapy, showing stable improvement.

In a small study, Eresund (2007) examined the effectiveness of twice-weekly 'supportive expressive play psychotherapy' for boys (n = 9) aged 6-10 with disruptive

behaviour disorder (including ODD, CD, ADHD and deficits in attention, motor control and perceptual abilities (DAMP)). Some of the boys improved, particularly those diagnosed with conduct disorder, although not those diagnosed with ADHD or DAMP. However the small numbers in this study and the lack of a control group limit the conclusions that can be drawn. A similarly small study conducted by Prout et al (2019) reported outcomes of three children with oppositional defiant disorder treated with Regulation-Focused Psychotherapy for Children (RFP-C), including play therapy and parent meetings. At the end of the treatment, significant improvements were achieved in both ODD symptoms and emotion regulation for all patients; one of whom was classified as 'recovered' by the end of treatment. Parental feedback indicated satisfaction with the therapy and a desire for a longer program was expressed.

The large Anna Freud Centre retrospective study looked at differences in outcome according to diagnostic category (Fonagy and Target, 1996). In general children with a diagnosis of disruptive disorder were harder to treat, particularly if the diagnosis was of CD rather than ODD (Fonagy and Target, 1994) and in comparison, those diagnosed with emotional disorders did better. Children with disruptive disorders were difficult to maintain in treatment and more liable to drop out, but despite this 46% of the sample of 135 children showed clinically reliable improvement (69% of those who remained in treatment).

The Heidelberg study (Kronmüller et al., 2002, 2005, 2010) also conducted a number of further analyses of their data according to diagnostic groupings. Winkelmann et al. (2000) compared children with behavioural disorders treated with short-term psychodynamic psychotherapy with a waiting list control. Thirty-one per cent of the children in the treatment group showed clinically significant improvement compared with 8% of those in the control group.

Given that behavioural treatments are often considered to be a first-line treatment for children with disruptive disorders, it may be important to identify specific sub-groups of children who are likely to benefit from a psychodynamic approach. Edgington and colleagues (2018) conducted a feasibility RCT of manualized psychoanalytical psychotherapy for children aged 5-11 experiencing treatment-resistant CD. 32 parent-child dyads participated. In the experimental treatment arm, therapy was delivered to the child, with parallel parent sessions, over a period of 3 months. The control group received treatment as usual. The study was not powered to evaluate outcomes, but summary measures indicate a more promising effect on behaviour problems as rated by teachers as compared to those rated by primary carers. The authors concluded that a large-scale confirmatory trial can be conducted, taking into consideration some difficulties in recruitment and follow-up which were identified through this trial.

One study investigated psychoanalytic psychotherapy in the treatment of disruptive behaviour disorders. 73 participants, aged 6–11 years old, with oppositional defiant disorder and/or attention deficit hyperactivity disorder (which DSM-5 categorises as a neurodevelopmental disorder) were recruited into this controlled observational study (Laezer, 2015). Participants were allocated to receive psychoanalytic psychotherapy, or behavioural therapy and/or medication. Both treatment groups demonstrated significant symptom reduction, with no significant differences between the two groups. The study had a relatively small sample size and allocation to the treatment arms was naturalistic, so these findings should be viewed as preliminary.

Overall, the studies reported here show promising findings regarding the effectiveness of psychodynamic therapy for children with externalizing disorders. There is some evidence that children and young people with externalizing disorders respond less well to psychodynamic therapy than those with internalizing disorders, in part because the former are more likely to drop out of treatment early. Children experiencing internalizing symptoms alongside externalizing disorders may have better outcomes. However, the majority of the studies that have been conducted with this group of children have small sample sizes, limiting the conclusions that can be drawn. The feasibility trial conducted by Edington and colleagues (2018) suggests that larger scale studies can be conducted, indicating that RCTs should be organized in the future in order to strengthen the evidence base, comparing psychodynamic therapy to both TAU and alternative evidence-based psychotherapies.

### **3.3 Children who have experienced trauma, physical, sexual or emotional abuse, neglect, or family conflict**

One in five adults in the UK are estimated to have experienced at least one form of child abuse before the age of 16, whether emotional abuse, physical abuse, sexual abuse, or witnessing domestic violence (ONS, 2020). Experiences of various types of abuse and maltreatment are even higher in clinical populations presenting to mental health services (Chapman, Dube & Anda, 2007; Springer et al. 2003), although exact levels of prevalence are not easy to establish. The harmful effects of various types of maltreatment can be long-reaching and wide-ranging, which makes finding effective treatments important (Fonagy, 2015).

Psychodynamic psychotherapy has been widely used with children who have experienced maltreatment, especially those who have been placed in foster care or have been adopted (Robinson, Luyten & Midgley, 2017; Lanyado, 2018; Music, 2019). A number of studies have investigated the outcomes of psychodynamic psychotherapy

for children who have experienced various forms of trauma or abuse: 8 have focused on children who have experienced various types of maltreatment or abuse, including children adopted or in foster care, and 3 on children exposed to parental conflict. A number of these interventions are delivered to parents rather than children, though the goal is to improve the child's wellbeing. Together, these studies can be understood as examining the impact of psychodynamic therapy on children experiencing various forms of trauma or early adversity.

### *3.3.1 Children who have experienced trauma and abuse*

The Tavistock study of children in the care system (Lush et al., 1991; Boston and Lush, 1994; Lush et al., 1998; Boston et al., 2009) was one of the earliest studies of psychodynamic psychotherapy with children who have experienced abuse, and gave some preliminary indication of the effectiveness of this approach. The first RCT, however, was conducted by Trowell and colleagues (2002), involving 71 girls (aged 6-14) who had been sexually abused. One group received focused individual psychodynamic psychotherapy for up to 30 sessions. The other group received up to 18 sessions of psycho-educational group psychotherapy. In addition, both groups had parent/carer work. Findings showed both treatments to be effective, with the psychodynamic treatment demonstrating an effect size of 0.65. Individual psychoanalytic psychotherapy appeared to have a greater impact on PTSD symptoms, compared to group treatment.

A study by Heede et al. (2009) looked at the effect of 'psychodynamic milieu therapy' on a group of children, aged 6-15, with histories of severe trauma and early deprivation. After two years of treatment, children showed improvements in intellectual and emotional functioning, greater self-confidence, and increased capacity for self-reflection. They also demonstrated more positive and realistic expectations of others. However, the lack of a control group limits the degree to which these findings can be interpreted.

Gilboa-Schechtman and colleagues (2010) conducted a pilot RCT, examining the efficacy of a developmentally adapted prolonged exposure therapy for adolescents (PE-A) compared with an active control who received time-limited psychodynamic therapy for decreasing post-traumatic and depressive symptoms in adolescents of single event traumas. Both treatments resulted in decreased PTSD symptoms and increased functioning across a range of measures. Gains were maintained in both groups at both six and 17-month follow-up.

Some studies have focused specifically on children in foster care. For example, Clausen and colleagues (2012) presented an initial empirical investigation of the

impact of a long-term, psychoanalytically oriented, relational play therapy intervention for foster children. The sample consisted of 20 children (aged 5-10 years). Results showed statistically significant reductions in mental health symptoms, improved peer relationships and reduced school problems (Clausen, Ruff, Wiederhold, & Heineman, 2012). These findings present some support for the use of long-term psychoanalytically orientated treatment for children in foster care. Yet, the study was limited by the small sample size, lack of control group, and change was measured based on therapist report, which poses the risk of bias as therapists may overestimate change.

Midgley and colleagues (2018) conducted a naturalistic, pre-post evaluation of a short-term (six-session) mentalization-based service, 'Adopting Minds', offered to 36 adoptive families (42 adopted children). Results showed positive outcomes with a reduction in emotional and behavioural problems in the children and increased levels of self-efficacy in adoptive parents. Although a significant difference between pre and post measures was identified, the sample was small, and pre-post data was only available for approximately 40% of the participants.

Building on the earlier study, Midgley and colleagues (2019) conducted a feasibility RCT with follow-up at 12 and 24 weeks post-randomisation, examining the effectiveness of MBT versus usual care (UCC) for children in foster care. Participants were 36 foster children (aged 5–16) referred to a targeted mental health service. Of these, 15 children received MBT and 21 received UCC. As a feasibility pilot, the study was not powered to detect group differences in outcomes, but a preliminary analysis of outcomes was conducted and yielded mixed findings. Results showed an indication of significant benefits for MBT compared to UCC for child-reported internalizing problems. In contrast, for the carer-reported outcome, the usual care group reported an improvement over time which was not reported in the MBT group.

Polek and colleagues (2020) conducted a feasibility study evaluating the effectiveness of 'Adopting Together', a time-limited psychodynamic couple-focused therapy model for adoptive couples. Fifty couples were offered therapy and outcome data were collected at intake, after 10 weeks of therapy and after completion at 20 weeks. Although the intervention did not offer direct work with the children, results showed that the programme had a positive effect in reducing parent-rated child mental health issues. Participants' also reported a significant reduction in depression and stress related to parenting and the quality of the relationship between partners. While the results are promising, this study is limited by the small sample, the absence of a control group and a 25% attrition rate for returned outcome measures.

### *3.3.2 Children impacted by parental conflict or domestic violence*

Research confirms that poor relationships between parents, and particularly parental conflict, can damage children's emotional wellbeing (Harold & Sellers, 2018). Indeed, a new condition, "child affected by parental relationship distress" (CAPRD), was introduced in the *DSM-5*, reflecting the impact that parental conflict, domestic violence, and acrimonious divorce/separation can have on children's mental health (Bernet et al. 2016). It is difficult to estimate the prevalence of CAPRD, though data suggests that as many as one in seven children and young people under the age of 18 will have lived with domestic violence (Radford et al. 2011); the number of children impacted by parental conflict more broadly is likely to be higher. The long-term deleterious impact of parental conflict is well documented, and therefore effective interventions that target children and their carers are critically important.

Three studies published since 2017 focus on psychodynamic interventions for children affected by parental conflict or domestic violence. The earlier reviews did not identify any studies in this specific area, perhaps suggesting a growth in research interest concerning the impact of parental relationships on children's wellbeing. Of the three studies identified, one intervention was delivered to the parents (with child outcomes collected), and two interventions were delivered directly to both the child and parent together.

Pernebo and colleagues (2018) designed a quasi-experimental study to measure the effectiveness of two group-based interventions for children who had witnessed domestic violence between their parents. Participants were 50 children aged 4–13 years, and their mothers (in all cases, the mother was the 'non-offending parent'), living in Sweden. The treatment group (n=20) received a psychotherapeutic treatment based on trauma theory, attachment theory, and psychodynamic theory within an outpatient child and adolescent mental health unit. The comparison group (n=34) received a psycho-educative intervention provided at a unit offering services in the community. Although children showed benefits from both interventions, symptom reduction was larger in the psychotherapeutic intervention, and children with initially high levels of trauma symptoms benefited the most. Despite these improvements, a majority of the children's mothers still reported child trauma symptoms at clinical levels post-treatment. Both interventions substantially reduced maternal post-traumatic stress.

