Treatment of Anxiety in Children and Adolescents

Using Child and Adolescent Anxiety Psychodynamic Psychotherapy

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KEYWORDS

• Anxiety • Behavioral inhibition
• Child and adolescent psychodynamic psychotherapy • Phobia

KEY POINTS

- As new developmental tasks emerge in childhood, anxiety can miscarry and become anxiety disorders, severe and/or persistent, and can interfere with normal developmental tasks.
- In a psychoanalytic frame, anxiety can be understood in part as representing a "compromise formation." A compromise formation represents a psychological compromise between unacceptable or ambivalent wishes and defense mechanisms in response to those wishes.
- Child and adolescent psychodynamic psychotherapy is a manualized, time-limited psychodynamic psychotherapy with twice-weekly sessions, for children ages 8 to 16 years old with primary *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision): generalized anxiety disorder, social phobia, or separation anxiety disorder. The therapeutic relationship is designed to help the child improve his or her capacity to reflect and better investigate and understand symptoms by beginning to articulate and explore underlying psychological meanings associated with them.

WHAT IS ANXIETY?

Anxiety is a universal human experience. Phenomenologically, it can comprise features of autonomic arousal, a subjective experience of tachycardia, increased respiration, and an acute sense of danger and dread. Human anxiety is closely related to mammalian fears and can be an inborn response to stimuli that the organism will actively attempt to avoid via flight or freezing.[1] Developmentally anxiety is adaptive and useful, alerting the child to the perceived threat of danger. Anxiety is also elicited

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Key Abbreviations: Anxiety	
CAMS	Child-Adolescent Anxiety Multimodal Study
CAPP	Child and adolescent psychodynamic psychotherapy
CBT	Cognitive-behavioral therapy
GAD	Generalized anxiety disorder
OCD	Obsessive-compulsive disorder
PD	Panic disorder
PFPP	Panic focused psychodynamic psychotherapy
PTSD	Posttraumatic stress disorder
RF	Reflective functioning

as a response to ruptured attachments. Separation anxiety is but the first of a sequence of danger signals during development. However, as new developmental tasks emerge in childhood, anxiety can miscarry and become anxiety disorders, severe and/or persistent, and can interfere with normal developmental tasks.

Anxiety disorders are the most frequent mental disorders among children and can cause substantial impairment in school, family relationships, and social functioning.[2–4] Childhood anxiety disorders most commonly present first as separation anxiety and specific phobias, followed by the onset of social phobia.[5,6] There is evidence that inhibited temperament is related to the development of anxiety disorders.[5,6] The slow-to-warm-up, cautious, and hyperalert stance of children with anxious temperaments, in its most extreme form, with behavioral inhibition, suggests a lower threshold for anxiety in response to environmental stressors.[7,8] Behavioral inhibition is operationally measured by cautious exploration of novel environments and even an aversion to novelty. Anxiety in adulthood is commonly preceded by anxiety in childhood.[4,9,10] One goal of early ascertainment and treatment of anxiety in childhood and adolescence is to try to limit the development of mood and anxiety disorders later in life.

Diagnoses classified as Anxiety Disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR)[11] include: generalized anxiety disorder (GAD), specific phobia, agoraphobia, panic disorder (PD), social phobia, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). Evolving neurobiological understanding, coupled with overlapping characteristics of the current diagnoses and the heterogeneity of signs and symptoms among anxiety disorders, has provided a rationale to realign these categories in DSM-V such that PTSD and OCD will be presented as distinct categories from the other anxiety disorders.[12,13]

