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Child psychoanalytic psychotherapy in the UK National Health Service: an historical analysis

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This review developed from a discussion with the late Professor Richard Harrington about interventions in Child and Adolescent Mental Health services (CAMHS) that lacked an evidence base. Our aim is to investigate the literature for signs that child psychoanalysis is a declining paradigm within the Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom (UK). We present the literature chronologically since the inception of the UK National Health Service. This study shows that there have been a number of threats to child psychoanalytic psychotherapy, but no significant consistent decline. The profession is beginning to develop the social profile of a scientific discipline. We conclude that child psychoanalytic psychotherapy does not consistently demonstrate features of a declining scientific paradigm.

Keywords: *Child and Adolescent Mental Health Services (CAMHS); history; National Health Service; psychoanalysis; United Kingdom*

Introduction

This review has arisen because of concerns raised by CAMHS practitioners about the place of child psychoanalytic psychotherapy within publicly funded services. Examples of perceived threats are: funded posts not being replaced; concerns about the potential employment of those currently in training; and newly funded posts being frozen because of financial pressures. Clearly these

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kinds of anxieties are not exclusive to the discipline of child psychoanalytic psychotherapy, but of particular interest was the lack of a formal evidence base as perceived by the medical establishment. (Goldbeck-Wood and Fonagy, 2004), which may put it at risk of becoming obsolete. Child psychoanalytic psychotherapy is an important part of the history of Child and Adolescent Mental Health Services and, some argue, an important part of the history of child psychiatry. To quote Pearsall (1997: 595): 'It is no idle task to ask, at this juncture, what place psychotherapy has in contemporary child and adolescent psychiatry. It has more than historical value: in many ways it is the history.'

Child psychoanalytic psychotherapy remains a component of child psychiatry training in the UK, and concepts such as transference and projected feelings form part of everyday practice. However, the availability of psychoanalytical treatment for children remains patchy (Northern School of Child and Adolescent Psychotherapy, 2007). This review looks at the development of child psychoanalytic psychotherapy since the inception of the National Health Service (NHS), both as a treatment and as a discipline.

Method

Definitions of child psychoanalytic psychotherapy

The literature search used both the terms psychotherapy and psychoanalysis. This more inclusive strategy was necessary because, while several studies and authors used the term psychotherapy to mean exclusively psycho-dynamically informed interventions, others used it, less specifically, to include a range of therapeutic interventions. Cognitive behaviour therapy, parent training and behaviour therapy are examples of these.

Underlying assumptions of this review

There is an extensive literature on the history of psychoanalysis and a range of opinion about whether it is a science (Hale, 1995; Rustin, 2003; Strenger, 1991). However, to have a place in the UK NHS in the later part of the twentieth century, it became necessary for a treatment to have a strong evidence base (Goldbeck-Wood and Fonagy, 2004). Therefore, this review looks for signs that child psychoanalytic psychotherapy is positioning itself as a scientific discipline, in recognition that this is a necessary prerequisite to establishing an evidence-based practice. The search terms used in the review are included in the Appendix.

Results

Chronological review of the literature

(i) Establishment of child psychoanalysis in the NHS (1948–57)

In the immediate post-war period, some training of psychoanalysts was established within the public sector, and a professional body for child psychotherapists

was set up. In the early days of the NHS the two main settings for child psychotherapy training were the Tavistock Institute and the Hampstead Clinic. At the Tavistock, psychotherapy training for doctors was funded by the state. Nine posts were agreed by the regional board in 1949, two of which were in the children's department run by Bowlby (Dicks, 1970). The Tavistock was also recognized for the training of other professional groups, with much of the funding for teaching coming from donations and grants. Training programmes were founded by John Bowlby and Ester Bick, entirely within the NHS (Lush, 1999). Bick initiated an infant observation in the early post-war period (Grosskurth, 1985). Bowlby also ran internationally recognized research projects with funding obtained from the Medical Research Council (Dicks, 1970; Pines, 1991).

Anna Freud, by contrast, funded the Hampstead Clinic from private monies, sourcing American Charitable Foundations (Solnit *et al.*, 1975). Although it opened in 1952 (Miller, 2004), she struggled for many years to gain recognition of her training from the International Psychoanalytical Association and The British Institute of Psychoanalysis (Geissmann and Geissmann, 1998). The controversies between Anna Freud and Melanie Klein had dominated the pre-NHS decade (King and Steiner, 1991) and led to conflict within the British Psychoanalytic Society (Essenhigh and Sinasoni, 1995). The Society's solution to this unresolved conflict was to set up different training streams in the UK, one based on Anna Freud's teachings (known as course B) and one based on the teachings of analysts not associated with her (known as course A) (Grosskurth, 1985).