Bernstein and colleagues (2019) conducted a RCT with a group of 113 mothers who had experienced interpersonal violence, and their young children (aged 2-6). The authors tested whether Child-Parent Psychotherapy, a treatment based on psychoanalytic principles, can change biases in mothers' perceptions of their child's

facial expressions, and consequently reduce child symptomology. In the study, 80 mother-child dyads received CPP, and 33 received supportive case management with individual psychotherapy for the mother and/or child. Results showed that mothers who participated in CPP showed significant reductions in bias toward fear (but not anger) from post-treatment to baseline, whereas mothers in the treatment-as-usual group showed no significant change. Importantly, results indicated that changes in bias did not mediate children's treatment gains, even though such biases are related to child symptoms.

Hertzmann and colleagues (2016; 2017) designed a MBT for parental couples experiencing high levels of conflict post separation/divorce (MBT-PT). This was a pilot feasibility study, with 15 pairs of co-parents randomly allocated to either MBT-PT (n=15), which parents attend together as a couple over 6-12 sessions, or to Separated Parents Group (PG), a psycho-educational intervention for separated parents consisting of 2 two-hour sessions which parents attended separately. Results showed that parents in both interventions reported significantly less expression of anger toward each other over the period of the study. This may reflect parents' improved capacity to mentalize and control their own feelings towards the co-parent, resulting in reduced expressed anger or conflict that might impact the child. However, there was no significant difference between the two interventions.

Overall these studies suggest promising findings for the use of psychodynamic treatment with children who have experienced parental conflict and or trauma, including those who are in foster care or who have been adopted. Results show potential for increased wellbeing for children, and decreased stress for their carers. However, research is still limited and most of the studies conducted in this area are with small samples in naturalistic studies. Future research should involve larger samples using an experimental design.

### **3.4 Emerging Personality Disorders (PD)**

Although the concept of personality disorder (PD) is well-established in relation to adults, there is on-going debate about whether the term can appropriately be used in relation to adolescents (Lenkiewicz et al., 2015), and hesitance among some professionals in making this diagnosis in young people (Hauber et al., 2017) since personality and psychopathology may still be somewhat fluid during this developmental phase. There is, however, increasing evidence to suggest that emerging PD is a meaningful construct when thinking about adolescent psychopathology (Paris, 2013). Psychoanalysis has played a key role in understanding personality development and disorders in adolescence, so it is not surprising that

there has been increasing interest in evaluating the effectiveness of psychodynamic therapies for this population.

In our review, we found 8 studies investigating psychodynamic psychotherapy in the treatment of young people with PD, with the number of studies clearly increasing over time. A significant proportion of these studies involved adapted versions of MBT, which it is not surprising given that this model of psychodynamic therapy it is established as an evidence-based treatment for Borderline Personality Disorder in adults (BPD)(Bateman & Fonagy, 2010; Storebø et al 2020). Of the eight studies identified, six focused specifically on Borderline Personality Disorder (BPD), one on Avoidant Personality Disorder (APD), and one included patients with various PDs or traits. All studies involved adolescents aged 14 and over.

Chanen et al. (2008) conducted an RCT evaluating the effectiveness of cognitive analytic therapy (CAT) versus usual clinical care for outpatients aged 15–18 who fulfilled two out of nine of the DSM-IV criteria for BPD. Both treatment groups demonstrated improvements at the final follow-up point (two years after baseline), as well as a substantial reduction over time in the chances of a parasuicidal behaviour incident. There were no significant differences in outcome between the two treatments.

Naturalistic evaluations of psychodynamic treatment of BPD have shown promising results. Salzer and colleagues (2014) conducted on an observational study assessing the effectiveness of psychodynamic psychotherapy with 28 adolescents with BPD. Pre-post analyses showed that 39.3% of the patients were remitted by the end of treatment, in addition to significant improvements on a range of other measures. Likewise, Schenk and colleagues (2019) conducted an exploratory study of psychodynamic therapy, involving 10 adolescents (aged 14-18) with identity diffusion and BPD symptoms. Psychosocial functioning and psychopathology were assessed at baseline, monthly during treatment, and at post-treatment. Results showed a significant reduction in psychopathology and an improvement in psychosocial functioning over time. A study by Sugar and Berkowitz (2011) gives some indication that improvements can be maintained through to adulthood, although the study was unsystematic and had a very small sample.

Of the 2 MBT studies for BPD, one was a naturalistic pre-post evaluation, the other was a RCT. Bo et al (2017) evaluated the effectiveness of a group-based MBT (MBT-G) for 34 female adolescents (aged 15-18). Twenty-five adolescents with BPD completed the study, of which the majority (n=23) displayed significant improvement regarding borderline symptoms, depression, self-harm, peer-attachment, parent-attachment, mentalizing, and general psychopathology. Building on this, Beck et al



(2020) conducted an RCT evaluating the effectiveness of a group-based MBT (MBT-G) versus treatment as usual (TAU) for adolescents with BPD. A total of 112 adolescents (111 females, aged between 14 to 17 years old) with BPD or BPD symptoms were randomized to a 1-year MBT-G or TAU. In both treatment arms, there was a statistically significant improvement, although it was considered clinically insignificant. No significant between-group differences were found in outcomes. A 3- and 12-month follow-up of the same sample showed similar results: both groups demonstrated improvement in the majority of clinical and social outcomes at both follow-up points (Jørgensen et al., 2020).

The effectiveness of MBT has also been evaluated for other PDs. Bo and colleagues (2019) reported on the effectiveness of an adaptation of MBT for 8 adolescents (aged 14-18) with Avoidant Personality Disorders (APD) (MBT-AA; Bo et al, 2019). Findings showed a significant change in avoidant personality pathology from baseline to end of treatment. At the end of treatment all patients scored below the cut-off point for APD. Furthermore, there were significant improvements in internalizing pathology, mentalizing, and peer- and parent attachment, but not for externalizing psychopathology. Similar results were found by Hauber and colleagues (2017), who examined the effectiveness of an intensive MBT with a psychodynamic group psychotherapy approach involving partial hospitalisation. The sample of this study comprised 62 adolescents (aged 16 and 23 years) with various personality disorders and high levels of co-morbidity. At the end of the treatment adolescents showed a significant reduction in personality disorder traits and symptoms.

Overall, these studies provide some preliminary support for the use of psychodynamic psychotherapy in the treatment of PDs, especially BPD, in adolescence. In particular, the evidence for various adaptations of MBT are promising and suggest that this model of psychodynamic treatment for adolescents with PDs may be particularly effective. However, only two of the six studies were RCTs; the others were all naturalistic pre-post studies, mostly with small sample sizes, and lacking long-term follow-ups. Given these methodological limitations, further research is needed to draw more robust conclusions about the effectiveness of psychodynamic treatments for PD in young people. Such research is especially important given the robust evidence-base in adults, and the costs to individuals, services and society of PDs.

### **3.5 Children with neuro-developmental disorders**

Neuro-developmental disorders – sometimes referred to as learning disorders/disabilities – comprise a range of diagnoses (Reiss, 2009). Some

classification systems also include Attention Deficit / Hyperactivity Disorder (ADHD) in this category, although for the purposes of this review studies of ADHD have been reviewed in the section on 'Behavioural Disorders'.

Children diagnosed with neuro-developmental disorders may experience limitations in core functional domains (e.g., motor, communication, social, academic) resulting from abnormal development of the nervous system (Reiss, 2009). Although these disorders are not usually considered 'mental illness', but developmental disorders; they overlap with and are risk factor for mental illness (Eapen, 2014). Therefore, the emotional or behavioural issues that are often experienced alongside developmental disorders are sometimes treated with psychotherapy interventions, delivered to the child and/or caregiver.

### *3.5.1 Children with specific learning difficulties*

Just two studies examined therapy for children experiencing learning difficulties. A study by Heinicke and Ramsay-Klee (1986) looked a sample of 12 boys aged 7-10 years, referred with reading difficulties and associated 'emotional disturbance'. The children received group-based psychoanalytic psychotherapy over a period of two years. All participants improved with treatment, particularly with regard to self-esteem, flexible adaptation, capacity for forming and maintaining relationships, frustration tolerance, and ability to work.

One non-controlled study focused on a small sample of very young children (mean age: 3 years and 8 months), the majority of whom suffered from developmental language delay, as well as oppositional defiant disorder or in some cases pervasive developmental disorder. The mean change in I.Q level was 27.9 following psychoanalytically based treatments (Zelmann et al., 1985), although the risk of bias in this study was high, so these findings should be treated with caution.

Although these studies showed positive improvements for participants in terms of increased IQ and greater wellbeing, it is not possible to draw general conclusions from this limited research. Larger, controlled studies are required.

### *3.5.2 Autism Spectrum Disorder*

Autism Spectrum Disorder (ASD) is a heterogeneous neurodevelopmental disorder characterised by deficits in social interaction and social functioning, and by certain repetitive behaviours and restricted interests. ASD typically begins in childhood and persists into adolescence and adulthood. ASD is a relatively common condition; the

prevalence is thought to be around 157 out of 10,000 in the UK (Baron-Cohen et al. 2009), though prevalence estimates vary globally.

There is a long and at times controversial history of using psychodynamic therapies in the treatment of ASD, but the clinical literature in this field is now substantial (Alvarez, 1992; Rhode, 2009). However, to date there has been only one empirical study of the effectiveness of this therapeutic approach for children with ASD. This quasi-experimental study focussed on children with ASD and their families (Enav et al 2019). Parenting a child with ASD can be challenging and stressful, and parents often get very little support to help manage those challenges; this study sought to improve parents' capacities to mentalize and regulate their emotions, such that they are better able to manage their child's behaviour. In this sample, 64 parents of children with ASD (child aged 3-18) were allocated to a mentalization-based treatment, delivered weekly over four consecutive weeks in a group format, or to a delayed-treatment control. The findings showed that, compared to delayed treatment group, parents in the mentalization-based group had increases in reflective functioning and in the belief that emotions can change. Moreover, they reported decreased behavioral and emotional symptoms in their children, and greater parental self-efficacy.

Overall, there is limited research focusing on psychodynamic approaches to neuro-developmental disorders and the studies that have been completed both involve a small sample and non-controlled study design. Future research should ideally use an RCT design with larger samples and robust assessments of child/parent outcomes.

### **3.6 Children with a physical illness**

A small number of studies have examined the impact of psychodynamic therapy on children and young people with a physical illness, especially in situations with psychological factors may impact on a child's capacity to manage their physical health condition. A series of three inter-connected studies by Moran and Fonagy have focused on young people with poorly controlled diabetes, using psychodynamic psychotherapy to support young people's motivation to manage their illness through various lifestyle factors, such as diet and exercise. Another study looked at the impact of psychodynamic therapy on 'idiopathic headache', a term used for severe 'stabbing' headache pain for which the cause is unknown.

Moran and colleagues undertook a series of well-designed studies looking at psychoanalytic psychotherapy as a means of helping young people with poorly controlled diabetes (Moran and Fonagy, 1987; Fonagy and Moran, 1990; Moran et al.,

1991). A quasi randomised study compared children with unstable insulin- dependent diabetes who received psychoanalytic psychotherapy intensively (three to five times a week for a mean period of 15 weeks) with a group of children who had unstable diabetes and who were in receipt of routine psychological input but did not receive individual psychotherapy over this period. At the end of treatment a significant improvement in diabetic control was noted in the experimental group compared to the control group. This improvement was maintained at one-year follow-up. Clinically relevant was the reduction in glyco-sylated haemoglobin (a reduction in glycosylated haemoglobin represents good diabetic control) to within the 'acceptable' range for diabetes in six of the experimental group, whereas none of the comparison group showed such an improvement. Four out of the experimental group and eight out of the comparison group were readmitted to hospital in the year after discharge (Moran et al., 1991).

