What do we know about the effectiveness of psychodynamic therapy for young people?

Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base
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For many years psychoanalytic and psychodynamic therapies have been considered to lack a credible evidence-base and have consistently failed to appear in lists of 'empirically supported treatments'. This study systematically reviews the research evaluating the efficacy and effectiveness of psychodynamic psychotherapy for children and young people. The researchers identified 34 separate studies that met criteria for inclusion, including nine randomised controlled trials. While many of the studies reported are limited by sample size and lack of control groups, the review indicates that there is increasing evidence to suggest the effectiveness of psychoanalytic psychotherapy for children and adolescents. The article aims to provide as complete a picture as possible of the existing evidence base, thereby enabling more refined questions to be asked regarding the nature of the current evidence and gaps requiring further exploration.

\textbf{Keywords:} child and adolescent psychotherapy; evidence-based practice; effectiveness; efficacy; outcome studies; psychodynamic psychotherapy
The treatment of depression in children and young people

Efficacy of Psychoanalysis for Children with Emotional Disorders

MARY TARGET, PH.D., AND PETER FONAGY

ABSTRACT

Objective: This is the second report from a chart review of 769 cases of child psychoanalysis at the Anna Freud Centre. Method: Three hundred fifty-two children and adolescents met diagnostic criteria for emotional disorders or who had sleep or somatoform symptoms with dysfunction. Of these, three hundred fifty-four were treated in full psychoanalysis, the remainder one to three times a week. Outcome was indicated by diagnostic change and by change in overall adaptive functioning as measured by the Global Assessment Scale (CGAS). Results: Of those treated for at least 6 months, 24% relapsed at termination, and 16% still had anxiety at termination. Patients with MDD were most likely to remit, and depressed children were least likely to return to normal by the end of treatment. Greater improvement in children with longer duration of illness was also associated with a greater likelihood of remission. Conclusions: Despite methodological limitations, the study identifies predictors of outcome (e.g., age, severity, and duration of illness) and shows that even high-risk children can benefit from intensive analytic help. J. Am. Acad. Child Adolesc. Psychiatry. 1994, 33, 3:361-367

Childhood depression: a place for psychotherapy
An outcome study comparing individual psychodynamic psychotherapy and family therapy

<table>
<thead>
<tr>
<th>Individual therapy N = 35</th>
<th>Family therapy N = 37</th>
<th>Total N = 72</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>Absent</td>
<td>Present</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>35 (100.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>End of therapy</td>
<td>9 (25.7)</td>
<td>26 (74.3)</td>
</tr>
<tr>
<td>Follow up</td>
<td>0 (0.0)</td>
<td>35 (100.0)</td>
</tr>
<tr>
<td>MDD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>32 (89.4)</td>
<td>3 (8.6)</td>
</tr>
<tr>
<td>End of therapy</td>
<td>6 (17.1)</td>
<td>29 (82.9)</td>
</tr>
<tr>
<td>Follow up</td>
<td>0 (0.0)</td>
<td>35 (100.0)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>20 (57.1)</td>
<td>15 (42.9)</td>
</tr>
<tr>
<td>End of therapy</td>
<td>6 (17.1)</td>
<td>29 (82.9)</td>
</tr>
<tr>
<td>Follow up</td>
<td>0 (0.0)</td>
<td>35 (100.0)</td>
</tr>
<tr>
<td>Double depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>17 (48.6)</td>
<td>18 (51.4)</td>
</tr>
<tr>
<td>End of therapy</td>
<td>3 (8.6)</td>
<td>32 (91.4)</td>
</tr>
<tr>
<td>Follow up</td>
<td>0 (0.0)</td>
<td>35 (100.0)</td>
</tr>
</tbody>
</table>

* Including imputed data for 4 “last to follow-up” cases

Child psychoanalysis, child psychotherapy, chart review, outcome.
The NICE guidelines on depression in children and young people (2005)

**Recommendations:**
- moderate/severe depression to be treated by a **psychological therapy** alone or in combination with medication

- CBT, IPT-A, family therapy and STPP all have some evidence

- that **further research should be carried out**, to examine whether talking therapies could help in preventing relapse in the medium-term
The study’s objectives

To identify which psychological treatments are most effective at maintaining reduced depressive symptoms 12 months after treatment.

