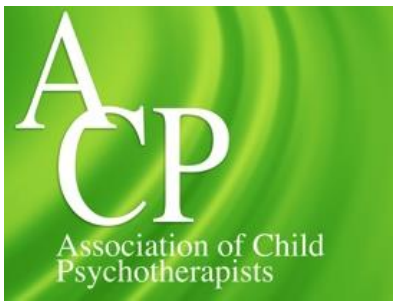


The competence framework for child and adolescent psychoanalytic psychotherapy

Authors

David Hadley
Jason Kaushal
Isobel Pick
Tony Roth
Graham Shulman

CONTENTS

Executive summary

This document identifies the skills and knowledge acquired by Child and Adolescent Psychoanalytic Psychotherapists (CAPPTs) during their six-year training. It describes a framework of the relevant competences, and discusses how this should be applied and its advantages for clinicians, trainers, managers and commissioners.

The framework organises the competences into seven domains, two of which are shared with the *Competence Framework for Child and Adolescent Mental Health Services*, in recognition of the shared competences required for any professional working therapeutically with children and young people. Five domains are specific to Child and Adolescent Psychoanalytic Psychotherapy (CAPP) and are founded upon a set of competences common to all psychoanalytic work.

In recognition of the need to take account of the context of the child, the competences include those psychoanalytic skills needed to work with the health, education, social and family systems around the child.

This report details the competences to be found in each domain and integrates the whole into an interactive 'map'. This assists in understanding how the domains interrelate, with the detailed competences accessible through the online map.

Finally the document addresses issues relevant to the implementation of the competences, their links to the organisational setting and their further development.

Acknowledgments

The work was led by Isobel Pick and David Hadley, CAPPTs, who co-chaired the Expert Reference Group (ERG), whose members are listed in Appendix A. The project was commissioned by the Training Council of the Association of Child Psychotherapists (ACP) through a Working Group whose members are listed in Appendix B. Graham Shulman and Jason Kaushal wrote drafts of the competences for the ERG to consider. The ERG was comprised of members of the ACP with particular expertise in practise and training from across the UK and also lay members from other mental health professions. Professor Tony Roth acted as external consultant to the ERG and the project team. Thanks are due to Anne Horne and Andrew Dawson for editing the final draft, to Sue Kegerreis and Nick Midgley for work on the research competences, to Biddy Youell and Catrin Bradley for work on the peri-natal and parent-infant work competences, and to Lydia Hartland-Rowe and Barbara Lund for advice on the process of this work, and for work on incorporating the framework within the ACP's Quality Assurance Framework for the training of CAPPTs.

A note on terminology: 'Child and Adolescent Psychoanalytic Psychotherapist'

Throughout this report we refer to Child and Adolescent Psychoanalytic Psychotherapists (CAPPTs). In so doing we are referring to therapists trained in psychoanalytic psychotherapy for parent/infant dyads, children, adolescents, parents and families. The professional role has been developed in the UK since the inception of the Association of Child Psychotherapists (ACP) in 1949 and has been commissioned by the NHS for the last 40 years. From 2014 the ACP has been regulated by the Professional Standards Authority, and manages the ACP Register of members in accordance with their high standards for the protection of the public.

Since the mid-1970s, when child and adolescent psychotherapists were recognised as core members of Child and Adolescent Mental Health Services (CAMHS – increasingly now called Children and Young Peoples Mental Health services (CYPMHs)), the Department of Health has recognised the ACP as the regulatory body for the profession and the historic title Child Psychotherapy has been used to define grades, pay scales and the commissioning of training. This title is in effect shorthand for Child and Adolescent Psychoanalytic Psychotherapist (or CAPPT) a term that more fully describes therapists with the specific training in CAPP. Others with distinct and less intensive trainings now use the title of 'Child Psychotherapist': to avoid confusion we have used the term CAPPT in this document.

The competences described are those that are required of CAPPTs at the point of qualification. They extend far beyond the competences required to work in the consulting room, reflecting the professional role of CAPPTs as part of multi-disciplinary teams in mental health services in a wide range of work settings.

Authorisation of the professional body

The decision to adopt these terms and the competences required at qualification was ratified by the Expert Reference Group and formally authorised by the Training Council and Board of Directors of the Association of Child Psychotherapists who commissioned the work.

Developing the competences

Oversight and peer review

The work described in this project was overseen by an Expert Reference Group (ERG), which included members of the ACP and members of other clinical, academic and research professions in child mental health. ACP members of the group were identified on the basis of their expertise in child and adolescent psychoanalytic psychotherapy: for example, through the extensive delivery of training and supervision in the field, through the development of innovative applications of child and adolescent psychoanalytic psychotherapy to particular work contexts or patient groups, or through the evaluation of research trials. The composition of the ERG ensured as far as possible representation from regions across the United Kingdom as well as representation of different theoretical orientations within the field, and a very wide range of clinical specialisms. Professor Tony Roth, who through his work with CORE at University College, London has extensive experience of developing competence frameworks, including those for CAMHS and Psychodynamic Psychotherapy with adults, was invited to act as an external consultant to the ERG in order to provide consistency with previously published competence frameworks.

The ERG helped to identify the research studies, manuals, and basic texts most relevant to CAPPTs. It aimed to ensure that the process of extracting competences was appropriate and systematic and established competences that were meaningful for child and adolescent psychoanalytic psychotherapists at the point of qualification.

Child and Adolescent Psychoanalytic Psychotherapy and the evidence base

The approach taken across other competence frameworks developed by UCL is to start by identifying therapeutic approaches with the strongest claims for evidence of efficacy, based on outcomes in clinical controlled trials. Almost invariably the therapy delivered in these trials is based on a manual, which describes the therapeutic approach and associated methods

However, there are a number of drawbacks in relying exclusively on clinical trials and treatment manuals in the development of a competence framework such as this. One concern is that this inappropriately narrows the evidence on which we can draw, partly because trials such as this may be hard to conduct, for example, research funding may not be forthcoming, but also because they tend to focus on clinical populations (e.g. those with a single diagnosis) which do not reflect the complex, co-morbid presentations that are the norm in a modern Child and Adolescent Mental Health Service (CAMHS). More fundamentally however, there is a view that evidence from clinical trials needs to be supplemented by ‘practice-based’ outcome studies, collecting data in the context of everyday clinical practice with everyday patients (Richardson, 2003), as well as qualitative approaches, or trials that are more process oriented. All these methods can contribute towards a better understanding of both the effectiveness of a treatment, but equally importantly to an

understanding of the mechanisms of change involved, and the acceptability of that therapy to service users. For treatment approaches where there is a great deal of expert consensus, but less empirical research, there is also a need to draw on professional opinion, as well as the views of training organisations and the views of service users.