In 1953 the training committee of the British Psychoanalytic Society reduced the proportion of training events run by Kleinian analysts to make more space for the Independent school championed by Winnicott, a children's doctor from Paddington Green Hospital. As a doctor, Winnicott had shared many of the medical profession's reservations about the NHS prior to its inception (Rodman, 1987). However he is credited with having the foresight, along with Bowlby, to prepare for the inclusion of psychotherapy in the state-funded service (Zaretsky, 1999). He expressed strong views about the structure of training programmes in child psychotherapy. In 1954 he wrote to Miss Freud and Mrs Klein asking them to abandon the separate training groupings. He clearly felt excluded by both the Freudians and the Kleinians as, for a significant period, neither Klein nor Freud would allow their students to use him as a training resource.

In contrast to the divisions between schools runs a parallel story of unity: the formation of the Association of Child Psychotherapists. This organization evolved from the Provisional Association of Child Psychotherapists (non-medical), which was formed in 1949. The impetus came from the British Psychological Society, which was concerned about the training and status of non-medical practitioners in child psychotherapy (Lush, 1999). The Provisional Association started with 15 members, all of whom had academic qualifications

in psychology and considerable experience in child psychotherapy. The term non-medical remained until the 1970s, when medically trained members were included.

Sander (1993) contrasts the working relationships that were maintained between the dominant schools in the UK in the post-war era with the situation in the USA. Compared with the USA, in the UK a coexistence of paradigms was nurtured. Sander credits Ernest Jones, the founder of the British Psychoanalytical Society, with the comparative harmony that was sustained, despite conflicting theoretical positions and differing practice between the different schools. Indeed the differences between the USA and Britain were reflected in the pre-war membership of the British Psychoanalytical Association, which had a strong non-medical component. This led to more opportunities for women, who tended to have backgrounds in education and were interested in child rather than adult psychoanalysis (Zaretsky, 1999). Interestingly, the emergence of the neo-Kleinians (including Winnicott) is characterized by Zaretsky as the 'remasculinization of British Analysis', i.e., Melanie Klein was no longer the 'emblematic analyst' (Zaretsky, 1999: 150) in the post-war period.

(ii) Early threats to psychotherapy (1952–77)

As child psychotherapy in the UK made steps to establish an identity separate from adult psychotherapy in the 1950s, psychotherapy started to receive attacks from the behavioural psychologists. Eysenck's challenge in 1952 is quoted by several authors (Eysenck, 1985; Hibbs, 2001; Kazdin, 1978; Tramontana, 1980). He reviewed the literature on the efficacy of psychotherapy and concluded that psychotherapy made no impact on the process of spontaneous remission (Eysenck, 1952/1973). His further work was dismissive of Freudian psychotherapy, while he championed behavioural therapy and learning theory. American behaviourists such as Wolpe produced outcome data that compared psychotherapy with behavioural methods, showing better outcomes for the behavioural approach.

Negative studies on the effectiveness of psychotherapy in children also began to emerge from across the Atlantic. Levitt (1957) reached conclusions similar to those of Eysenck. In 1957 Redl and Wineman (Donofrio, 1970) found psychotherapy to be 'useless' in their work with disturbed aggressive children in the Pioneer House Experiment. During this period, behavioural therapy was establishing itself as a rival paradigm. Behaviourists viewed psychodynamic approaches as the 'historically-dominant paradigm' (Kendall, 1995: 2).

Psychoanalysis was clearly feeling threatened by this new rival. In his history of the Tavistock Institute, Dicks (1970) refers to the attacks by Eysenck as 'sustained polemics' that adversely affected the standing of the Tavistock Institute. In the USA the effect appears to have been more dramatic. Several institutions had budget deficits in the 1960s and 1970s because of declining numbers of students (Hale, 1995; Leveille, 2000). Sander (1993) acknowledged a drop in the prestige of traditional psychoanalysis in the USA and

Western Europe. He believed that the introduction of psychoactive drugs was responsible for this change, representing a challenge by the more biologically oriented paradigm of pharmacological interventions. In addition to the introduction of psychotropic drugs, there were concerns about the welfare of patients in large institutions (Forrester, 1994), which ultimately led to the closure of big hospitals and the loss of dominance of psychoanalysis within psychiatry. As Forrester says, in the USA the history of psychoanalysis was more closely linked with the history of psychiatry, with psychoanalysis being a crucial part of training. Indeed, until 1989 it was considered to be essential to be medically qualified to practice.