Which would be cost effective as well as clinically effective.
**Psychological treatments**

- **CognitiveBehavioural Therapy (CBT)** – up to 20 sessions
  - **Delivered by**: Clinical psychologists or other professionals with post-qualification training in CBT
  - **Focus on**: engagement, identifying behaviours & biases that maintain low mood & amending these through a process of collaborative empiricism; adapted to include family where necessary.

- **Brief psychosocial intervention (BPI)** – up to 12 sessions
  - **Delivered by** child mental health practitioners (80% child psychiatrists, 20% mental health nurses)
  - **Focus on**: formulation, advice, problem solving, psychoeducation, mental & physical hygiene, activation, liaison, managing emotion, risk
Psychological treatments (cont.)

- **Short-term psychoanalytic psychotherapy** (STPP) – 28 sessions (plus 7 for carers)

- **Delivered by** child and adolescent psychotherapists (incl. senior trainees)

- **Focus on** observation of therapeutic relationship; non-judgemental enquiry; understanding feelings; conveying value of self-understanding
Method

• Pragmatic **randomised controlled trial.**

• Adolescent patients (11-17 years) with a DSM IV **major depressive episode.**

• Recruited from **15 NHS CAMHS clinics** in England.

• **Randomly assigned** to one of CBT or STPP or BPI, with medication offered as per clinical guidelines.

• **Primary outcome** was self-reported depression symptoms (MFQ) assessed at baseline, then 36, 52 and 86 weeks
Interview-based assessments:
- Kiddie Schedule for Affective Disorders and Schizophrenia (kSADS-PL)
- Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA)
- Zanerini Rating Scale for Borderline Personality Disorder (ZAN:BPD)
- Child and Adolescent Service Use Schedule (CA-SUS)

Questionnaire-based assessments:
- Moods and Feelings Questionnaire (MFQ)
- EQ-5D (Economic Health measure)
- Risk-Taking and Self-Harming Inventory for Adolescents (RTSHIA)
- Ruminative Responses Scale (RRS)
- NEO Five-Factor Inventory (NEO-FFI)
- Depressive Experiences Questionnaire (DEQ)
- Symptoms Checklist (SCL:90) [parent/carer only]
- Alabama Parenting Questionnaire (APQ)
- Family Assessment Device (FAD)
- Life Events Questionnaire (LEQ)
- Friendships questionnaire

Other measures:
- Adolescent Integrative Measure (AIM)
- Clinical Global Impressions Scale (CGI)
- Children’s Depression Rating Scale (CDRS)
- Working Alliance Inventory (WAI-S)
- Demographic questionnaire

Research Assistants conduct assessments separately with YP and parent.
Additional studies

**MR-IMPACT**
University of Cambridge, Brain Mapping Unit
Scanning for functional brain changes (John Suckling)

**Genes and Hormones**
University of Cambridge, Developmental Psychiatry
Genotypes predicting sensitivity to SSRI action and outcomes of therapy (Paul Wilkinson)

**IMPACT- My Experience (IMPACT-ME)**
Anna Freud Centre / UCL
Expectations and experience of treatment (Nick Midgley and Mary Target)
So what happened, and what did we find?
The experience of young people
The young people in the study
Consort Diagram

Baseline Assessments
(n = 557)

Excluded (n = 87)

- Not meeting criteria for moderate/severe depression: 73
- Manic: 4
- Substance abuse: 4
- Previous treatment: 2
- Autism: 1
- Pregnant: 1
- Would not engage with Assessor: 1
- Unable to read or understand information: 1

Randomized
(n = 470)
Withdraw consent before Starting treatment n=5

Allocated to BPI
(n = 155)
Received allocated intervention (n = 147)
Did not receive treatment: 11
Parent felt subject better x 1
Started private treatment x 1
Subject withdrew x 1
Did not attend sessions x 8

Allocated to CBT
(n = 154)
Received allocated intervention (n = 142)
Did not receive treatment: 13
Therapist felt subject better x 1
Withdraw due waiting time x 1
Subject withdrew x 3
Did not attend sessions x 8

Allocated to STPP
(n = 156)
Received allocated intervention (n = 136)
Did not receive treatment: 21
Transport problems x 1
Clinical decision to change case management x 2
Therapist felt inappropriate x 1
Mother withdrew subject x 2
Did not attend sessions x 15

Enrollment

Allocation

Analysis

Follow-up

6 week: 102 (65%) 12 week: 108 (69%) 36 week: 110 (70%)
36 week: 105 (68%) 52 week: 110 (71%)
86 week: 123 (78%)

