Short-Term Psychoanalytic Child Therapy for Anxious Children: A Pilot Study

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Few studies report treatment outcome for early childhood internalizing disorders following psychotherapy, especially psychodynamic techniques. We aimed to investigate effectiveness of a novel, developmentally appropriate, short-term psychodynamic treatment program for 4- to 10-year-olds with anxiety disorders in an outpatient setting. We conducted a quasi-experimental wait-list controlled study. Thirty children (12 females) with *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* anxiety disorders and their families received 20–25 sessions of manualized short-term Psychoanalytic Child Therapy (PaCT). We assessed outcome with standardized diagnostic interviews and parent reports of internalizing and total problems at all time points. Child puppet interviews and teacher reports were also available for pre–post treatment and follow-up analyses. While 18 families entered treatment immediately, 12 families were first wait-listed before receiving treatment. Analyses of symptom improvement were based on comparisons between groups (treatment vs. wait-list) as well as pre–post and 6-month follow-up data across all families (including wait-listed families). Among the 27 completers, 66.67% ($n = 18$) no longer met criteria for any anxiety disorder (59.88% in intent-to-treat analysis) while no children remitted across the wait-list interval. Parent-reported child internalizing and total problems significantly declined during treatment relative to wait-list. Child and teacher reports also revealed significant pre–post symptom reductions on internalizing and total problems. Diagnostic and symptom remission rates were maintained at 6-month follow-up except on child reports. This preliminary study adds to a growing database showing that psychodynamic treatments may offer an effective line of treatment for childhood internalizing symptoms and disorders in the eyes of clinicians, children, parents, and teachers.

Keywords: psychodynamic child psychotherapy, clinical outcome study, anxiety disorders, internalizing symptoms, preschool and early school age

Childhood anxiety disorders inflict an immense personal and economic burden on children, parents, teachers, and society at large. Anxiety disorders are the most common psychiatric disorders in childhood (Cartwright-Hatton, McNicol, & Doubleday, 2006), with high prevalence in children as young as 36 months (Egger & Angold, 2006; Lavigne et al., 1998). If untreated, moderate to severe anxiety disorders often persist or recur and predate other disorders (e.g., depression) at later stages (Kovacs & Devlin, 1998; Pine, Cohen, Gurley, Brooks, & Ma, 1998), giving rise to severe social and academic dysfunction (Essau, Conradt, & Petermann, 2000). From preschool age up to adolescence, anxiety disorders frequently co-occur with comorbid depressive disorders (Sterba, Egger, & Angold, 2007), in turn, impeding development and exacerbating treatment outcome (Langley, Bergman, Mc-

Cracken, Piacentini, 2004; Rapee et al., 2013). Should psychotherapeutic intervention programs prove effective in alleviating early childhood anxiety, developmental trajectories may permanently change for the better.

Several well-controlled treatment outcome studies support cognitive–behavioral therapy (CBT) for anxiety disorders as of age eight (Hudson et al., 2009; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Silverman, Pina, & Viswesvaran, 2008). Yet, to date there is little in the way of outcome research for anxiety disorders in preschool and early school age. Moreover, some scholars submit that effects engendered by CBT techniques capitalize on the consolidation of concrete operational thinking across middle childhood (Barrett, 2000; Grave & Blissett, 2004; Reynolds, Wilson, Austin, & Hooper, 2012). Nonetheless, several recent studies with children under age eight support the utility of developmentally adapted CBT for various disorders including anxiety (Creswell et al., 2010; Hirshfeld-Becker et al., 2010; Minde, Roy, Bezonsky, & Hashemi, 2010; Monga, Young, & Owens, 2009). With a few notable exceptions, however, CBT protocols mainly build on caregiver-directed interventions at this age. Indeed, in a study comparing a parent–child with a parent-only CBT protocol, both protocols achieved comparable treatment effects (Waters, Ford, Wharton, & Cobham, 2009). Moreover, ~40% of child anxiety cases retain their diagnosis after CBT (Albano & Kendall, 2002)—with younger age associated with poorer outcome in recent meta-analyses of anxiety (Reynolds, Wilson, Austin, &

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Hooper, 2012) and depression (Weisz, McCarty, & Valeri, 2006). Hence, psychodynamic protocols that target children more directly and place fewer cognitive demands by focusing on emotion, exploration of distressing thoughts, and identification of recurrent relationship themes via interaction and play (Shedler, 2010) may offer a fruitful extension to current clinical practice for young children.