The only other study on physical health was a pilot RCT, investigating brief psychodynamic psychotherapy in the treatment of idiopathic headache (Balottin et al., 2014). Participants were randomly allocated to receive brief psychodynamic psychotherapy or care as usual. The authors reported statistically significant greater gains for the treatment group on the frequency, intensity, and duration of headache attacks. Notably, as this was a pilot study, the sample size was small (N = 33) highlighting the need for a sufficiently powered study to build on these preliminary findings.

Overall, there is a limited amount of research evaluating the use of psychodynamic or psychoanalytic therapy for children with physical health conditions, though the research that has been done is of good quality, mostly using randomized or quasi-randomised designs. Overall, the findings reported here are promising, and suggest that further research should consider psychodynamic or psychoanalytic treatment for certain physical conditions, where symptoms or treatment adherence may have an important psychological component that could be treated with psychotherapy – particularly self-management of adolescent diabetes.

### **3.7 'Practice-based evidence' for psychodynamic therapy with mixed groups of children**

When comparing the research in child and adolescent psychodynamic therapy identified in more recent reviews with to earlier ones, it is noticeable that there has been a change in the direction and focus of research over time. Studies are increasingly experimental in design, focusing on a particular diagnostic or clinical

group, rather than analyzing data routinely collected in a naturalistic setting with children presenting with a mix of clinical difficulties.

Whilst this perhaps reflects growing recognition of the need to rigorously assess the efficacy of psychodynamic therapy by both researchers and funders, it is important not to overlook the value of naturalistic studies conducted in a real-world setting. 'Practice-based evidence' involves monitoring routine clinical practice, and observing what therapists actually do in their regular everyday activity as a means of studying what works (Manning, 2010). Whilst experimental designs may provide a more rigorous form of evaluation and help to establish the *efficacy* of a particular type of therapy, they do not always help us to understand what the *effectiveness* of routine psychodynamic therapy may be. In usual practice, children who are referred rarely fall into the neat diagnostic categories which are a core element of the RCT approach, and therapists are less likely to follow a pre-determined (manualized) approach, but rather flexibly respond to the specific clinical situation before them. Arguably, the findings of these naturalistic, effectiveness studies are more reflective of the kinds of outcomes experienced by children in 'real world' healthcare settings (i.e. they have good 'external validity'), and therefore have clear implications for usual clinical practice.

Although RCTs are often considered the 'gold standard' of evidence-based practice, Holmqvist et al. argue that RCTs and practice-based evidence 'are in fact complementary paradigms as both are needed in order to build a robust and rigorous science of the psychological therapies' (2015, p.20). In this review, we identified 29 studies of mixed diagnostic groups, nearly all of which were conducted in naturalistic settings. In what follows, we describe some of the larger and better-designed studies.

A majority of the studies of mixed populations focus on the treatment of children (aged 3-12). For example, Edlund and colleagues (2014) conducted a naturalistic study, with a relatively large sample of 207 participants aged 4-12 years. Results showed that psychodynamic psychotherapy was associated with a significant improvement in functioning, with a large effect size ( $d = 1.35$ ), and 40% of participants achieved clinically significant change on the CGAS. Improvement measured on the SDQ subscales were found with small-medium effect sizes ( $d = 0.21-0.50$ ).

In a comparable study, Deakin and Nunes (2009) looked at the effectiveness of child psychoanalytic psychotherapy in an outpatient setting in Brazil for children aged 6 to 11 years with a range of psychological disorders. The study used a paired control group of children from local public schools (22 in the control group and 23 in the treatment group), and found that children who received treatment showed a

significant reduction in total behaviour and internalising problems after 12 months of treatment, and improved interpersonal relationships and affect modulation. The authors report that treatment had an overall effect size of 0.696, with treatment being most effective for girls with internalising problems. Similar results have been found by studies in other countries. In an analysis of 89 children from Turkey aged 4-10 years old, experiencing a range of problems, Halfon and colleagues (2019) found that 54% of the children showed reliable improvement in externalizing and internalizing problems at the end of treatment.

Most practice-based evidence related to psychodynamic therapy with children has focused on individual therapy, but some research has examined the effectiveness of psychodynamic therapy when offered to young children in a group format. One small doctoral study (Levy 2017) looked at a group of 11 pre-school children (aged 3.5-6 years) identified as 'at risk' of mental health problems or developmental problems as a result of teacher and parent observations. Although very small-scale, this study suggested that peer-play psychotherapy can be effective for this group of 'at risk' children, and that collecting session-by-session data provides greater insight as to the process and direction of change.

There is also a considerable amount of practice-based evidence related to the psychodynamic treatment of adolescents. For example, in a community-based study of psychodynamic treatment for adolescents and young adults presenting with multiple difficulties, findings show that measurable change took place during the course of therapy in all domains of functioning (Baruch, 1995). However, 'externalising' problems were more difficult to treat than 'internalising' problems, although those with externalising problems did better if they also presented with emotional problems or if the individual was in more intensive treatment. As an open study, the findings were limited by the lack of a control group, but the sample has been followed up at a number of points (Baruch et al., 1998; Baruch and Fearon, 2002; Baruch and Vrouva, 2010).

In another naturalistic study, Tonge et al. (2009) report on the effectiveness of psychoanalytic psychotherapy for adolescents with serious mental illness, using a longitudinal design. Forty adolescents aged 12 to 18 years were offered psychoanalytic psychotherapy once or twice weekly, whilst 40 were offered treatment as usual (TAU). The findings showed those treated with psychodynamic psychotherapy had a greater reduction in clinical symptoms and social problems compared with those offered TAU; however the greater effectiveness of the psychodynamic treatment depended on initial level of symptomatology, with a 'floor effect' identified.

Two publications have resulted from a naturalistic study of adolescents receiving psychodynamic psychotherapy in outpatient clinics in Israel. The treatment group comprised 72 adolescents (aged 15–18), and the comparison group (n=?) was a non-clinical community control. The authors report that those in the treatment group became less rigid in their interpersonal patterns, developed more adaptive internal representations of relationships with parents, and improved significantly in their symptoms. No such changes were observed in the community sample (Atzil-Slonim et al., 2011; Slonim et al., 2013). Similar findings were reported by Tishby et al. (2007), in a small study of changes in interpersonal conflicts among adolescents during psychodynamic psychotherapy. Ten adolescents aged 15 to 18, with a range of diagnoses, were offered weekly psychodynamic therapy over 12 months. Over time there appeared to be a shift in the relationship with parents, with the young people reporting less angry and confronting relationships.

In a comparable study of 28 young people receiving psychodynamic psychotherapy (Seiffge-Krenke & Nitzko, 2011), the authors found that adolescents, their parents and therapists reported a significant reduction in symptomology by the end of treatment, across measures of somatic, mental and social impairment. The strengths of this study are that change was reported from multiple perspectives. The authors report a waitlist condition, but do not report the outcomes of the control group, and therefore while the study does suggest the therapy was effective, it cannot be reported whether this improvement was beyond what would be observed by spontaneous remission.

Overall, the studies of psychodynamic therapy for children and adolescents in naturalistic settings show encouraging findings. Although such evidence does not carry the same weight in most guidelines on evidence-based practice, these naturalistic studies can be seen as offering a 'bottom-up' model, whereby routine data is gathered at a service-level, with the possibility that findings can gradually be accumulated across services. Such an approach is in line with the increasing emphasis on models of quality improvement within mental health services (Ross & Naylor, 2017), and may give a more realistic sense of how psychodynamic therapies impact on the lives of children and families referred to mental health services.

### **3.8 The effectiveness of specific dimensions of psychodynamic therapy with children and young people**

In the sections above we have reviewed the evidence-base for different groups of children; but in this last section we review the evidence with regard to different

dimensions of the therapeutic model itself. Although such studies are rare, the evidence-base can help us to understand what the evidence is for offering longer-term or more intensive therapy, or therapy where parent-work is offered alongside the direct work with children.

### *3.8.1 The impact of treatment length on the effectiveness of therapy*

Psychoanalytic work has traditionally been associated with long-term, open-ended therapy. But because of the resources needed for the experimental study of long-term therapy, this form of therapy is especially hard to evaluate using clinical trials, so most evaluations of long-term work with children and young people have been naturalistic studies. Those studies which have tried to make systematic comparisons have had to be rather creative in their study design. For example, Krischer and colleagues (2020) used a quasi-randomised, semi-controlled, longitudinal design, to compare the effectiveness of these two models of psychodynamic therapy. 76 participants aged 4-17 years old experiencing a range of disorders received long-term psychodynamic treatment for an average of 66 treatment sessions (range 16-120) over an average of 30 months (Krischer et al. 2020). Outcome data for this treatment group was compared with a control group of 27 children of similar age and diagnoses. In the treatment group, comparison of pre-post scores showed a clinically significant symptom reduction based on parent and child-report measures. The study authors compare the results of this study alongside an earlier pilot study (Krischer et al., 2013), in which significant improvements had also been found for 30 children who had been offered short-term psychotherapy. In comparing the findings of the two studies, the authors noted that larger effects were associated with longer treatment duration, particularly in relation to quality of life, suggesting that long-term psychodynamic psychotherapy may be more effective both in symptom reduction, particularly internalizing symptoms, and quality of life improvement. However since the studies were not designed as a direct comparison between the two forms of treatment, the comparison must be treated with some caution.

A group of researchers in Heidelberg (Kronmüller et al., 2002, 2005, 2010) designed a comparable study, which also had two stages: the first stage examined the efficacy of *short-term* psychodynamic psychotherapy (compared to a waiting group control) for children and adolescents with a range of disorders, and the second stage (with a smaller group and no control) looks at the effectiveness of *long-term* psychodynamic psychotherapy for the same group. 71 young people were treated in the study. The authors report an effect size of 0.47 for the short-term treatment and an impressive 1.41 for the longer-term treatment, with security of attachment and family



functioning both acting as strong predictors of good outcome (Kronmüller et al., 2009; Stefini et al., 2009). However, the researchers acknowledge that the sample was relatively small and heterogeneous and the lack of a control group for the longer-term treatment limits the degree to which the results can be generalized.

One disorder-specific study also looked at the difference in outcomes for short and long-term treatments. Smyrniotis and Kirby (1993) found that long-term individual treatment and time limited individual treatment were equally effective in treating emotion disorders in a sample of children aged 5-7 years, though perhaps surprisingly, the 'minimal intervention' control group showed greater improvements than both treatment arms. This study is reviewed in more detail above.

Without making a direct comparison between long- and short-term therapy, a number of naturalistic evaluations have examined the association between treatment length and outcomes. For example, the studies by Weitkamp and colleagues all show that a longer treatment duration (more than 6 weeks) was needed to see significant improvements beyond those also seen in a 'minimal treatment' control group, though the small sample meant that the study was not powered to detect differences between those who received short term treatment and those who received long term treatment. Another observational study had a relatively large sample of 218 participants, aged 14–24 years (Edlund & Carlberg, 2016), who received psychodynamic psychotherapy in a naturalistic setting. The authors report that participants showed a significant improvement in general functioning with large effect sizes, as well as decreased symptom severity with a medium–large effect size, at the end of treatment. Those receiving longer term treatment improved more than those whose treatment was shorter in duration. However, participants were not followed up beyond the end of treatment, and participants were excluded from the analysis if they attended fewer than six sessions.