Nonpsychodynamic Treatment Approaches to the Treatment of Anxiety

Nonpharmacologic treatments for childhood anxiety are frequently preferred by children and their parents, and are recommended for the many youth with anxiety disorders who either do not respond well to medications or develop adverse events from antianxiety medication.[14–16] The largest study of note in childhood anxiety disorders, the Child-Adolescent Anxiety Multimodal Study (CAMS), demonstrated that children with anxiety disorders respond to cognitive-behavioral therapy (CBT) and pharmacologic interventions, and that CBT and their combination were superior to placebo.[17] In this randomized controlled trial conducted across 6 sites, 488 children aged 7 to 17 with primary DSM-IV diagnoses of social anxiety disorder (SAD), GAD, or social phobia were assigned to receive 14 sessions of CBT (based on the Coping CAT Program[18] adapted for the subjects' age and duration of the study),[18,19] sertraline or a combination of sertraline and CBT, or a placebo for 12 weeks. Roughly 50% of both sertraline and CBT-alone treated groups were found to be much improved or very much improved on the Clinical Global Impression of Improvement ($P<.001$), in contrast to 80% of those treated with the combination ($P<.001$) and 23.7% treated with placebo.

Psychodynamic Approaches to the Treatment of Anxiety

Psychodynamic psychotherapy has been used to treat anxious children since the 1940s but has yet to be systematically tested in children. In a psychoanalytic frame, anxiety can be understood in part as representing a "compromise formation." A compromise formation represents a psychological compromise between unacceptable or ambivalent wishes and defense mechanisms in response to those wishes. The emotional pressure of both the unacceptable wishes and their defense leads to symptoms. Defense mechanisms, which are themselves unconscious psychological processes, protect the individual from the psychological danger arising from unacceptable wishes and fantasies. If the defenses fail (ie, the child becomes aware of the depth of his rage at his mother, for example), the child experiences overwhelming anxiety. **Box 1** outlines a developmental progression of anxiety-provoking psychological situations that can engender these psychological processes that trigger symptoms of anxiety.

A symptom-focused manualized psychoanalytic psychotherapy, panic-focused psychodynamic psychotherapy (PFPP), was found to have efficacy for adults with primary PD with or without agoraphobia.[20] Child and adolescent anxiety psychodynamic psychotherapy (CAPP), the symptom-focused manualized form of psychodynamic therapy the authors have been testing in a small open clinical trial, has been adapted to younger developmental age groups from PFPP.[21]

CHILD AND ADOLESCENT ANXIETY PSYCHODYNAMIC PSYCHOTHERAPY MANUAL

CAPP is a manualized, time-limited psychodynamic psychotherapy with twice-weekly sessions, for children ages 8 to 16 years old with primary DSM-IV-TR: GAD, social

Box 1
Anxiety provoked by unconscious and ambivalent aspects of common childhood dilemmas

Unacceptable Ideas/Wishes Evoked By:

- Life events such as birth of sibling or loss of exclusive hold on parent
- Family relationships, such as parental discord, abuse
- Triangular allegiances and conflicts in family
- Meanings of events based on perceptual distortion and immature interpretation (eg, being trapped in an elevator and fearing never to see mother again)

Common Dynamisms Underlying Youth Anxiety:

- Fear of separation from attachment figures, ambivalence about autonomy, conflated with fears of loss
- Difficulty experiencing/acknowledging anger and/or ambivalence toward attachment figures
- Sexual conflicts as sexual identity emerges (eg, unacceptable masturbation fantasies)
- Guilty self punishment through the experience of anxiety symptoms per se

Normative Developmental Pressures—Stage-Related Equilibria, Transitioning from Home to Community, Cognitive Maturity

- 8 to 11 years old: latency search for mastery over intellectual and physical skills; phase-related righteousness (harsh superego)
- 12 to 16 years old: early adolescent search for independent identity and further mastery over preferred endeavors. New integration of bodily sensations, anatomy, sexuality

phobia, or separation anxiety disorder. CAPP is made up of 20 to 24 sessions divided into 3 phases (**Box 2**). The therapeutic relationship is designed to help the child improve his or her capacity to reflect, and better investigate and understand symptoms by beginning to articulate and explore underlying psychological meanings associated with them. Symptoms include the physiologic (autonomic) signs of anxiety such as shortness of breath, sweating, and shaking, as well as the associated cognitive accompaniments such as overwhelming fear and paralysis. Throughout the therapy, the therapist and patient work to better understand and articulate the underlying psychological conflicts that engender the anxiety (**Box 3**).

