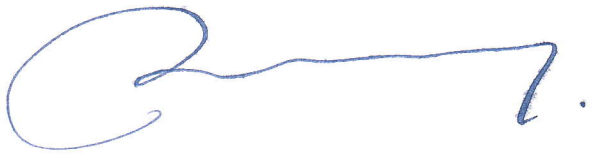
Submission to Minister Nicola Roxon on the contribution of long-term intensive psychoanalysis and psychoanalytic psychotherapy for depression, anxiety and severe mental illness within the Better Access Initiative

This submission was prepared by a working party consisting of members of:

- ***The Australian Association of Group Psychotherapists,***
- ***The Australian Centre for Psychoanalysis,***
- ***The Australian and New Zealand Society of Jungian Analysts,***
- ***The Australian Psychoanalytical Society,***
- ***The Psychoanalytic Psychotherapy Association of Australasia.***

It has been approved by the Executives of each Association, and is submitted on their behalf.



Paul McEvoy

(for the Working Party)

26th January 2010.

EXECUTIVE SUMMARY

This submission presents arguments and research that support the expansion of the Better Access Initiative (BAI) to include psychoanalysis and longer-term psychoanalytic psychotherapy for treatment of severe psychological disorders. It has been prepared by five professional associations representing more than 450 psychoanalysts and psychoanalytic psychotherapists throughout Australia. Our members treat patients for multiple or chronic mental disorders, personality disorders, psychotic disorders, anxiety, depression and those suffering long term abuse and trauma.

The members trained within our organizations have:

- extensive post-graduate training in psychoanalytic and psychotherapeutic theory and practice
- undergone their own personal analysis or therapy of a number of years
- have regular supervision of clinical work
- are involved in frequent professional development activities and peer assessment

Evidence-based research suggests that the treatment of complex psychological problems requires more frequent, in-depth intervention than can be offered by the brief, structured therapies. This research supports both the efficacy and lasting benefit of longer-term psychoanalytic and psychotherapeutic treatment for children, adolescents and adults. When employed, such treatment has led not only to reduced hospitalisations and hence, decreased loss of work and study time, but also to reduced need for costly pharmaceutical treatments.

It is our submission that, to be effective and inclusive, the BAI needs to be broadened to include highly-trained psychoanalysts and psychoanalytic psychotherapists. This is necessary to ensure equity and address ethical issues with regard to access to appropriate longer-term treatment for those with more complex psychological problems such as severe depression and personality disorders. It is also required to safeguard against those with serious mental health difficulties losing faith in psychological treatments as a result of short term treatment proving ineffective.

We respectfully recommend that:

1. Given the substantial evidence for the efficacy of psychoanalytic psychotherapies, they should be added to the list of approved interventions under the Better Access Program.

2. Given the evidence that patients with chronic or long standing mental health problems such as personality disorders, require longer term, more intensive therapeutic interventions, that the number of sessions available under the Better Access Program should be extended for these patients.

3. That Psychoanalytic Psychotherapists who demonstrate eligibility for membership of these or equivalent associations currently not eligible for Medicare rebates under the Better Access Program because they are neither Psychologists, Mental Health Social Workers nor Occupational Therapists, be added to the list of health professionals qualified to deliver psychological therapies under the Better Access Program.

We request a meeting with you, as federal Health Minister, to present our case in person, and to inform you of the economic and treatment benefits to be gained as a result of their inclusion in the current arrangements of the BAI.

Rationale

The Better Access Initiative was developed to address the increasing incidence of mental disorders, notably depression and anxiety, in specific communities. To achieve this goal, the BAI has relied entirely on short-term therapies. While such approaches have been demonstrated to be effective for certain patients, they have not proven effective with more complex, chronic conditions which are not responsive to specific symptom reduction. For such patients longer-term therapy is essential for a positive outcome. In this submission we argue for the proven benefits of longer-term therapies for patients with more complex mental health disorders, and the recognition of those members of our associations not presently covered by the BAI. While the majority of our members qualify as Mental Health Practitioners, others, who have undergone equally rigorous training, do not. They receive no rebates and their patients are required to pay GST. This is an inequitable oversight that has implications for optimum treatment and we request that it be redressed.

