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1 **The Effectiveness of Psychodynamic Therapy in an NHS Psychotherapy Service: Outcomes for**  
2 **Service-users with Complex Presentations**

3

4 Dr Rachel Hirschfeld<sup>a\*</sup>, Dr Scott Steen<sup>b</sup>, E.L. Dunn<sup>c</sup>, A. Hanif<sup>d</sup>, L. Clarke<sup>ef</sup>

5 *<sup>a</sup>Specialist Psychotherapies Service, Birmingham and Solihull Mental Health NHS Foundation Trust,*  
6 *Birmingham, UK*

7 *<sup>b</sup> The University of Hertfordshire, Hertfordshire, UK*

8 *<sup>c</sup> Specialist Psychotherapies Service, Birmingham and Solihull Mental Health NHS Foundation Trust,*  
9 *Birmingham, UK*

10 *<sup>d</sup> Specialist Psychotherapies Service, Birmingham and Solihull Mental Health NHS Foundation Trust,*  
11 *Birmingham, UK*

12 *<sup>e</sup> Warwick Medical School, University of Warwick, Coventry, CV4 7AL*

13 *<sup>f</sup> University of Birmingham, Edgbaston, Birmingham, B15 2TT*

14

15

16 \*Rachel.hirschfeld@nhs.net

17 Specialist Psychotherapy Service, Callum Lodge, 242 Lodge Road, Winson Green, Birmingham, B18  
18 5SJ, UK

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21

## 22 Abstract

23

24 **Introduction:** Complex and enduring mental health problems require greater treatment resources,  
25 usually in the form of multidisciplinary support, including providing psychological therapies. This paper  
26 reports on an NHS, tertiary-level specialist psychotherapy service offering Psychodynamic therapies  
27 with longer-term, exploratory transdiagnostic approaches to support complexity and sustained  
28 personality functioning.

29 **Method:** This paper adopts a naturalistic study design evaluating the effectiveness of Psychodynamic  
30 therapy using pre- and post-outcomes across a 10-year period. A total of n=474 participants self-report  
31 pre- and post-outcome measures were used as the marker of effectiveness along with therapist  
32 assessments during intake and engagement.

33 **Results:** The findings showed that Psychodynamic therapy was effective in reducing psychological  
34 distress based on service-user self-report and therapist assessments. While intake scores varied by  
35 socio-demographic factors, the rate of change across most groups was similar. There were several  
36 limitations relating to data quality and completeness which reflect the naturalistic design.

37 **Discussion:** Despite the limits of a naturalistic design, this study provides evidence of support for the  
38 place of Psychodynamic therapies within NHS mental health care, catering to those with complex and  
39 enduring mental health problems.

40

41 **Keywords:** Psychodynamic therapy, Practice-based evidence, Naturalistic study design, Clinical  
42 practice, Complex mental health problems

43

## 44 Introduction

45

46 Mental health problems exist along a continuum, ranging from common to complex conditions  
47 which need different treatments to accommodate symptom severities, service-user choice, and  
48 available resources. Individuals may experience brief episodic issues while others experience longer,  
49 multiple, and compounding problems that require ongoing engagement and intensive interventions.

50

51 Research shows around 4-15% of the population in England meets the diagnostic criteria for a  
52 personality disorder (McManus et al., 2016). Studies find that approximately 30-50% of those with  
53 severe mental health problems report co-occurring substance use (EMCDDA, 2015; Lai et al., 2015)  
54 and approximately 50% of those diagnosed with psychosis or schizophrenia will require substantial  
55 and ongoing support, with around 15% experiencing a chronic course with limited improvement, and  
56 10% dying by suicide (Santesteban-Echarri et al., 2017). Other statistics estimate severe mental health  
57 problems have increased from 7.9% in 2000 to 9.3% in 2014 (Stansfeld et al., 2014). Chronic conditions  
58 require high resources over an individual's lifetime including hospitalisation, medication use, and  
59 managing maladaptive behaviours (Jin & Mosweu, 2017; Naylor et al., 2012). Frequent service  
60 utilisation risks further distress by repeating past traumas and lost autonomy (NHS England, 2019).  
61 Socioeconomically disadvantaged groups are at increased risk of poor mental health which can worsen  
62 social conditions and thus produce an ongoing cycle (Kivimäki et al., 2020). Severe and chronic  
63 problems are exacerbated by other issues including family difficulties, stress, physical health problems,  
64 medication compliance, and substance use (Jin & Mosweu, 2017; Naylor et al., 2012), presenting  
65 further challenges for support. Accordingly, psychotherapeutic delivery requires a longer-term,  
66 intensive focus, alongside multifaceted and multidisciplinary, preferably community-based,  
67 approaches (NHS England, 2019; NICE, 2022).

68

## 69 Psychological therapies in the NHS

70

71 Within NHS England (2019), most adults with mental health problems (around 90%) are supported  
72 in primary care. These include common mental health problems including mild-to-moderate  
73 depression and anxiety disorders. Secondary care community mental health services play a role in  
74 delivering care for adults and older adults for those with moderate-to-severe mental health needs,  
75 including providing access to psychological therapies. Services use an over-arching stepped-care  
76 approach where those with the most clinical need are stepped-up to longer-term, multidisciplinary,  
77 and intense interventions. The NHS Long-Term Plan (NHS England, 2019) is committed to offering  
78 individuals greater choice and control over their care, and offering specialist support for those with  
79 complex, severe, and enduring conditions. NICE (2022) guidelines recommend a range of  
80 psychotherapeutic interventions, including short-term psychodynamic therapy for depression in those  
81 seeking insight-oriented and affect-focused interventions. Evidence suggests short-term therapies are  
82 not sufficient for those with complex conditions, including those with personality functioning  
83 difficulties, requiring longer-term approaches (Leichsenring et al., 2013; Lindfors et al., 2015). To  
84 optimise a psychotherapy's potential, interventions ought to adapt and accommodate the unique  
85 presentations of service-users including complexity, and long-standing and entrenched difficulties  
86 (NHS England, 2019; NICE, 2022).