This approach makes the basic assumption that symptoms carry specific psychological meaning, and that this can be ascertained through the exploration of personal fantasies and meanings connected with the anxiety. In the early phase of CAPP, the therapist develops a working psychodynamic formulation that itself is psychodynamic (ie, subject to change as more information is gathered) about the psychological

Box 2
Therapeutic process and strategies

Phase 1

- History from family (context)
- Developing alliance as narrative of symptoms unfolds in context of life events
- Therapist listening: tentative psychodynamic formulations
- Primary dynamisms identified
- Present dynamism to patient, focusing on meaning of continuing dialogue where it fits
- There is a continuous focus on anxiety symptoms by the therapist whether the patient brings it up or not

Phase 2

- Continue dialogue: patient sets focus/topics
- Anxiety focus
- Therapist finds redundant expositions, questions and clarifies/applies psychodynamic focus, repeatedly interpreting
- Patient begins to be reflective and self-observing about anxiety
- Loosening the fixity of reaction patterns: opens inquiry for new responses
- Patient considers other examples of how dynamisms effect anxiety/behavior
- Therapist reinforces reflective function, accenting tendency to repeat

Phase 3

- Commonly punctuated by anxiety symptom rearousal
- Demonstration of transference as recurrence of separation anxiety and difficulty with ambivalence and rage
- Revisit with family of younger patients/crises
- Repetition and working through dynamism discovered
- Reinforce reflection and newly established flexibility of response
- Advocate for new open behavior, diminishing tendency to withdraw/fall into repetitive patterns

Box 3
CAPP treatment overview

A. History from family and child
   a. 12 to 16 years old: at least one meeting with parents and adolescent. Delineate the role of anxiety in the family and the place of the adolescent's symptoms in the family
   b. 8 to 11 years old: 1 to 2 meetings with parents held without the child before treatment, then again throughout the course of the therapy as needed

B. Develop a specific psychodynamic formulation of meaning of anxiety symptoms
   a. Reflective functioning: awaken psychological curiosity
   b. Alternative meanings offered through interpretation of fantasies
   c. Developmental orientation

C. Talk/play (depending on age of patient): learn from the child what his/her point of view is, help the child conceptualize that he/she can understand what might be going on in the mind of another through imagining how he/she might feel in a given situation
   a. 8 to 10 years old: more activity driven (play and drawing)
   b. 11 to 16 years old: more verbal dialogue (play or drawing if necessary)

D. Interpret commonly appearing defenses
   a. Denial, turning passive into active, projection, regression, and isolation of affect

E. Rapid communication of patient's conflicts, verbally and respectfully: connecting anxiety symptoms, fantasies, affects, and interactions within the context of therapeutic relationship

F. Careful listening to patient reactions (modification of formulation) (feeling understood)

G. Discovery of unconscious fantasies through daydreams, dream, play, which can be expressed, tolerated, and treated as openings for inquiry

H. Connecting fantasies directly to the anxiety symptoms (loosening the entrenched constellations leading to maladaptations)

I. Fantasies and defenses reconsidered in light of present needs and coping abilities, with the new realization that they are anachronisms from earlier phases of life and can be dispensed with or altered so that the patient can move to the appropriate developmental stage

meaning of the anxiety symptoms. Later in the therapy, the therapist progressively returns to repetitive examples of dynamisms in the child's life and to the transference to reveal and further develop this evolving formulation and permit the child to witness the repetitive occurrence of the same psychological constellation. This process leads to symptom relief through various mechanisms (**Table 1**).