Training of Psychoanalysts and Psychoanalytic Psychotherapists

We consider the members of our associations to be the most qualified to deliver longer-term therapy. This is because training in psychoanalysis/psychoanalytic psychotherapy is specific to serious mental problems and occurs at post-graduate level. Such preparation is central, providing our members with the sound theoretical and practical basis for assessment and treatment of complex cases.

The minimum training required for membership of our professional associations is:

1. A tertiary degree and relevant clinical experience as a pre-requisite to training

2. Participation in a comprehensive professional training in psychoanalytic theory and clinical practice of between three to five years.

3. Weekly one-on-one clinical supervision of at least two clinical cases of psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy in which the patient or patients are seen a minimum of twice a week. One of these cases must be of at least 24 months duration, and one at least 12 months. Most practitioners would have far in excess of these clinical hours.

4. Personal psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy, at least twice weekly, with an approved psychoanalyst or psychoanalytic psychotherapist for the duration of training. This is a unique component as it provides an actual experience of the process and ensures analysts and therapists are aware of how their own personal characteristics may influence the treatment. This is essential for effective psychoanalytic work. Not uncommonly a personal psychoanalysis would continue beyond the training period.

Trainees undertake the main elements of training- personal psychoanalysis/ psychotherapy/ group psychotherapy; supervised clinical practice; and theoretical and clinical seminars – at the same time. In addition they have ongoing professional development and clinical supervision. There is no government funding for this and all costs are born by trainees. This is a substantial saving to Government and the community.

A gap in the BAI that overlooks fully trained practitioners and limits treatment

The majority of the members of the five Australian Associations that provide psychoanalysis and psychoanalytic psychotherapy are university qualified in the medical and allied health professions such as psychology and social work. They are thus eligible for registration as Mental Health providers. However, we also have highly trained and experienced practitioners who came to their psychoanalytic training via other professional pathways, which currently make them ineligible for registration as Mental Health Practitioners.

While these practitioners are not recognised under the BAI, they undertake the same post-graduate, theoretical and clinical psychoanalytical training, as all other members of our associations. Their theoretical understanding and clinical expertise for undertaking psychotherapeutic treatment of severe, complex and long standing mental health problems are equivalent in all respects to members from the medical and allied health sector. Their non-recognition under the BAI has meant that their caseloads have fallen, and their skills are underutilised while patients are encouraged to seek the help of practitioners who may not have had the training required to assist them with their complex problems. As a consequence, their ability to contribute to the treatment of serious mental health problems in the community has been diminished.

Evidenced-Based Research for Longer Term Psychoanalysis and Psychoanalytic Psychotherapy

Psychoanalysis and psychoanalytic psychotherapy have a distinguished international history of effective therapeutic work stretching back more than a century. Predominantly, this work has been with cases of serious mental illness that have not responded to briefer therapies. These treatments recognized and documented the importance of unconscious determinants in peoples' behaviour and thought patterns. Since then, psychoanalytically informed therapy has grown and developed in its clinical, theoretical and research base.

Some commentators suggest that psychoanalytic concepts and practice lack evidence-based research support, and that evidence shows other forms of treatment are more effective. This belief is based on a selective sampling of available research which ignores a vast amount of evidence.[1] The current emphasis on structured and time limited treatments has received strong support because such treatments are well suited to the dominant research paradigm, which is based on the model of physical medicine. However, it does not take into account a growing body of evidence for longer term psychotherapy demonstrated to be effective in both qualitative and quantitative studies for some decades. In addition it has been argued that an evaluation of psychoanalytic psychotherapy requires methodologies appropriate to the nature of the treatment and the European Federation for Psychoanalytic Psychotherapy in the Public Sector (EFPP) has been developing and employing these for a decade.[2]

The evidence-based literature, reviewed below, shows unequivocal support for the efficacy of long-term psychodynamic psychotherapy in treating a broad range of psychological conditions, particularly the more severe forms of mental dysfunction. The evidence strongly suggests that psychodynamic models are much more appropriate to this

[1] Shedler 2009, p.1

[2] Richardson, Kachele & Renlund (2004)

client population than the shorter-term models endorsed by the BAI, which does not provide for the establishment of a patient-therapist relationship and time frame appropriate to nature of the work. While there is evidence for the treatment modalities identified in the BAI, there are significant questions about the comprehensiveness of such evidence and it is generally based on studies which specifically exclude the type of complex cases that are suitably treated by longer term psychotherapy.[3]