Recent reviews and meta-analytic data support the effectiveness of psychodynamic approaches across a wide range of mental disorders in childhood and adolescence, including internalizing disorders (e.g., Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; Midgley & Kennedy, 2011). Albeit preliminary findings suggest that psychodynamic treatments may prove particularly effective in treating children with internalizing disorders under age 11 (Target & Fonagy, 1994) compared with CBT outcome research; studies of psychodynamic psychotherapy for young children with anxiety disorders are still surprisingly sparse. Though valuable, extant psychodynamic outcome studies on this particular developmental population exhibit several limitations, such as failure to define disorder-specific inclusion criteria, lack of age-appropriate manualized treatment protocols, well-defined control conditions, or widely accepted outcome assessments (e.g., multiple informants, standardized structured diagnostic interviews; e.g., Smyrnios & Kirkby, 1993). Manualization poses a formidable challenge, given the complexity of psychodynamic theory and as many psychodynamic scholars have traditionally resisted simplification and standardization (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002).

In light of promising findings from studies targeting internalizing disorders in young children (Abbass et al., 2013; Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003; Muratori et al., 2002; Palmer, Nascimiento, & Fonagy, 2013; Target & Fonagy, 1994; Trowell et al., 2007) and the strong demand for outcome research in the psychodynamic domain, we developed Short-Term Psychoanalytic Child Therapy (PaCT)—an emotion-oriented play-focused treatment (Göttken & von Klitzing, 2014). Here, we tested this new protocol in a practice-based study of 30 four- to 10-year-olds with *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* anxiety disorders. As is common for new treatment protocols, a wait-list control condition served as a comparison. We quasi-experimentally assigned families to treatment and control conditions on a first-come-first-serve basis, as this minimized interference with services provided by our outpatient unit, and is known to yield effect sizes commensurate to randomized designs (Leichsenring, 2004; Shadish et al., 2000).

Our primary aim was to assess effectiveness of PaCT in treating anxiety disorders on a wide array of validated diagnostic as well as multiinformant, dimensional outcome measures relative to wait-list. Besides immediate clinical remission, stability of treatment effects also represents a key criterion of intervention approaches. Accordingly, we also sought to evaluate the maintenance of treatment effects over a 6-month follow-up period.

Method

Patients

Thirty-seven children aged 4–10 years were referred (mainly by pediatricians) to the outpatient service of our university clinic, located in a medium-sized eastern German city with low ethnic diversity (mainly European Caucasian). The sample was almost exclusively composed of European Caucasian children, with one child of mixed European and Latin American descent. Reasons for referral were either extremely shy, fearful, and worried behaviors, and/or tantruming, oppositional, and aggressive behaviors accompanied by internalizing symptoms, such as dysphoric mood or various anxiety symptoms.

For inclusion, children had to meet criteria for a current *DSM-IV* anxiety disorder (American Psychiatric Association, 2000). Exclusion criteria were (a) active psychosis, acute suicidality, or substance abuse disorder of a parent; (b) cognitive disability (IQ <70); or (c) current or past psychiatric or psychotherapeutic treatment. The study was approved by the local ethics committee of the University of Leipzig/Medical Faculty. Parents signed informed consent after meeting with a clinician who explained the study procedures, risks, and benefits and answered any questions. All children were given age-appropriate explanations.

Procedure

Description of PaCT. PaCT comprises 20–25 weekly sessions[1] conducted in alternating settings (Göttken & von Klitzing, 2014). During these sessions, therapist, parents, and child seek to identify and modify the central conflict theme (at the level of interpersonal relationship and internal representations) underlying the child's symptoms and potential family dysfunction (Göttken & von Klitzing, 2011). During individual sessions with the child, the therapist aims to help the child work through his central conflict in free play. In five to six parent sessions (every fourth session), the therapist addresses the possible and partly unconscious meanings of the child's symptoms. Furthermore, the therapist uses a careful analysis of his own feelings toward parents and child to also grasp the central conflict theme at the level of the parent–child-therapist triad (transference/countertransference relationships; Freud, 1912b; Racker, 1953) and to establish a joint understanding and working through of the central conflict theme. The principles of PaCT are in concordance with the Practice Parameter for Psychodynamic Psychotherapy with children (AACAP, 2012). PaCT aims to help the child to reduce rigidly held maladaptive defense mechanisms giving rise to internalizing symptoms and interfering with healthy development. In addition, PaCT focuses on supporting the parent–child relationship, targeting mentalizing abilities (Fonagy, Gergely, Jurist, & Target, 2002) to enhance parental reflectiveness and sensitivity.