Reflective functioning (RF) is a proposed mechanism through which psychodynamic therapy works. RF is a way of codifying the ability to understand one's own mind and other people's minds. This "reflectiveness" develops when the caregiver's mindfulness about a child's mental state allows the child to develop capacities of self regulation, and the ability to envision and think about mental states in oneself and, therefore, the capacity for empathy and intimacy. When RF improves the patient's insight improves.[22]

Treatment begins with history gathering. With younger children, meetings take place with parents separately; developing and maintaining an alliance with parents is important. Individual therapy with the child includes a safe and cooperative environment where the focus is on the child's current experience and anxiety.

Table 1
Relationship between psychodynamic theory and interventions for anxiety in CAPP

Anxiety Disorder Features	Psychodynamic Theory in CAPP	Target Symptoms and CAPP Strategies
Social phobia	Extreme self consciousness and fears of embarrassing oneself are linked to conflicted wishes to be the center of attention and laced with guilt and self punishment; normal desire for attention feels unacceptably aggressive	Explore defenses against wishes to stand out, conflicted patients' overly critical evaluation of others as entrée to connections with uncomfortable competitive wishes and conflicted, unacceptable aggression. This raises SSRF
GAD	Extreme inability to relax, hypervigilance, and dread of many life situations arises from conflicts related to personal meanings of curiosity and exploration of new and novel situations; normal curiosity and desire for exploration is associated with feeling dangerously out of control and overwhelmed	Focus on terror of internal urges, including aggression and desire for autonomy. Emerging fantasies actively connected with symptoms and persistence of anxiety. This raises SSRF
Separation anxiety	Severe, developmentally inappropriate separation distress arises from conflicts between normal strivings for autonomy and concerns about hurting or infuriating the emotionally needed parent. Clinging to parent leads to anger at parent and self; normal strivings for autonomy are associated with feeling unacceptably lonely and frighteningly rejecting of the parent	Explore transference, an emotionally vibrant paradigm for understanding and altering separation fears. Intensity (twice a week) and brevity (for 12 weeks) are key CAPP aspects making emotional significance of termination central to the final third of treatment. This raises SSRF
Anxiety reestablishing age-appropriate autonomy, common to these disorders	Conflicts and fears about normal autonomy (ie, growing wish to manage by oneself, curiosity and independence) common in SP, GAD, and SAD patients emerge in transference. Assertiveness (seeking attention, exploring and attempts at independence), perceived as destructive anger, creating conflict	CAPP focus on transference highlights conflicts about autonomy, especially as incorporated into fantasies of bodily harm; sense of inadequacy is experienced as physical anxiety and symptoms

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Table 1
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Anxiety Disorder Features	Psychodynamic Theory in CAPP	Target Symptoms and CAPP Strategies
Comorbid major depression-when present	Conflicted aggression leads to guilt and negative self evaluation, depressive symptoms, and somatic anxiety	CAPP focus on conflicted aggression detoxifies and helps patient redirect it, improving autonomous function and assertion. Mitigates guilt, with improvement in autonomy, negative views of self improvement

Abbreviations: CAPP, child and adolescent psychodynamic psychotherapy; GAD, generalized anxiety disorder; SAD, social anxiety disorder; SP, social phobia; SSRF, symptom specific reflective functioning.

For older children and adolescents, encouraging parental support while fostering developmentally appropriate autonomy is central to the success of therapy. Maintaining an alliance with the family can be essential to engaging the child, particularly at moments of emotional turmoil. Throughout the course of treatment, the therapist first develops a working formulation about underlying meanings of the patient's anxiety, then refines it, to connect current crises that emerge (eg, child stops going to school, has panic attack on bus, and so forth) with underlying anxiety psychodynamics. Transference is explored to the extent that it is possible in the context of a time-limited psychotherapy. Core anxiety psychodynamics (wishes, adaptation to reality, atoning for guilty transgressions) are identified across various areas of the patient's life. Emphasis is placed on ways in which the child's coping style may have been adaptive for the child earlier, and yet is not serving him or her in current circumstances. This approach helps the child develop more appropriate, less dysfunctional mechanisms for handling emotional conflicts.