6 week: 99 (64%) 12 week: 105 (68%)
36 week: 105 (68%) 52 week: 110 (71%)
86 week: 130 (84%)

6 week: 106 (69%) 12 week: 108 (69%)
36 week: 110 (70%) 52 week: 110 (70%)
86 week: 119 (76%)

Analysed (n = 132)
Excluded from analysis n=3 consent withdrawn

Analysed (n = 133)
Excluded from analysis n=1 consent withdrawn

Analysed (n = 127)
Excluded from analysis n=1 consent withdrawn
Participant characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age in yrs</td>
<td>15.6 (1.4)</td>
</tr>
<tr>
<td>Females</td>
<td>74%</td>
</tr>
<tr>
<td>Mean (SD) HoNoSCA mean</td>
<td>18 (6.0)</td>
</tr>
<tr>
<td>Mean (SD) Mood/Feelings Questionnaire</td>
<td>46 (10.6)</td>
</tr>
<tr>
<td>Lifetime NSSI</td>
<td>56%</td>
</tr>
<tr>
<td>Current suicidal ideation</td>
<td>60%</td>
</tr>
<tr>
<td>Lifetime Suicide Attempts</td>
<td>37%</td>
</tr>
<tr>
<td>Comorbidity (1+)</td>
<td>46%</td>
</tr>
</tbody>
</table>

N.B. Approx. 25% on anti-depressant medication at referral
Prevalence of Depressive Symptoms At Entry

- Sleep
- D Mood
- Poor Conc.
- Fatigue
- Worthless
- Anhedonia
- Irritable
- Suicidal Thts

BPI
CBT
STPP
How young people described their depression

“I hate myself all the time... I just don’t like things I am doing, I think I’m doing everything wrong” (Ada, 17)

“I just can’t go out, no matter how much I want to see my friends – I just want to stay at home and just be by myself” (Shauna, 14)

“What’s the point of even trying to make friends if they are only ever going to hurt me, or turn their back on me” (Brian, 12)

“I’d punch walls and nearly break my knuckles because I was that angry, but I didn’t want to take it out an anyone else ... I just felt like hurting myself”

Description of the therapies and treatment outcomes
### Duration Of Therapy In Weeks

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Med</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPI</td>
<td>22.1</td>
<td>111.9</td>
<td>27.5</td>
<td>21.5</td>
<td>130</td>
</tr>
<tr>
<td>CBT</td>
<td>23.1</td>
<td>99.6</td>
<td>24.9</td>
<td>17.7</td>
<td>130</td>
</tr>
<tr>
<td>STPP</td>
<td>30.1</td>
<td>97.0</td>
<td>27.9</td>
<td>16.8</td>
<td>131</td>
</tr>
</tbody>
</table>

### Number of therapy sessions attended *

<table>
<thead>
<tr>
<th></th>
<th>BPI</th>
<th>CBT</th>
<th>STPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>6</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Planned</td>
<td>12</td>
<td>20</td>
<td>28</td>
</tr>
</tbody>
</table>

* 37% of young people dropped out of therapy
Treatment outcomes: depression (MFQ) Scores

End of treatment

Mean MFQ Score

- BPI
- CBT
- STPP

Baseline | 6 week | 12 week | 36 week | 52 week | 86 week
--- | --- | --- | --- | --- | ---

[Graph showing mean MFQ scores across different time points and therapies.]
Depression Sum Scores (MFQ) Over The Study

Not significant (ns)
- Sample loss over follow up makes analysis very weak
- 11% in remission at 36 wk but relapsed by 86 wk
Non depressive symptom change

Anxiety - RCMAS

Obsessionality - LOI

Social Impairment - HoNOSCA
Suicide Attempts & NSSI

No between treatment group differences
### Cost Effectiveness in UK Pounds

#### TABLE 18 Total cost per participant (£) over the 86-week follow-up

<table>
<thead>
<tr>
<th>Type of cost</th>
<th>Treatment group, mean (SD)</th>
<th>BPI (n = 92)</th>
<th>CBT (n = 92)</th>
<th>STPP (n = 91)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, social care and education costs</td>
<td></td>
<td>1368.04 (1368.04)</td>
<td>1459.26 (3481.02)</td>
<td>1668.51 (3425.68)</td>
</tr>
<tr>
<td>Treatment costs</td>
<td></td>
<td>1292.91 (1292.91)</td>
<td>904.57 (607.25)</td>
<td>1396.72 (1133.41)</td>
</tr>
<tr>
<td>Total costs</td>
<td></td>
<td>2678.39 (2678.39)</td>
<td>2379.01 (3643.85)</td>
<td>3081.70 (3573.17)</td>
</tr>
</tbody>
</table>