Case Vignette

Presentation: J.[2] (6 years old) suffered from a persistent fear of attending the kindergarten and exhibited severe temper tantrums at home. He met *DSM-IV* criteria for Social Phobia and oppositional defiant disorder (ODD) as well as subclinical Separation Anxiety. His mother reported that J. showed no interest in playing with other children or even visiting his father who had separated soon after J.'s birth. J.'s mother also recalled traumatic experiences during

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[1] Notably, within the German health care system, all forms of psychotherapy that do not exceed 25 sessions in length are defined as short-term.

[2] Informed consent was obtained and de-identification has been used to protect the confidentiality of this child and family.

her own childhood. At the evaluation sessions, she stated that social contacts were not of great importance to her and she did not need anyone but her son. Upon arriving at the first treatment sessions J.—unbeknownst to his mother—enthusiastically and gleefully glanced at the therapist through the window of the waiting room. Suddenly, he made a gesture of shooting the therapist while the mother was greeting the therapist. The mother urged her son to stop this behavior, but the therapist inferred from her joyful facial expression that she also enjoyed this destructive gesture. In the play situation of the first individual sessions, the therapist observed that J. dominated her during interaction, pointing out that he "was never scared of anything." In her countertransference during interaction, the therapist felt relegated to a passive and helpless position.

Treatment: According to PaCT, the aim of the therapy was to identify and modify the central conflict theme underlying the child's symptoms and potential family dysfunction. The therapist interpreted the family dynamics as follows: The mother appeared to have the unconscious wish that J. would replace her missing partner and undo all her negative experiences. Therefore, she appeared to behave ambivalently regarding J.'s developmental task of separation and individuation. In the therapist's understanding, these behaviors rendered J. confused and ambivalent as to whether he may individuate. The therapist hypothesized that this family situation spurred fantasies of power and omnipotence in the boy, but being a child, he simultaneously felt that he could not possibly meet his mother's demands. This conflict might have elicited a mix of anger and anxiety in J. as well as feelings of guilt when he showed interest in anyone, but his mother. From a psychoanalytic vantage point, there might have been further important conflicts, but in accordance with PaCT the therapist merely focused on the predominant one. The therapist tried to communicate her impressions to the mother, for example, by saying to her: "It must be difficult for you to encourage your son to grow and move away from you, because if he does, who will be taking care of you?"

In the first individual sessions, the therapist used mentalization techniques, labeling affective states of the doll figures ("this doll seems to be angry," ". . . afraid" etc.) during pretend play and carefully comparing them with J.'s fears ("Could it be that you sometimes experience the same feelings as the doll in your play?"). In a second step, she interpreted his behavior during the therapy session (when he was seeking bodily contact to her in a rather noninhibited way during play interaction) and linked it to his symptom: "You like playing with me in the same way as you would love to play with the other kids in kindergarten. At the same time being so close to me may frighten you, because then you're no longer just the favorite boy of your mother." His facial expression became sad and he interrupted his impulsive play, revealing that he felt helpless at kindergarten, because he felt the other children were reluctant to play with him. In the course of treatment, J. formed a positive alliance with the therapist offering access to his inner world. In parent work, the therapist encouraged the mother to perceive J.'s growing strivings for autonomy and separation and to tolerate them. The father was prompted to actively define contact with his son.

Outcome: After 25 sessions J. had made important progress, spending weekends at his father's place and seeking the company of his peers to the point of being able to spend the night with the other children at a kindergarten sleepover. After the end of therapy, as well as at follow-up six months later, J. no longer showed symptoms of a social phobia, separation anxiety, and his temper tantrums had also abated.

Participant flow and characteristics. Recruitment took place between July 2009 and January 2012 (see Figure 1).

