Psychodynamic Formulation and Psychodynamic Psychotherapy for Pediatric Anxiety Disorders

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KEYWORDS

• Psychodynamic • Formulation • Treatment • Anxiety • Pediatric

KEY POINTS

- Psychodynamic formulation of pediatric anxiety can help clinicians view symptoms in a biopsychosocial context influenced by development.
- The psychodynamic formulation can help the clinician select the most appropriate treatment for the patient and family.
- Psychodynamic psychotherapy is an evidence-based treatment of pediatric anxiety disorders.
- Psychodynamic therapy can be manualized and used as a short- or long-term treatment.

INTRODUCTION

Anxiety disorders are the most common psychiatric conditions that occur across the lifespan.[1,2] Untreated anxiety disorders in childhood or adolescence place young people at risk of developing comorbid mood disorders, substance use, academic/vocational underachievement, and suicidal thoughts and attempts.[1] The assessment of childhood anxiety should involve determining whether the anxiety is expected and proportionate in the associated context or developmental challenge. Children develop typical fears and worries that are appropriate on a developmental level, such as stranger anxiety in infants and toddlers, fears of monsters around bedtime in preschool years, and worries about social status and performance in adolescence.[1] A disorder would be marked by severity that greatly impairs day-to-day functioning or is out of proportion to the child's developmental level. A psychodynamic or psychoanalytic viewpoint would help frame the anxiety symptoms in an appropriate developmental context, which is imperative in working with young people, and a rationale for

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Child Adolesc Psychiatric Clin N Am 32 (2023) 559–572
https://doi.org/10.1016/j.chc.2022.11.001
childpsych.theclinics.com

maintaining psychodynamic concepts as an integral part of child psychiatry.[3] Given the prevalence of impairment associated with pediatric anxiety disorders, advancing multiple evidence-based treatments for anxiety provides more options for patients, families, and clinicians through which to achieve improvement; psychodynamic psychotherapy is one of these options.

HISTORY OF PSYCHODYNAMIC APPROACHES TO UNDERSTANDING PEDIATRIC ANXIETY

Before selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT), psychodynamic or psychoanalytic psychotherapy was the mainstay of treatment of childhood anxiety disorders.[4] Dating back to Sigmund Freud's publication in 1909 of 5-year-old "Little Hans" and his phobia of horses,[5] psychodynamic psychotherapy for childhood anxiety is long in the way of tradition but initially came up short regarding scientifically sound evidence. The emphasis on evidence-based medicine beginning in the 1990s led to the development of manualized treatments and a surge in randomized controlled psychotherapy trials. These trials primarily focused on CBT, which was easier to operationalize and dismantle into components than psychodynamic psychotherapy.[6] Methodological issues also plagued the perception of evidence for different psychotherapy modalities. For example, in one study comparing CBT to psychodynamic psychotherapy in the treatment of adolescents with posttraumatic stress disorder (PTSD), psychodynamic therapists were forbidden from discussing the trauma,[7] which conflicts with the standard practice of all trauma-based psychotherapies in youth. Other methodological issues that have complicated psychotherapy trials in youth include the lack of a placebo in control conditions of several studies, as "treatment-as-usual" is still treatment, and the design of short-term trials might obscure the ability to see long-term treatment gains achieved through psychodynamic psychotherapy,[8] all symptoms of a broader problem on defining what evidence-based psychotherapy really means.[9]

The focus on evidence-based medicine ultimately improved clinical trials in the early 21st century, and as a result, there is sufficient evidence showing the efficacy of psychodynamic psychotherapy,[10] including in children and adolescents. This has paved the way for several manualized, time-limited psychodynamic psychotherapies that have established efficacy for several disorders in children and adolescents, including anxiety disorders.[4,6,11–14] This evidence for psychodynamic psychotherapy in children and adolescents is buttressed by meta-analyses,[15] and systematic reviews.[16]