In the case of CAPP, there is now a small, but growing evidence base of outcomes in clinical controlled trials. (Four systematic meta-analytic studies by Abbas et al. (2013), Barlow et al. (2016), Palmer et al (2012) and Midgley et al. (2017) are described in Appendix D) The majority of these studies were undertaken in clinically referred samples rather than samples recruited for research, involving children with a range of diagnoses or problems and involving trained psychotherapists. These findings from practice based evidence are likely to have greater relevance to the 'real world' setting. Midgley's (2017) systematic review found that many of the children included in studies had high levels of clinical disturbance, and most trials made use of a broad range of outcome measures, including standardized psychiatric and psychological measures. Most studies were of children presenting with a range of difficulties, rather than one specific diagnostic group, although some also focused specifically on particular diagnostic categories.

There has been a considerable growth in the literature of CAPP over the last 40 years, represented both in the Journal of Child Psychotherapy and in a wide range of influential, international publications (e.g. Tustin, 1986; Alvarez, 1992; Waddell, 2002). The current surge in research activity is linked both to the development opportunities for doctoral work in CAPP and to the recognition of the importance of adding to the evidence base for CAPP clinical approaches. While the summary in Appendix D indicates the growing body of evidence in support of the effectiveness of CAPP, it also suggests that more research is needed to understand the mechanisms of change, and to help identify which children and young people, under what circumstances, are likely to most benefit from this approach.

Identifying the competences

The competences were developed from five sources: manuals of controlled trials of CAPP, key textbooks in the field, pre-existing competences frameworks, learning outcomes developed by ACP-accredited Training Schools and professional consensus within the ERG.

There were some therapy manuals to draw on (see Appendix C), but more frequently descriptions of the practice of CAPPTs are available in textbooks that combine statements of theory with indications of specific practice. The ERG drew on a series of core texts that were considered to be representative of child and adolescent psychotherapy (for example those used by courses in the field listed in Appendix C), from which competences were extracted.

A further and significant source of competences was two pre-existing (and highly pertinent) competence frameworks: the *Competence Framework for Psychoanalytic/Psychodynamic Psychotherapy*, and the *Competence Framework for Child and Adolescent Mental Health Services*. Both of these frameworks utilised a range of manuals and source materials, and these are

detailed in the associated background documentation (at www.ucl.ac.uk/CORE/).

The ERG also drew on the extensive work that had already taken place within ACP-accredited training schools on the development of competences, listed or described in CAPP Training School course handbooks or documents. Competence frameworks or documents of related professions (Clinical Psychology, Psychiatry, Social Work, Counselling) were also consulted and drawn on. Finally, competences were developed on the basis of strong professional consensus within the ERG regarding their importance and value.

Future developments

This report is a 'living document', in the sense that it is based on the evidence available at time of development, but may be revised and updated as new data and areas of practice emerge. For instance, further controlled trials are already under way and may augment – or challenge – the competences detailed in this document.

In addition, competences for post-qualification training and professional development are under consideration, covering areas of expertise such as clinical and service supervision of CAPPTs and professionals from other disciplines, a core area for many CAPPTs working in hard-pressed multi-disciplinary teams in public services and elsewhere.

Scope of the work

THE WORK OF CHILD AND ADOLESCENT PSYCHOANALYTIC PSYCHOTHERAPISTS

Unlike some therapies offered to infants, children and young people, child and adolescent psychoanalytic psychotherapy is not a single therapeutic modality, but rather a powerful combination of skills, knowledge and experience that can be applied to a wide range of patients, groups and work contexts. This equips CAPPTs with the capacity to work with complex cases characterised by severity of disturbance, co-morbidity and, often, multi agency involvement.

The cornerstone of the approach is an observational, reflective stance which, allied with an understanding of the unconscious mind and its manifestations, allows therapists to work with patients, their families and the wider systems around them. In CAMHS services CAPPTs are often needed to work with cases where the patient has not responded to therapist led treatments. CAPPTs are trained to focus especially on observation of the relationship the patient makes with the therapist and the treatment, using this as a source of understanding of the patient's difficulties.

CAPPTs draw on knowledge of child development and its vicissitudes from before birth to adolescence. This involves an understanding of the complex interaction between the life experiences of the child and their internal world and psychic development, conscious and unconscious. Psychoanalytic child and adolescent psychotherapy requires the capacity to identify and differentiate between the impact of deficits in the formative experiences children need in order to develop, and unconscious defences against change and growth. It also requires knowledge of the range of developmental disorders that can contribute to developmental delay and the ability to work with the conscious and unconscious meaning of these for patients.

CAPPTS do not just work alone in the consulting room, but often as part of multi-disciplinary teams in a wide range of public mental health services. This requires a thorough grasp of and ability to work with the mental health, educational and social care systems that support children and families in the UK. The framework therefore includes competences that describe the core therapeutic approach of CAPPT, and also competences that reflect the professional role of the CAPPT within the team, the service and the networks that surround children. The same observational, reflective approach is brought to bear in understanding where emotional distress is held in the family and professional system and thus where an intervention may need to focus.

This framework describes the competences that a CAPPT will have on qualification from an ACP-accredited training. This is a six-year training, comprised of a two-year post-graduate pre-clinical course and a four-year full-time post-graduate training, which combines a wide range of supervised

clinical work in a variety of settings, predominantly in the NHS, with an academic course often leading to a masters or professional doctorate level qualification. A central focus of the training is the development of clinical skills and capacities that enable graduates to withstand and work with complex and deep-rooted emotional disturbance in children, young people, parents and families. This approach has been applied successfully to client groups with a wide range of types and severity of psychopathology. It has also been adapted to work with parents, parent-infant dyads, families and groups, and all CAPPT graduates will be able to work with most of these client configurations. The competences for this range of work are captured in the framework as applications of the central therapeutic approach.

CAPPTs are equipped to work as autonomous members of multi-disciplinary teams in all tiers of CAMHS services and in a wide range of other contexts. They deliver core CAMHS assessment and interventions, offer highly specialist treatments to a range of patient groups in a variety of work contexts, and support other professionals in working with high levels of distress.

Age range

CAPPTs can work with infants, children and young people across the age range from 0-25 years old, depending on the service context. Therapeutic and assessment competences involving work with individual children and young people, and competences for working with mothers in the perinatal period, and for parent-infant work, are described under Specialist Applications and Interventions.