An important development is the emergence of neurobiological studies that have established the efficacy of psychodynamic psychotherapies. As Nobel prize-winning neuroscientist Eric Kandel[4] points out: "There is no longer any doubt … that psychotherapy can result in detectable changes in the brain." The brain restructures itself during psychotherapy and "the more successful the treatment the greater the change".[5] The evidence emerging in these studies emphasises the role of the relationship between therapist and patient and the need for a significant time to enable these changes to become expressed as physical changes in the brain.[6]

Evidence for longer-term psychoanalysis and psychoanalytic psychotherapy with children and adolescents

Many members of our associations work with children, adolescents, parents and families, and in parent-infant psychotherapy. A review of 15 years of work on the outcomes of child psychoanalytic therapy concluded that:

> *"The follow-up study is consistent with the long-term good outcome of the early treatment of these relatively seriously disturbed children. We were again and again surprised to meet adults who, as children, manifested serious and in many instances "hopeless" conditions; yet who, following successful treatment, had become relatively high-achieving individuals with stable social circumstances and no history of further psychiatric problems."* [7]

A number of other studies and reviews have shown the effectiveness of psychodynamic therapies with children and adolescents.

- An extensive review[8] of research in child and adolescent psychotherapy found that psychodynamic therapy is beneficial. The magnitude of the effect is approximately 0.7, thus about the same effect as in other psychotherapy with adults.
- The positive change continues after the termination of treatment. ie there is a positive, so-called, "sleeper effect". When tested, it emerges that this effect is maintained in adulthood.[9]
- Less disturbed children seem to have been able to be helped by therapy once a week. [10]
- More disturbed children need more intensive and longer treatment.[11]

---

[3] Hardy, Barkham, Shapiro & Reynolds 1995, King, 1998.
[4] Quoted in Doidge 2007, p. 234.
[5] Doidge, 2007, p.234
[6] See research reviewed in Cozolino (2002, 2006)
[7] Fonagy & Target (2002),p. 54
[8] Ellis Kennedy (2004)
[9] Schachter, 2004; Schachter and Target, in press; Midgley and Target, 2005; Midgley et al., 2006
[10] Muratori et al., 2002, 2003; Fonagy and Target, 1996
[11] Lush et al., 1998; Schachter and Target in press; Heinicke and Ramsay-Klee, 1986

- If the psychotherapy is too short or not sufficiently intensive, or if parallel work with parents is lacking, psychotherapy may in certain cases be damaging for seriously disturbed children.[12]

Psychotherapy has been found in formal studies to be effective for children with:

- Depression[13]
- Poorly controlled diabetes[14]
- Anxiety disorders[15]
- Personality disorder[16]
- Specific learning difficulties[17]
- Pervasive developmental disorders[18]
- Eating disorders[19]
- Infants exposed to violence[20]

Psychotherapy has had significant therapeutic benefits for severely deprived children, children in foster care and sexually-abused girls.[21] In the UK, studies have resulted in psychodynamic psychotherapy (PDT) being included as a recommended form of treatment in public health care (NICE Guidelines).

We believe that it is necessary for Government to draw on evidence-based research from a broad range of therapeutic approaches. European evidence-based research in the effects of psychoanalysis and psychoanalytic psychotherapy show that our members belong to a group of mental health providers whose treatment outcomes are positive for their patients, and result in decreasing patient re-admissions to hospital.

Evidence for longer-term psychoanalysis and psychoanalytic psychotherapy with adults

Recent studies indicate that psychoanalysis and psychoanalytic psychotherapy, both individual and group, are effective. These studies also show that patients continue to improve even after treatment has ended and for longer follow-up periods. Statistically significant and clinically meaningful improvements in panic, depression, anxiety, and functional impairment – both at treatment termination and at follow-up six months after completion – occur with psychodynamic psychotherapy.[22] A meta-analysis of the effectiveness of long-term psychodynamic psychotherapy showed that it "was significantly superior to shorter-term" modalities and that long-term psychodynamic psychotherapy yielded large and stable effect sizes in the treatment of patients with personality disorders, multiple mental disorders, and chronic mental disorders. [23] These