DEFINITIONS

The diagnostic and statistical manual of mental disorders, fifth edition, text revision (*DSM-5-TR*) defines anxiety and fear differently although acknowledges there is overlap.[17] Anxiety is defined as the anticipation of a future threat, compared with fear, defined as an emotional response to a real or perceived imminent threat.[17] The term "fear" is warranted when it is the general consensus of objective observers that the individual's response is justified by real danger.[11] Fear responses are more often associated with surges in autonomic arousal and typically associated with fight, flight, or freeze behaviors due to an immediate danger.[17] In contrast, anxiety is generally marked more by muscle tension, vigilance, and avoidance,[17,18] in preparation for a future danger.[17] Phobias refer to fear responses to a known object and are characterized by awareness of the phobic stimuli; the response is excessive, exaggerated, or inappropriate to an objective observer and phobias are generally characterized by avoidance.[11] However, these delineations are artificial, and the terms are sometimes

used interchangeably. An example of overlap would be panic attacks, which symptomatically mimic a fear response,[18] yet are classified as symptoms of anxiety disorders[17] and are also seen in non-anxiety disorders as well.[17] PTSD is marked by symptoms of vigilance and avoidance, which the DSM-5 marks as symptoms of anxiety,[17] but PTSD is not classified in the *DSM*-5-*TR* as an anxiety disorder[17]; phobic disorders and anxiety disorders are not separated from each other via diagnostic categories. Therefore, it may be helpful to understand all experiences along an "anxiety spectrum" related to development, evolution, psychophysiology, and psychodynamics. This article focuses on generalized anxiety disorder (GAD), separation anxiety disorder (SAD), social phobia (SP), and panic disorder (PD).

Psychoanalytic Views

Psychoanalytic and psychodynamic theory has historically interpreted anxiety as the result of repression of some other affect or as a signal responding to threats associated with impulses of the id.[19] A traditional psychoanalytic position is that anxiety results from "threatened eruption into conscious awareness of unconscious thoughts and feelings" about which the individual feels they must avoid due to guilt, shame, or another intolerable emotional experience.[11] A contemporary psychodynamic interpretation would view anxiety as a defense mechanism that guards against and expresses a conflict between unacceptable or ambivalent intrapsychic forces.[4]

Developmental/Evolutionary Views

From a developmental and evolutionary perspective, anxiety is adaptive and serves as an alarm system, alerting the individual to a perceived threat of danger.[4] What constitutes "danger" may be subjective and needs to be evaluated within a developmental context, such as attachment ruptures in a young child. Thus, anxiety is an innate, unconscious experience with "inborn responses" such as fight or flight,[4] driving the individual to act. Evidence suggests a "progression" from separation anxiety in young children to specific phobias or generalized anxiety in school-age children, followed by social anxiety in adolescence.[4] Neuroimaging research has pointed to a trend that in typical development, functional connectivity between brain regions such as the amygdala and medial pre-frontal cortex starts more positively in childhood, then shifts negatively during adolescence in response to fearful stimuli.[20] Other studies have corroborated such findings, particularly in cases of childhood abuse, where amygdala response to perceived threats was hyporeactive in younger children and hyperactive in adolescents.[21] It is theorized that young children must remain strongly attached to threatening caregivers to satisfy basic and attachment needs, with survival depending on the ability to reduce their responses to threats; adolescents, on the contrary, may be better able to provide for themselves and may have a more practical fight-or-flight opportunity to escape threatening situations.[21]

Biological Views

The inhibited temperament of young children, which has been consistently associated with future risk of developing anxiety disorders, implies a biologic or genetic component contributing to a lower threshold for anxiety in response to environmental stressors.[4] Similarly, some individuals who are more prone or sensitive to a fear response; this lower threshold may predispose them to have fear mechanisms triggered by objectively minimal or innocuous stimuli.[11] Thus, in some patients, biochemical and neurophysiological mechanisms are operative, leading to some anxiety disorders being viewed as "biological" rather than psychoanalytic.[11]