Organisational context

CAPPTs train and work in settings including CAMHS, in-patient units, Looked After Children Teams, hospital and primary care settings, eating disorder services, peri-natal and parent-infant services, learning disability teams, forensic services, schools and other educational settings, and sometimes in voluntary or third sector organisations. They will qualify with experience in one or more of these areas, with the competences to undertake tasks specific to those work settings (such as Choice and Partnership Approach (CAPA), or specific risk assessments) as well as the ability to adapt their core therapeutic approach to the needs of other work settings. For this reason the framework includes competences which describe the core therapeutic approach of CAPPTs, and also competences that reflect the professional role of the CAPPT within the team, the service and the networks that surround children. Thus they describe the skills and knowledge that are required in order to function in these contexts effectively, safely and in the best interests of the young person.

FOUNDATIONS OF CHILD AND ADOLESCENT PSYCHOANALYTIC PSYCHOTHERAPY

Professional foundations

Psychoanalytic psychotherapy with children and young people is a well-established, highly specialist treatment for emotional and developmental difficulties in childhood and adolescence. Its intellectual roots are in psychoanalysis, particularly drawing on the classic contributions of Melanie Klein, Anna Freud, Wilfred Bion and D.W. Winnicott and also in the study of child development. This includes both the more academic and empirical research domain (e.g. Trevarthen, Stern, Murray) and work in the tradition of psychoanalytically informed naturalistic observation of babies and young children (Bick, A. Freud). More recently it has also been influenced by the development of family therapy paradigms, attachment theory (John Bowlby, an early member of the ACP) and the field of developmental psychopathology.

An association of practitioners in this field was set up in 1949 – the Association of Child Psychotherapists (ACP). The first ACP training was established at the Tavistock Clinic under the auspices of John Bowlby and Esther Bick, and trainees and qualified practitioners often worked in the newly established child guidance clinics. This commitment to public service was consolidated in the 1970s when CAPPT was accepted as a core profession of CAMHS within the NHS.

There are now five training schools across the UK. Each school places different emphases on the various psychoanalytic theoretical orientations which have evolved over the last 60 years, but there remains a common approach, still based on the careful observation of verbal and non-verbal communication by the child or young person, and in particular, the detailed tracking and exploration of the relationship between the young person and therapist so that feelings and ideas present and active unconsciously in the patient can become amenable to conscious communication and thought.

Principles and techniques of Child and Adolescent Psychoanalytic Psychotherapy

CAPPTs accept that each human being has a unique combination of neurological, physiological, emotional, social, cultural, genetic and psychological factors, conscious and unconscious, which influence their relationships to people and events. Each child is seen and understood within the context of their family and their wider environment, and careful thought is given to the need for support for parents or carers, and other family members. CAPPTs are trained to provide parent/carer work, work with siblings and to work with families as a whole when appropriate, in a way that is sensitive to their cultural and social environment.

An essential component of the work is the capacity in the therapist to maintain an open, non-judgmental and empathic stance. The roots of this are laid down in the two-year pre-clinical training. Here a detailed, weekly observation of a mother and infant, from birth to two years, and a one-year, weekly observation

of a toddler provide an emotionally intense, purely reflective experience that is psychoanalytically and developmentally informed. This approach is also brought to bear in thinking about the students' organisational context.

Clinical training includes a personal psychoanalysis for the duration of the training, which safeguards a thoughtful and objective stance and supports the development of the self-awareness necessary for the understanding and tolerance of emotional states in oneself and others. Once this is in place, in addition to a broad range of clinical experience, three intensive patients at different developmental stages, of mixed gender and presentations are seen long term, up to five times a week, over the course of the training. Weekly supervision for these cases is provided from three different supervisors. Whilst work at this level within the NHS is infrequent, experience suggests that, as a learning experience and as an intervention, it is unparalleled. The children and young people seen as in need of such work are, with few exceptions, very challenging emotionally and intellectually in terms of the severity and complexity of their difficulties. Alongside the intensive supervision and tutorial support offered within training schools, the personal analysis provides an opportunity for individual vulnerabilities and personal problems to be explored and understood, thus promoting the emotional resilience that is necessary to be able to sustain relationships with such seriously troubled young people whose behaviour will at times be very disturbing. The belief that behaviour is communicative and carries meaning is strengthened by the experiences of reflective observation of others and oneself, limiting the tendency to react without sufficient thought. This capacity to remain thoughtful in the face of distress enables CAPPTs to work more effectively in demanding roles within services under significant pressures of different kinds.

CAPPTs value their grounding in psychoanalytic theory and technique, but also draw on attachment theory and knowledge of child development, neuroscience and research. This range of knowledge allied with the emphasis on close observational skills enables CAPPTs to assess and engage with patients with complex, co-morbid and severe difficulties, and to differentiate and work with developmental delay, deficit, trauma, and other contributors to psychopathology within the child. Helping the child/young person encounter the therapist through their relationship can in itself provide support to the child's emotional and social development. This developmental aspect of CAPP may sometimes be the initial aim of the work with more vulnerable or otherwise less emotionally developed children, helping them to move forward before they can take part more fully in therapeutic work.

The techniques of child psychotherapy are primarily based on close and detailed observation of the relationship the child or young person makes with their therapist and the theoretical assumption that the child or young person's free play, drawings and conversation can be seen as equivalent to 'free association' (Klein). A suitable play-room with toys (for younger children) or simple consulting-room (for adolescents) is required. Sessions take place in this same room and at the same time each week for ongoing therapy, and the regularity of the setting is an essential component of the therapeutic process and relationship. The therapist introduces the context to the child or young person as one for understanding feelings and difficulties in their life. Undirected play and talking are the fundamental sources of the relevant 'clinical facts' (O'Shaughnessy, 1994).

The aim is to put into words the therapist's understanding of what the child communicates through play, behaviour and verbal expression. This will include conscious and unconscious thoughts and feelings. The therapist attempts to convey an openness to all forms of psychic experience – current preoccupations, memories, day-dreams, fantasies and dreams – but will be attuned specifically to evidence of unconscious phantasies which underlie the child or young person's relationship to self and others. This attentiveness to unconscious phenomena is specific to psychoanalytic psychotherapy, is related to the theoretical importance attributed to these deep layers of the mind, and is closely linked to the techniques employed by the therapist.