#### TABLE 19 Between-group differences in total costs over the 86-week follow-up

<table>
<thead>
<tr>
<th>Treatment group comparisona</th>
<th>Coefficient</th>
<th>95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT vs. BPI (n = 180)</td>
<td>-338.54</td>
<td>-1333.17 to 656.09</td>
<td>0.503</td>
</tr>
<tr>
<td>STPP vs. BPI (n = 174)</td>
<td>609.55</td>
<td>-406.73 to 1625.83</td>
<td>0.238</td>
</tr>
<tr>
<td>CBT vs. STPP (n = 178)</td>
<td>-709.23</td>
<td>-1836.04 to 417.58</td>
<td>0.216</td>
</tr>
</tbody>
</table>

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*a Adjusted for region and baseline cost, behavioural disorder and antidepressant use.*
In summary...

All three treatments associated with an average 49–52% reduction in depression symptoms and 78% in remission after 86 weeks.

There were no significant differences between treatments in clinical- and cost-effectiveness over the follow-up period.
Implications for treatment guidelines?

“Short-term psychoanalytic therapy was as effective as CBT and, together with brief psychosocial intervention, offers additional patient choice for psychological therapy, alongside CBT, for adolescents with moderate to severe depression who are attending routine specialist CAMHS clinics” (Goodyer et al., 2017).
So where do we go from here?

“The absence of difference between the three treatments assessed in the present study might be due to a putative shared common effect, but could also be a result of alternative explanations, including three unique effects leading to the same outcome” (Goodyer at al. 2017).
Exploring the therapeutic process in IMPACT

Therapists and young people self-rated the Working Alliance using the Working Alliance Inventory (WAI-S)

A sub-sample of young people, parents and therapists were interviewed about their experience of therapy (IMPACT-ME)

All therapy sessions were audio-recorded, and permission was given by young people for these to be used to help “explore and understand the therapeutic process”
How have we studied the therapy tapes?

To learn as much as we can from this study, a sample of audio-recorded sessions have been rated using:

- The Comparative Psychotherapy Process Scale (CPPS)
- The Cognitive Therapy Scale - Revised (CTS-R)
- The Brief Psychosocial Intervention Scale (BPI-S)
- The Adolescent Psychotherapy Q-set (APQ)
- The Working Alliance Inventory – observer version (WAI-OS)
- The Rupture Resolution Rating Scale (3RS)
- The Innovative Moments Rating Scale
How have we studied the therapy tapes?

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- The Comparative Psychotherapy Process Scale (CPPS)
- The Cognitive Therapy Scale - Revised (CTS-R)
- The Brief Psychosocial Intervention Scale (BPI-S)
- The Adolescent Psychotherapy Q-set (APQ)
- The Working Alliance Inventory – observer version (WAI-OS)
- The Rupture Resolution Rating Scale (3RS)
- The Innovative Moments Rating Scale
Aims of the current study

This study aimed to explore the use of therapist techniques by psychological therapists working on the IMPACT study.

1) Whether CBT and STPP treatments differed from each other, and also differed from the control condition (BPI), along critical dimensions of therapist technique ('treatment differentiation').

2) Whether some specific techniques are shared or distinct between therapists offering each of these three forms of talking therapy?
The Comparative Psychotherapy Process Scale

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Explicit advice or direct suggestion</td>
</tr>
<tr>
<td>3</td>
<td>Therapist initiation of topics and activity</td>
</tr>
<tr>
<td>6</td>
<td>Focus on irrational/illogical belief system</td>
</tr>
<tr>
<td>9</td>
<td>Specific outside of session activity or task</td>
</tr>
<tr>
<td>11</td>
<td>Explain rationale, technique, or treatment</td>
</tr>
<tr>
<td>12</td>
<td>Focus primarily on current life situations</td>
</tr>
<tr>
<td>15</td>
<td>Provide information symp, disorder, or tx</td>
</tr>
<tr>
<td>17</td>
<td>Practice behaviors between sessions</td>
</tr>
<tr>
<td>18</td>
<td>Teach specific techniques to patient</td>
</tr>
<tr>
<td>20</td>
<td>Interacts in teacher-like (didactic) manner</td>
</tr>
</tbody>
</table>