Social Learning Views

Anxiety can also be a consequence of social learning.[22] Studies have shown that observing a parent/caregiver interact in a non-anxious way with a potential threat can buffer against anxious responses in future encounters[22]; similarly, studies have shown that adults with social anxiety disorder reported more observances of their parents/caregivers to be avoidant in social situations; findings which were corroborated from the parents themselves.[22] Other avenues of social reinforcement of anxiety include direct social reinforcement, verbal instruction, and culturally transmitted rules and norms.[22]

EVALUATION OF ANXIETY IN YOUTH: A PSYCHODYNAMIC PERSPECTIVE

Combining the theories mentioned above leads to an understanding that anxiety at its core is evolutionarily adaptive and protective, with the experience and expression of anxiety informed by genetic predispositions, temperament, biologically-based sensitivities and thresholds, learned or modeled responses based on early childhood experiences, and a tension that arises from conflicts between all of these internal forces, which may oppose each other. The Affect Phobia model is a short-term psychodynamic treatment based on Malan's Triangles of Conflict[23–25] (**Fig. 1**A), which succinctly and coherently blends this bio-psycho-social view of anxiety through the psychodynamic lens while appreciating biological and social contributions.[23]

In the affect phobia model, an "affect" is a biologically endowed set of physiologic, physical, and psychological responses that motivate people to act. The affect of fear—including the spectrum of alarm, and fright—leads to an activation of fear responses, such as running away or being hypervigilant, including fight or flight responses.[23] This view most corresponds to biological correlates of anxiety, including the propensity for oversensitivity to fear responses; from a psychodynamic viewpoint, this is most similar to the "feeling pole" of the affect phobia model, which symbolizes innate drives or feelings (id for Freudians, neurophysiology for biological psychiatrists). Inhibitory affects result in ceasing, withdrawing, or preventing action. Inhibitory affects, which include guilt and shame, function to restrict or hold back action-oriented innate feelings. Inhibitory affects are useful to moderate the response to an initial impulse so the impulse is expressed in a healthy, controlled way or are not expressed if the impulsive action would be socially prohibited. "Anxiety," which includes panic, fear paralysis, and apprehension, would inhibit behavior, thus giving the inhibitory affects its other name as the "anxiety pole."

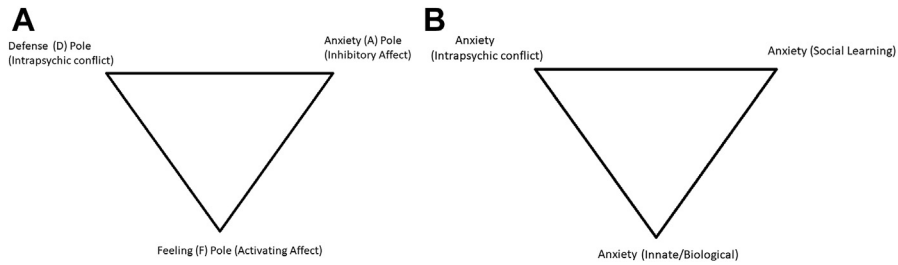

Fig. 1. (*A*) Malan's Triangle of Conflict (1979) adapted from Lindqvist et al (2020). (*B*) Triangle of Conflict with Anxiety serving as unconscious feeling/impulse, inhibitory anxiety, or defense mechanism.