These principles underlie the focus on the transference relationship made to the therapist. That is, the relationship made not in response to 'real' aspects of the therapist's person and behaviour, but arising from the way in which people are characterised in the young person's internal world. This picture of the world and people in it can be externalised (projected) on to the therapist, so that the child perceives them to have these qualities. Systematic observation of these transference elements allows for clarification of the young person's fundamental assumptions about the external world. The anxieties that underlie these beliefs, (which are also related to Bowlby's concept of "internal working models" of attachment) can be analysed and discussed, thus enabling the child or young person to begin to differentiate psychic from external reality. As a result the young person may become more able to test out reality, and establish a fruitful relationship to it.

Also important as a source of information to the therapist are the emotional responses evoked in her/him by the child or young person. These are broadly referred to as 'countertransference' phenomena. They can include personal factors which intrude and distort the therapist's capacity for objective understanding, but also many responses arising from primitive non-verbal forms of communication (projective identifications) which the therapist becomes aware of. These are somewhat similar to the ways in which infants can communicate to their caretakers prior to the development of language, and depend on emotional availability and space for 'reverie' (Bion, 1965) in the therapist. These primitive modes of relationship can be used to control anxiety by ridding oneself of it and pushing it elsewhere rather than for communicative purposes.

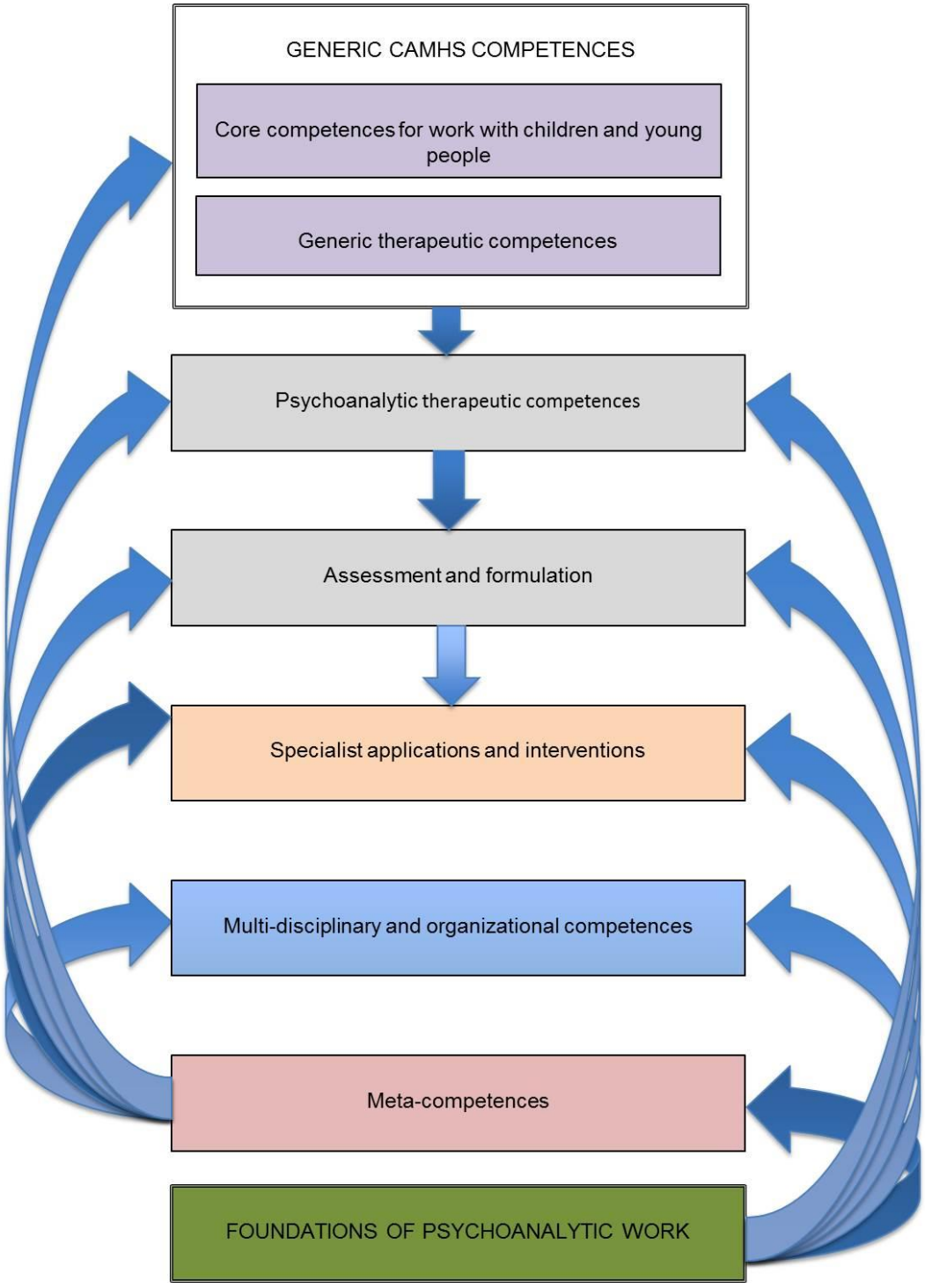
Toys used by a pioneer of therapeutic work with children, Melanie Klein

The competence framework for child and adolescent psychoanalytic psychotherapists

The structure and content of the framework

Figure 1 shows the way in which competences have been organised into seven domains and how they relate hierarchically to each other.

Figure 1: The structure and content of the competence framework



Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid or they are too vague to be of use. The aim has been to develop competence lists ordered in a way which reflects the practice they describe, set out in a framework that is both easily grasped and recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application.

From the outset it was clear that a CAPPT competence framework would be substantively different from the model developed for modality-specific frameworks for Adult Mental Health. It would need to describe the particular competences associated with psychoanalytic therapeutic work, but also include the competences that the work of CAPPTs shares with other approaches offered within CAMHS, and the competences that describe the professional role associated with CAPPT as practised in the context of CAMH services.