[12] Target and Fonagy, 2002; Szapocznik et al., 1989
[13] Target and Fonagy, 1994b; Trowell et al., 2007; Horn et al., 2005.
[14] Fonagy and Moran,1991.
[15] Kronmüller et al., 2005; Target and Fonagy, 1994b
[16] Gerber, 2004
[17] Heinicke and Ramsey-Klee, 1986
[18] Reid et al., 2001
[19] Robin et al., 1999
[20] Lieberman et al., 2005
[21] Lush et al., 1998, Trowell et al., 2002
[22] Milrod et al, (2000)
[23] Leichsenring and Rabung, (2008)

patients are commonly regarded as "difficult", and it is particularly with respect to such patients who have "failed" or been excluded from other, briefer, therapies that psychoanalysis, or longer-term psychoanalytic psychotherapy have proven effective. Doidge, in an earlier review of the efficacy of psychoanalytic approaches, makes the observation that with such patients, "therapeutic benefit is consistently and strongly associated with treatment length" (p123). He also points out that significant health care cost savings arise from the reduction of demand for other services.[24]

Overseas research shows that patients diagnosed with a Borderline Personality Disorder who completed a program of longer-term psychodynamic psychotherapy not only maintained their substantial gains at the end of treatment but also showed a statistically-significant, continued improvement on outcome measures.[25] A similar outcome, with a similar population, has been demonstrated in Australia.[26] This long-term follow up of patients treated intensively using psychoanalytic psychotherapy not only revealed positive clinical outcomes but positive economic outcomes in terms of increased productivity, and reduced demand on other health services.[27]

A Swedish study of more than 400 people during and after, subsidized psychoanalysis or longer-term psychotherapy showed continued improvement following the completion of treatment.[28] This observation lends support to the notion that psychoanalytic treatment initiates a process that continues in the patient after the formal termination of treatment. The implication is that an advantage exists for extended, in-depth psychotherapy or psychoanalysis over short-term therapy and/or medication for a group of complex problems. For many people, psychodynamic forms of psychotherapy may foster inner resources and capacities that allow richer, freer, more productive and fulfilling lives.[29]

Significance of the research findings

The above findings are of crucial importance to Government as it restructures the Australian mental health system. For optimum economic and preventative impact, longer-term psychodynamic psychotherapy cannot be overlooked. It has been shown to result in markedly reduced medical utilization (sick days, hospital days, number of physician visits, drug intake) in the majority of patients studied in a review of health insurance.[30] This research indicates that patients reduced sick days by two thirds in the year after therapy, and by a further 50 per cent after five years. Hospital days were reduced by 87.5 per cent in the year after therapy and 50 per cent after five years.

Access to Appropriate Treatment

We support the BAI's aim to provide improved access to treatment services for high need and under-serviced populations. However, we believe there remains a problem for equitable access across all populations requiring psychological services. This is particularly the case for patients requiring longer-term psychotherapy as the time-limited nature of the rebates system means that longer-term psychotherapy is cut off prematurely.

[24] Doidge (1997)
[25] Bateman and Fonagy, (2001)
[26] Meares, Stevenson & Comerford , (1999)
[27] Stevenson & Meares 1999; Hall, Caleo, Stevenson & Meares, 2001.
[28] Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F.
[29] Shedler, 2009, p. 18
[30] Keller et al 2006, p. 33

Our members not uncommonly offer treatment, at reduced fees, to some patients with serious mental illnesses who are unemployed, or on low incomes, and who would otherwise be unable to afford the cost of psychotherapy. However, there is both a limit to the extent to which our members can offer subsidised treatment, and there are many patients who cannot afford even such reduced fees. Short-term treatment cannot meet the needs of such patients, and would ultimately prove costly in human and economic terms. Treatment that is prematurely curtailed may well be damaging to the mental health of the patient. This raises ethical issues for us as to whether we are able to take on seriously ill patients if we cannot offer treatment beyond the mandated 18 individual or 12 group sessions. This then leaves patients with no therapeutic help or with the less trained and skilled practitioners offering short-term work, perhaps not even having the appropriate assessment skills to understand what is required.

Concluding remarks: The limitations of the BAI

The BAI has been predicated on a limited range of treatment modalities (CBT, Interpersonal Therapy, and Narrative Therapy with indigenous populations). An expanded range of therapeutic modalities would be more inclusive and would meet the needs of a broader range of target groups. Many of our members report working with patients who have tried brief, structured interventions and found them to be of limited effectiveness. This is not to suggest that such approaches are not helpful, but rather, their usefulness is greatest with certain patient populations.