In the latter part of therapy, termination must be discussed actively by the therapist. This period is often a symptomatic time, during which primary conflicts about being able to act autonomously, accelerated by the experience of ambivalent anger about separation from the therapist as termination is approached, necessarily emerge in the therapeutic relationship. This situation can provide the opportunity for the child to experience these conflicts directly in the room with the therapist.

THE CASE OF MAX

Max was a 16-year-old boy of high academic achievement, from a professional family, who presented with symptoms of GAD (6/8), social phobia (5/8), and dysthymia (4/8) on the Anxiety Disorders Interview Scale (ADIS) for Child and Parent, with a score of 22 on the Pediatric Anxiety Rating Scale—Revised (PARS-R). Max's presenting symptoms included generalized anxiety and worry about academic performance, social acceptance, and heightened conflict with his mother. He was very anxious with peers, socially inhibited in the classroom, and had difficulty sleeping and fatigue. His mother was concerned about his waning school performance, lack of initiative, and poor response to limit setting. Max felt he was doing "OK" in school, and wished his parents would "leave him alone."

Max's family was beset by the economic downturn and a recent apartment move. Max had suffered injuries preventing him from playing sports, involvement with which was central to his identity. In addition, his parents did not approve of his new girlfriend.

During the first phase of treatment, rapport was easily established. Although he was "not used to this," the therapist helped him express feelings and experiences. Max explained, in his quiet manner, that being quiet helped him manage at home where he perceived his mother to be "the dictator." The therapist noted that it appeared that he and his "father both seemed to have similar responses" to his mother. The patient acknowledged, "I kind of copied him…" By the next session the patient's silence provided an opportunity for the therapist to interpret Max's routine manner of handling social interactions, repeated with him, in the transference. The initial dynamism explored was suppression of both anger and expression of age-related assertiveness.

During the second phase of treatment Max's conflict avoidance emerged during intercurrent crises: escalating active conflict with his parents around weekend activities. The now more expressive and angry Max heightened parental concern that "things are exploding." In session Max reported that his "parents are the source of my anxiety." The therapist pointed out that Max needed to find the source of his feelings and behaviors outside himself rather than within as conflicted wishes. His worried parents called to see if medication was not called for. At the same time as increasing "storms" were reported by Max's parents there was "calm" during sessions, combined with Max missing/forgetting sessions and long silences in the room. As the crisis with his parents resolved, Max began to emphasize his improved school performance and a return to sports. The brevity of treatment can lead to an acting out of therapeutic health that needs to be interpreted.

The treatment entered the termination phase, and Max reported feeling "a lot better." There was a mild reemergence of original symptoms of fatigue, insomnia, conflicts at home, and avoidance of social interactions. During this phase the subject of the loss of his therapist was highlighted and discussed. Max's anxiety remitted with therapy. On termination his PARS-R score was 12; on the ADIS he had lost his diagnoses for GAD and social phobia, and dysthymia was 4/8.

Discussion

This case represents an example of a teen living in a relatively supportive environment where the developmentally appropriate conflict between his desire for greater autonomy and the acceptance of developmentally necessary levels of dependence on parents (financial, educational, and so forth) was expressed in anxiety symptoms. Max did several things that augmented his dependence (ie, his passivity, encouraging his mother to step in) and obscured awareness of feelings by "checking out" regarding his mother. His unrealistic expectations and attitudes toward his current developmental situation and the emergent anger and resentment frightened him, but he quickly bypassed evidence of this suppressed rage with anxiety.