Children were assessed at baseline and reassessed immediately after treatment and at a 6-month follow-up. Of 52 children screened positive for internalizing problems, 37 parents whose children met the inclusion criteria were invited for an initial diagnostic assessment using a standardized clinical interview. After this initial assessment, seven children were excluded, as they either failed to meet criteria for *DSM-IV* anxiety disorder ($n = 3$), or were found ineligible owing to parental custody disputes ($n = 4$). All parent and child evaluation interviews were videotaped to facilitate coding and double coding. The remaining children ($N = 30$) were allocated to immediate treatment or to the wait-list. Eight licensed psychologists and child psychiatrists who were in psychodynamic psychotherapy training delivered treatment following a completion of 4-day training package. Among these therapists, two had no prior or minimal experience in providing child psychotherapy, four had gained at least some experience with other forms of psychotherapy while two were at an advanced level, with high levels of experience practicing psychodynamic child psychotherapy. Provided a treatment slot was available, the child entered treatment immediately after Time 1 assessment ($n = 18$). If all slots were taken, the child was assigned to the waiting list after Time 1 assessments and commenced treatment later with a second assessment before treatment ($n = 12$). We found no evidence for systematic bias in group assignment owing to this procedure (see Results and Table 1).

The drop-out rate from pre- to posttreatment across all patients was 10% ($n = 3$). In the immediate treatment group, one participant started therapy, but was referred for inpatient treatment after session 4 owing to intensification of externalizing
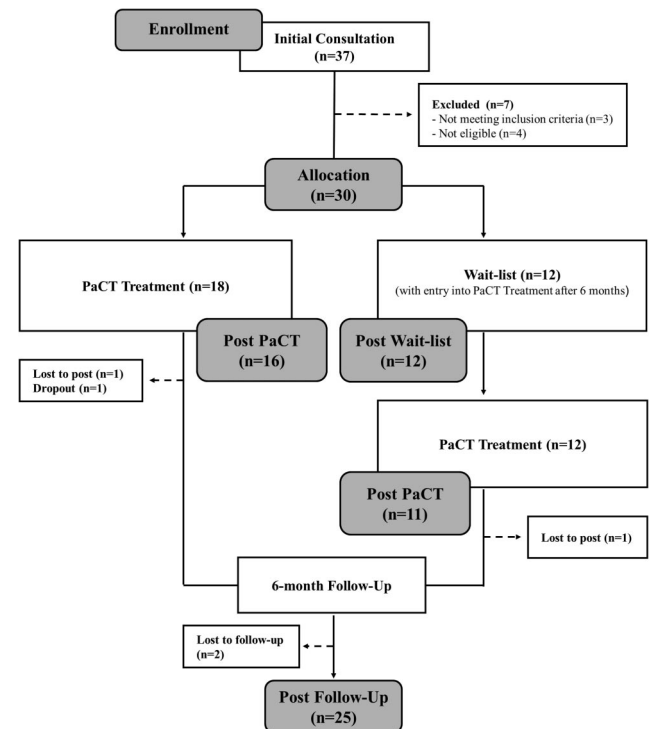

Figure 1. Participants flow through each phase of the study.

Table 1
Baseline Demographic Features of the Sample (N = 30)

Demographic	Treatment group (n = 18)	Wait-list control (n = 12)
Mean age	84.83 months (range 61–122; *SD* = 18.76)	84.75 months (range 52–112; *SD* = 16.02)
Gender	Boys 11 (61.1%)	Boys 7 (58.3%)
	Girls 7 (38.9%)	Girls 5 (41.7%)
Family status		
Single parent	7 (38.9%)	6 (50.0%)
Foster home	1 (5.6%)	2 (16.7%)
Educational level, mother	*N* = 18 (0 missing)	*N* = 12 (0 missing)
No school graduation	0 (0.0%)	3 (25.0%)
Special needs school	1 (5.6%)	0 (0.0%)
Primary school/Hauptschule	3 (16.7%)	0 (0.0%)
Secondary school/Realschule	6 (33.3%)	4 (33.3%)
University-entrance dipl./Abitur	4 (22.2%)	3 (25.0%)
University/college degree	4 (22.2%)	2 (16.7%)
Educational level, father	*N* = 16 (2 missing 11.1%)	*N* = 10 (2 missing 16.7%)
No school graduation	3 (16.7%)	1 (8.3%)
Special needs school	0 (0.0%)	0 (0.0%)
Primary school/Hauptschule	3 (16.7%)	0 (0.0%)
Secondary school/realschule	5 (27.8%)	5 (41.7%)
University-entrance dipl./Abitur	0 (0.0%)	1 (8.3%)
University/college degree	5 (27.8%)	3 (25.0%)
Any anxiety disorder (%)	17 (1 missing 5.6%[a])	12 (100%)
Anxiety disorders:		
Specific phobia	14 (77.8%)	6 (50%)
Generalized anxiety Disorder	14 (77.8%)	12 (100%)
Social phobia	8 (44.4%)	4 (33.3%)
Separation anxiety	0 (0%)	0 (0%)
Panic attacks	3 (16.7%)	3 (25%)
Agoraphobia	1 (5.6%)	0 (0%)
Selective mutism	0 (0%)	1 (8.3%)
Depression		
Major depression	2 (11.1%)	2 (16.7%)
Depression not other specified	5 (27.8%)	1 (8.3%)
Dysthymia diagnosis	1 (5.6%)	2 (16.7%)