87

88 Longer-term therapies are recommended by NICE (2022) as an alternative for those who have not  
89 responded to other interventions like CBT. The dose-effect literature suggests the longer a service-user  
90 remains engaged in therapy, the higher their chances of improvement (Robinson et al., 2020). Those  
91 with complex presentations may benefit from longer-term work to enact a larger dose-effect towards  
92 stabilisation. Longer-term psychodynamic therapies appear a worthwhile choice for enabling sustained  
93 personality functioning improvements (Lindfors et al., 2015), making them a viable option for those  
94 with complex and enduring difficulties.

95

96 Psychodynamic therapy

97

98 Psychodynamic therapy is a specialist psychological intervention focused on relational factors,  
99 childhood experiences, and attachment and defensive patterns relevant to psychological distress  
100 (Waddell, 2002). The focus on relating patterns is interpreted through transference and  
101 countertransference to inform and understand the potential redirection and impact of emotional  
102 states. Through open and exploratory approaches, the model aims to enable service-users to become  
103 aware of painful and disturbing feelings and the defences to manage them (e.g., splitting, dissociation,  
104 projective identification). It encourages practitioners to allow themselves to be emotionally stirred to  
105 attune to a service-user's emotional state and dynamically contain and process experiences through  
106 which the service-user comes to know themselves fully and tolerate previously unbearable affects and  
107 states of mind (Bion, 1963).

108

109 Psychodynamic therapies are positioned as a valuable framework for supporting those with  
110 complex conditions based on the idea that traumatic relational patterns are founded on  
111 developmentally organised psychic structures (Lindfors et al., 2015). Psychodynamic therapy focuses  
112 on past experiences and how they can exist in the present, influencing interpersonal patterns and  
113 psychological and emotional difficulties. There is evidence of severe adverse childhood experiences in  
114 those with complex mental health problems (Bellis et al., 2014) showing a potentially valuable role for  
115 psychodynamic approaches. Systematic reviews have demonstrated the effectiveness of  
116 psychodynamic therapies for personality disorders (Haskayne et al., 2014; Leichsenring et al., 2013;  
117 Lindfors et al., 2015). Ingrained personality difficulties can be more challenging to work with and show  
118 worse outcomes than episodic presentations and appear to benefit from longer-term relationally-  
119 focused approaches (Fonagy et al., 2015; Rost et al., 2019).

120

121 The service reported in this paper offers time-limited (up-to-two-years) psychodynamic therapy to  
122 those with complex and enduring conditions. Service-users are informed at the outset that these  
123 therapies can last between one-to-two years. This limit is determined by service resources, the need  
124 to set a therapeutic frame, and ensuring individuals are fully informed. Given the long-term nature of  
125 psychodynamic therapies, there are challenges for research and evaluation. The model's emphasis on  
126 transdiagnostic presentations and general psychological functioning means focusing on single 'pure'  
127 diagnostic groups, which is well-suited to controlled trial methodologies, is not clear cut. There are  
128 ongoing debates about the appropriateness of how NICE reviews psychotherapeutic interventions and  
129 the nature of psychodynamic therapies which may not lend themselves to Randomised Controlled Trial  
130 (RCT) methodologies but to naturalistic approaches (Mollon, 2009). Service-users with complex  
131 emotional needs may respond in challenging ways to the therapeutic process, including reassurance  
132 seeking, criticising, and straining personal and professional boundaries, each of which can take an  
133 emotional toll. Research indicates the presence of differential treatment effects based on personality  
134 traits and interpersonal styles, including the need for validation, dependency, and managing self-  
135 criticism (Rost et al., 2019).

136

137 The literature shows that long-term psychodynamic therapies are useful for improving treatment-  
138 resistant depression (Fonagy et al., 2015) and may offer an alternative for those with complex  
139 conditions for which primary NICE-recommended therapies decrease in effectiveness (Taylor et al.,  
140 2012). Greater clinical complexity is associated with other research challenges including a greater  
141 likelihood of premature disengagement and confounding factors including difficult social  
142 circumstances (Swift & Greenberg, 2015). The remit of longer-term psychodynamic therapies to treat  
143 these groups therefore creates a disadvantage when attempting to assess their effectiveness.

144

## 145 Practice-based evidence

146

147 Recent decades have seen a shift towards practice-based evidence to bridge the implementation  
148 challenges in translating evidence-based treatments into routine clinical practice, and to acquire more  
149 ecologically valid and clinically relevant findings (Barkham et al., 2010; Wakefield et al., 2021). Whereas  
150 traditional questions of efficacy are suited to controlled methodologies, effectiveness and practice  
151 research considers how and which interventions are provided to service-users within clinical systems.  
152 These approaches for evaluating interventions are not considered opposing but complementary  
153 (Barkham et al., 2010).

154

155 Practice research typically involves a bottom-up approach, involving a range of presentations from  
156 routine practice that might otherwise be excluded from controlled trials. Such an approach is beneficial  
157 for complex presentations and multiple conditions because it acknowledges a multifaceted profile as  
158 opposed to focusing on primary diagnoses, therefore more closely reflecting the realities of complexity  
159 in clinical practice. Practice research enhances the representation of participants for which controlled  
160 studies of complex conditions are restricted. As outlined earlier, the debates around the best-suited  
161 methods for evaluating psychotherapy effectiveness, especially longer forms and exploratory models,  
162 necessitate the need for practice research. Accordingly, practice-based evidence of NHS  
163 psychodynamic therapies represents an appropriate and valuable source of knowledge about a  
164 model's effectiveness for routine clinical samples of complexity. Although such an approach reduces  
165 internal validity due to the number of confounding factors, it does provide an account of therapeutic  
166 activity within a particular service and setting, delivering other valuable insights.

167

168 A common practice research approach involves analysing service datasets from routine clinical  
169 measurements. Obtaining routine clinical data has been enhanced in recent years through the

170 advancements and implementation of outcome systems which log psychometric data and produce  
171 datasets about service quality and intervention effectiveness within a specific service context. This  
172 paper aims to:

- 173 1. Assess the effectiveness of psychodynamic therapies within a West Midlands NHS mental  
174 health service using routine clinical data.
- 175 2. Use these findings to develop an understanding of complex presentations within a routine  
176 clinical frame of reference and assess the suitability of psychodynamic therapies.