This means the framework needs to:

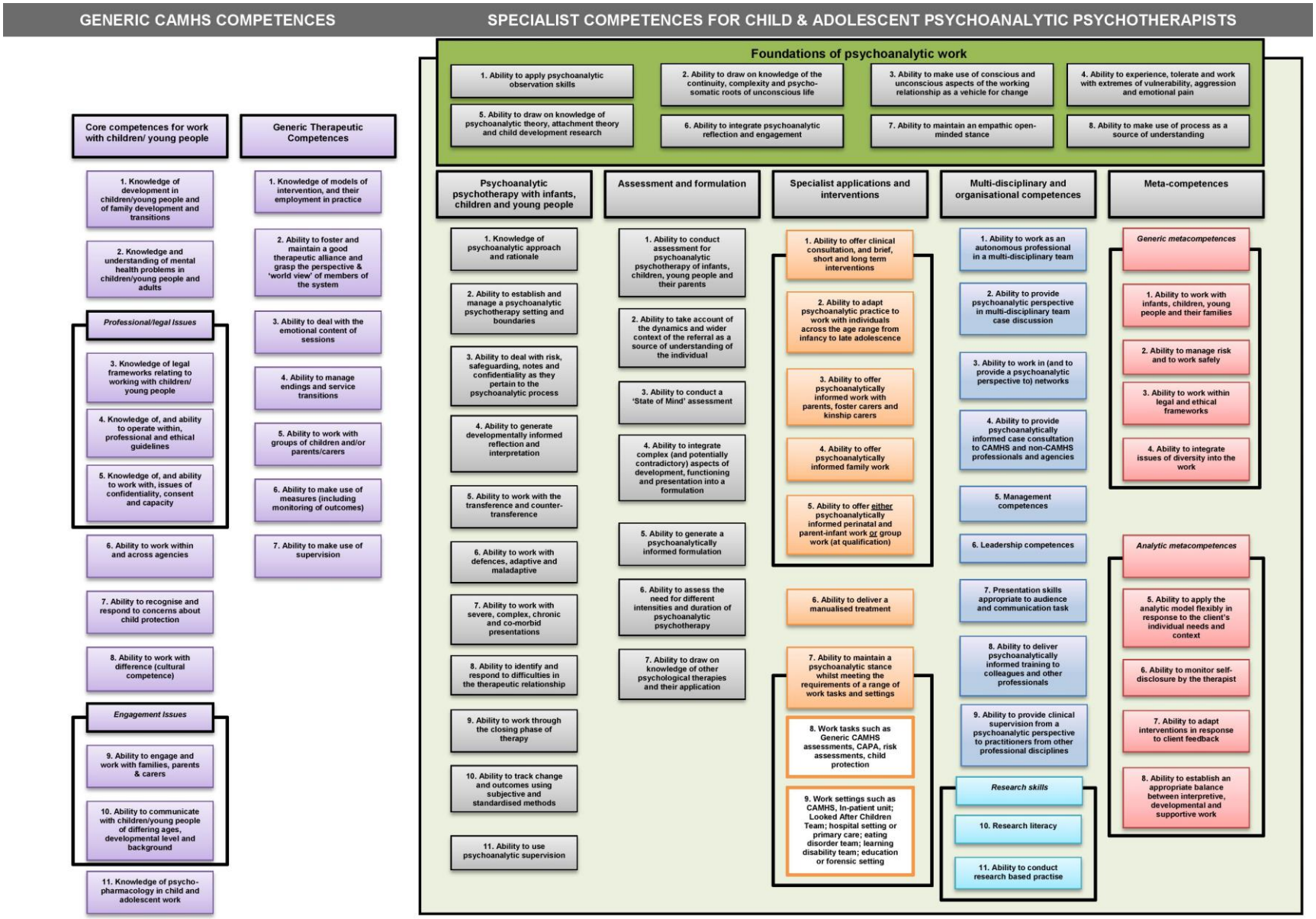
- describe the competences needed for effective work with the patient(s) in the therapy room

and also

- recognise that, as well as focusing on an individual client, most CAPPT interventions, like other interventions in CAMHS settings, are ‘systemic’ in that when children and adolescents present with problems, these are best understood in the context of their family life and the wider interpersonal contexts in which they function (for example in school, or their peer relationships)
- recognise that work in CAMHS frequently requires close liaison with other team members, and also with individuals from a range of agencies who may also be involved with a child or young person
- identify the professional and legal responsibilities inherent to CAMHS working – for example, safeguarding children and identifying and responding to concerns regarding risk.

This is reflected in the colour coding of the boxes in Fig.1 which is replicated in the columns of the map in Fig. 2 on the next page.

Figure 2: The map of competences for CAPPTs



The map framework begins with two domains of competences in columns 1 and 2 held commonly across CAMHS. The first is '**Core Competences For Work With Children And Young People'**, which identifies the knowledge and skills needed by staff to a) orient them to the styles of work which characterise contact with children, young people and their families, b) liaise with CAMHS colleagues and other agencies, and c) apply the professional and legal frameworks which exercise governance over CAMHS procedures. The second of these is '**Generic Therapeutic Competences'** which identifies the competences required to manage clinical sessions and any form of psychological intervention. Taken together, the skills in these two domains should be demonstrated by all CAMHS workers as they secure the integrity of *all* CAMHS assessments and interventions.

The next five columns describe the specialist competences of CAPPTs.

Overarching these five specialist domains, in the green box, are the '**Foundations of psychoanalytic work'**. These capture the knowledge and skills which define the particular approach that informs all the psychoanalytic domains described below it.

'**Psychoanalytic therapeutic competences'** in column 3 describes the skills and knowledge required to carry out effective psychoanalytic therapeutic work with children and young people. Here the focus is on the work with the referred child or young person. Work with parents and liaison with other professionals and organisations is covered in other domains.

CAPPTs are required to be able to provide '**Assessment and Formulation'** including State of Mind assessments, Emotional State Assessments, risk assessments and assessment for therapy. The competences needed for this, including the need to see the child in the context of the family and wider network, to formulate a view, consider and recommend a range of treatment options and interventions, are described in column 4.

Individual work with children and young people is only one part of the work of a qualified CAPPT. The domain '**Specialist applications and interventions'** (column 5) covers the competences needed to apply therapeutic competences to a range of interventions with different patient groups and in a range of work contexts. The domain is divided into three sections. The first describes the competences needed to be able to offer a range of psychoanalytic interventions. At the point of qualification, CAPPTs will have gained a very wide variety of experiences in psychoanalytic therapeutic work with individual children and adolescents; of work with parents, carers or foster carers; of work with family groups; and of group work or perinatal/parent-infant work. These can all be offered as clinical consultation or as brief, short or long-term work as indicated by clinical need. The second section covers the competences needed to apply a manualised treatment model such as Short Term Psychoanalytic Psychotherapy (STPP). The third section covers the competences needed in particular work settings, since CAPPTs train and work in a wide range of organisational contexts. Many gain experience, during training and beyond, of work in specialist services and in community settings such as primary care or schools: the range of possible work contexts is indicated in the white box.

Multi-disciplinary and organizational competences (column 6): the ability to work effectively as an autonomous professional within a multi-disciplinary team, knowledge of the wider organisational context and engagement with research are all essential to support effective practice. CAPPTs are trained to a high level of expertise and qualify as autonomous professionals able to manage a case load, to relate effectively to the management structure of their organisation, taking on leadership roles as appropriate, and to provide training and supervision to other professionals from other disciplines.