Maladaptive patterns of affect expression develop when children are taught that there is something wrong with their inner emotional responses; this could also be that their emotional reaction is frightening to others and, therefore themselves. Importantly, many inhibitory affects are learned through early childhood experiences with parents/caregivers. Such adults use inhibitory affects such as fear, guilt, or shame to shape their children's behavior; when excessive inhibition is placed on a child's adaptive activating affects, this can lead to a phobic avoidance of that affect and that only certain expressions are allowable. The socially learned component of anxiety best correlates with what is known as the "Anxiety Pole" of affect phobia theory ("superego" for Freudians, cognitive distortions for behaviorists). We therefore can have a situation where adaptive anxiety, interpreted as the need to protect oneself and others, can be neutralized or opposed by maladaptive anxiety, including traumatic anxiety and panic. Defense mechanisms arise to manage such conflicts. As any feeling can function as a defense, it is important to recognize that anxiety can also present as a defensive affect. According to McCullough, affects that are likely to be defensive present as atypical or inappropriate for the context. Although they may be maladaptive, they can also be seen as functioning to meet the patient's needs in some way.[23] A list of "defensive behaviors" contains many examples of what may be attributed to anxiety: passivity, withdrawing, not speaking up, and avoiding eye contact (**Box 1**).[23]

Anxiety as a symptom can therefore represent any of the three poles of Malan's triangle: innate excessive biological response (Feeling), learned reaction in response to early childhood experiences (Anxiety), or a defensive affect responding to internal conflicts (Defense; **Fig 1**B). The first task of the psychodynamic formulation of anxiety is to determine whether anxiety is being experienced as a defense mechanism, as an innate but excessive/exaggerated biological process, or as something learned from early experiences that are blocking the experience of naturally occurring affect phenomenon. A psychodynamic perspective is important as the answer to this question has implications regarding treatment planning (**Fig. 2**).

Box 1
Example of defensive anxiety

- An adolescent had recently gone to a public event with their family, hoping to spend quality time together. Once at the event, the family split off in different directions, leaving the adolescent alone.
- The adolescent identified feeling angry at being deserted and wanted to ask their family to come back, but felt guilty about being "selfish" by exerting control over the family.
- The adolescent felt anxious and developed a panic attack, marked by shortness of breath, tachycardia, and a sensation of choking. Owing to the choking, the patient texted the rest of the family that they were having a panic attack as they were unable to vocally call to them. The family received the text messages and returned to comfort the adolescent.
- The defensive nature of the panic attack can be identified by:
  - Being inappropriate to context, where anger or disappointment would have been expected
  - Preventing the adolescent's conscious awareness/expression of the unacceptable affect–anger
  - Functioning to express the conflict by meeting the patient's need for closeness while avoiding feelings of anger and guilt

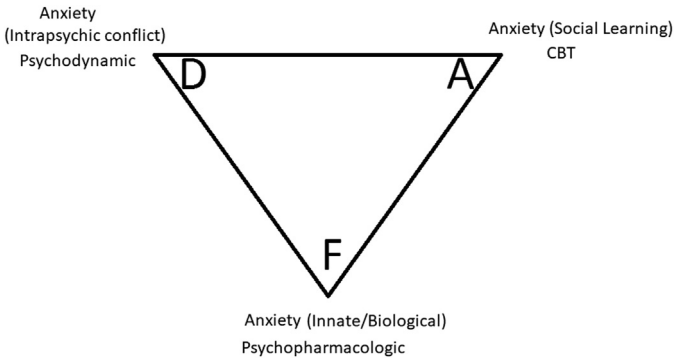

Fig. 2. Interpretation of Malan's Tringle of Conflict with targeted treatment interventions based on whether anxiety as a treatment focus is experienced: psychodynamic therapy when anxiety is a defense mechanism (*D*), CBT when anxiety is a learned inhibitory response (*A*), and psychopharmacology when anxiety is due to excessive innate physiologic response (*F*).