177

## 178 Method

179

### 180 Service model

181

182 The service is an NHS specialist outpatient psychotherapeutic service providing psychodynamic-  
183 based interventions, including individual and group formats. It offers assessment, interventions, and  
184 consultation for adults aged 25 and over experiencing complex mental health problems who have  
185 already tried other secondary care psychotherapeutic interventions. It accepts referrals from various  
186 sources in community mental health, usually secondary care professionals, who deem those on their  
187 caseload as benefitting from a longer-term, psychodynamic approach treating underlying trauma and  
188 relational difficulties. Referrals remain under the remit of community mental health care teams for the  
189 duration of their engagement and therapies with the service.

190

191 Referrals are screened by a team of specialists working for the service who review the case  
192 materials and jointly decide whether to offer an assessment. The eligibility criteria considers whether  
193 the service-user can commit and work collaboratively in therapy, if they have engaged in therapies  
194 previously, and if there are support networks in place for the containment of therapy given the focus

195 on painful emotional material. The service is not diagnosis specific and is open to those with complex  
196 conditions and previous difficulties with engagement, treatment-resistant disorders, complex trauma  
197 and attachment issues, personality disorders, previous psychotic episodes that are in remission and  
198 not active, and those with some alcohol and/or drug problems that are managed appropriately by their  
199 wider healthcare service.

200

201 For those allocated an assessment, service-users undergo a three-to-four-session assessment  
202 process to collaboratively explore the reasons for their referral and jointly agree with the service-user  
203 and in collaboration with a supervising team an appropriate intervention. For those for whom the  
204 interventions appear unsuitable, alternative options are discussed, and they are referred to their  
205 supporting clinical team. Those deemed likely to benefit are placed on a waiting list to start therapy  
206 subject to service-user preference and clinical need and availability. The waiting time from assessment  
207 decision to starting therapy averages around 6-months. The practitioners delivering psychodynamic  
208 therapies range from trainees to specialists with each supported with weekly supervision. Therapists  
209 possess core mental health training with additional specialist psychodynamic training, and team  
210 allocation, assessment, and supervision ensure model fidelity and workforce skill sharing.  
211 Appointments occur weekly with lengths of therapy averaging from 12-to-24 months. During the  
212 therapy, the service-user's progress is collaboratively monitored in session and endings are discussed  
213 subject to clinical judgment and service-user request. As an open-ended exploratory approach, these  
214 are managed flexibly to respond to a service-user's ongoing and developing needs.

215

216 **Measures**

217

218 CORE-OM

219

220 The CORE Outcome Measure (CORE-OM) is a transdiagnostic, pan-theoretical measure of  
221 psychological distress covering a range of presenting problems (Barkham et al., 2010). It contains 34-  
222 items about the last week using a 5-point Likert scale from 'Not at all' to 'Most or all of the time' across  
223 four dimensions of Subjective well-being (4-items), Problems/symptoms (12-items), Functioning (12-  
224 items), and Risk (6-items). Responses are averaged to produce a score of overall distress and by  
225 subdomain, with higher scores indicating higher distress or symptom severity. Mean scores are  
226 commonly multiplied by 10 to give a clinical score, with a threshold of above 10 indicating clinical  
227 populations, and severity bandings of mild (10-14), moderate (15-20), moderate-to-severe (20-25),  
228 and severe (25+). Reliable change, that is a score change exceeding what might be expected by chance  
229 or measurement error, is defined as 5 or more (Barkham et al., 2010). Clinically significant change is  
230 defined as scores moving from above 10 to below 10, and clinically reliable change are scores that  
231 additionally change by more than 5. The measure is typically completed before and after therapy to  
232 calculate pre- to post-therapeutic change. The CORE-OM has reported good internal consistencies  
233 ( $\alpha=.91-.95$ ) and test-retest reliabilities between 1 to 4-months ( $r=.88-.80$ ) (see Barkham et al., 2010).  
234 In the present sample, the internal consistency was  $\alpha=.94$ .

235

236 Therapist Assessment and End of Therapy forms

237

238 There are two practitioner-completed forms designed to complement the CORE-OM with  
239 contextual information including the Therapy Assessment Form (TAF) which further profiles the  
240 service-user about their problems and journey into therapy, along with the End of Therapy Form (EOT)  
241 which records their problems and pathway through therapy. Both the TAF and EOT contain domain  
242 measures of problems including Depression, Anxiety, Personality Problems, Trauma/Abuse, Self-  
243 Esteem and Interpersonal relationships, rated on a 6-point Likert scale from 'Not at all' (0) to 'Causing  
244 severe impairment in all areas' (5), along with Risk categories of Suicide, Self-Harm, and Harm to  
245 others, rated 'None' (0), 'Mild' (1), 'Moderate' (2), and 'Severe' (3). The TAF provides information on

246 Assessment Outcome (Accepted, Unsuitable/Referred On, Assessment Only) and Waiting Times (from  
247 the Date of Referral to the Date of First Assessment Session), while the EOT records information about  
248 Therapy Engagement (Sessions Attended and Non-attended) and Ending Type (Planned, Unplanned,  
249 or Unknown (for those without an ending recorded)). To review the missing data effects on Ending  
250 Types, those marked 'Unplanned' endings were also combined with those missing endings data  
251 ('Unknown'). While it's not possible to accurately know what proportion of those with missing data were  
252 Unplanned, it offers a comparative estimate with reduced sampling bias.