[a] The one missing was drop-out and demanded to delete data.

problems. One participant in the treatment group and one participant in the wait-list control group completed the treatment, but failed to attend posttreatment assessments (lost to post). At 6-month follow-up, 25 families completed assessment. Parents of two participants (who had been allocated to the treatment condition) declined follow-up assessments owing to time constraints (lost to follow-up).

All diagnostic interviews were conducted by a doctoral student who was not part of the team of psychotherapists and who was not informed about the treatment course. As he knew whether the families came for the first (pretreatment), second (posttreatment), or third time (follow-up), he could not be blind to the treatment condition. As the interview training and reliability checks were time consuming, funding limitations prevented us from training and using several interviewers who could have been blinded to treatment condition. For the same reason, we trained only two research assistants to administer child puppet interviews. Hence, they usually knew whether they were conducting a pre-, post, or follow-up assessment, but they were both not part of the psychotherapeutic team and not systematically informed whether the children they assessed were part of the immediate treatment or the wait-list group.

Baseline Assessments

Structured diagnostic interview. The doctoral student received intensive training with a certified expert interviewer trained by the authors of the Preschool Age Psychiatric Assessment, PAPA (Egger, Ascher, & Angold, 2004). The PAPA is a semistructured interview designed for preschool and schoolchildren with established test–retest reliability and construct validity (Egger et al., 2006). It assesses the intensity, frequency, duration, and onset of all relevant *DSM-IV* disorders. To enhance comparability, we used the same diagnostic interview (PAPA) for the whole sample. Interrater reliability on primary diagnoses and subthreshold diagnoses were high on average (10% of all pre-, post-, and follow-up interviews were double coded; kappa coefficient = .92; range: .62–1.00). Of the three 9- and 10-year-olds in our sample, all received a diagnosis of generalized anxiety disorder where criteria for older children closely resemble those defined by the *DSM-IV* for younger children.

Internalizing and externalizing symptoms. Parents and teachers completed the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), a 25-item screening instrument, found to yield valid and reliable scores on internalizing symptoms, conduct problems, hyperactivity/inattention, and peer problems among

children and adolescents (Goodman, 2001; Klein, Otto, Fuchs, Zenger, & von Klitzing, 2012; Rothenberger, Becker, Erhart, Wille, & Ravens-Sieberer, 2008; Woerner, Becker, & Rothenberger, 2004). Parents also completed the widely used 113-item Child Behavior Checklist (CBCL/4–18; Achenbach, 1991), found to yield reliable and valid scales for dimensions of behavioral problems of children and adolescents, aged 4 to 18 (e.g., Achenbach & Rescorla, 2003; Schmeck et al., 2001). For the present purposes, we chose to focus on the scale assessing total problems, superordinate scales indexing internalizing and externalizing problems, as well as the subscales of the internalizing dimension (anxious/depressed; withdrawn). Child self-reports were assessed via the Berkeley Puppet Interview (BPI; Measelle, Ablow, Cowan, & Cowan, 1998), yielding the compound scales "Internalizing" and "Externalizing." To elicit children's self-perceptions, the examiner presents two identical hand puppets, making two opposing statements (e.g., I am a happy child–I am not a happy child). Next, the child is requested to indicate how he acts (verbally/nonverbally). Interviews were videotaped and scored on 7-point scales by raters blind to all other data. Several studies support the BPIs validity and reliability (Ringoot et al., 2013), detecting consistent and predictable patterns between children's self perceptions and ratings by adult informants (Measelle et al., 1998). The BPI was administered and coded from video by trained research assistants.