CLINICS CARE POINTS

- A psychodynamic formulation of anxiety examines whether anxiety is experienced as:
  - an innate/excessive biological process, and may respond to medications
  - learned through early social experiences, and may respond to CBT
  - a defensive affect responding to internal conflicts and may respond to psychodynamic psychotherapy

GUIDELINES

The American Academy of Child & Adolescent Psychiatry (AACAP) Clinical Practice Guideline for the treatment of pediatric anxiety disorders[2] includes only two treatments purported to have sufficient evidence meriting recommendation: CBT and SSRIs. In this analysis, CBT is defined as interventions that target three primary dimensions of anxiety: cognitive distortions, behavioral avoidance, and physiologic/autonomic arousal. CBT involves changing maladaptive beliefs and attitudes while using graduated exposure, processes which are learned in a social context. Medications, including SSRIs, target the biologic/physiologic "innate feeling" pole. Although the validity of the serotonin hypothesis for depression has been questioned recently,[26] serotonin may modulate of fear, worry, and stress and the associated neurocircuitry in pediatric anxiety disorders.[2,27] Despite the guideline advocating that the evaluation of anxiety leads to the development of a clinical formulation that includes "hypothesized psychological vulnerabilities," including those derived from psychodynamic theory, such as unconscious conflicts, and that treatment planning is derived from the clinical formulation, the guideline suggested insufficient information to conclude non-CBT psychotherapies that contrast with a surfeit of evidence for other psychotherapeutic interventions—including psychodynamic psychotherapy—in pediatric anxiety disorders.

PSYCHODYNAMIC APPROACH

Psychodynamic psychotherapy has traditionally not been tailored to single diagnoses or specific symptoms[19]; instead, it focuses on core underlying processes common to

various disorders, including unresolved conflicts, affect regulation, internalizing object relations, and insecure attachment.[19] This may limit the perception of its efficacy in randomized trials compared with CBT, as in such studies, CBT tends to be specifically tailored to treat anxiety, setting up unfair comparisons.[7,9,19] However, as previously discussed, anxiety may have clear psychodynamic origins in some situations, including those in which it is rooted in unconscious conflicts, and systematic study of alternatives to CBT may identify which type of intervention works best for whom.[6] Another important difference between psychodynamic psychotherapy and CBT is the delayed treatment effects that may be seen in psychodynamic psychotherapy compared with CBT. Several studies suggest that psychodynamic psychotherapy has a "sleeper effect," such that significant improvement is seen most clearly after the end of the active treatment.[8] This has important ramifications not only for patient/family treatment preference but also in evaluating the evidence of short-term trials, which may favor behavioral treatments like CBT or other symptom-focused therapies. It is theorized that psychodynamic psychotherapy, by working on internal object representations, reflective functioning, and insight and self-awareness, produces a delayed treatment response as these changes precede behavioral changes; treatments that directly modifying behavior may produce earlier improvement, especially when using behavior-specific outcomes that are common in anxiety inventories used as outcomes in most pediatric anxiety studies,[28,29] but such changes may not be as long-lasting.[8] In addition, it is possible that without addressing the core conflicts, the resolution of some symptoms may lead to the emergence of new symptoms or defense mechanisms that merely take their place.

Psychodynamic psychotherapy is distinguishable from CBT in that it focuses on understanding the unconscious meaning of anxiety symptoms.[4,6] Practically speaking, CBT addresses cognitive distortions, automatic thoughts and avoidance that produce anxiety, but psychodynamic psychotherapy examines the context and unconscious processes that originally fuel the cognitive distortions. Manualized psychodynamic therapies for anxiety have several common core principles. In addition to elements common to almost all psychotherapies—such as psychoeducation, setting treatment goals, and establishing a therapeutic alliance—psychodynamic psychotherapy for anxiety involves identifying core conflicts, focusing on warded-off affects, modifying internalized object relations, and changing defenses and avoidance.[19] The process of understanding the meaning of the symptoms verbally or acting out/in-play with younger children, reworks memories and unconscious associations to improve dysregulated attachment and promote normal reflective functioning. In psychodynamic psychotherapy with children, anxiety is viewed as being related to underlying emotional meanings of conflicts operating outside of children's awareness; when young people are able to access and better define their emotional understanding, this promotes a sense of safety and allows them to act autonomously and to be less avoidant. Psychodynamic psychotherapy is also distinguishable from CBT in that while presenting anxiety symptoms remain in therapist's focus, there is more attention paid to what is absent (the warded off against affects), who is not mentioned (past conflicts), contextual elements pointing to where vigilance and soft spots occur, and dominant themes that connect the symptoms together.