CAPPTs routinely communicate with professionals from other agencies such as schools and social work, as well as drawing on the expertise of other disciplines within the CAMHS team itself. Inter-agency and inter-disciplinary working requires a knowledge of the responsibilities of the other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation**.** It also demands skills in information sharing and communication as well as the ability to contribute to the co-ordination of case work, and the ability to recognise and manage challenges to effective inter-agency working.

CAPPTs engage in understanding and applying a range of research methodologies essential to developing effective practice throughout and beyond their training, described in '**Research Skills'**. These include quantitative health outcome studies as well as the in-depth case study methodologies and particular approaches to process analysis that are referred to as 'psychoanalytic research' in the framework.

The final domain in the framework focuses on '**Meta-competences'**, so-called because they permeate all areas of practice. Meta-competences are characterised by the fact that they involve making procedural judgments – for example, judging when and whether something needs to be done, or judging how an intervention needs to be made or to be modified. They are important because such judgments are seen by clinicians as critical to the fluent delivery of an intervention.

Note on terminology

In the domains for psychoanalytic psychotherapy and for assessment and formulation, the competences refer to work with the 'patient', since the focus here is the work with the referred child or young person. In other domains, where the focus may be parents or carers, families or colleagues in the MDT or wider network, the term 'client' is used.

Integrating knowledge, skills, attitudes and personal qualities

A competent CAPPT brings together knowledge, skills and attitudes, as well as personal qualities: it is this combination that defines competence; an ability to integrate these areas is a prerequisite for good practice.

CAPPTs need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills and also judgment, to think not just about *how* to implement their skills, but also *why* they are implementing them.

Beyond knowledge and skills, the CAPPT's stance and attitude to therapy is also critical – not just their attitude to the relationship with the child or young person, but also to their parents or carers, the wider family, the organisation in which treatment is offered, the network supporting the child and family, and the many cultural contexts within which the organisation and network are located (which includes a professional and ethical context, as well as a societal one). In addition the CAPPT needs to integrate the knowledge and skills with their own personal qualities and make them their own. In this way they can engage genuinely with the difficulties of patients in a sensitive but robust way. All of this needs to be held in mind by the CAPPT, since all have a bearing on the capacity to deliver a treatment that is ethical, conforms to professional standards, and is appropriately adapted to the child or young person's needs and cultural contexts.

Using the map of competences for child and adolescent psychoanalytic psychotherapists

The map of competences for child and adolescent psychoanalytic psychotherapists is shown in Figure 2. It organises the competences in the seven domains into columns, plus the overarching foundations as outlined above, and shows the different activities, each in its own box, which, taken together, constitute each domain. Each activity is made up of a list of detailed competences, which can be seen by clicking on the relevant box in the interactive map.

The interactive map, with an introduction on how to use it, is on our website. Direct access to that interactive map can be made through http://childpsychotherapy.org.uk/competence-map-child-and-adolescent-psychoanalytic-psychotherapists-point-qualification.

Access to the lists of competences for each of the boxes, independently of the map, can be found at http://childpsychotherapy.org.uk/core-competences-child-and-adolescent-psychoanalytic-psychotherapy.

The map shows the ways in which the activities fit together and need to be integrated in order for practice to be proficient.

The boxes in the map are coloured differently to indicate the structure of the map as a whole. The first two columns are the same colour as the competences in these columns are all generic competences from the CAMHS competence framework. The boxes that are not coloured contain lists (of work contexts for example) not competences.

Using the competence lists

The competences 'within' each box are laid out in numbered lists. The ordering of competences attempts, where possible, to mirror the natural sequence of skills and knowledge in clinical practice. At a number of points the competences have subsections and indented sections. This occurs when a higher level skill is introduced, and needs to be 'unpacked'.

Because the competences within each set are developed as a whole, some competences are repeated across the framework. Wherever possible, we have attempted to minimise duplication; but we have also been mindful of ensuring that each competence set gives a comprehensive, detailed and integrated description of the abilities necessary for its attainment.

As with the overall layout of the map it is the integration of the specific skill or area of knowledge into the whole that best expresses the purpose of the competence framework. **The competences are not intended to be applied or assessed as a set of specific skills or areas of knowledge to be accumulated independently.**

In the therapeutic competences, most obviously in ‘Assessment and Formulation’, there is reference to the way in which psychotherapy is organised and delivered – for example, the duration of each session, frequency of sessions, and whether the therapy is time limited or longer term. This includes consideration of the range of interventions and resources available in the service, the resources of the family and those of the supporting network. The competences describe the way in which the weighting of these factors is a central part of the work of a CAPPT.

It is insufficient to see the therapeutic procedures, alone, as the basis for change, because this divorces methods from the support systems that help to ensure the delivery of competent and effective practice. Hence, claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with implementation is neglected. In this respect, practitioners working within the psychoanalytic competence framework will be best supported by supervisors who are also skilled in this work.

The present competence lists represent the detailed and considered record of a strong working group with expertise and experience relevant to their involvement here. At this stage empirical evidence as to the relative merits of individual competences is insufficient to differentiate between them in terms of effectiveness. The likelihood is that it is the combination of competences described here that is effective, that is to say the whole is greater than the sum of its parts. With this qualification, it has the approval of the professional body and will act as a benchmark for further refinement and improvement as new evidence comes to light.

Applying the competence framework

This section sets out the various uses to which the CAPPT competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed.

Training

Two key aims of the development of this framework were to:

- create a framework to guide the ACP-accredited training schools to develop a curriculum & training experience that is fit for purpose
- support the training schools in their task of developing a child psychotherapy workforce that best meets the needs of infants, children, young people and families.

Effective training is vital to ensuring increased access to well-delivered psychotherapy. The framework will support this by:

- providing a clear set of competences which can guide and refine the structure and curriculum of training programmes accredited by the ACP across the UK.
- providing a basis on which training schools can develop methods for the assessment of trainees qualifying from ACP-accredited training programmes, thus assuring the high levels of proficiency met by qualified members of the ACP.

Accreditation

The Quality Assurance Framework of the ACP, of which the competence framework forms a part, assures a high level and quality of training experience, and high standards of proficiency amongst qualified members of the ACP.

The framework also help the ACP Professional Standards Committee to assess requests by Child Psychotherapists qualified in the EU or Overseas, judge their suitability to become a member of the ACP and thus to practise in this country.