253

## 254 Procedure

255

256 The service collects and collates routine CORE-OM data at assessment and then every 6-months  
257 during treatment, with the first and last completed measures representing pre- and post-scores. Given  
258 the delay between assessment and therapy starting, score changes were calculated as pre- and post-  
259 therapy. The CORE-OM is completed independently by the service-user and is handed to clerical staff  
260 who then enter the responses into an information management system (CORE IMS) where it is  
261 available for practitioners to review. The supporting practitioner completes the TAF following the  
262 assessment process and EOT upon completion of the intervention, recording whether the ending was  
263 planned or unplanned (i.e., a premature disengagement not jointly agreed upon by the service-user  
264 and practitioner). A service dataset extracted cases assessed, accepted into therapy, and completed  
265 interventions (planned/unplanned).

266

## 267 Data analysis

268

269 Descriptive statistics for each variable and the proportions of cases reaching the thresholds for  
270 clinical and/or reliable improvement as defined by the CORE-OM will be reported. Pre- and post-  
271 treatment data, including change in CORE-OM scores, TAF to EOT number of problems, and risk ratings,

272 were analysed statistically using non-parametric Wilcoxon and Mann-Whitney U tests to assess the  
273 magnitude of change.

274

275 Participant complexity is calculated using the baseline CORE-OM scores and TAF problem ratings.  
276 A series of non-parametric Wilcoxon and Mann-Whitney U tests assessed the profiles accessing  
277 therapy versus those declining as well as those with planned versus unplanned endings. Non-  
278 parametric tests were used based on the psychometric data and parametric analytic requirements not  
279 being satisfied. All statistical analyses were performed using SPSS v.28.

280

## 281 Ethical considerations

282

283 Data collection complied with data protection and information governance protocols and service-users  
284 gave consent for their data to be used for this research. This study obtained ethical approval from the  
285 NHS Research Ethics Committee (Ref: 17/WM/01202).

## 286 Results

287

### 288 Participants

289

290 Over 10 years, the service received n=2,042 referrals, of which n=1,349 were offered an  
291 assessment, n=1,049 were assessed, and n=729 was Accepted for Therapy. Of those assessed, n=1,022  
292 had a valid pre-CORE, and n=474 had a valid pre- and post-CORE. The sample with a valid pre-CORE  
293 had an average age of 37.7 years (SD=11.46), were mostly Female (71.3%), White (82.7%), either  
294 Employed (25.8%) or not stated (26.9%), on Medication (at intake) (69.0%), Not living with a Partner  
295 (61.7%), and were not Caring for Children (74.6%) (see Table 1 for Sample Characteristics).

296

## 297 Engagement

298

299 The average Waiting Time was 49.25 days (SD=55.95) and there were no significant differences  
300 between subgroup characteristics. The average Attendance was 31.7 (SD=30.14) sessions and  
301 nonattendance was 26.0% (SD=22.60%) with no significant differences in characteristics except for  
302 Gender and Living Situation. Although there were no differences in Nonattended rate between  
303 Genders ( $p=.617$ ) or Living with a Partner ( $p=.165$ ), Females ( $M=36.7$ ; Mean Rank (MR)=180.10)  
304 reported significantly higher sessions attended than Males ( $M=26.1$ ;  $MR=149.88$ ) ( $Z=2.64$ ,  $p=.008$ ), as  
305 did those Living with a Partner ( $M=35.3$ ;  $MR=184.20$ ) than without ( $M=29.7$ ;  $MR=159.57$ ) ( $Z=2.26$ ,  
306  $p=.024$ ).

307

## 308 Assessment outcomes

309

310 The majority were Accepted for Therapy (69.5%), followed by those deemed Unsuitable/Referred  
311 on (15.6%), offered an Assessment Only/Long Consultation (13.1%), and No Data (1.9%). Kruskal-Wallis  
312 and Chi-squared tests analysing Assessment Outcomes of all assessed ( $n=1,030$ ; excluding No Data  
313 ( $n=19$ )) showed no significant differences in sample and engagement characteristics apart from  
314 Employment status ( $X(8)=0.191$ ,  $p<.001$ ) and pre-CORE scores ( $H(2)=10.03$ ,  $p=.007$ ). Post-hoc  
315 comparisons using Bonferroni adjustments and adjusted residuals showed those Employed (78.4%)  
316 had higher proportions of Accepted ( $Z=3.44$ ,  $p<.001$ ), and those on Long Term Sick, Disabled or  
317 Benefits (54.2%) had lower proportions of Accepted ( $Z=-5.06$ ,  $p<.001$ ) and higher proportions of  
318 Unsuitable/Referred on (24.3%) ( $Z=3.84$ ,  $p<.001$ ). Those Accepted ( $M=22.2$ ;  $MR=485.89$ ) had  
319 significantly lower pre-CORE scores than Assessment only ( $M=24.0$ )  $MR=570.43$ ) ( $p=.006$ ) but no  
320 differences for either with Unsuitable/Referred on ( $p>.340$ ).

321

## 322 CORE-OM

323

324 Table 1 details overall and subgroup pre- and post-CORE scores. The overall pre-CORE score  
325 (n=1,022) was in the 'moderate-to-severe' range (M=22.7, SD=7.15) and post-CORE score (n=474) in  
326 the 'moderate' range (M=17.8, SD=8.47). These scores are higher than an NHS benchmarking study of  
327 primary, secondary, and tertiary care services (n=1,309), with pre-CORE scores of 17.41 and post-  
328 scores of 8.50 (Stiles et al., 2006).