He was enraged and guilty toward his father too for being so passive in dealing with his demanding, intrusive mother, yet identified most with him in his passive role in the family. He unconsciously punished himself and his family for gratification of his unconscious passive wishes. Max's maladaptive use of passivity as solution to conflict with his mother and sister contrasted with his unconscious wishes for success and triumph over his parents. During treatment and based on a new relationship that permitted expression of emergent feelings, he was able to articulate and tolerate some of these age-appropriate wishes and also explore his feelings in the transference. He increasingly engaged with family, and sought greater

developmentally congruent independence and success in his endeavors. The new consideration of feelings from within rather than reaction to external behavior of others is a hallmark of a psychodynamic approach. CBT or other approaches that are based on response prevention or fear appraisal would not engender the reflection necessary to reappraise the sources of anxiety and the defenses against inner drives and affects. The experience of affects previously suppressed permitted age-appropriate developmental advances as well.

MARC: CAPP FOR A COMPLEX CASE

Marc was a 12-year-old seventh grader at a parochial day school who lived with his mother and stepfather. He presented with escalating anxiety in school and in other public arenas. He was encouraged by his school counselor to enter the CAPP study. Mother was concerned that he did not want to invite friends home, staying both physically and emotionally on "the fringe of things." During wrestling practice he stayed in an adjoining gym with her until practice started, and he sat away from other teammates when not wrestling. Marc never raised his hand in class, and he became extremely anxious when tested or when there was a change in routine. Mother informed the therapist that as a small child Marc had had a little stuffed animal that he would suck on in times of stress, which his parents took away from him when he was age 8 or 9, at which point he developed a tic that looked like a sucking motion.

On presentation, mother described Marc as having tics at times of increased stress. He was so soft spoken that people would often ask him to speak up, and at other times because of his extreme reserve, cousins asked his mother if he was angry about something, which he always denied. Marc had been overweight, and lost 30 lb before presenting in an effort to meet athletic standards. He was uncomfortable eating in public, and worried that people were thinking "look at that fat pig eating that food."

At age 9 Marc had a grand mal seizure, but evaluation including electroencephalography was normal. For a short time after this he asked his mother to sleep with him, which she did for a month. Mother indicated that he sought proximity in whichever room she or his step-dad chose. Mother described him as overly sensitive with others, worrying that he was not liked or loved, and easily felt criticized or embarrassed. When he felt he was on display, such as the wrestling award ceremony, he became distraught and threw up. He refused to have a birthday party, and only enjoyed social events with his cousins. However, he was comfortable performing when he played the saxophone.

Mother and father separated when Marc was 4 years old, when they moved from the West Coast to New York City. Marc's biological father, a fireman, suffered from bipolar disorder and was abusive, "just not a good person." Mother is in the Navy and often on duty. Marc was intermittently raised by his maternal grandparents when his mother was deployed to distant war zones every 2 to 3 years. (She had been deployed for 4 months on when he was 2 and 4, and when he was 10 she was overseas for a year.)

When Marc began CAPP he scored 26 on the PARS-R,[23] and on the ADIS[24] he was diagnosed with social phobia (6/8), SAD (4/8), and GAD (5/8). His mother was scheduled to leave for duty in a war zone toward the end of the scheduled 24 sessions. Marc had seen his father during the summers until 4 years before the start of treatment, when his father fell out of touch. The Christmas before treatment started, mother contacted father to tell him to call his son and he told her, "just tell him I called and sent my love." Father was in another relationship after the divorce from Marc's mother, and had a daughter with whom Marc has had some contact and whom he called his sister. Father currently sees neither child.

In New York City, Marc is the eldest of 9 cousins and spends much of his free time with them and his 5 maternal aunts and their husbands. In addition, he has a relationship with his paternal grandparents, and with his stepfather's family.