Other studies of mixed populations have examined the outcomes of long-term treatments, without a direct comparison to short term therapy. For example, in a retrospective analysis of long-term treatments, Fahrig et al. (1996) reported an 80% treatment success rate for a range of children and adolescents referred to clinics specialising in psychoanalytic psychotherapy, with effect sizes comparable to those of behavioural therapy. A five-year follow-up study (Winkelmann et al., 2000) concluded that improvement in the period after treatment seldom occurred if difficulties were not resolved in the therapy itself; but improvements seen during therapy continued after therapy.

More recently, Stefini and colleagues (2013) carried out a study to examine the effectiveness of long-term psychodynamic psychotherapy with a focus on the role of

attachment security as both a predictor of outcomes and an outcome measure itself. The study included a heterogeneous sample of 71 children and adolescents (6–18 years old), who met criteria for a mental disorder as determined by ICD-10. Participants received long-term psychodynamic psychotherapy, with an average 82 sessions (SD = 52.6). Three quarters of participants achieved reliable and clinically significant change (ES = 1.95). Further gains were made by the one- year follow-up, with 87% having achieved good outcomes. At baseline, 22.5% were rated as having secure attachments; by the end of treatment, those with secure attachments had increased to 63.4%, and this figure increased to 76.6% by one- year follow-up. The authors concluded that there is support for the hypothesis that long-term psychoanalytic treatment can shift clients' attachment towards a secure style. Participants with both secure and insecure attachments were successfully treated with psychoanalytic treatment in this study, but those with insecure attachments required more sessions than those who were securely attached.

Taken together, the research seems to suggest that long-term therapy can be effective in the treatment of young people experiencing a range of different mental health difficulties, with some indication that larger effect sizes across a wider range of measures may be seen with longer-term psychodynamic therapy. This is consistent with findings from research with adults that seem to show that long-term psychodynamic therapy is superior to short term psychodynamic therapy for complex mental disorders (Leichsenring, Abbas et al 2013). However few studies have directly compared long- and short-term psychodynamic work in children, so this conclusion must be taken with some caution, and further research is required.

### *3.8.2 The impact of treatment intensity on the effectiveness of therapy*

Although weekly therapy sessions are probably the most common form of psychodynamic therapy offered in most settings, psychoanalysis also has a long tradition of offering more intensive treatment, which in this context means therapy delivered three or more times per week. However, research into the comparative effectiveness of intensive and non-intensive work is rare.

Two studies identified in this review explicitly compared the effectiveness of intensive and non-intensive work. The Anna Freud Centre study (Fonagy & Target, 1996), aspects of which are described above, involved a retrospective analysis of 763 closed cases (covering over 90% of all treatments at the Centre between 1956 and 1996) of a heterogeneous sample of children aged 3-18 years. 76% of these children received intensive treatment. Overall, 60–70% of children with 'moderately' severe disturbance showed reliable improvement. But for those with more 'severe' disturbance (based on

a range of retrospective measures), only 20% responded well to weekly psychotherapy, whereas over 80% showed reliable improvement in more intensive (four or five times weekly) treatment. In terms of age, younger children (but not adolescents) benefited more from intensive treatment than once-weekly psychotherapy (Target and Fonagy, 1994b). Whilst this study provides some important indicators of when intensive therapy may (or may not) be warranted, it is a retrospective study, and as such its findings must be treated with some caution. Further, despite the attempt to match cases, there may have been differences between those children who were offered intensive vs. non-intensive therapy, which again limits the conclusions that can be drawn from comparison between the two types of therapy.

Relatedly, the studies by Heinicke and colleagues (1965; 1986), discussed above, directly compared the outcomes of intensive psychoanalytic treatment (four times/week for two years, or once/week for the first year followed by four times/week for the second year) and non-intensive treatment (once/week for two years) for children with learning difficulties. All participants improved with treatment, but those who received intensive treatment improved most on a range of measures.

Just two other studies looked at the outcomes of intensive treatment, but without a direct comparison to non-intensive treatment. Moran and colleagues examined outcomes for young people with poorly controlled diabetes who received intensive therapy (three to five times a week) (Moran and Fonagy, 1987; Fonagy and Moran, 1990; Moran et al., 1991). Whilst this study did not directly compare intensive and non-intensive treatment, it did show the intensive treatment to be effective relative to a TAU control group. Zelman (1985) found that young children's IQs increased after intensive long-term therapy, though the study was relatively poorly designed with a small sample, limiting the conclusions that can be drawn.

These studies seem to suggest that many children can benefit from both intensive and non-intensive therapy, but greater treatment gains are sometimes associated with more intensive therapy, and younger children with severe and complex difficulties may require intensive therapy in order to see significant change. Some research in adult psychotherapy has suggested that more intensive treatment is associated with better outcomes; in a review of the literature, Robinson et al (2020) found that weekly therapy may accelerate the course of improvement by comparison to a fortnightly treatment schedule (Erekson et al., [2015](#)), and this finding fits with meta-analytic evidence that more frequent treatment schedules (e.g., twice per week vs. once per week) are more effective for the treatment of depression (Cuijpers et al., [2013](#)). Further, in a different review, Fonagy (2015) reports that intensive psychodynamic treatment has been shown to be effective in personality disorders,

and there is some evidence that intensive treatments may result in more sustained improvement at long-term follow up across a range of diagnostic groups. However, more research is needed in this area if we wish to better understand when intensive therapy may be recommended for children and adolescents, both in terms of clinical- and cost-effectiveness.

### *3.8.3 The impact of age on the effectiveness of therapy*

Few studies have directly compared the effectiveness of psychodynamic work with children at different developmental stages, but in general most therapy research indicates that treatments are more effective with younger children than older ones, which supports the principle of early intervention. Although many of the studies discussed above have demonstrated the effectiveness of psychodynamic therapy with both children and adolescents, few studies have directly examined the association between the child's age and treatment outcomes. Where they have done so, this has mostly been secondary analyses of data from larger naturalistic studies. For example, Edlund and colleagues (2014), in their naturalistic evaluation of psychodynamic therapy described above, found that younger children (4–6 years) showed larger improvements in general functioning at the end of treatment than older children (10–12 years old).

One of the few studies to explicitly examine the impact of age on treatment outcomes was Target and Fonagy (1994). Using data from the Anna Freud Centre retrospective study, the authors selected 127 children from each of three age bands (under 6, 6–12, and adolescents) and matched on a broad range of features, including diagnosis, gender and session frequency. The study found that younger children generally improved to a greater extent, with children under 12 benefitting from intensive treatment more than from non-intensive treatment.

None of the studies examining the impact of age on outcome reported here were designed to explicitly test how age impacts on treatment outcome, so no strong conclusions should be drawn. However, they do provide some preliminary evidence that younger children may show greater improvements with psychodynamic therapies than older children, supporting the principle of early intervention.

### *3.8.4 The impact of parallel parent work on the effectiveness of therapy*

Work with parents has sometimes been considered a neglected element of psychodynamic child psychotherapy. Yet, Novick and Novick entitled their 2005 book 'Working with Parents Makes Therapy Work', suggesting that parallel parent work

could be an important factor in determining outcomes. However, little research has been conducted to try and unpick the contribution working with parents actually makes to the effectiveness of psychodynamic child psychotherapy.

A number of naturalistic evaluations of child psychotherapy have included parallel parent work. For example, the Erica Process Outcome Study (EPOS, Odhammar et al 2011) investigated the effectiveness of an intervention involving child sessions and parallel parent work, over a relatively long time period (range: 20 to 152 sessions). Parents received between eight and 91 psychotherapy sessions. In this study, large effect sizes of between 1.80 and 1.98 were identified for changes in global functioning. The study was especially interesting in the way in which it compared change in global functioning on well-validated measures (e.g. the C-GAS) with in-depth case studies that revealed some of the complexities of trying to 'capture' change processes using research measures; however it was not able to clarify what specific contribution was made by the parallel work with parents. However, one study (Szapocznik et al., 1989) in which no parent work was offered noted that as the child got better family functioning deteriorated. This suggested a potential adverse effect of offering individual psychotherapy in the absence of parallel parent work.

A promising start at investigating this issue more systematically has been made by Gatta and colleagues, who published two papers reporting on a pilot and then follow-up study of weekly psychodynamic psychotherapy, with parent work alongside it, for children aged 4-17. The initial pilot study (Gatta et al., 2016) showed promising findings with regard to reductions in internalizing symptoms, and this led to a larger study (Gatta et al., 2019). Children and young people aged 6-18 with a range of diagnoses were offered short-term psychodynamic psychotherapy (STPP) for one year. Participants were divided into two groups; Group 1 received 40 (weekly or fortnightly) sessions of individual STPP, and Group 2 received the same dosage of STPP in addition to 20 (fortnightly or once/month) parallel parent sessions (for a period of 12 months). The authors found a significant effect in both groups, with a reduction in the severity of the problems in all the investigated areas (internalizing, externalising, and total problems), with no significant difference in outcomes between the two groups. However, it should be noted that the two groups were dissimilar at baseline in some respects: the parents in Group 2 being offered parallel parent sessions because their children had greater behavioural problems, on the assumption that these parents would benefit from support with managing challenging behaviour, and because they seemed to present with more difficulties with parenting. Because the two groups were not similar at baseline, it is difficult to draw conclusions about the relative effectiveness of the two therapy models. Whilst this study demonstrates

the effectiveness of STPP, the value of parallel parent sessions requires further investigation before conclusions can be drawn.

Some other studies in this review have included parallel parent work, mostly with school age or with children in early-adolescence – however, these studies have not directly compared therapy that does and does not include parent work. As such, it is not possible to understand the specific contribution or value of the parallel parent sessions. Overall, however, these studies show that therapy that includes parent work can have good outcomes for children. For example, Muratori and colleagues (2002; 2003) found that children aged 6-11 showed improvements in both internalizing and externalizing symptoms after receiving time-limited psychodynamic therapy with parallel parent sessions. Similarly, Trowell (et al 2007) found that children with depression benefitted from psychodynamic therapy with parallel parent sessions, and that this was shown to be more effective than family therapy when outcomes were assessed at 6 month follow up. In a different study by the same lead author, Trowell and colleagues (2002) found that psychodynamic therapy with parent work demonstrated an effect size of 0.65 in a sample of girls who had experienced sexual abuse. One study had less promising results: Chirico (2019) found that psychodynamic play therapy with parent sessions did not produce statistically significant improvements for children with 'eating and evacuation' disorders, but the therapy was successful in building a positive therapist-parent alliance, indicating a possible value of parent work in psychodynamic therapy.

Taken together, it seems that psychodynamic therapy with parallel parent sessions can be effective for children, though most evidence to date has focussed on younger children and those in early adolescence. Future research should directly compare the outcomes of therapy that does and doesn't include parallel parent work, in order to explore the specific effects of including parents in a child's treatment.