329

## 330 Pre-CORE (intake) scores

331

332 Spearman's rank correlation tests found no significant associations between pre-CORE scores and  
333 waiting times or sessions attended. The analysis did find a significant, small, and positive correlation  
334 with nonattendance rate ( $r=.147$ ,  $p=.009$ ), indicating those with higher intake scores were more likely  
335 to not attend sessions. Mann-Whitney U tests showed significantly higher scores for Females (M=23.0;  
336 MR=524.10) to Males (M=21.9; MR=480.15) ( $Z=-2.15$ ,  $p=.031$ ), those on Medication (at intake)  
337 (M=23.6; MR=539.51) to not (M=20.5; MR=415.24), ( $Z=-6.21$ ,  $p<.001$ ), and those not Living with a  
338 Partner (M=22.9; MR=532.31) to those that were (M=21.5; MR=463.93) ( $Z=-3.62$ ,  $p<.001$ ), but no  
339 differences in Caring for Children ( $p=.202$ ). Although a Kruskal-Wallis test reported significant  
340 differences in Ethnic Origin ( $H(4)=14.80$ ,  $p=.005$ ), when post-hoc comparisons were adjusted using  
341 Bonferroni corrections, the differences between specific groups were non-significant ( $p>.054$ )  
342 suggesting that subgroup comparisons were underpowered due to their relative sizes. There were  
343 significant differences in Employment ( $H(4)=72.65$ ,  $p<.001$ ) with post-hoc comparisons using  
344 Bonferroni adjustments showing those Unemployed (M=24.4; MR=582.06) had higher scores than  
345 Employed (M=20.7; MR=431.17) ( $p<.001$ ), or Other (M=21.2; MR=455.25) ( $p=.002$ ) and those on Long  
346 Term Sick, Disabled or Benefits (M=25.9; MR=645.91) showing higher scores than Employed ( $p<.001$ ),  
347 or Other ( $p<.001$ ).

348

349 *Table 1: Overall and subgroup pre- and post-CORE scores*

|  | Pre-CORE Score    |             | Post-CORE Score   |             |
|--|-------------------|-------------|-------------------|-------------|
|  | N<br>(% of Total) | M (SD)      | N<br>(% of Total) | M (SD)      |
| <b>Total</b>                               | 1,022             | 22.7 (7.15) | 474               | 17.8 (8.47) |
| <b>Age (Years)<sup>1</sup></b>             | 37.7 (11.46)      |             | 38.7 (11.5)       |             |
| <b>Gender</b>                              |                   |             |                   |             |
| Male                                       | 293 (28.7%)       | 21.9 (7.03) | 128 (27.0%)       | 17.2 (8.31) |
| Female                                     | 729 (71.3%)       | 23.0 (7.15) | 346 (73.0%)       | 18.0 (8.48) |
| <b>Ethnic Origin</b>                       |                   |             |                   |             |
| White/Caucasian                            | 845 (82.7%)       | 22.5 (7.08) | 399 (84.2%)       | 17.6 (8.43) |
| Asian/Asian British                        | 70 (6.8%)         | 21.4 (7.83) | 34 (7.2%)         | 16.3 (8.52) |
| Black, Black British, Caribbean or African | 36 (3.5%)         | 24.1 (7.26) | 18 (3.8%)         | 21.6 (6.95) |
| Other/Mixed/Multiple                       | 39 (3.8%)         | 24.7 (6.42) | 8 (1.7%)          | 19.2 (8.01) |
| Not Stated                                 | 32 (3.1%)         | 26.1 (6.16) | 15 (3.2%)         | 21.2 (9.26) |
| <b>Employment</b>                          |                   |             |                   |             |
| Employed                                   | 264 (25.8%)       | 20.7 (6.87) | 141 (29.7%)       | 15.5 (7.70) |
| Unemployed                                 | 167 (16.3%)       | 24.4 (6.53) | 78 (16.5%)        | 20.6 (7.70) |
| Long Term Sick, Disabled or Benefits       | 177 (17.3%)       | 25.9 (6.24) | 67 (14.1%)        | 21.2 (8.39) |
| Other <sup>2</sup>                         | 139 (13.6%)       | 21.2 (6.74) | 59 (12.4%)        | 17.3 (8.38) |
| Not Stated                                 | 275 (26.9%)       | 22.1 (7.50) | 129 (27.2%)       | 17.2 (8.80) |
| <b>Medication (at intake)</b>              |                   |             |                   |             |
| Yes  | 705 (69.0%)       | 23.6 (6.86) | 326 (69.8%)       | 18.3 (8.30) |
| No   | 299 (29.3%)       | 20.5 (7.29) | 141 (30.2%)       | 16.6 (8.66) |
| No Data                                    | 18 (1.8%)         | 24.6 (8.50) |                   |             |
| <b>Living Situation</b>                    |                   |             |                   |             |
| Living with a Partner                      | 389 (38.5%)       | 21.5 (6.78) | 191 (40.7%)       | 17.3 (8.43) |
| Not Living with a Partner                  | 622 (61.5%)       | 22.9 (6.85) | 278 (59.3%)       | 18.2 (8.44) |
| <b>Caring for Children</b>                 |                   |             |                   |             |
| Yes  | 257 (25.4%)       | 21.8 (6.64) | 128 (27.0%)       | 17.6 (8.00) |
| No   | 754 (74.6%)       | 22.5 (6.91) | 346 (73.0%)       | 17.9 (8.67) |
| <b>Assessment Outcome</b>                  |                   |             |                   |             |
| Accepted for Therapy                       | 710 (69.5%)       | 22.2 (6.87) | -                 | -           |
| Assessment Only/Long Consultation          | 133 (13.0%)       | 24.0 (7.78) | -                 | -           |

|                                 |             |                    |             |                    |
|---------------------------------|-------------|--------------------|-------------|--------------------|
| Unsuitable/Referred on          | 160 (15.7%) | 22.8 (7.53)        | -           | -                  |
| No Data                         | 19 (1.9%)   | 28.1 (5.34)        | -           | -                  |
| <b>Ending type<sup>3</sup></b>  |             |                    |             |                    |
| Planned                         | 284 (40.0%) | 21.4 (6.87)        | 238 (52.0%) | 15.9 (8.66)        |
| Unplanned                       | 122 (17.2%) | 23.8 (6.92)        | 62 (13.5%)  | 20.3 (8.77)        |
| <b>Unplanned &amp; Unknown?</b> | 429 (60.0%) | <b>22.6 (6.71)</b> | 221 (48.0%) | <b>19.8 (7.21)</b> |

<sup>1</sup> N=1,019

<sup>2</sup> Other=Student, Homemaker not working or actively seeking work, Unpaid voluntary work, not working or actively seeking work, Retired

<sup>3</sup> Of Accepted for therapy (n=729) with valid pre/post CORE measures

\*\*p<.001

350

351 Pre-to-Post Change

352

353 For those with both valid pre-and-post CORE forms, the average score change was M=4.3 (SD=7.32).

354 A Wilcoxon signed rank test found significant differences in pre-to-post CORE scores (Z=-10.99, p<.001)

355 with a moderate effect size of r=-.50. There were no significant differences in CORE scores for all sample

356 and engagement characteristics.

