CHILD *and* ADOLESCENT ANXIETY PSYCHODYNAMIC PSYCHOTHERAPY

A Treatment Manual

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Give me a child until he is seven and I will show you the man—Aristotle

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Introduction

Anxiety is universal and ubiquitous, but only about 30% of people, including children, are burdened with an anxiety disorder (1). Crippling anxiety in childhood and adolescence, if left unchecked, grows and casts a dark shadow on later development. This book will operationalize a relatively brief, accessible psychotherapy intervention for children and teens with anxiety disorders. It is a time-limited adaptation of a commonly practiced form of non–exposure-based, affect-focused, psychodynamic psychotherapy (2). The hope is to broaden the therapeutic armamentarium of operationalized psychotherapies for children and teens in order to minimize the burden of anxiety in childhood.

1.1. Rationale for CAPP

Child and adolescent anxiety psychodynamic psychotherapy (CAPP) is a time-limited, manualized psychodynamic psychotherapy treatment for children and adolescents aged 8 to 16 years suffering from a variety of anxiety disorders, including generalized anxiety disorder, separation anxiety disorder, social anxiety disorder, panic disorder, and comorbid posttraumatic stress disorder (PTSD). We have found this treatment to be useful in a small case series (3, 4), as well as relatively easy to implement by mental health clinicians with some amount of knowledge of psychodynamic principles and treatment who have been trained in this method. CAPP is a manualized psychotherapy that is individualized for each patient, yet it follows principles that are presented in this manual and is relatively easily taught and applied.

In this introductory chapter, we review the significance and impact of anxiety disorders in childhood. We then briefly review the current interventions used and describe the rationale for CAPP, elucidate its origins, give a synopsis of the main principles of treatment, and delineate its structure.

Children and teens with anxiety disorders are a large and clinically important population, and anxiety disorders are the most prevalent mental health disorders in youth. The combined prevalence of generalized anxiety disorder, separation anxiety disorder, and social phobia in youth is 15.4% (5, 6). Childhood anxiety disorders can be debilitating if untreated or partially treated. Youths risk continuing symptoms into adulthood and the development of major depression (1) and substance abuse disorders (7). Youngsters with anxiety disorders have an increased likelihood of suffering from more than one mental health condition. Suicide attempt rates are remarkably high: 14.3% for social phobia and 16.4% for generalized anxiety disorder across age (8).

In addition to the suffering of the child or teen, anxiety disorders have noticeable consequences for the family. A recent study of preschoolers with separation anxiety, generalized anxiety, and social phobia (9) describes how anxiety disorders in very young children affect families as well. The authors found that parents of children with early-onset anxiety disorders were 3.5 times more likely than parents of children who had developmentally expectable anxiety to report a negative impact on the four areas of finances, the ability to engage in activities, quality of relationships, and parents' well-being and mental health.

Kossowsky et al. (10) conducted a meta-analysis of 25 studies including 14,855 separation anxious children and found a convincing association between childhood separation anxiety disorder and later development of adult anxiety disorders, in particular panic disorder, but the results did not show an increased risk for depression and substance abuse. However, the latter sample size was small. Copeland et al. (11) suggest that generalized anxiety disorder alone accounts for the association between anxiety disorders and later depression (12).

The large population-based prospective study, the Great Smoky Mountains Study, by Copeland et al. (13) examined 1,420 children prospectively. The authors found high rates of separation anxiety disorder in younger children, less anxiety in older school-aged children, and an upsurge of social phobia, panic disorder, and agoraphobia in teenagers (14, 15). The transition from adolescence to young adulthood puts individuals at greatest risk for a diagnosis of an anxiety disorder. By their mid-20s more than one in five individuals carried a diagnosis of an anxiety disorder (1) (28.8% lifetime in the National Comorbidity Survey Replication [NCSR]). Each individual childhood anxiety disorder was associated with adverse functioning in at least one young adult functional domain, such as health outcome, financial outcome, and interpersonal functioning. Generalized anxiety disorder and *Diagnostic and Statistical Manual of Mental Disorders, third edition, revised* (DSM-III-R) overanxious disorder were associated with poor functioning in all domains, separation anxiety disorder was associated with poor health outcomes, and social anxiety disorder was associated with significant interpersonal problems.

Anxiety can be transmitted from one generation to the next (16). This transmission is thought to occur because of biological and genetic vulnerabilities as well as epigenetic (environmental) factors, parental behaviors, and often subtle verbal as well as nonverbal

communications to the child. A central example is separation anxiety disorder. Separation-anxious children often have parents who themselves have been struggling with separation anxiety for many years. A common presentation is a school-aged child who refuses to sleep in his/her own bed, at a time and place in which family culture and the larger culture would expect the child to do so. Parents who present with now modified but nevertheless ongoing separation anxiety may feel unable to soothe the child's distress or to limit agitation unless they acquiesce to anxious demands, which aggravates the child's difficulty in relinquishing the symptom. They often feel particularly uncomfortable not acceding to the child's anxiously fueled wishes.