This is particularly the case with the more serious disorders, including multiple or chronic mental disorders, personality disorders or long-term abuse and trauma victims. The National Mental Health Policy 2008 recognizes the need to have a broad range of treatment modalities, stating that:

> *Central to the population health framework is a range of high quality, effective interventions that target those at different levels of risk or with different levels of need. The interventions should be comprehensive, ranging from prevention and early intervention through treatment, to continuing care and prevention of relapse.(p.10)*

Our members draw on many models of mental dysfunction. As a result the patient is not fitted into one model, but rather diagnosis leads to a treatment guided by the specific character of the patient's experience and type of assistance most effective for them.We strongly support diversity in service providers to reflect the diversity in patients' needs. These needs are not necessarily obvious to the patient in treatment, but it is crucial that the treating clinician is aware of them. Clinicians (both treating and referring) need to have the training and experience to recognise and respond to the complex psychological treatment needs of their patients.

The BAI system as it currently functions may engender a false sense of security by implying that those professionals who have access to rebates possess the training and experience to treat serious mental health disturbances when this is not necessarily the case. Psychoanalytic and psychodynamic therapies have been specifically developed over more than a century to provide effective treatments for complex, chronic and resistant mental health conditions. The thoroughness of a training that includes theory, practice, supervision and personal analysis equips our members to be in the best position to treat

patients with such disorders. Unfortunately, there are psychotherapists and psychoanalysts who are trained to deal with complex mental disorders, including psychosis, but are not eligible to receive referrals under the BAI, and are not being referred such patients. This means that highly-trained practitioners in the mental health field can be under-utilised while those who may not be adequately trained in these areas are being referred patients whose complex disorders may be beyond their training and experience. There are also practitioners trained in other schools of psychotherapy including CBT, who are qualified to undertake longer term, relationship-oriented treatment of complex cases, but are unable to do this under the current arrangements of the BAI, because of the short-term orientation.

In promoting a six or 12 session treatment framework, the BAI appears to be inadvertently fostering the idea that all problems can and should be able to be effectively addressed within the time-frame of short-term therapy. There is a serious risk that consumers may attend ill-trained practitioners, who may begin psychotherapy with them, but terminate prematurely because there is no further Medicare rebate available. This can have a negative effect in that the patient's expectation of the usefulness of therapy is not met. Indeed, the consequences of the BAI in this instance could be damaging in fostering in the patient, a negative attitude to therapeutic work. Even more serious damage may occur when seriously disturbed and fragile patients are referred to practitioners who, not being trained to recognise or deal with such complex cases, offer brief interventions, terminate prematurely, and leave the patient traumatised and damaged.

The broad range of psychological conditions which generate severe chronic distress require longer term psychotherapy as opposed to briefer interventions. The evidence derived from numerous recent studies strongly supports the appropriateness of psychodynamic approaches in complex cases.

RECOMMENDATIONS

1. Given the substantial evidence for the efficacy of psychoanalytic psychotherapies, we recommend that psychoanalytic psychotherapies be added to the list of approved therapeutic interventions under the Better Access Program.

2. Given the evidence that some groups of patients, namely those with chronic or long standing mental health problems such as personality disorders, require longer term and/or more intensive therapeutic interventions, we recommend that the number of sessions available under the Better Access Program should be extended beyond the current 12 -18 session limit, or be unlimited for these patients.

3. We recommend that Psychoanalytic Psychotherapists (those who can demonstrate eligibility for membership of these or equivalent associations) currently not eligible for Medicare rebates under the Better Access Program by virtue of their being neither Psychologists nor accredited Mental Health Social Workers or Occupational Therapists, be added to the list of health professionals qualified to deliver psychological therapies under the Better Access Program.

Selected Bibliography

Barkham, Michael; Rees, Anne; Shapiro, David A; Stiles, William B; et al. (1996) Outcomes of time-limited psychotherapy in applied settings: Replicating the Second Sheffield Psychotherapy Project. *Journal of Consulting & Clinical Psychology. Vol 64(5),* 1079-1085.

Bateman, Anthony; Fonagy, Peter. (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry. Vol 156(10),* 1563-1569.

Bateman, Anthony; Fonagy, Peter. (2001) Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *American Journal of Psychiatry. Vol 158(1),* 36-42.

Caleo, J. S., Stevenson, J., Meares, R. (2001) An economic analysis of psychotherapy for border line personality disorder patients. *The Journal of Mental Health Policy & Economics. Vol 4(1*), 3-8.