CPPS CB subscale

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Explore uncomfortable feelings</td>
</tr>
<tr>
<td>4</td>
<td>Feelings &amp; percepts linked to past exp.</td>
</tr>
<tr>
<td>5</td>
<td>Similar relationships over time</td>
</tr>
<tr>
<td>7</td>
<td>Focus on patient–therapist relationship</td>
</tr>
<tr>
<td>8</td>
<td>Experience and expression of feelings</td>
</tr>
<tr>
<td>10</td>
<td>Address avoid topics &amp; shift in mood</td>
</tr>
<tr>
<td>13</td>
<td>Alternative understanding of experiences</td>
</tr>
<tr>
<td>14</td>
<td>Recurrent patterns of action/feel/exp.</td>
</tr>
<tr>
<td>16</td>
<td>Patient initiates discussion</td>
</tr>
<tr>
<td>19</td>
<td>Explore wish, fantasy, dream, EM</td>
</tr>
</tbody>
</table>

CPPS PI subscale

Hilsenroth et al., Comparative Psychotherapy Process Scale (CPPS)
Methods

Sample:
- 232 audiotapes randomly selected from the 3 arms stratified by age, centre and phase of therapy (first third, vs middle/last third)

Rating:
- Blind double-rating by trained psychologists, of all 232 audiotapes of sessions using the Comparative Psychotherapy Process Scale (CPPS).
**Treatment differentiation**

FIGURE 7 Treatment differentiation based on the CPPS. CB, cognitive–behavioural; PI, psychodynamic interpersonal.
Shared and non-shared features of STPP with the other therapy approaches

Which techniques were used most by STPP therapists?

Item 13 (PI sub-scale) - the therapist suggests alternative ways to understand experiences or events not previously recognized by the patient

Item 8 (PI sub-scale) - the therapist encourages the patient to experience and express feelings in the session

Item 16 (PI sub-scale) - the therapist allows the patient to initiate the discussion of significant issues, events, and experiences

On scale 0-6, all three items had a mean score of 4 or above for STPP sessions.
Techniques which distinguish STPP from other therapy approaches

Item 1 (PI sub-scale) - the therapist encourages the exploration of feelings regarded by the patient as uncomfortable

Item 7 (PI sub-scale) - the therapist focuses discussion on the relationship between the therapist and patient

Item 14 (PI sub-scale) - the therapist identifies recurrent patterns in patient’s actions, feelings, and experiences

These items were used significantly more in STPP than in BPI and CBT sessions.
Techniques which STPP therapists use less than CBT (or BPI) therapists

Item 2 (CB sub-scale) - the therapist gives explicit advice or direct suggestions to the patient

Item 9 (CB sub-scale) - the therapist suggests specific activities or tasks (e.g., homework) for the patient to attempt outside of session

Item 11 (CB sub-scale) - the therapist explains the rationale behind his or her technique or approach to treatment

These items were used significantly more in CBT and BPI than in STPP
Preliminary conclusions from the CPPS so far...

Generally ratings on CPPS seem to be lower for adolescent therapy than in previous studies of adult therapy.

Overall, STPP, CBT and BPI can be clearly differentiated.

However, certain items (all from ‘PI’ sub-scale), seem to be common to all therapy work with adolescents; whilst other items are more characteristic of STPP or CBT.

Future studies will explore the links between treatment techniques and outcome...
In conclusion: What does the IMPACT study mean for psychoanalytic therapy with young people?

“This is in one way a great result for STPP – it stood up absolutely as well as the most “credible” treatments, CBT and psychiatric management, in terms of outcomes for moderate to severe clinically referred depression, and although patients attended more sessions, it was not significantly more expensive [...]"

The challenge to specify and demonstrate the added value from a deeper, less easily grasped and often longer therapeutic approach, showing a greater or broader immediate benefit or long-term resilience – remains there for the generation now in their research prime and for their students currently engaging with these issues for their first time.” (Target, 2018)
Thank you!

For more information please contact:
Dr Nick Midgley
Nick.Midgley@annafreud.org

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• The views expressed are those of the authors and do not necessarily reflect those of the HTA programme, NIHR, NHS, or the Department of Health.