Undiagnosed and untreated anxiety disorders contribute to increased and perhaps unnecessary health care utilization, well known from studies in adults with anxiety disorders (NCSR: 42.3 billion annually) (17). In youth, this occurs in part as a result of somatic symptoms anxious children experience (18), in the absence of a diagnosed medical condition, or in excess of what would typically be expected in the course of a diagnosed medical illness. Cardiac symptoms (rapid heartbeat and chest pain), respiratory symptoms (shortness of breath), gastrointestinal symptoms (nausea, vomiting, abdominal pain, and diarrhea), and neurological symptoms (dizziness and headaches) are commonly reported, particularly among children whose anxiety disorders are not properly diagnosed and treated. The child or teen may undergo unnecessary diagnostic procedures as well as otherwise avoidable medical treatments. The cost offset of earlier proper identification and treatment is large.

A limited number of evidence-based treatments have been adequately tested for efficacy, namely cognitive-behavioral therapy (CBT) and antianxiety medications, primarily selective serotonin reuptake inhibitors (SSRIs). CBT treatment is thought to work by exposure to feared situations (exposure-response-prevention), except in adolescents, in whom stage-related brain development is thought to interfere (19, 20). Elements of typical CBT protocols include psychoeducation, cognitive restructuring, relaxation training, and exposure to feared stimuli, often repeated in homework that is monitored.

CBT and medication are effective treatments. In the Child/Adolescent Anxiety Multimodal Study (CAMS) (21, 22), 60% responded to CBT alone and 55% to SSRI alone. Nonetheless, more than 40% of anxious children and adolescents do not respond to medication or CBT alone. When combined, medication and CBT have higher response rates at treatment termination (80.7%, but decreases to 45.6 at follow-up) (23), but limiting factors of CBT arise when patients may be unwilling to expose themselves to feared situations and are reluctant to complete necessary homework assignments, both of which decrease treatment efficacy (24).

Medication use, primarily SSRIs, has increased in children with a positive risk-benefit ratio of SSRIs (25, 26). However, reports of increased suicidal ideation and behavior on SSRIs (27) have compounded some parents' and physicians' reluctance to allow children to take medication (28). Many patients with anxiety disorders prefer psychotherapy to medication, as parents of children with anxiety disorders often do.

It would be beneficial if the parents of pediatric anxiety patients had a choice of efficacious psychosocial interventions, which would allow acknowledging personal preferences for different treatment approaches and potentially different types of patients with different response profiles. Systematic study of alternative treatments can help identify which type of intervention works better for whom and will potentially clarify underlying mechanisms, which may in turn illuminate fundamentals of anxiety in childhood. Thus, although evidence-based treatments such as medications and CBT are available, there is ample justification to establish alternative interventions, which can then be assessed as to their evidentiary basis, to accommodate the needs of other families and children and allow access to a tailored match of treatment.

CAPP is distinguishable from CBT in that it fosters a deeper psychological understanding of the meaning of the child's anxiety symptoms. This process occurs verbally or in play by reworking anxious memories and associations, making them accessible to modification using techniques other than exposure/response-prevention that are focused on improving dysregulated attachment and promoting and ideally normalizing reflective functioning (29). CAPP relates anxiety symptoms to underlying emotional meanings of conflicts operating outside of children's awareness. This helps patients to access and better define their emotional understandings, focuses on better articulation and subsequent sense of mastery over dysregulated and excessive emotional activation in relation to attachments, and helps promote a sense of safety to act autonomously in the world. Such approaches appeal to a child's reflective function and personal sense of coherence.

The ability to think about one's own mind is referred to as "reflective function" (see Chapter 2, Section 2.2), a normative developmental capacity that can be fostered and developed during psychotherapy with subsequent better understanding of the meaning of one's own and others' thoughts, emotions, and actions. This allows individuals treated with this method to use the acquired insights in the future. For example, a socially inhibited child beset with anxiety who cannot speak up in class can be helped by reflecting on her tendency to believe that 100% accuracy in performance is required in order to be loved and respected.

An advantage of this manualized psychodynamic treatment approach is that it can relatively easily be taught to clinicians with moderate levels of psychodynamic psychotherapy knowledge.

1.2. Psychoanalysis, Dynamic Psychotherapy, and Symptom-Focused Psychotherapy: Background and Comparisons

It may be said that Freud invented psychoanalysis during the last decade of the 19th century and continued to revise its tenets into the early 1930s. What has happened since may be taken as derivative paths that grew out of the foundational experience of the original

group of psychoanalysts (30). Freud himself made major changes in his theory and practice as he came upon obstacles or new clinical phenomena that required revision. Among these shifts were the recognition of transference as a tool rather than only being seen as a resistance to therapy, the introduction of aggression as a primary drive to match sexuality, the structural theory (id, ego, and super ego) was added to the topographic theory (conscious / unconscious), and others. In addition, practical changes occurred, such as the use of the couch and the turn away from hypnosis to free association, as well as the change from the brief time spent in psychoanalysis of the early cases to longer treatments that focused more on personality change than on symptom alleviation. These internal alterations would provide a basis for future changes that were not possible during Freud's time with its struggle to preserve the "psychoanalytic revolution."