Cozolino, L. (2002) *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain.* New York, W. W. Norton.

Cozolino, L. (2006) *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain*. New York, W. W. Norton.

Doidge, Norman. (1997) Empirical evidence for the efficacy of psychoanalytic psychotherapies and psychoanalysis: An overview. *Psychoanalytic Inquiry. (Suppl),* 102-150.

Fonagy, P. & Moran, G.S. (1991). Understanding psychic change in child analysis. *International Journal of Psychoanalysis*, *72*, 15-22.

Fonagy, P., Target, M. (2002). The History and Current Status of Outcome Research at the Anna Freud Centre . *Psychoanalytic Study of the Child*, 57:27-60.

Hall, Jane; Caleo, Sue; Stevenson, Janine; Meares, Russell. (2001) An economic analysis of psychotherapy for borderline personality disorder patients. *The Journal of Mental Health Policy & Economics. Vol 4(1),* 3-8.

Hardy, Gillian E; Barkham, Michael; Shapiro, David A; Reynolds, Shirley; et al. (1995) Credibility and outcome of cognitive-behavioural and psychodynamic-interpersonal therapy. *British Journal of Clinical Psychology. Vol 34(4),* 555-569.

Hardy, Gillian E; Barkham, Michael; Shapiro, David A; Stiles, William B; Rees, Anne; Reynolds, Shirley. (1995) Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting & Clinical Psychology. Vol 63(6),* 997-1004.

Hardy, Gillian E; Shapiro, David A; Stiles, William B; Barkham, Michael. (1998) When and why does cognitive-behavioural treatment appear more effective than psychodynamic-interpersonal treatment? Discussion of the findings from the Second Sheffield Psychotherapy Project. *Journal of Mental Health. Vol 7(2),* 179-190.

Heinicke, C.M. & Ramsey-Klee, D.M. (1986). Outcome of child psychotherapy as a function of frequency of session. *Journal of the American Academy of Child Psychiatry, 14*, 561-588.

Kachele H, Krause R, Jones E et al (2000). An Open Door Review of Outcome Studies in Psychoanalysis. Fonagy P, ed London International Psychoanalytical Association. Available at www.ipa.org.uk

Kennedy, E. & Midgley, N. (2007). *Process and outcome research in child, adolescent and parent-infant psychotherapy: a thematic review*. London: North Central London Strategic Health Authority.

Keller W, Westhoff G, Dilg R, Rohner R, Studt HH. (2006). Effectiveness and utilization of health insurance benefits in long-term analyses: Results of an empirical follow-up study on the effectiveness of Jungian Analysis. http://www.uni-saarland.de/fak5/krause/ulm97/keller.htm

King, R (1998) Evidence-based Practice: Where is the Evidence? The Case of Cognitive Behaviour Therapy and Depression. *Australian Psychologist*, 33, 83-95.

Leichsenring, F & Rabung, S (2008) Effectiveness of Long-term Psychodynamic Psychotherapy: A Meta-analysis . *JAMA.* 300(13):1551-1565.

Lieberman, A. F., Van Horn, P. & Ghosh Ippen, C. (2005). Towards evidence-based treatment: Child-Parent psychotherapy with preschoolers exposed to marital violence. J. *Amer. Acad. Child. Adolesct. Psychiatry,* 44(12): 1241-8.

Lush, D., Boston, M., Morgan, J. & Kolvin, I. (1998). Psychoanalytic psychotherapy with disturbed adopted and foster children: a single case follow-up study. *Clinical Child Psychology & Psychiatry*, *3*, 51-69.

Meares R, Stevenson J, Comerford A (1999), Psychotherapy with borderline patients: I. A comparison between treated and untreated cohorts. *ANZ J Psychiatry 33(4,* 467-472.

Meares, Russell; Stevenson, Janine; D'Angelo, Roberto. (2002) Eysenck's challenge to psychotherapy: A view of the effects 50 years on. *Australian & New Zealand Journal of Psychiatry. Vol 36(6),* 812-815.

Midgley, N. & Target, M. (2005). Recollections of being in child psychoanalysis. A Qualitative Study of a long-term follow-up project. *The Psychoanalytic Study of the Child, 60*, 157-177.

Midgley, N., Target, M. & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*, 257-269.