In the first phase of treatment, Marc was very quiet. He initially told the therapist much of the same information that he and his mother reported to the diagnostician, but soon after that he became nearly silent. The therapist's initial formulation included the impression that Marc was stalled developmentally, and acted as if he were around 4 or 5 years old. At that age he had been separated from his father, and had witnessed his father physically and emotionally abuse his mother. Marc was thought to have unresolved conflicts about what it might mean to be a man, as well as a great deal of fear about losing his mother, who frequently disappeared to her naval duties and who was at realistic risk of death. The therapist interpreted Marc's silence as a way to avoid painful and unacceptable feelings of anger that he felt toward his mother and biological father for leaving him. Because he could not tolerate the rage he felt for his mother, the woman he most loved and on whom he was dependent, or the rage at the father who could abandon him, he resorted to silence as a defense against what he felt would be a dangerous rage, and overwhelming sadness. This constellation was addressed as the first central dynamism; the therapist told Marc that a secondary gain of silence was the possibility of denying the existence of such feelings altogether. He tried to protect himself from these feelings by literally not giving them a voice. During an early session he talked about not wanting to go to the camp his mother had planned for him because he wanted to go to wrestling camp, but he literally could not tell her. First, the therapist interpreted his anger about his mother making decisions for him without consulting him, and then highlighted his contribution to this situation by not speaking up for fear of making her angry and the perceived threat of abandonment.

After this interpretation he uncharacteristically approached his mother about camp. He also began telling the therapist about how his mother made him feel like a Mama's boy because "she treats me like a 6-year-old." He described mother's demanding too loudly that he put on his socks or drink his Gatorade in practice. The therapist then interpreted how he might have conflicting feelings, wanting to be a Mama's boy, and wanting to be more independent, but how very unfair it was that he has had less control because his mother has had to leave so many times and for such long periods of time, and that once again separation was looming ahead. Marc verbally rejected this interpretation, but for the next weeks he was much more talkative than he was during the first phase of treatment. He began discussing some of his frustrations and experiences in school and at home. He began to seem less anxious and more irritable.

In the middle phase of treatment Marc spoke more spontaneously, and readily described interactions with friends and family. Mother prepared to leave and met with the therapist and Marc during one session. In that session she became tearful. In the following session, Marc and the therapist discussed how difficult it might be to express his anger with mother if he feared she might get weepy in response. During the sixth week of therapy, after a session in which he told the therapist that he hadn't wanted to come, he'd have "preferred to stay home and prepare for practice," he was able to describe how anxious he became about the matches, how unsure he was that he "will do the right thing." He described feeling strongly that he should be able to know all the moves expected and yet he found it "difficult to remember."

The therapist pointed out how hard he was on himself, how infrequently he allowed himself to be proud of himself, and how quick he was to experience himself as inadequate even when his shortcomings were shared by many of his peers; this led to

a discussion of how fearful he was that strangers would think he was weird if he was reading a book about wrestling on the subway. The therapist highlighted Marc's sense that he had something very shameful about himself hidden, but dangerously ready to be discovered.

At the next session Marc disclosed what felt to him like a very big, bad secret, that his father was Moroccan (the therapist had not known this), and the therapist pointed out the possibility of whether he might be even more afraid of people knowing that his father was mentally ill and behaved so erratically. This notion was explored, and he admitted how afraid he was that people would know about his father. He secretly worried that this reflected on his having some hidden flaw or inadequacy. After this set of discussions, Marc engaged with friends with greater frequency and more openly. He began to wrestle more seriously, and experienced himself as a valued member of his team.

Early in the third phase of therapy, Marc talked a good deal about a plan he had to visit his biological father during the summer. He talked about his paternal family and their country life. In talking about them sometimes his voice broke from its usual monotone into a more expressive and brighter rhythm, but he would quickly catch himself. If the therapist brought his attention to this liveliness he denied it, and conversation would stall.

As per CAPP protocol, the therapist began talking with Marc about the treatment ending at the beginning of the third month. Soon after she did this, he fell silent again. This time, he did not hide his reluctance to come but told his grandparents that he didn't want to come. He also missed a few wrestling practices, and was sick and stayed home from school. Marc and the therapist discussed this reluctance to attend sessions in the context of how frequently he could not control the comings and goings of people dear to him, like his mother and father, and how terrible it must feel because he had had so many losses and separations in his life. More importantly, he was being separated from his mother again for 3 to 4 months, and now the therapist too was going to leave him. He responded to these interpretations with relief.