Practice

The competence framework provides a valuable reflective tool whereby individual CAPPTs can assess their current knowledge and skills and identify areas for continuing professional development (CPD). It also provides opportunities for ‘self-supervision’ whereby CAPPTs can reflect on their practice with individual clients and consider the extent to which they are demonstrating the competences necessary for effective practice.

Research

The framework has the potential to make a major contribution to research in the field by establishing a common set of principles and practices that can be evaluated in controlled trials in naturalistic outcome studies and practice-based research studies (i.e. those that do not have control groups, but take place in 'real world' settings). Other areas of research in which the framework can contribute include the further exploration of the relationship between therapy process and outcome, and the evaluation of training programmes and supervision systems.

Commissioning

The framework can contribute to the development of effective services and use of resources by clarifying the distinctive strengths and contribution of CAPPTs as part of local multi-disciplinary services. This will enable commissioners to specify the appropriate levels and range of psychotherapy for identified local needs.

It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and development of psychological therapy services

The framework represents a set of competences that describe best practice – the activities that qualified CAPPTs should be able to undertake.

Although further work is required on the utility of the competences and associated methods of measurement and auditing, they will enable:

- the identification of the key competences required to be an effective CAPPT working with infants, children, young people and families
- the identification of the range of competences that a service or team should demonstrate in order to meet the needs of young people
- the likely training and supervision competences needed amongst those managing the service.

Continuing professional development (CPD)

The framework, in providing a map of competences at the point of qualification does not address the development of CAPPTs beyond this. In common with other professionals, CAPPTs will deepen and extend their skills in addition to ensuring that those they have are kept up to date with contemporary practice.

Supervision

The framework provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences known to be associated with effective practice by CAPPTs.

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The framework could achieve these aims through its integration into professional training programmes and through the specification of the requirements for supervision in both local commissioning and clinical governance programmes.

Supervisor training

It is important that therapists receive supervision from supervisors who themselves have knowledge of relevant competence frameworks, and who can also demonstrate their own competence in the requisite skills, knowledge and attitudes that ensure high quality supervision. The ACP is developing a set of competences for supervisors, and ACP training schools have developed trainings for service supervisors and clinical supervisors which could form part of these future competence frameworks.

Concluding comments

This document describes a framework that identifies the activities that characterise effective interventions by CAPPTs with young people, and locates them in a ‘map’ of competences.

The work has been guided by two overarching principles. First, it stays as close to evidence based practice as possible, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for young people. Second, it aims to be helpful for those who use it, clustering and ordering competences in a manner that reflects the way that CAPP is actually delivered and hence facilitating their use in routine practice.

Putting the framework into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, research or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, not in isolation. Delivering effective psychoanalytic psychotherapy involves the application of a complex matrix of knowledge and skills, as well as personal qualities, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Therapists of all persuasions need to operate using clinical judgement in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and the infants, children, young people and families that they work with.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the health and care system. The more stringent test is whether it results in increasingly effective interventions and better outcomes for clients.

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Appendix A – Membership of the Expert Reference Group

David Hadley – Co-chair: CAPPT in independent practice
Isobel Pick - Co-chair, Consultant Child and Adolescent Psychotherapist, Tavistock and Portman Trust, Chair of ACP's Training Council
Graham Shulman – Drafting pair, Consultant Child and Adolescent Psychotherapist, Head of Child Psychotherapy, CAMHS NHS Lanarkshire
Jason Kaushal – Drafting pair, Child & Adolescent Psychoanalytic Psychotherapist, 'Training Portfolio Lead', Northern School of Child & Adolescent Psychotherapy
Tony Roth – Consultant, Professor of Clinical Psychology and Joint Course Director, Doctorate in Clinical Psychology, University College London
Heather Stewart – Chair of ACP

Dr Louise Allnutt - Lead Child and Adolescent Psychotherapist at Mosaic CAMHS
Neil Austin - Consultant child and adolescent psychotherapist, Trust head of child psychotherapy Great Ormond Street Hospital for Children NHS Foundation Trust
Anne Alvarez - Consultant Child and Adolescent Psychotherapist, Visiting Lecturer and retired co-convener of autism workshop, Tavistock
Kevin Booth - Head of Training, Director of BTPP, Consultant Child Psychotherapist
Catrin Bradley - Head of Child Psychotherapy Training, Tavistock and Portman NHS Foundation Trust
Dr Andrew Dawson - Professional Lead for Child Psychotherapy, Specialist Children's Services, NHS Greater Glasgow and Clyde
Ricky Emanuel - Consultant child and adolescent psychotherapist and Head of Child Psychotherapy Services at the Royal Free hospital
Ann Horne - Consultant Child & Adolescent Psychotherapist (semi-retired)
Sue Kegerreis - Senior Lecturer, Centre for Psychoanalytic Studies, University of Essex
Dr Eilis Kennedy - Consultant Child and Adolescent Psychiatrist and Director of Research and Development, the Tavistock and Portman NHS Foundation Trust
Patricia Langton - Child & adolescent psychoanalytic psychotherapist
Dr Duncan Law - Consultant Clinical Psychologist, Consultant Clinical Associate at the Anna Freud National Centre for Children and Families & Director of MindMonkey Associates
Nick Midgley - Senior Lecturer at UCL and co-director of the Child Attachment and Psychological Therapies Research Unit (ChAPTRe) at the Anna Freud National Centre for Children and Families / UCL
Lisa Miller - Consultant Child Psychotherapist, Visiting Lecturer, Tavistock Clinic
Selina Perocevic - Consultant Child & Adolescent psychotherapist/Head of Service
Margaret Rustin - Honorary Consultant Child and Adolescent Psychotherapist

Rajni Sharma - Consultant Child & Adolescent Psychotherapist, Manchester/Salford CAMHS & NSCAP
Janet Shaw - Director of Clinical Training, NSCAP
Janine Sternberg - Clinical Course Director, Independent Psychoanalytic Child & Adolescent Psychotherapy Association, British Psychotherapy Foundation
Biddy Youell - Consultant child and adolescent psychotherapist (retired) visiting lecturer at Tavistock

Appendix B – Membership of the Quality Assurance Framework Working Group

The ERG was commissioned by a working group of the ACP's Training Council, the QAF Working Group. This was commissioned to review and update the Quality Assurance Framework (QAF) for the training of CAPPTs.