Midgley, N., Anderson, J., Grainger, E. Nesic, T. & Urwin, C. (Eds.) (2009). *Child Psychotherapy and Research: New Approaches, Emerging Findings*. London: Routledge.

Milrod, B, Busch, F, Leon, AC, Shapiro, T, Aronson, A, Roiphe, J, Rudden, M, Singer, M, Goldman, H, Richter, D, & Shear, MK. (2000) Open Trial of Psychodynamic Psychotherapy for Panic Disorder: A Pilot Study. *Am J Psychiatry 157:*1878-1880,

Muratori, F., Picchi, L., Bruni, G., Patarnello, M. & Romagnoli, G. (2003). A two-year follow-up of psychodynamic psychotherapy for internalising disorders in children. *Journal of American Academy of Child Adolescent Psychiatry*, *42*, 331-339.

Reid, S., Alvarez, A. & Lee, A. (2001). The Tavistock autism workshop approach: Assessment, treatment and research. In J. Richter & S. Coates (Eds.), *Autism – the search for coherence* (182-192). London: Jessica Kingsley.

Richardson P, Kächele H, Renlund C (eds) (2004). Research on psychoanalytic psychotherapy with adults. London: Karnac.

Robin, A. et al. (1999). A controlled comparison of family versus individual psychotherapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, *38*, 1482-1489.

Roth, A & Fonagy P (1996) *What Works for Whom? A Critical Review of Psychotherapy Research.* Guilford Press. New York.

Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F. *Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP)* http://www.ipa.org.uk/research/sandell.asp

Schachter, A. (2009). *The adult outcome of child psychoanalysis: A long-term follow-up study*. Unpublished PhD thesis, University College, London.

Schachter, A., & Target, M. (2009). The adult outcome of child psychoanalysis: the Anna Freud Centre long-term follow-up study. In N. Midgley et al. (Eds.), *Child psychotherapy and research: new approaches, emerging findings*. London: Routledge.

Shapiro, David A; Barkham, Michael; Hardy, Gillian E; Morrison, Leslie A. (1990) The second Sheffield psychotherapy project: Rationale, design and preliminary outcome data. *British Journal of Medical Psychology. Vol 63(2),* 97-108.

Shapiro, David A; Barkham, Michael; Rees, Anne; Hardy, Gillian E; et al. (1994) Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 62(3),* 522-534.

Shapiro, David A; Firth, Jenny. (1987) Prescriptive v. exploratory psychotherapy: Outcomes of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 151,* 790-799. *Royal Coll of Psychiatrists, England*

Shapiro, David A; Firth-Cozens, Jenny. (1990) Two-year follow-up of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 157,* 389-391.

Shapiro, D A., Barkham, M., Rees, A., Hardy, G. E., et al. (1994) Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 62(3),* 522-534.

Shapiro, David A; Rees, Anne; Barkham, Michael; Hardy, Gillian. (1995) Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 63(3),* 378-387.

Shapiro, D. A., Firth, J. (1987) Prescriptive v. exploratory psychotherapy: Outcomes of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 151,* 790-799. Royal College of Psychiatrists, England.

Shedler J. (2009) The Efficacy of Psychodynamic Psychotherapy. http://www.internationalpsychoanalysis.net.2009.11.12 In press *American Psychologist.*

Stevenson, Janine; Meares, Russell. (1992) An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry. Vol 14 (3),* 358-362.

Stevenson, Janine; Meares, Russell. (1999) Psychotherapy with borderline patients: II. A preliminary cost benefit study. *Australian and New Zealand Journal of Psychiatry 1999;* 33:473–477.

Szapocznik, J. et al. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology*, *57*, 571-578.

Target, M. & Fonagy, P. (1994a). The efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*, 361–371.

Target, M. & Fonagy, P. (1994b). The efficacy of psychoanalysis for children: Prediction of outcome in a developmental context. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*, 1134-1144.

Target, M. & Fonagy, P. (2002). Anna Freud Centre studies 3: The long-term follow-up of child analytic treatments (AFC3). In P. Fonagy (Ed.) *An open door review of outcome studies in psychoanalysis* (2nd ed.), (141–146). London: International Psychoanalytic Society.

Trowell, J. et al. (2002). Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry*, *180*, 234–247

Trowell, J., Joffe, I., Campbell, J. Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., & Tsiantis, J. (2007). Childhood depression: a place for psychotherapy: an outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child and Adolescent Psychiatry. 16*, 157–167.