However, as behavioural therapy became established in the early 1970s, authors began to highlight similarities between behavioural techniques and psychotherapy (Kazdin, 1978), and the attacks diminished. It appears that much of the criticism of psychotherapy had been part of a marketing strategy by the behaviourists. Criticisms of behavioural therapy began to emerge. Kazdin (1978) pointed out that many of the techniques used in behaviour therapy do not neatly stem from learning theory. In 1972, in a paper delivered to the Association for Child Psychology and Psychiatry in London, Graham argued for a more eclectic training of psychologists, including both psychoanalytical and behavioural techniques (Graham, 1974). He criticized both camps: psychoanalysts for their lack of evaluation and neglect of disadvantaged communities; psychologists for their emphasis on diagnostic testing at the expense of healing.

In the meantime, several positive outcome studies of psychoanalysis in adolescents were published (Tramontana, 1980). There was also some evidence of a dose-response relationship in children. Increased frequency of psychotherapy and longer treatment seemed to have better results (Heinicke and Strassmann, 1975), although not all studies were consistent. The phenomenon of the 'sleeping' effect (Wright, Moelis and Pollack, 1976) emerged: outcomes were more positive if they were assessed after a period of follow-up, rather than at the end of therapy. This suggested that previous research might have missed treatment effects by premature outcome measurement. As more research emerged, Eysenck's original work was reassessed. Two researchers reanalysed Eysenck's first study and criticized it for overestimating the recovery rate in the untreated group (Tramontana, 1980).

Yet the critics were not completely silenced. Although psychotherapy survived these threats during the 1960s and 1970s, further challenges were to present themselves in later years, suggesting that the doubts cast by Eysenck retained a legacy.

(iii) Consolidation of child psychotherapy in the UK (1960–89)

Reading the published material by child psychotherapists during the 1960s and 1970s in the *Journal of Child Psychotherapy*, there is no hint of any professional insecurity being generated by the external criticisms outlined above. Although there was no sign of unease in scientific papers, there is evidence of awareness

of a rival paradigm. Winnicott launched a vitriolic attack on behaviour therapy in the treatment of maladjusted children in a letter to the editor of *Child Care News* in 1969. 'I, personally would think of behaviour therapy as an insult to the higher apes' (Winnicott, 1969/1989: 560). He was also an advocate of brief therapy in the form of the squiggle game for selected cases (Kahr, 1996) and less intensive therapy (Rodriguez, 1999), challenging the view that the psychoanalytic approach always involved intensive long-term intervention.

Equally, Anna Freud clearly understood the need to present a robust coherent front to potential critics. Sullivan (1972: 602) describes how she was able to play to her audiences:

It is not difficult to detect two attitudes in A Freud's works, one when she is commenting on psychoanalysts to non-analysts and another for internal consumption. In talking to psychologists, a sharply polemical defensive stance is taken and psychoanalysis is defended as if the doctrines were clear and not contradictory. The misunderstandings seem to be attributed to poor scholarship or defects in attitudes. In internal discussions, the differences of doctrine are discussed with a cool detachment remarkable free of polemical style.

As well as defending themselves against the rise of alternative paradigms, the child psychotherapists took gradual steps towards securing their base within publicly funded programmes. During the 1950s there was little publicly funded provision of child psychotherapy in the UK. The Tavistock clinic received government funding at its inception, but the Anna Freud Centre did not receive any public funding until the late 1960s. In 1967 the Hampstead Clinic (as the Anna Freud Centre was then known) made active steps to offer therapy to underprivileged children (Solnit *et al.*, 1975) by approaching the local authority with the offer of vacant nursery places. A survey of psychiatric social workers in 1969 showed that 30–50% of children referred to them were taken into some form of psychotherapy, yet formally trained psychotherapists were rare outside London (Sampson, 1980)

There were no recognized career structure or salary scales for child psychotherapists, and the discipline lacked a trade union. Eventually, the Association of Scientific, Technical and Managerial Staffs (ASTMS) agreed to negotiate on behalf of the child psychotherapists. Finally, in 1974 child psychotherapists were offered the choice of joining either the Education Service or the National Health Service; they chose the NHS (Radford, 1999). The following year, the Secretary of State formed a Grading Committee to advise Health Authorities on established posts, and psychotherapists became fully-fledged public sector employees.