357

358 *CORE subdomain scores*

359

360 The sample reported significant reductions and moderate effect sizes in each of the CORE

361 subdomains including Subjective Wellbeing (Z=-10.81, p<.001, r=-.50), Problems/Symptoms (Z=-11.21,

362 p<.001, r=-.51), Functioning (Z=-9.26, p<.001, r=-.43), and Risk (Z=-7.72, p<.001, r=-.35). The effect

363 sizes were lower than the NHS Benchmark figure of 1.36 (Stiles et al., 2006).

364

365 *Table 2: Comparisons of CORE Total and Domain Scores for those with valid pre-and-post CORE scores (n=474)*

|                             | Pre-Score   | Post-Score   | Z        | Effect Size (r) |
|-----------------------------|-------------|--------------|----------|-----------------|
|                             | M (SD)      | M (SD)       |          |                 |
| <b>CORE Total</b>           | 22.1 (6.77) | 17.8 (8.47)  | -10.99** | -0.50           |
| <b>Subjective Wellbeing</b> | 27.1 (8.17) | 21.7 (10.49) | -10.81** | -0.50           |

|                          |             |             |           |       |
|--------------------------|-------------|-------------|-----------|-------|
| <b>Problems/Symptoms</b> | 26.2 (7.51) | 21.2 (9.72) | -11.201** | -0.51 |
| <b>Functioning</b>       | 22.5 (7.20) | 18.7 (8.90) | -9.26**   | -0.43 |
| <b>Risk</b>              | 9.4 (8.56)  | 6.6 (7.66)  | -7.72**   | -0.35 |

---

\*\* $p < .001$

366

## 367 Ending types

368

369 The ending types of those Accepted for Therapy (n=729) were 44.0% Unknown, 39.2% Planned,  
 370 and 16.7% Unplanned. There were no significant differences in Age between Planned (M= ;  
 371 MR=394.83) and Unplanned (M= ; MR=352.50) ( $p > .182$ ), unless Unplanned was combined with  
 372 Unknown (M= ; MR=) ( $Z = -3.074$ ,  $p = .002$ ). Chi-Squared tests showed no significant findings in other  
 373 sample characteristics or Waiting times. Due to the source of data for engagement (e.g., EOT form),  
 374 those with Unplanned and Unknown endings were combined. There were significantly higher sessions  
 375 attended ( $Z = -7.96$ ,  $p < .001$ ) for Planned (M=38.8; MR=200.03) than Unplanned and Unknown (M= ;  
 376 MR=109.58), and lower Nonattendance rates ( $Z = -9.83$ ,  $P < .001$ ) for Planned (M=17.2%; MR=121.73)  
 377 than Unplanned and Unknown (M= ; MR=229.65). There were significantly higher pre-CORE scores  
 378 between Planned (M=21.4; MR=327.72) and Unplanned (M=23.8; MR=401.13) ( $p = .003$ ) endings but  
 379 no significant differences between Planned to Unplanned and Unknown (M= ; MR=363.14) ( $p > .109$ )  
 380 ( $H(2) = 11.67$ ,  $p = .003$ ). There were also statistically significant differences in CORE score changes  
 381 between Ending Type ( $H(2) = 18.95$ ,  $p < .001$ ). Post-hoc comparisons using Bonferroni corrections  
 382 revealed no significant differences between Planned (M=5.7; MR=254.74) and Unplanned (M=3.5;  
 383 MR=222.28) ( $p > .258$ ) though did so when Planned was compared with Unplanned and Unknown (M=  
 384 ; MR=203.36) ( $Z = -4.147$ ,  $p < .001$ ).

385

## 386 Therapist ratings

387

388 *Problem severity*

389

390 There were significant reductions in therapist assessments of problem severity from pre-to-post-  
 391 treatment, with the highest changes recorded for Depression (M=0.85, SD=1.15) (Z=-10.70, p<.001)  
 392 and Anxiety (Z=-9.66, p<.001) (M=0.73, SD=1.10) and least Personality problems (M=0.49, SD=1.10)  
 393 (Z=-5.81, p<.001). The effect sizes ranged from moderate-to-large (r=-0.58 to -0.41) with severity  
 394 classifications moving from around 'Moderate' (3) to 'Mild' (2) (see Table 4). These effect sizes are  
 395 slightly higher but equivalent to the overall CORE effect sizes detailed in a previous section.

396

397 *Table 3: Therapist problem severity ratings pre-and post-treatment*

|                                    | Pre-Treatment              |             | Post-Treatment       |             | Pre-to-Post Problem Severity |                |                 |
|------------------------------------|----------------------------|-------------|----------------------|-------------|------------------------------|----------------|-----------------|
|                                    | Severity Rating            |             | Severity Rating      |             | Rating Change                |                |                 |
|                                    | N (% of assessed (n=1049)) | M (SD)      | N (% of EOT (n=464)) | M (SD)      | M (SD)                       | Test Statistic | Effect size (r) |
| <b>Depression</b>                  | 918 (87.5%)                | 2.79 (0.90) | 357 (76.9%)          | 2.00 (1.00) | 0.85 (1.15)                  | Z=-10.70**     | -0.58           |
| <b>Anxiety</b>                     | 851 (81.1%)                | 2.88 (0.87) | 347 (74.8%)          | 2.17 (0.98) | 0.73 (1.10)                  | Z=-9.66**      | -0.55           |
| <b>Personality Problems</b>        | 671 (64.0%)                | 2.97 (0.87) | 252 (54.3%)          | 2.39 (0.95) | 0.49 (1.10)                  | Z=-5.81**      | -0.41           |
| <b>Trauma Abuse</b>                | 583 (55.6%)                | 3.01 (0.92) | 226 (48.7%)          | 2.34 (1.02) | 0.70 (0.99)                  | Z=-7.79**      | -0.57           |
| <b>Self Esteem</b>                 | 754 (71.9%)                | 3.02 (0.86) | 314 (67.7%)          | 2.25 (0.99) | 0.72 (1.12)                  | Z=-8.90**      | -0.54           |
| <b>Interpersonal relationships</b> | 909 (86.7%)                | 3.08 (0.86) | 379 (81.7%)          | 2.40 (0.99) | 0.58 (1.17)                  | Z=-8.38**      | -0.47           |