APPLICATION

In general, the typical dynamic of pediatric anxiety involves parents who attempt to protect their child from what they perceive as frightening and overwhelming experiences and situations, leading to a situation where the child forms a symbiotic

relationship with the parent by identifying with the anxiety, while also desiring and yet being fearful of separation/individuation needs that may be viewed by the parent as rejecting or dangerous.[14] In other words, the anxiety symptoms result from the need to compromise wishes for separation/individuation against the perception those wishes are unacceptable due to guilt or fear of harm befalling the child or the parent by attempting to make efforts toward separation/individuation.[4] The task of the therapist is to encourage separation and individuation and allow the child to experience aggressive and individuating behaviors and see that they do not damage the self or the other.[14] Common psychodynamic themes that underly pediatric anxiety include fear of separation/autonomy from attachment figures, difficulty experiencing/acknowledging anger, sexual or identity conflicts, and conflicted guilt and/or anger expressed as self-punishment.[4]

Child and Adolescent Anxiety Psychodynamic Psychotherapy (CAPP) is a short-term, manualized psychotherapy adapted from Panic-Focused Psychodynamic Psychotherapy (PFPP), another manualized psychodynamic psychotherapy with evidence in adults with PD.[4,6] CAPP is a transdiagnostic approach intended for children 8 to 16 years of age as a twice-weekly intervention, composed of 20 to 24 sessions divided into opening, middle, and termination phases marked by specific tasks[4–6]:

1. Opening Phase—Obtaining history, developing an alliance, theorizing tentative formulations, psychoeducation on emphasis on anxiety symptoms, and uncovering the meaning behind the symptoms
2. Middle Phase—Applies psychodynamic focus to patterns revealed through the history, provide interpretations on these patterns and possible hidden meanings, normalizing age-appropriate wishes/fantasies, encouraging self-reflection, reducing the rigidity of defensive behaviors
3. Closing Phase—Reinforce self-reflection and new flexibility, anticipate anxiety rearousal, interpret the transference, revisit with family, demonstration of new behavior patterns

CAPP also suggests common themes and conflicts prevalent among the various disorders. These will be briefly summarized.

Generalized Anxiety Disorder

A common theme found in children and teens with GAD is the fear of losing control, and that the loss of control will lead to catastrophe and the resultant guilt and shame. The persistent anxiety can result from the emergence of unacceptable feelings or wishes that threaten maintaining control or perfectionism, and these upsetting feelings are experienced as frightening, dangerous, or disruptive. Somatization may also appear as a defense. The worry itself may function as almost a magical thinking belief that enough worrying will prevent catastrophe or bad outcomes, thus the prospect of worrying less may paradoxically be accompanied by more fear of loss of control.

Social Anxiety Disorder

Patients with social anxiety symptoms frequently have conflicted emotional responses to attachment figures, including fear of separation and tolerating their own angry feelings. There may be a predominance of conflicted views of assertiveness and fantasies of grandiosity and exhibitionism. Symptoms, risk factors, and central dynamics may mimic those of PD and have been associated with behavioral inhibition and inhibited temperament in early childhood and in family members. Individuals with social anxiety may have a core sense of inadequacy at acting autonomously, including a sense that

they may betray others, including their family, by increasing their social network, and fear that doing so will threaten existing attachment relationships. Patients then project intense anger onto others whom they perceive as rejecting.

Separation Anxiety Disorder

Core underlying fears of abandonment of either themselves or parents speaks to ambivalence or discomfort with the level of durability in their current attachment, and inability to tolerate ambivalent feelings in relationships. Precipitants may be real or imagined threats of abandonment, including projected fears of a parent, or past traumas that threatened the attachment of either the child or the parent to the other. Therapeutic techniques will need to incorporate the inevitable threat of separation with the therapist at termination.