The *Journal of Child Psychotherapy* started publication in 1963 (Miller, 2004), through the auspices of the Association of Child Psychotherapists (ACP) (Lush, 1999). It continued to be published in-house until 1994 when Routledge Publications took over and increased the number of issues published each year

(Hurst, 1999). Membership of the ACP expanded: in 1962 it was less than 100 (Radford, 1999); by 1986 it had doubled to 200, and by 1989 it had trebled to 300, 200 of whom were working in the UK (Lush, 1999). There was also an expansion in the number of training institutions during this period. The Society of Analytical Psychology and the British Association of Psychotherapists started child psychotherapy training in 1973 and 1982, respectively.

(iv) Further threats to psychotherapy (1977–2000)

As child psychotherapists finally crossed the threshold of the NHS in the UK, psychotherapy in the USA was competing with brief therapies preferred by the Health Maintenance Organizations (HMOs). Cost-effectiveness dominated commissioning strategies (Koocher and D'Angelo, 1992). However, the popularity of brief therapy appears to have been driven by a response to the market, rather than a shift between scientific paradigms by practitioners. A survey of psychiatrists and psychologists working with children, published by Koocher and Pedulla (1977), showed that psychoanalytic theory was still powerful. Only 4% of psychiatrists and 19% of psychologists rejected it totally. The 1970s and 1980s represented the 'age of accountability' (Garfield, 1995: 262) for psychotherapy, and the US Congress was demanding proof of effectiveness prior to agreeing funding for Medicare. Such proof began to be published in the late 1970s as meta-analysis was gaining popularity as a scientific method. The first meta-analysis of psychotherapies in adults appeared in 1977, followed by a more comprehensive study in 1980 (Smith and Glass, 1977; Smith, Glass and Miller, 1980). These studies showed a large effect size for psychotherapy, and were welcomed by psychotherapists. However, the critics of these studies soon emerged, and the debate about efficacy continued into the 1980s.

A similar quest for evidence of efficacy unfolded for child psychotherapy in the USA. The first meta-analysis appeared in 1985 (Casey and Berman, 1985). Subsequent meta-analyses pepper the literature through the next two decades (for a summary of these, see Weisz and Weiss, 1993). All these studies show large effect sizes for psychotherapy. However, these meta-analyses all used a very broad definition of psychotherapy. Psychodynamic methods made up a small proportion of the studies included in the analyses, usually less than 10%. These analyses were also heterogeneous in selection of subjects. Three of the meta-analyses looked at differences in effect sizes between behavioural and non-behavioural methods. Two of these three studies showed higher effect sizes for behavioural treatments. In the late 1980s randomized controlled trials (RCTs) of child psychoanalytic psychotherapy began to appear. Over the next 10 years, at least five RCTs were published (Robin *et al.*, 1999; Sinha and Kapur, 1999; Smyrniotis and Kirby, 1993; Szapocznik *et al.*, 1989; Weiss *et al.*, 1999). One trial of brief intervention was positive, two trials showed equivalent outcomes for family therapy and psychodynamic therapy, and two trials were negative.

In the mid-1990s the American Psychological Association Task Force on Psychological Intervention Guidelines developed templates for the evaluation

of treatment efficacy (Chorpita, 2001). This stimulated the concept of 'empirically supported treatments'; the first official list of these appeared in 1995. Psychodynamic therapy in children has been noticeably absent from this list and subsequent updates (for details, see Kazdin, 2003). In 1999 the American Academy of Child and Adolescent Psychiatry expressed concern that junior doctors were receiving inadequate exposure to psychotherapy (Ritvo *et al.*, 1999). The factors contributing to the lack of psychotherapy were cited as: the shift to managed care delivery systems; lack of financial support for research; lack of professional support for research; and a paradigm shift in psychiatric research towards addressing problems at a symptom level.