## 4. Summary and discussion

The aim of this review was to provide an update on the evidence base for psychodynamic therapy with children and adolescents published between January 2017 and May 2020. In addition, this paper provides a narrative synthesis of the published research to date, i.e. synthesising the findings of this new update (2017-2020) with those reported in the 2011 and 2017 reviews.

This updated review identified 37 papers that had been published between January 2017 and May 2020, reporting on 28 distinct studies. These were combined with the findings of the previous reviews, to include a total of 123 papers, comprising 82 distinct studies. Overall, both the quality and quantity of research in this field has increased over time. For example, the proportion of studies using an experimental and quasi-experimental design has grown with each update of the review. This is especially important given that many clinical guidelines only draw on evidence from studies with such designs. Whilst in previous reviews the vast majority of studies were observational, now 22 of the 82 studies are RCTs. These are mostly focused on specific diagnostic groups. There is particularly good quality evidence for the treatment of young people with depression (3 good quality RCTs, one of which is the large IMPACT trial). There is also some high-quality research evaluating psychodynamic therapy in the treatment of mixed emotional disorders, including a well-designed RCT evaluating the effectiveness of psychodynamic therapy for young people with comorbid disorders of conduct and emotions (Salzer et al. 2014), and an RCT of self-harm (Rossouw & Fonagy 2012). Studies like this offer greater confidence that any conclusions reached about the effectiveness of psychodynamic therapy for children and young people are based on the most robust scientific evidence.

Nevertheless, the majority of studies in this review were conducted in naturalistic settings using clinically referred rather than recruited samples. Many used an observational design, though some included matched community or TAU control groups. Whilst the findings of these studies cannot be considered as 'rigorous' as those of experimental studies, such studies may be more representative of a 'real-world' context, where treatments are not often delivered according to a specific manual, treatment length is not predetermined, and patients often present with a mixed picture of mental health issues. The large number of studies in this area means that there can be greater confidence that any outcomes identified in more controlled settings can be replicated in routine clinical practice.

The research reviewed in this study makes it possible to identify some tentative indications about who is likely to benefit most (or least) from psychodynamic child

psychotherapy, and to indicate which forms of psychodynamic therapy might be most effective. Based on the studies reviewed here, we would tentatively draw the following initial conclusions:

- There have been a relatively large number of studies evaluating the outcome of psychodynamic therapies for children with emotional disorders: 21 studies, of which 12 are RCTs. Taken together, these studies indicate that emotional disorders respond well to psychodynamic therapy; with a number of studies suggesting that psychodynamic treatment is more effective for internalizing than externalizing symptoms (Target & Fonagy 1994a; Deakin & Nunes, 2009; Krischer et al. 2014; Baruch, 1995; Rynänen et al., 2015; Kronmüller et al., 2005).
- Within the Emotional Disorders category, the quality of research has been particularly high for the treatment of depression, where 3 RCTs have been conducted, including the IMPACT study. This was the largest study to date to include a psychodynamic treatment arm either in children or young people (n = 465). Taken together, these studies indicate that psychodynamic psychotherapy is equally effective to other psychological treatments such as CBT or systemic family therapy, and that it can result in good outcomes across a range of domains, with those outcomes maintained beyond the end of treatment. For example, the IMPACT study found that 85% of adolescents receiving STPP no longer met criteria for depression one year after the end of treatment.
- The comparative effectiveness of psychodynamic therapies also seems to be demonstrated for other disorders, such as Bulimia Nervosa and Anorexia Nervosa. Two RCTs focused on Anorexia and one focused on Bulimia found psychodynamic treatment to be equally effective to an alternative treatment.
- The 2017 review found no sufficiently high-quality studies in samples of children and adolescents with anxiety disorders, disruptive behaviour problems, or personality disorders. Whilst there are still very few RCTs evaluating the effectiveness of psychodynamic therapies in the treatment of disruptive behavior problems in children and young people, the evidence base for anxiety and personality disorders has grown in recent years. There are now 3 RCTs focused on anxiety disorders and 2 on emerging Personality Disorders, with several observational studies of the psychodynamic treatment of BPD published in the last three years.
- For the treatment of anxiety disorders, a number of studies have found psychodynamic treatment to be effective. The best designed study of psychodynamic therapy for children with anxiety disorders was an RCT carried out by Salzer et al. (2018), which showed both active treatments were superior



to a waitlist condition, with medium-to-large effects for CBT and medium effects for PDT. Overall, the evidence to date suggests that psychodynamic therapy, even when relatively short-term (<30 sessions) is effective in the treatment of anxiety disorders, and that these outcomes have been maintained at a 6-month follow-up period. One retrospective study showed that children with anxiety disorders did better than children with either depression or disruptive disorders (Horn et al., 2005; Winkelmann et al., 2000)

- There is evidence to suggest that a contemporary psychodynamic therapy such as mentalization based treatment may be effective for treating self-harm in adolescents. Two RCTs have been conducted to date, and both demonstrated that a mentalization based intervention was equally or more effective than TAU for the treatment of self-harm.
- Comparatively, the psychodynamic treatment of externalizing disorders has received less research attention, and this may partly be because the evidence-base for a range of parenting interventions in this area is well-established (Fonagy et al., 2015). There have been only 6 studies of psychodynamic therapies for this group of children, and only one of these was an RCT. However, despite the accepted wisdom that non-behavioural therapies are less effective for disruptive disorders, these studies show promising findings, particularly when the child also presents with some emotional difficulties. Research suggests that children with disruptive disorders may be difficult to engage, but those who remain in treatment can see significant symptom reduction. Although comparative studies are lacking, one study found psychodynamic therapy to be similarly effective to a behavioural intervention (Laezer 2015). It may be, as with the feasibility study conducted by Edginton et al. (2018), that future studies of psychodynamic therapy should focus especially on those children with disruptive disorders who have not been responsive to a first-line treatment, including parenting interventions.
- Some areas have received growing research interest in recent years, with more studies identified in more recent reviews. Emerging PD have been examined in 8 studies, of which 2 are RCTs. 5 of these 8 studies have been published since 2017. The two RCTs of BPD both showed the psychodynamic treatment to be equally effective to the control condition: cognitive analytic therapy (Chanen et al 2008) and MBT-G (Bo et al 2017). Given the high personal and social costs of PDs across the lifespan, and the evidence of the effectiveness of psychodynamic therapies for adults with PD (Storebø et al., 2020), this may be an area where psychodynamic therapies have an especially important role to play.
- Similarly, in recent years more studies have focused on children impacted by parental conflict or domestic violence – this review found three studies, all

published since 2017, of which two were RCTs. These three studies were designed quite differently, such that it is difficult to draw together their findings. However, the study by Pernebo (2018) suggests that children experiencing trauma symptoms are particularly able to benefit from group psychodynamic therapy, suggesting a promising area for future research with children impacted by parental conflict.

- A number of studies have evaluated the effectiveness of psychodynamic therapies with children who had experience trauma more, including children in foster care and post-adoptoin. We identified eight studies, three of which are RCTs. These are promising, and show that psychodynamic therapy is as effective as alternative treatments in the treatment of young people who have experienced trauma (Trowell et al. 2002; Gilboa-Schechtmann et al. 2010). These findings support those of Perenebo (2019), who also found that children who have experienced trauma may benefit from psychodynamic therapy. Recent reviews of the work of psychodynamic child psychotherapists have highlighted the wide range of settings in which psychodynamic therapists work with children who have experienced maltreatment, especially those children who have been adopted or who are in care (Robinson, Luyten and Midgley, 2017, 2019). Therefore, there is an urgent need to build on the preliminary research in this area, with larger and better-designed studies.
- We identified only 2 studies examining the effectiveness of psychodynamic therapy for physical illness, though these are both well designed. Moran and colleagues (Moran & Fonagy, 1987; Fonagy & Moran 1990; Moran et al. 1991) show psychodynamic therapy to be effective in the treatment of adolescents with poorly controlled diabetes. There is also evidence from a pilot RCT that psychodynamic therapy can reduce symptom severity for young people experiencing idiopathic headache (Balottin et al 2014). These findings suggest that further research should consider psychodynamic treatments for certain physical conditions, where symptoms or treatment adherence may have an important psychological component that could be treated with psychotherapy.
- There are a number of areas where very little research has been carried out evaluating the effectiveness of psychodynamic therapies. This includes research into the treatment of children and young people with ASD, OCD and the range of eating disorders. If psychodynamic therapy is to be offered to children with these clinical presentations, it is vital that more outcome research is carried out.

In addition to reviewing the evidence-base in relation to diagnostic groups, this review also attempted to draw together the evidence in relation to certain characteristics of

psychodynamic therapy. Based on this review, the following tentative conclusions can be drawn:

- Few studies have directly compared long- and short-term psychodynamic work in children, and therefore it is difficult to draw conclusions regarding the impact of treatment length on outcomes. However, preliminary evidence suggests that long-term therapy can be effective in the treatment of young people experiencing a range of different mental health difficulties, with some indication that larger effect sizes across a wider range of measures may be seen with longer-term psychodynamic therapy. This is consistent with findings from research with adults that seem to show that long-term psychodynamic therapy is superior to short term psychodynamic therapy for certain complex mental disorders (Leichsenring et al. 2013).
- Similarly, very few studies have directly compared intensive and non-intensive therapy. The evidence to date suggests that greater treatment gains are sometimes associated with more intensive therapy, and one study has suggested that younger children with severe and complex difficulties may require intensive therapy in order to see significant change. In contrast, in samples that can be assumed to have lesser degrees of complexity either because of the setting or selection criteria, it seems intensive treatment is not necessary, and short-term and even minimal interventions have been shown to be effective (Smyrniotis & Kirby, 1993; Sinha & Kapur, 1999; Muratori et al., 2002, 2003). More research is needed in this area if we wish to better understand when intensive therapy may be recommended for children and adolescents, both in terms of clinical- and cost-effectiveness.
- None of the studies examining the impact of age on outcome reported here were designed to explicitly test how age impacts on treatment outcome, so no confident conclusions should be drawn. However, the studies that have tested age as a variable associated with treatment outcome do provide some preliminary evidence that younger children may show greater improvements with psychodynamic therapies than older children, supporting the principle of early intervention.
- Likewise, although no studies have directly tested the effectiveness of psychodynamic therapy with or without parallel parent work, the preliminary evidence suggests that psychodynamic therapy with parallel parent sessions can be effective for children. Most evidence to date has focused on younger children and those in early adolescence, and there have been no 'dismantling' studies which have attempted to isolate the specific impact of this parallel work with parents. The role of parent work, which is a core element of most

psychodynamic therapy with children, remains a rather neglected element among researchers.

- There are some indications that psychodynamic treatment may be associated with different trajectories of change from other treatments. For example, when compared to systemic family therapy, depressed children appeared to recover more quickly when receiving family therapy, whilst improvements for those receiving individual psychodynamic therapy appeared to be slower but more sustained, with some young people continuing to improve after the end of treatment (Trowell et al., 2003, 2007). A similar pattern of improvement continuing beyond the end of treatment was found in a study of children with emotional disorders, giving some evidence of a possible 'sleeper effect' in psychodynamic therapy (Muratori et al., 2003, 2005). However, in the IMPACT study no differences were found in trajectories of change between those in the three treatment arms of the study, with young people across all three arms continuing to improve, on average, beyond the end of treatment (Goodyer et al 2016).