Panic Disorder

Conflicted fantasies and worries about separation and autonomy are often at the core of PD. Precipitants can also be real or fantasized loss of separation, including fear of separation due to conflict anger, need for autonomy, and sexual feelings/identity.

CURRENT EVIDENCE

Muratori and colleagues[13,16] performed a preliminary study of 14 children with SAD assigned to psychodynamic psychotherapy (ten children were assigned to treatment-as-usual) comprising 11 sessions: five with the child alone, five parent-child join sessions, and a final joint termination session. The Child Behavior Checklist (CBCL) and the Children's Global Assessment Scale (C-GAS) were assessed at baseline, at the end of active treatment at 6 months, and at 2-year follow-up. The group treated with psychodynamic psychotherapy had fewer problems and better functioning at 6 months and this superiority was still observable at 2-year follow-up. Although both groups improved during the 6-month active treatment phase,[13,16] only the psychodynamic treatment group had significant improvement at the 2-year follow-up.[8] These results support previous evidence that psychodynamic psychotherapy with young people produces a "sleeper effect" leading to continued improvement even after the end of the study period.[8]

Göttken and colleagues[12,16] evaluated manualized, short-term psychoanalytic child therapy (PaCT) in children aged 4 to 10 years with anxiety disorders. A younger age group was selected due to the perceived limitation of CBT in children who have not attained concrete operations and CBT studies yielded improvement but less remissions than expected. The treatment consisted of approximately 20 to 25 weekly psychotherapy sessions for 18 families, including parent-child, child-alone, and parent-alone appointments; 12 families served as waitlist controls before themselves receiving the intervention. Sessions focused on identifying and modifying core conflicts underlying the symptoms and family dynamics using play therapy with the children, and parent sessions every fourth session, with the therapist addressing possible unconscious meanings of the child's symptoms, aiming to uncover and work through relational themes underlying anxiety symptoms. The most common diagnoses were GAD, social anxiety and specific phobias and the study included children with comorbid depression and externalizing behaviors. Parents completed (CBCL) weekly and two-thirds of youth who completed therapy achieved remission. Impressively, remission was maintained at a 6-month follow-up visit.

Weitkamp and colleagues[14,16] compared both short-term ($\leq$24 sessions) and long-term ($\geq$25 sessions) psychoanalytic psychotherapy (n = 86) compared with minimally

supportive control ($n = 35$) for children and adolescents with severe anxiety disorders. The final length of treatment was determined by clinical need, with this flexibility included due to a previous study of 25 sessions, which, although showed clinically significant and reliable improvement compared with the wait list (62% vs 8%), observed some youth appeared to have more severe symptoms and require more intense treatment.[30] Patients received twice-weekly individual therapy sessions mixed with parent sessions at a ratio of 4:1 over 3 months. Anxiety was assessed using the Screen for Child Anxiety-Related Emotional Disorders (SCARED)[31] and Quality of Life (QoL) was also assessed. In this flexible-dose model, 87% of patients completed long-term therapy (>25 sessions); the average duration of treatment was 90 sessions over 2 years. Over the initial 25 sessions, comprising the first treatment period, there were no statistically significant differences in improvement between the intervention group and the control group, as both led to significant decreases in symptoms. There was significant improvement at the end of the therapy period, gains that remained at 6-month and 12-month follow-up after therapy ended. By both patient and parent evaluation, symptoms and functioning at 6 months after treatment termination were better than at the end of treatment although patients reported greater improvement than did their parents and half of the sample met criteria for recovery/remission.