In the UK the Department of Health commissioned a report on the evidence base to inform a Strategic Review of Psychotherapy Services, which commented on the lack of evaluation of psychodynamic therapy in children (see Hodges, 1999; Roth and Fonagy, 1996). Carr (2000) published an analysis of the evidence base for psychological interventions in children, and psychodynamic psychotherapy was not advocated as an evidence-based intervention. Public sector clinics had become less psychoanalytically focused (Sampson, 1980: 35), more eclectic in their approaches and more multidisciplinary. Contracting and commissioning of services had reduced joint working of cases, and clinicians were feeling under pressure to be accountable to external bodies rather than to the patient. Increases in referrals had increased the ratio of brief to long-term work, and cases taken on by psychotherapists tended to be more complex and demanding (Shuttleworth, 1999). Also psychoanalysis was being used as a second or third line when less costly treatments had failed (Fonagy and Target, 1994). Cognitive behavioural therapy (CBT) was adapted for children and adolescents in the early 1990s and, unlike child psychoanalysis, developed an evidence base for effectiveness in depressive illness (Fonagy *et al.*, 2002).

(v) Developments at the turn of the millennium (1990–2004)

The 1990s were a time of assimilation for child psychotherapists working in the UK National Health Service. In 1991 they benefited from a national regrading exercise, which established a salary structure within the NHS. There was an expansion in the number of training schools: in 1993 a Scottish Training School was established and in 1995 the Birmingham School was founded (Hurst, 1999). The Northern School was commissioned in Leeds and commenced in 2003 (University of Leeds, 2004). Good Practice Guidelines were developed under the auspices of the UK Standing Conference for Psychotherapy in 1991. These were followed by the introduction of disciplinary procedures in 1994, and the ACP became a regulatory body. The following year the directory of the ACP became a register, and a year later a code of professional conduct was published. These steps taken by the profession to self-regulate helped to establish child and adolescent psychotherapy as a legitimate discipline within the public sector. In 1995 the NHS Executive Report on Psychotherapy Services in England included child psychotherapy within the context of Child and Adolescent

Mental Health Services (CAMHS). In 1999 the Royal College of Psychiatrists included individual non-directive psychotherapy in the core experience required by child psychiatry trainees. In the same year, the American Academy of Child and Adolescent Psychiatry recommended that psychotherapy should remain a core competence of child and adolescent psychiatrists (Ritvo *et al.*, 1999).

Child psychotherapists openly acknowledged the need to demonstrate evaluation to the external world and they debated appropriate research methodology (Fonagy, 2003; Hurst, 1999; Lush, 1991; Rustin, 2003). In a strategic meeting in 1997 the ACP highlighted the need for evidence-based practice (Hurst, 1999). Four years later, Barrows (2001: 372) challenged child psychotherapists to 'give a good account of themselves'. Fonagy, in the *Journal of Child Psychotherapy* in 2003, suggested that the attitude of the profession to trial-based research was problematic: 'seeing scientific research and psychoanalysis as at the opposite ends of the epistemological continuum shielding us from appropriate criticisms' (Fonagy, 2003: 131).

Two approaches to the challenges faced by child psychoanalysis appear in this period. The first was to adapt to the needs of the market by further development of briefer therapies such as Interpersonal Psychotherapy (Mufson *et al.*, 1994). The second was to commission systematic reviews of the literature. The Child Psychotherapy Steering Group of the North London Strategic Health Authority commissioned and funded a large systematic review by Kennedy, published in 2004. This group acted as the lead commissioner for child psychotherapy for eight Strategic Health Authorities in England. The review cites five randomized controlled trials in the highest category of evidence. Unlike previous meta-analyses, only psychoanalytic therapies were included. It concludes that there is evidence to support the effectiveness of psychoanalytic psychotherapy for children and young people. Although this document may not claim to have the status of an independent review, such as those commissioned by NICE (National Institute for Clinical Excellence), it shows that child psychotherapy in the UK has responded to the challenge posed by the prevalent climate of evidence-based commissioning.

In 2007 a second publication emerged from the above group, now linked to the Central London Strategic Health Authority (Kennedy and Midgley, 2007). This document summarized 'process and outcome research', and the foreword is written by the Co-chair of the External Working Group of the CAMHS module of the National Service Framework (NSF), a UK government-funded initiative that steers NHS practice, demonstrating important connections to policy formation in the Service. The document has a two-fold agenda: to show to the external world that child psychotherapy is taking research seriously; and to stimulate research within the profession.

Discussion

Using Kuhn's signs of a crisis in a science (Kuhn, 1996), one can see evidence of these in the narrative. The first sign of a crisis was the appearance of anomalies,

discoveries that do not fit with the theoretical framework which underpins the paradigm in question. The first apparent anomalies surfaced prior to the inception of the NHS, within the differences of opinion that remain unresolved between Melanie Klein and Anna Freud. However, these apparent anomalies did not result in a total paradigm shift. Indeed, the two different schools of thinking co-exist within the paradigm, even today.