As treatment ended, Marc increased his engagement with friends, even doing things he was not supposed to do in school and at home, testing limits for the first time. He began speaking up for himself, much to the relief and frustration of his parents and grandparents. One day he told the therapist that he had been running around with some of his friends in the staircase at school, and a few of them had waited for another friend and tripped him at the bottom of the stairs. This prank was one of a few he ever engaged in and had gotten into trouble for at school. The therapist said she wondered if he hadn't begun to more ably express aggression, but maybe it wasn't actually that boy he was angry at. He agreed but seemed pleased with himself that he had been part of the trouble instead of looking in from the outside and feeling like an outsider. At the time of termination his mother was deployed, and Marc was doing better in school and at home. His termination PARS-R was 13, and ADIS was GAD 4/8. He had lost his diagnoses of SAD and separation anxiety disorder on the ADIS.

Discussion

This study is a fairly representative case of a youth with anxiety presenting for treatment with evidence of severe, limiting anxiety, withdrawal, and a developmental derailment. This 12-year-old boy had experienced a severe trauma (abuse of his mother by his father, separation from both parents, divorce) at 4 years old, and presented with the defensive style and coping skills of a 4- to 5-year-old. The familial style of this military family was quite reserved, and Marc's preference to contain his feelings about his repeated losses interfered with his ability to develop a sense of safety and of

an autonomous self. His conflicts about his own aggression toward and fear of his father left him unable to explore his own fantasies, feelings, or preferences, much less to be assertive about realizing them.

Because his conflicted need to be the center of his mother's attention was so frequently impossible to realize, he was not able to develop healthy self refection and a compassionate conscience. Through this brief anxiety-focused psychodynamic intervention his symptoms remitted, his reflective functioning improved, he developed the capacity to be increasingly and more age-appropriately assertive, and he overcame his sense of danger and inner prohibitions without threat of abandonment. His final evaluation revealed remission of his symptoms, as can be seen by his posttreatment scores.

The use of a psychodynamic approach in this treatment seemed apt given the complexity of his environment. He could not easily see that some of what he experienced derived from inner conflict. He was not accustomed to reflection and metacognitive exploration. The opening phases of a new relationship that encouraged exploration and expression permitted the elaboration of a primary dynamism to be confronted repeatedly. This sort of intervention was again apt because at each encounter new events could be absorbed into the ongoing exploration, and the boy felt he was understood and could consider his transference wishes.

Given his father's chronic and severe symptomatology and diagnosis of bipolar disorder, it is quite likely that this patient is biologically vulnerable to anxiety and mood dysregulation. Nonetheless, Marc demonstrably benefited from a time-limited, symptom-focused psychodynamic treatment. By treatment termination he began to behave and conceptualize himself in a more developmentally appropriate fashion, revealing that treatment is more than a reduction of symptoms.

SUMMARY: LOOKING TO THE FUTURE OF CAPP

Anxiety disorders are common among children, causing substantial impairment in school, family relationships, and social functioning. Given the evolving understanding that mood and anxiety disorders likely share neurobiological genetic vulnerability, and that childhood anxiety, temperamental disposition, and separation anxiety frequently precede adult anxiety and mood disorders, it behooves us to identify and offer a range of treatments for children who are suffering from these disorders. Pharmacotherapy is frequently not the treatment of choice. CBT is efficacious for youth anxiety, although excellent response rates attenuate over time.[16] Preliminary results of the CAPP protocol have been promising, with subjects experiencing significant, clinically meaningful improvements across all measured areas. As with the case examples, most subjects not only had symptom relief but also were able to advance in developmental experience and use their therapeutic experience reflectively. In conclusion, it may be beneficial to treat children and adolescents with anxiety disorders with symptom-focused, manualized psychodynamic psychotherapy, and once a sufficient pilot sample can be reported it should be replicated in a randomized controlled trial.

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