Although this summary indicates that we are now in a position to draw some tentative conclusions, caution is needed. The number of clinical trials evaluating psychodynamic therapies for children and young people remains very small when compared to studies of psychopharmacological interventions, or even other psychosocial treatments for children and young people, such as CBT. For example, in a systematic review of studies examining the effectiveness of CBT with children and adolescents, Oud and colleagues (2019) identified 31 RCTs focused on Depression alone, this compares to 3 RCTs of psychodynamic therapy as a treatment for adolescent depression identified in this review. The numbers are also small compared to the research focused on psychodynamic therapy with adults, where one review suggested that over 250 RCTs have been published to date (Lilliengren, 2017). The reasons for this paucity of research are complex, and include the fact that psychodynamic child therapy trainings have not traditionally been affiliated to university departments, and don't always have a strong research culture. This is beginning to change in some countries, such as the UK, where most child psychotherapy trainings are now professional doctorate programmes.

However, the lack of funding opportunities is the single biggest obstacle to further research being carried out. A report by MQ in 2017 noted that mental health research is chronically under-funded compared to physical health, but that even within mental health research, only 3.9% of funding goes towards prevention of mental illness, 5.5% towards the development of new treatments, and 18.3% to the evaluation of treatments. The report also notes that "only 26% of money spent on mental health

research goes towards projects on children and young people, despite 75% of mental illness beginning before the age of 18" (MQ, 2017, p.3). Without greater priority being given to the study of mental health interventions for children and young people, especially those evaluating treatments models beyond CBT, there is little chance that commissioners or families will be able to draw conclusions about effective therapies based on high-quality science.

The current review also suffers from a number of limitations itself. First, the data extraction and quality assessment process was carried out by different groups at each stage of carrying out this review (2004, 2011, 2017 and 2020), which means that there may not have been complete consistency in how this was done. For example, no formal evaluation of 'risk of bias' was carried out in the 2011 review, and different 'risk of bias' measures were used in 2017 and 2020. Further, because of significant variation in study reporting, it was not possible to provide consistent reporting of the key study components from each study – for example, treatment effect sizes. Likewise, the great variation in study design – including outcome measures and methods of data analysis - meant that no meta-analysis of the data was carried out. Additionally, including research examining the *process* of therapy (e.g. Fisher et al., 2016; Calderon, Schneider, Target & Midgley, 2019; and for a review, Kennedy & Midgley, 2007), or qualitative studies examining the experience of psychodynamic child and adolescent psychotherapy (e.g. Løvgren et al., 2019; Marotti, Thackeray & Midgley, 2020), were both beyond the scope of this report. Likewise, this review did not include studies that have not been published in English (though where non-English-language publication were included in the 2011 review, they are included here). Nor did this review include studies evaluating the effectiveness of psychodynamic therapy with parents and infants – an area where child psychotherapy has played a significant role for a number of years. Other reviews have covered this important area (e.g. Sled and Bland, 2007; Barlow et al., 2016), but this absence means that there is a gap in the presentation of the evidence-base for psychodynamic child and adolescent psychotherapy across the whole age range.

## 5. Conclusion

It has been reported that 75% of mental illnesses start before a child reaches their 18th birthday, while 50% of mental health problems in adult life (excluding dementia) first appear before the age of 15 (MQ, 2017). These widely-quoted figures highlight the urgent need for interventions that are effective in childhood to limit the impact of mental health problems that may persist into adulthood, at considerable individual, social, and economic cost. Yet in a society in which there are increasing levels of mental health problems among children and young people, and very real restrictions on services available, it is inevitable that every health system needs to make choices about what is provided (and what is not). How such choices are made is controversial, but in the broadest sense there is a logic in making those choices based on the 'best available evidence'.

In 2002, the Evidence Based Practice Unit in the attempted to summarise the available evidence for a range of the most common childhood mental health problems. On nearly every page of the resulting pamphlet, the same phrase was repeated: 'There is insufficient evidence to draw conclusions about the effectiveness of psychodynamic child psychotherapy' (Wolpert et al., 2002). Of course a lack of evidence is not equivalent to evidence for a lack of effectiveness; but in a mental health system where commissioning was based on the principles of evidence-based practice, it raised serious questions about the future role of psychodynamic therapies within child and adolescent mental health services. The 2004 review, and those which have followed, have been intended to bring together the research that has been done in the field, to ensure that current and future decision-making in child mental health settings is informed by the best available evidence. Although the number of studies is still very small compared to other modalities of treatment, there is now a growing evidence-base that suggests, broadly speaking, that psychodynamic therapies can be effective for children and young people presenting with a wide range of clinical issues. Although much of the research is with small samples, or has other methodological weaknesses, both the number and the quality of studies has been gradually increasing. For some areas, such as the treatment of adolescent depression, there is now a fairly good basis to consider psychodynamic therapy an 'evidence based treatment', whereas for other areas, such as the treatment of autism spectrum disorders, there is a striking lack of research.

Although progress has been made, challenges with regard to research funding, as well as research capacity, mean that it is unlikely that we will ever reach a point where there is a significant number of large-scale, well-designed studies examining the evidence-base for psychodynamic therapy across the full range of psychodynamic

therapies. It may be that future research will need to focus more narrowly on those clinical fields – such as children who have experienced early maltreatment and trauma – where there is a lack of other, evidence-based treatments, combined with a strong clinical logic for using a psychodynamic approach.

This updated review has also indicated the increasing difficulty in distinguishing between treatments that should be designated as 'psychodynamic', given the fact that many treatment approaches are now integrative, drawing on the most effective elements of different treatment models. This can be seen as a positive development from a clinical perspective, as we move towards an increasing focus on 'empirically supported change processes', rather than 'empirically supported treatments' (Ablon, Levy & Katzlenstein, 2006). Researchers are increasingly moving beyond the question: 'what treatment brand works best for disorder x or y?', to questions such as 'what kind of services would we need to give best outcomes to wide range of clients?', 'what does the evidence tell us we can do to optimise the effectiveness of the talking therapies?', or 'what does the experience of service users tell us about what kinds of services we commission?'.

For a wide range of reasons, it is clearly important to be able to systematically review the evidence-base for psychodynamic therapies with children and young people. But going forward, there is clearly a need to balance this demand with a greater focus on practice-based evidence (PBE), including large-scale routine outcome monitoring and the emerging field of practice-research networks (Barkham, Hardy & Mellor-Clark, 2010). There is also an increasing need to pay attention to the findings of qualitative research, including studies of client experience and service-user preferences (Midgley, Ansaldo & Target, 2014). Such research can help to identify helpful and unhelpful aspects of therapy and puts the needs and experiences of children, young people and families at the heart of evidence-based practice; this can have many beneficial consequences, for example, understanding why service-users end therapy early can help improve treatment adherence, or enhance our understanding of groups who feel that they 'get what they need' after a short number of sessions (O'Keeffe et al., 2019). Relatedly, change process research (Elliott, 2010) can help us to understand *why* change takes place, and what aspects of the therapeutic encounter help to promote change - thereby leading to development of better treatments.

The field of evidence-based practice is clearly evolving. Hofmann and Hayes (2019) go as far as to talk about a 'paradigm shift' in how we think about developing and evaluating treatments, moving beyond the idea of 'latent disease entities' (such as social anxiety or depression) targeted with specific therapy protocols, towards a model of process-based, trans-diagnostic therapies that target underlying

mechanisms, such as emotion regulation or the capacity for social cognition. They argue that such a shift 'might see a decline of named therapies defined by set technologies, a decline of broad schools [...] These changes could integrate or bridge different treatment orientations, settings, and even cultures' (p.37). By widening what 'counts' as credible evidence and by broadening the kind of questions we ask about that evidence, as well as promoting more interdisciplinary studies, research can truly help ensure patient choice, and to enable provision of diverse range of effective treatments, with service user experience at the heart of all decision making.



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### Part 1 – Empirical studies included in the review

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## Appendix 1: Search Strategy

Search Terms	Databases Searched (January 2017 – May 2020)
<p>(child* OR teenage* OR adolescent* OR * young person* OR * young people)</p> <p>AND</p> <p>(psychoanaly* OR psychodynamic* OR psychotherapy*)</p> <p>AND</p> <p>(therap* OR intervention* OR treatment*)</p> <p>AND</p> <p>efficacy* OR effective* OR outcome* OR trial* OR experiment* OR empirical* OR investigate* OR outcome*OR finding* OR result* OR measur* OR evaluat*</p>	<p>PsycInfo</p> <p>EMBASE</p> <p>Scopus</p> <p>Web of Science</p> <p>CINAHL</p> <p>PubMed</p> <p>Medline</p> <p>The Cochrane Library</p>

The evidence-base for psychodynamic psychotherapy with children and adolescents

<b>Inclusion criteria:</b>	<b>Exclusion criteria:</b>
<i>Language:</i> English	<i>Method:</i> Studies that report only on qualitative findings; single case studies; review papers; and meta-analyses.
<i>Study focus:</i> Studies primarily concerned with evaluating treatment outcomes, using any design involving quantitative measurement of outcomes (e.g., randomised control trials, quasi-experimental studies, and naturalistic evaluation).	<i>Outcomes:</i> Studies where child outcomes are not reported (e.g., only parent outcomes reported) and studies focusing only on the process rather than outcome of therapy.
<i>Participant age:</i> Studies where a majority of participants were aged between 3 and 18 years old but none of the child/adolescent participants were over 25.	<i>Interventions:</i> Parent-infant psychotherapy (where the intervention is primarily focused on therapeutic work with children under three years of age).
<i>Intervention:</i> Individual or dyadic (parent-child) psychodynamic and/or psychoanalytic therapy, including family or group therapy where the therapeutic intervention is described as psychodynamic or psychoanalytic. As psychodynamic treatments are based on a range of theories, this review included all studies where the researchers defined the treatment model under investigation as primarily psychodynamic or psychoanalytic.	
<i>Study outcomes:</i> Outcomes related to any mental health condition or problem, including sub-threshold mental health conditions and prevention of mental health difficulties.	

## Appendix 2: Data Extraction Table for Studies 2017-2020

Author/ Date	Design	Location	Presenting Problem	Age of Participants	Sample Size	Intervention	Control Group / Comparison Treatment	Outcome Measure
Beck, et al. (2020); Jørgensen et al. (2020)	RCT	Denmark	BPD	14-16	112	Mentalization-Based Treatment (Group)	TAU	Borderline Personality Features Scale for Children (BPFS-C); Beck's Depression Inventory for Youth (BDI-Y); Risk-Taking and Self-harm Inventory for Adolescents (RTSHI-A); Youth Self-Report (YSR), Borderline Personality Features Scale-Parent (BPFS-P); Child Behavior Checklist (CBCL); the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD); the Children's Global Assessment Scale (CGAS).