Posttreatment and Follow-up Assessments

Immediately after treatment completion, a doctoral student administered the PAPA interview to mothers. Six months after therapy was completed, all families were reinvited for an abbreviated 1-hr PAPA interview covering all relevant internalizing disorders. In addition, both at posttreatment and follow-up, parents and teachers completed symptom scales and children were again queried via the BPI.

Treatment integrity. To assess adherence to the PaCT protocol, the first author of the PaCT manual constructed a PaCT prototype for an ideal PaCT psychotherapy session, drawing on the items provided by the Child Psychotherapy Q-Set technique (CPQ) (Schneider & Jones, 2009). Every fifth therapy session was videotaped and discussed in a weekly supervision. An independent research assistant, trained by the author of the CPQ technique, rated a sample of 53 out of 58 available sessions in the early and late stages of each treatment (session 5 and session 15 across all therapies; five videos were not available owing to data loss; one child dropped out before the first session was recorded).

Acceptability. Treatment acceptability was indexed by widely used, normed parent- and therapist-rated questionnaires for treatment evaluation on a 5-point scale (0 = bad, 1 = not sufficient, 2 = moderate, 3 = good, 4 = very good; Mattejat & Remschmidt, 1998). Total scores (sum of subscales) of parent ratings (FBB-E) and the therapist's ratings (FBB-T) were computed.

Data Analysis

χ^2-tests served as statistical tests for categorical measures and mixed-design ANOVAs and repeated measures ANOVAs for dimensional measures. Dichotomous presence/absence of anxiety disorder and parent-reported dimensional internalizing and total

problems scales (SDQ, CBCL) were used as our primary outcome measures. All other measures served as our secondary outcome measures including child and teacher reports, which were only available at pre- and posttreatment as well as follow-up. We report per protocol (PP) analyses and account for drop-outs in intent-to-treat (ITT) analyses using the last point carried forward technique. Two-tailed tests were used throughout.

Results

Preliminary Analyses

Descriptive results. Treatment and wait-list groups did not differ significantly on any of the demographic or primary outcome variables (see Table 1). No children received concurrent treatments or medication. Mean treatment duration was 21.72 sessions (SD = 2.80 sessions; 40.96 weeks, SD = 9.62 weeks). On average, the wait-list condition lasted 16.39 weeks (SD = 2.51 weeks) before treatment commenced. Owing to the significantly longer treatment duration compared with wait-list duration, we checked associations between treatment duration with all our outcome measures to assess whether longer duration predicted better outcome. All correlations were nonsignificant and very low (all rs < .10, all p values > .65).

Acceptability. On average, parent-rated FBB-Es yielded a score in the good range (M = 3.11; SD = .75); the average of therapist-rated FBB-Ts was moderate to good (M = 2.35; SD = .40).

Treatment integrity. The mean correlation between the rated treatment sessions (of all eight therapists) to the PaCT prototype was M_r = .78 (range: rs = .70–.80; p < .001; two-tailed).[3]

Primary Analyses

Pre–posttreatment results on categorical measures (diagnoses). After PaCT, 66.67% (n = 18) of completers (n = 27) showed full diagnostic remission (see Figure 2; $\chi^2(1, N = 27) = 27.00$, p < .001). In ITT analyses 59.88% (n = 18) of the children were free of any anxiety disorder by posttreatment, $\chi^2(1, N = 30) = 25.71$, p < .001. All children (n = 12, 100%) retained their anxiety diagnoses throughout the wait-list period while 12 children (75%) from the treatment group were free of anxiety disorder by posttreatment, $\chi^2(1, n = 16) = 15.27$, p < .001.

Pre–posttreatment results on parent-rated dimensional measures (symptoms). We conducted mixed-design ANOVAs with time (pre, post) as within-subjects factor and group (treatment group, wait-list control group) as between-subjects factor for all relevant parent-reported symptom subscales to test for interaction effects (see Figure 3 for interaction effects and cutoff scores on primary outcome variables; see Table 2 for per protocol F, p, and η_p^2 values). SDQ Emotional Symptoms revealed a significant main