\*\*p&lt;.001

398

399

400 *Risk*

401

402 There were significant reductions in therapist assessments of risk from pre-to-post-treatment, with  
 403 the largest change observed in Self-Harm (M=0.20, SD=0.70) (Z=-5.67, p<.001), followed by Suicide  
 404 (M=0.14, SD=0.68) (Z=-4.07, p<.001), and then Harm to Others (M=0.09, SD=0.42) (Z=-4.12, p<.001)  
 405 (see Table 5). Risk ratings shifted from around 'Mild' (1) to 'None' (0), with the effect sizes in the low  
 406 range, and lower than the CORE Risk score effect sizes detailed in a previous section.

407

408 *Table 4: Therapist risk ratings pre-and-post-treatment*

|                | Pre-Treatment              |             | Post-Treatment       |             | Pre-to-Post Risk Rating Change |                |                 |
|----------------|----------------------------|-------------|----------------------|-------------|--------------------------------|----------------|-----------------|
|                | Risk Rating                |             | Risk Rating          |             |                                |                |                 |
|                | N (% of Assessed (n=1049)) | M (SD)      | N (% of EOT (n=464)) | M (SD)      | M (SD)                         | Test Statistic | Effect size (r) |
| Suicide        | 1,016 (96.9%)              | 0.75 (0.75) | 417 (89.9%)          | 0.51 (0.66) | 0.14 (0.68)                    | Z=-4.07**      | -0.20           |
| Self-Harm      | 1,006 (95.9%)              | 0.98 (0.86) | 412 (88.8%)          | 0.66 (0.76) | 0.20 (0.70)                    | Z=-5.67**      | -0.28           |
| Harm to Others | 963 (91.8%)                | 0.28 (0.55) | 400 (86.2%)          | 0.14 (0.36) | 0.09 (0.42)                    | Z=-4.12**      | -0.21           |

\*\* $p < .001$ 

409

410

411

## 412 Discussion

413

### 414 The effectiveness of psychodynamic therapies within an NHS mental health service

415

416 In a naturalistic study of retrospective clinical data, psychodynamic therapy provided within this  
417 NHS service appeared to be effective. The analysis uncovered moderate-to-large effect sizes, including  
418 overall and within subdomains, and around half moving towards reliable improvement. These findings  
419 were observed in a complex caseload, as evidenced by intake scores and problem severity ratings.  
420 Improvement in problems/symptoms and subjective wellbeing showed higher effect sizes than  
421 functioning and risk. Functional items contain complex relational components and may reflect  
422 entrenched and difficult-to-address aspects of psychological distress (e.g., *"I have felt humiliated or*  
423 *shamed by other people"*). It aligns with the psychodynamic approach of exploring and processing  
424 underlying object relations to alleviate distress (Lindfors et al., 2015). The therapist's problem severity  
425 ratings showed greater changes in depression and anxiety than personality and interpersonal  
426 difficulties. This observation strengthens the idea of entrenched aspects of distress being more  
427 challenging to address. That said, the results do demonstrate meaningful change across multiple  
428 components of measured psychological distress. Accordingly, psychodynamic therapy provided within  
429 this service seems to be a valuable option for addressing ingrained, complex, and long-standing mental  
430 health problems, producing changes in symptoms, wellbeing, functioning, and interpersonal relating.  
431 This is particularly fitting for complex presentations and enacting long-lasting change demanded of  
432 NHS therapy provision at a tertiary level.

433

### 434 Understanding the suitability of Psychodynamic Therapies for Complex Presentations 435 within an NHS mental health service

436

437 Regarding this paper's second objective, certain characteristics of the sample displayed varying  
438 levels of severity and engagement styles that are informative for service provision. The sample

439 consisted mainly of middle-aged, White/Caucasian, or those Unemployed or on Long-term sick,  
440 Disabled, or Benefits, which corresponds with data from NHS England (NHS Digital, 2022). Participants  
441 who were employed and had lower intake scores were more likely to be accepted for therapy than  
442 referred on, in comparison to those who were on long-term sick, disabled, or benefits or had higher  
443 intake scores. As the overall intake scores were classified as "moderate-to-severe," it is possible those  
444 in the "severe" category along with being more likely to experience social adversities, may not be  
445 suitable for therapy at that time. It is worth noting the decision to accept or signpost elsewhere is a  
446 collaborative process with the service-user and based on priority interests.

447

448 Female participants, those with partners, or those with lower scores recorded higher session  
449 attendance and engagement than males, those without partners, or those with higher intake scores.  
450 Notably, individuals without partners, unemployed, on medication, or female reported higher intake  
451 scores, which could indicate a marginalised or disenfranchised group more likely to face social  
452 adversity or have longer standing contact with services (Jin & Mosweu, 2017; Naylor et al., 2012). Once  
453 engaged, those attending more sessions more consistently were likely to have a planned ending,  
454 perhaps reflecting a positive therapeutic relationship to produce an agreed ending. It is worth  
455 mentioning there were associations between the ending type and intake scores or age, but no  
456 apparent link with other engagement factors such as waiting times. This suggests that service-user  
457 characteristics more than waiting to access was more informative at determining eventual  
458 engagement.