Salzer and colleagues[16,32] performed a multicenter randomized controlled trial comparing CBT and psychodynamic psychotherapy for adolescents with social anxiety disorder. Patients aged 14 to 20 years were randomized to 25 sessions of CBT ($n = 34$), psychodynamic psychotherapy ($n = 34$), or a waitlist ($n = 39$). In both CBT and psychodynamic psychotherapy arms, the 25 sessions were scheduled weekly, with some twice-weekly at the start of treatment. The Liebowitz Social Anxiety Scale for Children and Adolescents and the Social Phobia Anxiety Inventory were administered as baseline and follow-up assessments at the end of treatment, and 6- and 12-month post-treatment. Both CBT and psychodynamic psychotherapy were superior to the control condition and efficacious in reducing social anxiety symptoms, with medium-to-large effects for CBT and medium effects for psychodynamic psychotherapy; effects were stable at 12-month follow-up for both treatments.[16,32]

SUMMARY, AND FUTURE DIRECTIONS

Psychodynamic psychotherapy is an effective treatment of pediatric anxiety disorders that can be implemented in time-limited and manualized formats and produces positive outcomes that appear to be maintained. When considering treatment of children and adolescent anxiety disorders, patient and family preference should be considered with regard to other evidence-based treatment approaches (eg, CBT, SSRIs).

There are limitations. As not all patients benefit from CBT or SSRIs,[29] not all patients will improve with psychodynamic psychotherapy.[16] Psychodynamic psychotherapy may be considered a first-choice approach for patients with at least average cognitive capacity and cognitive flexibility and both secure and insecure working models of attachment.[33] Future research should consider providing guidance on which patients or families benefit most from psychodynamic treatments compared with other treatment modalities, how to more easily and quickly detect such patients and families, and how to conceptualize the cost-benefit ratio of short-term compared with long-term psychodynamic psychotherapy for pediatric anxiety disorders. In addition to length of treatment, dose of treatment should be further studied, as previous studies of psychoanalytic psychotherapy for a variety of diagnoses and disorders suggested that younger children benefit from more intense treatment frequency compared with adolescents.[34]

This is an exciting time for psychodynamic psychotherapy. The quantity and quality of research supporting the effectiveness of psychodynamic psychotherapy has grown exponentially in the last decade,[10] and specifically the evidence for use in children and adolescents has dramatically increased.[16]

Novel delivery methods have also been studied and are proving effective, especially Internet-based psychodynamic psychotherapy.[25,35–40] Several trials have already been completed for Internet-based psychodynamic psychotherapy for adults with anxiety disorders[35–37] and for adolescents with depression.[25,38,39] These studies have suggested Internet-delivered psychodynamic psychotherapy is acceptable to patients,[37,38] and one study of 36 adults with social anxiety showed that Internet-based psychodynamic psychotherapy was preferred more often than ICBT (63.9% vs 36.1%), although without reaching statistical significance.[37] In addition to being acceptable and even preferable, Internet-based psychodynamic psychotherapy appears effective[25,35,36,38,39] and comparable in effectiveness to Internet-based CBT (ICBT) for depression and anxiety disorders.[35,37,39] One study of Internet-based group psychodynamic psychotherapy for adults showed effectiveness of anxiety and somatic disorders, particularly for social anxiety.[40] More studies for Internet-based psychodynamic psychotherapy for child and adolescent anxiety disorders is warranted.

The ability to provide high-quality care via Internet-based delivery methods was an important development In light of the paradigm shift to telemedicine during the COVID-19 pandemic.[38,40,41]

One albeit small study found that children and adolescents with anxiety disorders were particularly well-suited for video-mediated psychotherapy during the pandemic.[41] In addition, the rapid proliferation of tele-mental health may be a venue in which high-quality psychodynamic and psychoanalytic psychotherapies can be delivered to traditionally underserved populations, including racial/ethnic minorities, and those without insurance coverage or in lower socioeconomic strata.[42] We join previous calls to improve efforts at making psychodynamic and psychoanalytic psychotherapy training and delivery more inclusive, accessible, and affordable.[42–44]

DISCLOSURE

The author has no commercial or financial conflicts of interest.

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