Isobel Pick, Consultant Child and Adolescent Psychotherapist, Tavistock and Portman Trust, Chair of ACP's Training Council
Lydia Hartland-Rowe
Barbara Lund
Kevin Booth
Janet Shaw
Andrew Briggs
Susannah Marks
Nick Midgley
Catrin Bradley
Patricia Langton
David Hadley
Phillip McGill

Appendix C – List of sources

1. Texts, manuals and sources of manuals

UCL/NES CAMHS Competence Framework
UCL Psychodynamic Competences Map
UCL PPC Basic Analytic Competences
UCL PPC Specific Analytic Techniques
Practice Parameter For Psychodynamic Psychotherapy With Children - American Association of Child and Adolescent Psychiatry
Psychoanalytic Psychotherapy Handbook - American Association Of Child & Adolescent Psychiatrists
Short Term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual

Tavistock/NSCAP/Essex Course Handbook for Clinical Training in Child Psychotherapy
Tavistock Clinic Placement Handbook for Clinical Training in Child Psychotherapy
Birmingham Trust For Psychoanalytic Psychotherapy Child Psychotherapy Course Handbook
Human Development Scotland Child Psychotherapy Course Handbook
IPCAPA Criteria for evaluating trainees

BPS Standards For Doctoral Programmes In Clinical Psychology
Social Work Competences framework
A Competency Based Curriculum For Specialist Training In Psychiatry – Core Module Royal College Of Psychiatrists

The Association Of Child Psychotherapists (ACP) Quality Assurance Framework For The Training Of Child Psychotherapists
ACP Research Competences Document
ACP Guide to Code Of Professional Conduct And Ethics

2. Background texts drawn on as helpful sources of information regarding child and adolescent psychoanalytic psychotherapy

Alvarez (2012) *The Thinking Heart: Three Levels of Psychoanalytic Therapy with Disturbed Children*, Routledge, East Sussex.

Anastasopoulos, Laylou-Lignos and Waddell (eds.) (2011) *Psychoanalytic Psychotherapy for the Severely Disturbed Adolescent,* Karnac, London

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Tsiantis, Sandler, Anastasopoulos and Martindale, (eds.) (2011) *Countertransference in Psychoanalytic Psychotherapy with Children and Adolescents*, Karnac, London.

Williams (2011) *Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies*, Karnac, London.

Tsiantis, Boethious, Hallerfors, Horne and Tischler (eds.) (2011) *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescents*, Karnac, London.

Appendix D – Research Digest

In addition to the evaluation of treatment outcomes, Child and Adolescent Psychoanalytic Psychotherapists are actively engaged in a wide range of research (Midgley et al., 2009). It should be recognised, though, that there are strengths and limitations to the research designs used to evaluate all forms of psychotherapy and questions still remain about how well such findings can be translated to the actual clinical setting.

A meta-analysis of short-term psychoanalytic psychotherapy with children and adolescents (Abbass et al., 2013), identified 11 studies with a total of 655 patients covering a broad range of conditions including depression, anxiety disorders, anorexia nervosa, and borderline personality disorder. STPP did not separate from what were mostly robust treatment comparators, but there were some subgroup differences. Robust (g ¼ 1.07, 95% CI ¼ 0.80–1.34) within group effect sizes were observed suggesting the treatment may be effective. These effects increased in follow up compared to post treatment (overall, g ¼ 0.24, 95% CI ¼ 0.00–0.48), suggesting a tendency toward increased gains. The review concluded that STPP may be effective in children and adolescents across a range of common mental disorders; however heterogeneity was high across most analyses, suggesting that this data need be interpreted with caution.

With regard to parent-infant psychotherapy, Barlow et al.'s 2016 meta-analysis, based on a 2015 Cochrane Review, identified eight studies that provided data comparing parent–infant psychotherapy with a no-treatment control group (four studies) or comparing PIP with other kinds of treatment (four studies). Meta-analyses indicated that parents who received PIP were more likely to have an infant who was rated as being securely attached to the parent after the intervention; however, there were no significant differences in studies comparing outcomes of PIP with another model of treatment. The meta-analytic review concluded that although PIP appears to be a promising method of improving infant attachment security, there is inconclusive evidence of its benefits in terms of other outcomes, and no evidence to show that it is more effective than other interventions for parents and infants. However many studies had limitations in their design, making any firm conclusions difficult to draw.

Whilst the Abbas et al. (2013) and Barlow et al. (2016) meta-analyses restricted themselves to controlled trials of short-term psychoanalytic psychotherapy and parent-infant psychotherapy respectively, there have been two systematic reviews (Palmer et al., 2012; Midgley et al., 2011, 2017) which have assessed the evidence for psychoanalytic psychotherapy with children and young people more broadly. The most up-to-date review (Midgley et al. 2017) Palmer includes over 50 studies, of which thirteen are randomized controlled trials (RCTs). A vast majority of these studies were undertaken in clinically referred samples rather than samples recruited for research, involving children with a range of diagnoses or problems and involving trained psychotherapists. This would indicate that the findings are likely to have relevance to the ‘real world’ setting. The 2017 systematic review found that many of the children studied had high levels of clinical disturbance, and most

of the studies made use of a broad range of outcome measures, including standardized psychiatric and psychological measures. Most studies were of children presenting with a range of difficulties, rather than one specific diagnostic group, although some studies also focused more specifically on particular diagnostic categories.

The systematic review noted that the number of clinical trials evaluating CAPPT has gradually been increasing, with five such studies published since 2011. One of these RCTs, the IMPACT study (Goodyer, 2016) is the largest study to date to include a psychodynamic treatment arm either in children or adults (n=465). IMPACT was a pragmatic trial comparing two specialist therapies, Short-Term Psychoanalytic Psychotherapy (STPP) and Cognitive-Behavioural Therapy (CBT), with a brief psychosocial intervention (BPI), in the treatment of depression in adolescents (aged 11-17) (Goodyer et al., 2016). 465 participants who met criteria for moderate to severe depression were recruited into the trial. 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-morbid 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 as 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, compared with 75% and 73% in the CBT and BPI arms respectively. This difference was not found to be statistically significant, but does provide an indication of the effectiveness of STPP in terms of long-term depression remission. This would suggest that extending the provision of psychodynamic psychotherapy as a treatment option for children and young people with a variety of clinical diagnoses where it shows promise as an intervention is warranted.

The four other Randomised Controlled Trials published since 2011 (Balottin et al., 2014; Kolaitis et al., 2014; Rossouw & Fonagy, 2012; Salzer et al., 2013) had relatively small sample sizes (n=33, 72, 80 and 66 respectively), yet all studies showed potential benefits of a psychodynamic treatment for patients with complex and severe difficulties (self-harm and depression; adolescent with co-morbid diagnoses; and idiopathic headaches), indicating that further randomized evaluation involving a larger sample of adolescents could more definitively evaluate whether this is a treatment that might benefit young people with such complex conditions.

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