459

460

## 461 Implications

462

463 Within the psychodynamic therapy field, the range of study methodologies is diverse (Fonagy et al.,  
464 2015) and there is growing appreciation for methodological pluralism and practice-based evidence

465 (Barkham et al., 2010; Wakefield et al., 2021). Studies using controlled methodologies support the use  
466 of psychodynamic therapies (Leichsenring et al., 2013) and the findings from this study support its use  
467 in clinical settings by extending its ecological validity. This research examined routine clinical data to  
468 observe psychodynamic therapies in action and within an NHS specialist service context. Aside from  
469 the confounding factors common to practice-based research, particularly in supporting those with  
470 multiple, complex, and enduring mental health problems, the findings support the role of this  
471 specialist model. This value is further supported by evidence suggesting other therapeutic models  
472 reduce in effectiveness within secondary and tertiary care settings (Taylor et al., 2012).

473

474 Specialist therapy services provide support for those with complex and enduring mental health  
475 problems who have not responded to other interventions or require longer and more exploratory  
476 approaches. The findings support the use of psychodynamic therapies within this service context and,  
477 as shown by the equitable changes across subgroups, likely reflects the value of a responsive, flexible,  
478 and relational dynamic approach for those with complex and changing needs. Psychodynamic therapy  
479 tends to be longer-term than comparators such as CBT but as argued by Shedler (2010), there is greater  
480 emphasis on sustaining underlying psychological change as opposed to symptom management which  
481 seems relevant for targeting underlying personality functioning. The Tavistock group champion  
482 interventions that adapt to personality features when treating resistant depression (Rost et al., 2019),  
483 demonstrating the value of this specialist service delivering dynamic approaches.

484

485 The study supports the use of psychodynamic therapies within a specialist NHS service treating  
486 complex mental health problem which is in keeping with other findings (Fonagy et al., 2015;  
487 Leichsenring et al., 2013). It is possible the relational approach of psychodynamic therapy which  
488 attempts to uncover unconscious and unexpressed emotional states enables symptom reduction and  
489 increased daily functioning. These changes can be experienced in therapeutic relationships as an

490 emotional struggle between the service-user and therapist (Haskayne et al., 2014). The therapeutic  
491 couple contract to engage in trying to understand the personal meanings of the stories, enactments,  
492 and feelings the individual brings to the therapeutic relationship, which in turn reduces psychological  
493 distress. This way of working facilitates integrated thinking about clinical containment of risk, which is  
494 particularly important when working with a high-risk population.

495

496 The analyses reveal several important clinical characteristics that appear to influence  
497 psychodynamic therapy engagement and outcome within this service context. While the acceptance  
498 rate was moderately high, those with higher intake scores and Unemployed/Long Term Sick, Disabled  
499 or on Benefits appeared less likely to be accepted although no more likely to have an unplanned ending  
500 once accepted. There were also indications that younger service-users were more likely to have an  
501 unknown than planned ending which as whole reported lower session attendance and CORE score  
502 change. While unknown does not infer unplanned, its suggestive of younger individuals losing contact  
503 with services without notification. Comparisons between therapist and self-report recordings of  
504 problem severity suggest a slight level of discrepancy in how each perceives the difficulties, prompting  
505 a need for greater dialogue regarding shared understandings of a service-user's problems. Accordingly,  
506 this supports initial and ongoing assessments of a person's responses to psychodynamic therapy in  
507 clinical settings while being mindful of the factors reducing acceptance and engagement rates. The  
508 limited difference in observed CORE score changes across other socio-demographic factors and  
509 variable intake scores indicate a responsive approach towards diverse presentations.

510

## 511 Limitations

512

513 Many of this study's limitations are common to naturalistic, practice-based studies, including the  
514 lack of control groups, non-measured treatment fidelity, variable data quality, and cross-sectional

515 design. Learning from the dose-effect and common factors literature suggests the length of therapy  
516 may be beneficial in and of itself, regardless of modality, thereby challenging the role of intervention-  
517 specific techniques from simply delivering higher sessions (Robinson et al., 2020). As part of the service  
518 pathway, the service-user's referring care team is responsible for reviewing and supporting ongoing  
519 care plans. While consultation and joint appraisal occur, it is unclear to what extent additional  
520 interventions, including psychotropic medication, are provided. While service-users must not receive  
521 parallel psychotherapy as stipulated by the service's criteria, it is not possible to attribute the observed  
522 effects to the intervention alone versus other concurrent medication or psychosocial programmes  
523 including occupational and nursing support. That said, as the service operates along tertiary levels and  
524 acts as an alternative for referrers, it's typical that service-users will have received other psychosocial  
525 interventions previously as shown by their longer-standing issues. Such is the nature of complex and  
526 enduring mental health problems that the provision of psychotherapies in isolation is not in keeping  
527 with the clinical realities of treating difficulties requiring multidisciplinary support. Finally, as well as  
528 the low to variable data quality of post-treatment CORE scores, these measures represent a narrow  
529 perspective of improvement and are limited in conveying the level of inner change, characterised by  
530 increased emotional resilience, insight, and sense of meaning (Shedler, 2010; Waddell, 2002). While  
531 this study attempted to address these limitations by triangulating service-user and therapist measures,  
532 future work would benefit from qualitative assessments of inner change as recommended by the  
533 Operationalised Psychodynamic Diagnosis Manual (OPD Force, 2008). The service has also began  
534 implementing 6-to-12-month follow-up psychometric assessments to evaluate change beyond the end  
535 of therapy.

536

## 537 Conclusions

538

539 This paper analysed 10-years of retrospective clinical data to assess the effectiveness of  
540 psychodynamic therapies within an NHS mental health service. The results showed that

541 psychodynamic therapy delivered within a naturalistic context was effective based on self and  
542 therapist-reported psychometrics. Analyses of intake presentations indicated a characteristically  
543 complex population, supporting the service's role in treating entrenched difficulties. Certain subgroup  
544 characteristics appeared less likely to engage and were interpreted as a potentially marginalised and  
545 disenfranchised group requiring greater attention and input from services. Limited score changes  
546 between subgroups suggest that despite the variable intake profiles, the therapy was responsive and  
547 flexible according to individual needs. Overall, the data reported a mostly consistent effectiveness rate  
548 and moderate-to-large effect sizes at broader and subdomain levels relevant to mental health care.

549

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