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Bernstein, Timmons, & Lieberman (2019)	RCT	USA	Children exposed to Parental Violence	2-5	113 mother-child dyads	Child-Parent Psychotherapy	Monthly case management / individual treatment in the community	The IFEEL Picture System (IFP), Clinician-Administered PTSD Scale, Child Behavior Checklist (CBC).
Bo et al. (2017)	Observational without control	Denmark	BPD	15-18	34	Mentalization-Based Treatment (Group)	none	Borderline Personality Features Scale for Children (BPFS-C); The Youth Self-Report (YSR); Beck Depression Inventory for Youth (BDI-Y); Risk-Taking and Self-Harm Inventory for Adolescents (RTSHI-A); Inventory of Parent and Peer Attachment—Revised (IPPA-R); Reflective Function Questionnaire for Youth (RFQ-Y)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Bo, Bateman, & Kongerslev (2019).	Observational without control	Denmark	Avoidant Personality Disorder	14-18	8	Mentalization-Based Treatment	none	Millon adolescent clinical inventory (MACI); Youth self-report (YSR); Child behavior checklist (CBCL); Inventory of parent and peer attachment – revised (IPPA-R); Reflective function questionnaire for youth (RFQY)



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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Chirico et al. (2019)	Observational without Control	Italy	Eating and evacuation disorders	2-5	17 couples	Focal Play Therapy	none	The Working Alliance Inventory-Short Form; the System for Observing Family Therapy Alliances-Self report; the Parenting Stress Index-Short Form. Parent-Child Interactions were coded according to the 4th edition of the Infancy/Early Childhood Version of the Emotional Availability Scales
Cropp et al. (2019)	RCT	Germany	Comorbid disorders of conduct and emotions	15-19	38	Psychodynamic psychotherapy	Waitlist	The Reflective Functioning Scale (RFS); the German version of the Symptom Check List 90-R; the German version of the Global Assessment of Functioning Scale.

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Author/ Date	Design	Location	Presenting Problem	Age of Participants	Sample Size	Intervention	Control Group / Comparison Treatment	Outcome Measure
Edginton et al. (2018)	RCT	UK	Conduct disorders	5-11	32 parent-child dyads	Psychoanalytic child psychotherapy	TAU	Child Behavior Checklist (CBCL* and TRF); Parental Reflective Functioning Questionnaire (PRFQ); General Health Questionnaire 12 (GHQ-12); Parenting Stress Index (PSI); Beck Depression Inventory (BDI); EuroQol 5 Dimension (EQ-5D™, 3-level version); EuroQol 5 Dimension Youth (EQ-5D-Y™, 3-level version)

The evidence-base for psychodynamic psychotherapy with children and adolescents

<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Enav et al. (2019)	Quasi-experimental	USA	ASD	3-18	68 parents	Mentalization-Based Treatment	Waitlist	Parent Development Interview (PDI); The emotion regulation questionnaire (ERQ); The child behavior checklist (CBCL); the aberrant behavior checklist (ABC); the parenting sense of competence scale (PSOC)
Gatta et al. (2019)	Observational without control	Italy	Mixed Diagnoses	6-18	57 families (each including one minor, 2 parents)	Short-Term Psychodynamic Psychotherapy (STPP)	none	The Child Behaviour Checklist (CBCL); the Youth Self-Report (YSR); Family Empowerment Scale (FES)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Aitken et al. (2020); Davies et al (2020); O’Keefe et al (2019); O’Keefe, Martin & Midgley (2020); Reynolds et al. (2020); Goodyer et al. (2017)	RCT	UK	Major Depressive Disorder	11-17	465	Short-Term Psychoanalytic Psychotherapy (STPP)	Two comparison therapies: 1) Brief Psychosocial Intervention (BPI). 2) Cognitive-Behavioural Therapy (CBT).	The Mood and Feelings Questionnaire (MFQ); Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA); the Revised Children’s Manifest Anxiety Scale (RCMAS); the revised Leyton Obsessional Inventory (LOI); the Kiddie-SADS28. O’Keefe et al (2020) also used: the Rupture Resolution Rating System and Working Alliance Inventory (observer version).

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Griffiths et al. (2019)	RCT	UK	Self-Harm	12-18	53	Mentalization-Based Treatment (Group)	TAU	The Risk-Taking and Self-Harm Inventory for Adolescents (RTSHI); Self-harm related hospital use as reported by emergency department presentation in NHS electronic records; the Risk-Taking and Self-Harm Inventory (RTSHI); the Revised Child Anxiety and Depression Scale (RCADS); Reflective Functioning Questionnaire for Youths (RFQ-Y); Difficulties in Emotion Regulation Scale (DERS); Interpersonal Sensitivity Measure (ISM); short version of the Borderline Personality Features Scale for Children (BPFSC); short version of the Experiences in Close
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The evidence-base for psychodynamic psychotherapy with children and adolescents

Author/ Date	Design	Location	Presenting Problem	Age of Participants	Sample Size	Intervention	Control Group / Comparison Treatment	Outcome Measure
								Relationships Scale-Revised Child version (ECRS-RC)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Halfon & Bulut (2017); Halfon, Cavdar, & Yilmaz (2019); Halfon, Ozsoy, & Cavdar (2019)	Observational without control	Turkey	Mixed Diagnoses	4-10	89	Psychodynamic Play Therapy	none	The Child Behavior Checklist (CBCL); the Children's Global Assessment Scale (GCAS); The HoNOSCA; the Children's Play Therapy Instrument (CPTI); the Child Psychotherapy Q-Set (CPQ); Emotional Regulation Checklist (ERC); The Therapy Process Observational Coding System TPOCS-A
Hauber, Boon, & Vermeiren(2017)	Observational without control	Netherlands	Personality Disorder	15-22	63	Mentalization-Based Treatment (Group)	none	Dutch Questionnaire for Personality Characteristics; Symptom Checklist 90; Structured Clinical Interview for DSM Personality Disorders

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Hertzmann et al. (2017)	RCT - feasibility	UK	Child exposed to Parental Conflict	Not Specified	15 parental couples	'Parenting Together' (Mentalization-Based Group Treatment)	A psycho-educational intervention for separated parents	The Stait-Trait Anger Expression Inventory-2; the Parental Reflective Function Questionnaire; the Perceived Stress Scale; the Patient Health Questionnaire (PHQ-9); the Parenting Alliance Measure; the Relationship Attribution Measure; the Strengths and Difficulties Questionnaire (parent report); the Security in the Marital Subsystem-Parent Report (SIMSPR)



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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Krischer et al. (2020)	Quasi-experimental	Germany	Mixed Diagnoses	4-17	83	Psychodynamic psychotherapy	Waiting List	Child Behaviour Checklist (CBC); Youth Self-Report (YSR); QoL Inventory for Adolescents
Levy (2018)	Observational without control	USA	At risk of mental health difficulties	3.5-6	11	Relationships for Growth and Learning (RfGL) Peer Play Psychotherapy	none	The Coding Interactive Behavior (CIB) Rating Scale; Parent and teacher reports on the Penn Interactive Peer Play Scale.
Lindqvist et al. (2020)	RCT	Sweden	Major Depressive Disorder	15-18	76	Internet-based psychodynamic therapy (I-PDT)	Online Therapist Support	The QIDS-A17-SR; the Generalized Anxiety Disorder 7-item scale (GAD-7); the Montgomery Åsberg Depression Rating Scale-self-rated (MADRS-S); the Self-Compassion Scale short-form; the Difficulties in Emotion Regulation Scale

The evidence-base for psychodynamic psychotherapy with children and adolescents

<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Midgley et al. (2018)	Observational without control	UK	Adopted children	2-17	36 families, including 42 children	Adopting Minds (Mentalization-Based Family Treatment)	none	Brief Assessment Checklist (BAC), Brief Parental Self Efficacy Scale (BPSES); Experience of service questionnaire (ESQ)
Midgley et al. (2019)	RCT	UK	Children in Foster Care	5-16	36	Mentalization-Based Treatment (Family)	TAU	Strengths and Difficulties Questionnaire; Brief Assessment Checklist; Revised Children's Anxiety and Depression Scale (RCADS); Parenting Stress Index-short form; Parenting Efficacy Scale; Parenting Scale; Goal Based Outcomes; Significant Events Log

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Schenk et al. (2019)	Observational without control	Switzerland	BPD and Identity Diffusion	4-18	10	Adolescent Identity Treatment (AIT)	none	The Children's Global Assessment Scale (CGAS); Youth Outcome Questionnaire Self-Report (Y-OQ)
Pernebo, Fridell, & Almqvist (2018)	Quasi-experimental	Sweden	Children exposed to inter-parental violence	Apr-13	50 children and 50 mothers	Trauma-focused time-limited psychodynamic psychotherapy (group)	Community-based psychoeducative intervention	The revised Conflict Tactics Scale (CTS2); the Swedish parental version of the Strength and Difficulties Questionnaire (SDQ-P); the Trauma Symptom Checklist for Young Children; the Emotion Questionnaire for parents (EQ-P), the Brief Symptom Inventory (BSI); the Impact of Event Scale-Revised (IES-R)

The evidence-base for psychodynamic psychotherapy with children and adolescents

<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Polek & McCann (2020)	Observational without control	England	Adopted children	approx 5-8 years	51 couples	Time-limited psychodynamic therapy for couples	none	The CORE-OM; the six-item Quality of Marriage Index; the parent-rated Strengths and Difficulties Questionnaire (SDQ); the Experience of Service Questionnaire (ESQ)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Prout et al. (2019)	Observational without control	USA	ODD	5-9	3	Regulation-focused psychotherapy for children (RFP-C)	none	The Kiddie-Schedule for Affective Disorders and Schizophrenia–Present/Lifetime (K-SADS-PL); Subscales of the Child Behavior Checklist (CBCL); the Wechsler Abbreviated Scale of Intelligence (twosubtest form); the Oppositional Defiant Disorder Rating Scale (ODD-RS); the Emotion Regulation Checklist (ERC)
Ryan & Jenkins (2020)	Observational without control	UK	Mixed Diagnoses	Not Specified	--	The Bridge in Schools program	none	Strengths and Difficulties Questionnaire (SDQ); Child Global Assessment Scale (CGAS); Child Outcome rating Scale (CORS)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Salzer et al. (2018)	RCT	Germany	Social Anxiety Disorder	14-20	107	Psychodynamic Psychotherapy	Waiting List	The Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA); the Social Phobia Anxiety Inventory (SPAI)
Stefini et al. (2017)	RCT	Germany	Bulimia Nervosa	14-20	81	Psychodynamic Psychotherapy	CBT	Eating Disorder Examination (EDE); the German SCID-I28 and SCID-II29 for the DSM-IV; The Symptom Check List (SCL-90-R)

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Strangio et al. (2017)	Quasi-experimental	Italy	Feeding and eating disorder, and comorbid Addictive and/or Impulse Control Disorders.	13-18	26	Psychodynamic Psychotherapy	none	Eating Disorder Inventory-3; the Symptom Checklist-90; the Barratt Impulsiveness Scale-11; the Dissociative Experiences Scale; the Global Assessment of Functioning; the Semi-structured Interview for DSM-IV Axis II (SCID-II); the Childhood Trauma Questionnaire-short form

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<b>Author/ Date</b>	<b>Design</b>	<b>Location</b>	<b>Presenting Problem</b>	<b>Age of Participants</b>	<b>Sample Size</b>	<b>Intervention</b>	<b>Control Group / Comparison Treatment</b>	<b>Outcome Measure</b>
Weitkamp et al. (2017)	Quasi-experimental	Germany	Externalising Disorders	4-21	93	Psychoanalytic Psychotherapy	Waiting List with supportive bridging sessions	The externalising scale from the Child Behaviour Checklist/Youth Self Report (CBCL/YSR); the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS)
Weitkamp et al. (2018)	Quasi-experimental	Germany	Anxiety	4-21	88	Psychoanalytic Psychotherapy	Waiting List with supportive bridging sessions	The Screen for Child Anxiety Related Emotional Disorders (SCARED); K-SADS-P interview; Treatment fidelity checklist.