More specific to this manual, during the 1920s and thereafter, the psychoanalytic model was applied to children and adolescents, requiring further alterations of what had seemed a specific method by which the psychoanalyst plumbed the unconscious and sought discovery of the meanings of symptoms and the salience of defenses. Among the many developmental modifications of technique was a substitution of play for free association as an open-ended approach to uncovering underlying emotional content and meaning (31, 32, 33). The number of sessions per week and the observational stance that the therapist took remained similar. Practitioners who followed Anna Freud held regular visits with parents who reported the context of daily life to the psychoanalyst, who could use such information in tandem with the child's play. These sources of information served as a basis for interpretations of meaning to help the child improve coping. Thus the beginnings of child psychoanalysis represented a breach from psychoanalytic practice with adult patients in the service of exploring meanings derived from the child's psyche as connected with his/her real life as reported by another person. The technique was adapted to the task.

Psychodynamic psychotherapy and manualized psychotherapies, among other modifications, originated during the latter half of the 20th century. One could argue that some of Freud's early analyses were psychodynamic psychotherapies or psychodynamic consultations, such as his Katharina case (34).

Some of the older generation of psychoanalysts have broken ranks completely and supplanted psychodynamic therapies with their own brand names and practices. Beck (35) stands out as the original proponent of a new therapy, CBT, originally also an open-ended psychotherapeutic treatment, which has had a significant role in launching evidence-based treatments, as is the case for interpersonal psychotherapy (IPT) (36, 37). Researchers such as Mufson (38, 39) have adapted IPT for adolescents.

The subsequent advent of randomized controlled trials that were the gold standard of pharmacological studies seriously challenged the use of psychotherapy treatments and called for studies of efficacy. CBT is relatively easier to operationalize and dismantle by components than affect-focused psychotherapies and offers more generalized rules (true do's and don'ts) and sequences of interventions that convert much of the psychotherapy

experience to learning strategies. It is necessary to examine how the current manualized psychodynamic and symptom-focused psychodynamic treatments still represent a variant of the original psychoanalysis and **continue to feature the aim of understanding the unconscious psychological meanings of symptoms and explication of narrative themes confounded by defensive avoidance. These aims require a self reflective grasp of one's own unconscious operations and fantasies**.

Freud's earliest case descriptions were brief treatments, focused on symptoms. Davanloo (40), Mann (41), and others during the 1970s and later also had clear psychodynamic aims, such as separation anxiety, conceived as a core issue in the treatment approach. These brief psychodynamic treatments required fewer sessions than the psychoanalytic prescription of four or five visits per week. These time-limited, but not manualized, dynamic therapies were never well adapted in a systematic way to children. However, many child psychiatrists did apply dynamic psychotherapies that were not psychoanalysis, employing play during one or two visits per week (42). The Anna Freud Center in London pioneered the experiment of fewer visits per week for children. These treatments depended on parental participation and were briefer and more focused. They were not subject to the rigor of manualization and differentiation from other psychotherapies, nor were they subjected to clinical trials of efficacy. These interventions were the most used approaches in children with "neurotic" symptoms during the second half of the 20th century, including those with anxiety disorders. Target and Fonagy (42) studied the Anna Freud Center cases retrospectively ($n = 763$) and sorted the differential outcomes in relation to diagnoses (disruptive disorders and anxiety/depressive disorders, either alone or combined), session frequency, and duration of treatment and developmental stage of the patient. The patients who improved most were those with anxiety disorders.

The notion of manualized, time-limited psychotherapies applied to specific disorders arrived later for children than adults. This manual is a relatively new and rare event in the psychotherapy arena for children, in that very few psychodynamic treatments for children have been operationalized. Kernberg and Chazan (43), and recently Hoffman, Rice, and Prout (44), offered publications of psychodynamic psychotherapies directed to youth with conduct disorders and behavioral impulse control disorders. However, neither group has published pilot outcome studies to date.

It is important to examine how this time-limited psychodynamic psychotherapy is related to the principles of child psychoanalysis. The frame is different because the treatment maintains *temporal limits and is conducted at a lower, twice-weekly, frequency. Parents are included,* but on an as-needed basis. The treatment is directed toward the meaning of symptoms, obeys the structural inquiry into defense mechanisms and transferences, and probes for significant unconscious constellations that drive symptoms and problematic behavior. These latter practices are derived from psychodynamic theory.

This manualized description provides an operationalized approach to children's behavior and psyche that draws on this rich recent movement while maintaining a core focus on the analysis of meaning.