The second anomaly to appear was the development and application of learning theory. Although behavioural therapy clearly established itself as a rival paradigm, there was not a major paradigm shift. Well after behavioural therapy had established itself, both psychiatrists and psychologists still found the theoretical framework of psychoanalysis to be useful. There was evidence of loosening of rules such as the development of briefer psychodynamic therapies, while the behavioural paradigm evolved into the current dominant model of cognitive behavioural therapy. Child psychotherapists made concerted efforts to establish themselves within the NHS and were clearly more than a few residual dissenters from an aging paradigm. This was demonstrated by the expansion of training places in child and adolescent therapy over the last three decades. Twenty-first century CAMHS represent an eclectic mix of paradigms, rather than one dominant heritage.

There was also evidence of child psychotherapists developing the social profile of a science (Golinski, 1998). Child psychotherapists have been included as paid practitioners in public institutions in the UK, and there has been a modest increase in numbers. Training schools have risen with an expansion in the number of training places. The *Journal of Child Psychotherapy* has not multiplied into a number of specialist publications, but the number of issues published per year has increased since its inception. Finally, has the discipline developed an autonomous reward system? This is a difficult question to answer. If one considers that an autonomous reward system is purely monetary, then there seems little evidence of this. However, the literature is full of celebrations and accolades to individuals (a few examples are: Edgcumbe, 2000; Grosskurth, 1985; Rodman, 1987; Williams, 1987).

Is there evidence of child psychoanalysis becoming an obsolete therapeutic technology? Fox and Swazey (1974) identified three reasons why a health technology may decline in use. These are that the treatment becomes recognized as dangerous, that a newer and better therapy takes over or that the therapy is demonstrated to be ineffective. There was no evidence in the narrative history of child psychoanalytic psychotherapy causing harm, although health economists would argue that using resources for ineffective interventions takes resources away from interventions that could lead to benefit. Although rival treatments have been developed, none has fully taken the place of child psychoanalytic psychotherapy. In terms of demonstrating effectiveness, recent publications have made efforts to address this, although much of the research published in the two recent reviews may not fit criteria currently used in the

NHS for effectiveness of treatment. The most recent publication attempts to shift the debate from whether child psychoanalytic psychotherapy works, to understanding how it works (Kennedy and Midgley, 2007). Thus, the assumption is that child psychoanalytical psychotherapy is effective, and now the need is to understand why.

Psychoanalysis and child psychoanalytic practice may always be vulnerable to criticism. Forrester, writing at the end of the twentieth century, says that for the previous 25 years there had never been a time when psychoanalysis was not controversial or viewed with suspicion (Forrester, 1997). Indeed, Schwartz puts into words the sentiments of many psychoanalysts when he says that there are 'deeply ingrained prejudices in the West against the human inner world of affect, mood and feelings' (Schwartz, 2002: 200).

Conclusion

We conclude that child psychoanalytic psychotherapy has survived threats and anomalies and is retained as a scientific paradigm in the UK. It is beginning to develop a social profile consistent with a scientific discipline. Recently the profession has recognized the need to be seen by the external world to be undertaking evidence-based practice.

Appendix: Literature search strategy

Name of database	Years searched	Keywords used	No. hits
Psychinfo	1872–2002	'child' and 'psychotherapy' 'child' and 'psychoanalysis'	490
Psychinfo (Ovid)	1872–2004	'psychiatry' and 'decline'	477
Psychinfo (Ovid)	1872–2004	'psychotherapy' and 'decline'	173
Psychinfo (Ovid)	1872–1973	'psychoanalysis' and decline'	21
Wellcome library	1900–Mar. 2004	'treatment' and 'decline'	1
Wellcome library	1900–Mar. 2004	'psychoanalysis' and 'decline'	1
Wellcome library	1900–Mar. 2004	'child' and 'psychiatry'	1
Wellcome library	1900–Mar. 2004	'psychiatry' and 'decline'	1
Wellcome library	1900–Mar. 2004	'psychotherapy' and 'decline'	1
Wellcome library	1900–Mar. 2004	'child psychoanalysis'	1
Psychoanalytical electronic publishing	up to Aug. 2003	'child' and 'training'	10
Psychoanalytical electronic publishing	up to Aug. 2003	'evidence'	0

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