## Appendix 3: Studies 2012-2020, grouped by presenting problem and study design

Study Design	Definition
<b>Observational</b>	<i>A naturalistic study with no control group</i>
<b>Observational with control</b>	<i>The study includes a paired/matched control, such as a community sample or TAU, but with no allocation of study participants to this control group</i>
<b>Quasi-Experimental</b>	<i>The study employed quasi-experimental methods, using a control group with non-randomised allocation of participants to each treatment arm</i>
<b>RCT</b>	<i>Randomised Control Trial, with random allocation of participants to each treatment arm</i>

Presenting Problem	Papers	Study Design
<b>Mixed Emotional Disorders</b>	Target et al. 2002; Haslam 2008.	Observational
	Muratori et al. 2002; Muratori et al. 2003; Muratori et al. 2005.	Quasi-experimental
	Smyrnios & Kirby, 1993.	RCT
	Sinha & Kapur, 1999.	RCT
	Target & Fonagy, 1994a.	Observational (secondary analysis)
	Salzer et al. 2014; Cropp et al. 2019	RCT
<b>Depression</b>	Goodyer et al., 2017; Goodyer, et al. 2016; Aitken et al. 2020; Davies et al. 2020; O'Keefe et al. 2019; O'Keefe et al. 2020; Reynolds et al. 2020.	RCT
	Trowell et al. 2007, 2003, 2009, 2010; Kolaitis et al. 2014; Garoff et al. 2011.	RCT
	Weitkamp et al. 2014.	quasi-experimental
	Lindqvist et al. 2020.	RCT
	Horn et al. 2005	Observational (secondary analysis)
	Salzer et al. 2018	RCT
<b>Anxiety</b>	Weitkamp et al. 2018	quasi-experimental
	Göttken et al. 2014	quasi-experimental
	Milrod et al. 2013	Observational

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	Kronmuller et al. 2005.	Observational (secondary analysis)
	Muratori et al. 2005.	Quasi-experimental (secondary analysis)
<b>OCD</b>	Apter et al. 1984.	Controlled observation study
<b>Self Harm</b>	Griffiths et al. 2019.	RCT
	Rossouw & Fonagy, 2012.	RCT
<b>Eating Disorder</b>	Chirico et al. 2019.	Observational
	Strangio et al. 2017.	Observational with control
	Stefini et al. 2017	RCT
	Lock et al. 2010.	RCT
	Robin et al. 1995; Robin et al. 1999.	RCT
	Vilvisk & Vaglum, 1990.	Observational
<b>Externalising Disorders</b>	Edginton et al. 2018.	RCT
	Prout et al. 2019.	Observational
	Weitkamp et al. 2017.	quasi-experimental
	Eresund, 2007.	Observational
	Fonagy & Target, 1994	Observational (secondary analysis)
	Laezer, 2015.	Observational with control
	Jordy & Gorodscy, 1996.	Observational with control
	Winkelmann et al. 2000.	Observational (secondary analysis)
<b>Mixed Diagnostic Groups</b>	Gatta et al., 2019.	Observational
	Halfon & Bulut, 2017; Halfon, Cavdar, & Yilmaz, 2019; Halfon, Ozsoy, & Cavdar, 2019.	Observational
	Krischer, 2020.	Observational with control
	Ryan & Jenkins, 2020.	Observational
	Bury et al. 2007	Observational
	Barbre, 2005	Observational

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	Deakin & Nunns, 2009.	Observational with control
	Odhammar, 2011; Carlberg et al. 2009.	Observational
	Schachter & Target; 2009; Midgley & Target, 2005; Midgley et al. 2006.	Observational with control
	Tishby et al. 2007.	Observational with control
	Tonge et al. 2009.	Observational with control
	Urwin, 2007.	Observational
	Edlund et al. 2014.	Observational
	Edlund & Carlberg, 2016.	Observational
	Emanuel et al. 2014.	Observational
	Gatta et al. 2016.	Observational
	Krischer et al. 2013.	Observational
	Ryynänen et al. 2015.	Observational with control
	Seiffge-Krenke & Nitzko, 2011.	Observational
	Atzil-Slonim et al. 2011; Slonim et al. 2013	Observational with control
	Stefini et al. 2013.	Observational
	Sugar & Berkovitz, 2011a.	Observational
	Petri & Thieme, 1978.	Observational
	Szapocznik et al. 1989.	RCT
	Fahrig et al.1996.	Observational
	Baruch, 1995; Baruch et al., 1998, Baruch & Fearon, 2002; Baruch & Vrouva, 2010.	Observational
	The Heidelberg Study: Kronmuller et al., 2002, 2005, 2010; Horn et al., 2005; Windaus, 2005, Stefini et al. 2009.	quasi-experimental
	Anna Freud Retrospective Study: Fonagy & Target, 1994; Target & Fonagy, 1994a, 1994b; Fonagy & Target, 1996	Observational
	Levy, 2018.	Observational
<b>Developmental Disorders</b>	Heinicke, 1965; Heinicke & Ramsay-Klee, 1986.	controlled observation study
	Zelmann et al. 1985.	Observational
<b>ASD</b>	Enav et al. 2019.	quasi-experimental

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<b>Emerging Personality Disorders</b>	Hauber et al. 2017.	Observational
	Schenk et al. 2019.	Observational
	Beck et al., 2020; Jørgensen et al. 2020.	RCT
	Salzer et al. 2014.	Observational
	Sugar, & Berkovitz, 2011b.	Observational
	Bo et al. 2017.	Observational
	Chanen et al. 2008.	RCT
	Bo et al., 2019.	Observational
<b>Adoption/Foster Care</b>	Midgley et al. 2018.	Observational
	Midgley et al. 2019.	RCT
	Polek et al., 2020.	Observational
	Clausen et al., 2012.	Observational
	Lush et al. 1991; Boston & Lush, 1994; Lush et al. 1998; Boston et al. 2009.	controlled observation study
<b>Trauma/Abuse</b>	Heede et al. 2009.	Observational
	Gilboa-Schechtman et al. 2010.	RCT
	Trowell et al., 2002	RCT
<b>Parental Conflict</b>	Hertzman et al. 2017.	RCT (feasibility)
<b>Domestic Violence</b>	Bernstein et al. 2019.	RCT
<b>Domestic Violence</b>	Pernebo et al. 2018.	quasi-experimental
<b>Physical Illness</b>	Balottin et al. 2014.	RCT
	Moran & Fonagy, 1987; Fonagy & Moran 1990; Moran et al. 1991.	quasi-experimental

## Appendix 4: Studies 2017-2020 grouped by Internal Validity (Risk of Bias) Rating

Where a study is rated as having 'high internal validity' this means that the outcome results reported in the study have a greater probability of being truly attributed to the intervention or exposure being evaluated, and not to biases, measurement errors, or other confounding factors that may result from flaws in the design or conduct of the study.

<b>Studies Rated using the NIHR tool for Controlled Intervention Studies</b>	<b>Internal Validity Rating</b>	<b>Studies rated using the NIHR tool for Pre-Post Studies with no Control Group</b>	<b>Internal Validity Rating</b>
<b>Cropp et al (2019)</b>	High	Gatta et al (2019)	High
<b>Beck et al (2020); Jørgensen et al (2020)</b>	High	Pernebo et al (2018)	High
<b>Lindqvist (2020)</b>	High	Hauber et al (2017)	High
<b>Goodyer et al (2017); O'Keefe et al (2020); Reynolds et al (2020); Davies et al (2020); O'Keefe et al (2019); Aitken et al (2020)</b>	High	Halfon and Bulut (2017); Halfon, Cavdar, & Yilmaz, 2019; Halfon, Ozsoy, & Cavdar (2019)	High
<b>Midgley et al (2019)</b>	High/Medium	Strangio et al (2017)	High/Medium
<b>Salzer et al (2018)</b>	High/Medium	Levy (2018)	Medium
<b>Stefini et al (2017)</b>	High/Medium	Polek & McCann (2020)	Medium
<b>Griffiths et al (2019)</b>	High/Medium	Chirico et al (2019)	Medium
<b>Hertzmann et al (2017)</b>	Medium	Midgley et al (2018)	Medium/Low
<b>Edginton et al (2018)</b>	Medium	Bo et al (2017)	Medium/Low
<b>Krischer (2019)</b>	Medium/Low	Bo et al (2019)	Medium/Low
<b>Weitkamp et al (2017)</b>	Medium/Low	Schenk et al (2020)	Medium/Low
<b>Weitkamp et al (2018)</b>	Medium/Low	Prout et al (2019)	Medium/Low
<b>Enav et al (2019)</b>	Medium/Low	Ryan & Jenkins (2020)	Low
<b>Bernstein et al (2019)</b>	Low		

## Appendix 5: Evidence Mapped onto the Categories of the Scottish Matrix

<b>Scottish Matrix Category</b>	<b>Section of the Review</b>
<b>Attachment, Adoption, Risk of Care</b>	Section 3.3: Children who have experienced trauma, physical, sexual or emotional abuse, neglect, or family conflict
<b>Autism</b>	Section 3.5.2: Autism Spectrum Disorder
<b>Disruptive Behaviour Disorders</b>	Section 3.2: Behavioural Disorders
<b>Anxiety Disorders</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.3: Anxiety
<b>Panic Disorders</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.3: Anxiety
<b>Obsessive Compulsive Disorders</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.3: Anxiety
<b>Social Anxiety Disorder/Social Phobia</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.3: Anxiety
<b>Specific Phobia</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.3: Anxiety
<b>ADHD</b>	Section 3.2: Behavioural Disorders
<b>Bipolar</b>	No specific evidence
<b>Body Dysmorphia Disorder</b>	No specific evidence
<b>Chronic Fatigue Syndrome</b>	No specific evidence
<b>Eating Disorders</b>	Section 3.1.4 Feeding and Eating Disorders
<b>Insomnia</b>	No specific evidence
<b>Mood Disorders, including Depression</b>	Section 3.1 Emotional Disorders, and specifically section 3.1.1: Depressive Disorders

<b>Schizophrenia / Psychosis</b>	No specific evidence
<b>Self Harm / Interpersonal Difficulties</b>	Section 3.1.2: Self-harm
<b>Substance Use Disorders</b>	No specific evidence
<b>PTSD and complex trauma</b>	Section 3.3: Children who have experienced trauma, physical, sexual or emotional abuse, neglect, or family conflict
<b>Neuropsychology and aquired brain injury</b>	No specific evidence
<b>neuropsychology / epilepsy</b>	No specific evidence
<b>Adherence to medication</b>	Section 3.6: Children with a Physical Illness
<b>Chronic Pain</b>	No specific evidence
<b>Procedural Distress</b>	No specific evidence
<b>Support/Coping/Adjustment with chronic illness</b>	No specific evidence