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[3] To check for potential therapist effects, we estimated intraclass correlation coefficients (ICCs) from the output of hierarchical linear modeling, following Woltman, Feldstain, MacKay, and Rocchi (2012). SDQ total problems and emotional symptoms indicated no systematic difference between therapists. Similarly, no effect was detected on CBCL total and internalizing problems after taking differences in pretreatment levels into account (all ICCs = .001).
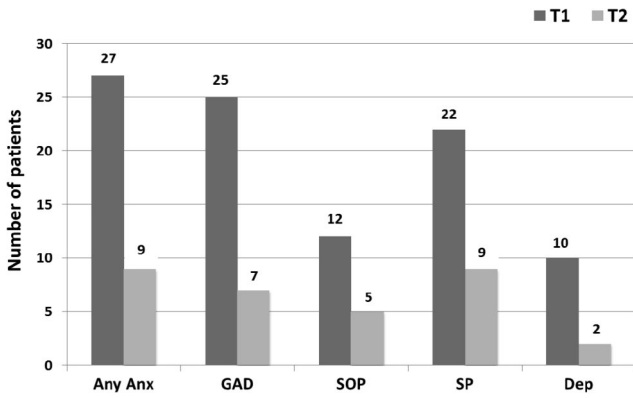
Figure 2. PAPA diagnoses before and after PaCT treatment (per protocol analysis). * Note: Any Anx = any anxiety disorder; GAD = generalized anxiety disorder; SOP = social phobia; SP = specific phobia; Dep = depression (major depression, depression not other specified, dysthymia).

effect of time, which was qualified by a significant group by time (G × T) interaction, with the treatment group displaying greater symptom reductions than their wait-list counterparts at posttreatment. The same result emerged for SDQ Total Difficulties, CBCL Internalizing Problems, CBCL Withdrawn, and CBCL Total Problems scales. For CBCL Depression/Anxiety subscale, this analysis revealed a significant main effect of time and a trend toward a G × T interaction. For CBCL Externalizing scale, we found no significant main effect of time, but a significant G × T interaction. The SDQ Conduct Problems subscale failed to show significant effects.

In ITT analyses, all main effects remained significant. For the parent-rated CBCL Total Problems scale, ITT analysis yielded a significant G × T interaction $F(1, 29) = 7.18$, $p = .012$, $\eta_P^2 = .20$, while interaction effects were consistently reduced to statistical trends for all other relevant primary outcome measures (SDQ Emotional Symptoms: $F(1, 29) = 3.78$, $p = .062$, $\eta_P^2 = .12$; SDQ

Total Difficulties: $F(1, 29) = 3.34$, $p = .078$, $\eta_P^2 = .11$; CBCL Internalizing Problems: $F(1, 29) = 3.74$, $p = .063$, $\eta_P^2 = .12$).

Teacher reports. As shown in Table 3, we conducted repeated measures ANOVAs for teacher reports on pre–post treatment differences on all relevant SDQ subscales. This analysis revealed a significant effect of treatment on SDQ Emotional Symptoms subscale, SDQ Conduct Problems subscale, and SDQ Total Difficulties scale (see Table 3 for F, p, and η_P^2 values). These effects were robust to ITT analyses.

Children's self-reports. Repeated measures ANOVAs (pre, post) on the BPI subscales "Internalizing" and "Externalizing" revealed a significant effect of treatment for BPI "Internalizing" and a trend for "Externalizing" subscales (see Table 3). These effects were robust to ITT analyses.

Six-Month Follow-Up

At follow-up, one participant sought additional psychotherapeutic treatment. Six months (mean: 6.10 months; $SD = 1.17$) after the end of treatment, we collected follow-up data from 25 families ($n = 14$ from immediate treatment condition and $n = 11$ from control condition).

Baseline (T1) to follow-up (T3) results of categorical measures. After the 6-month follow-up, 22 of the 25 children completing follow-up assessments showed complete diagnostic remission, $\chi^2(1, N = 25) = 39.28$, $p < .001$.

Baseline (T1) to follow-up (T3) results of dimensional measures. A repeated measures ANOVA on parent-rated SDQ Emotional Symptoms revealed a large effect of treatment after follow-up. Comparable results were found for parent-rated SDQ Conduct Problems subscale, SDQ Total Difficulties scale, CBCL Internalizing Problems, CBCL Anxiety/Depression, CBCL Withdrawn, CBCL Externalizing Problems, and CBCL Total Problems scale as well as teacher-rated SDQ Emotional Symptoms and SDQ Total Difficulties scales. Neither the repeated measures ANOVA for BPI "Internalizing" nor BPI "Externalizing" scales revealed
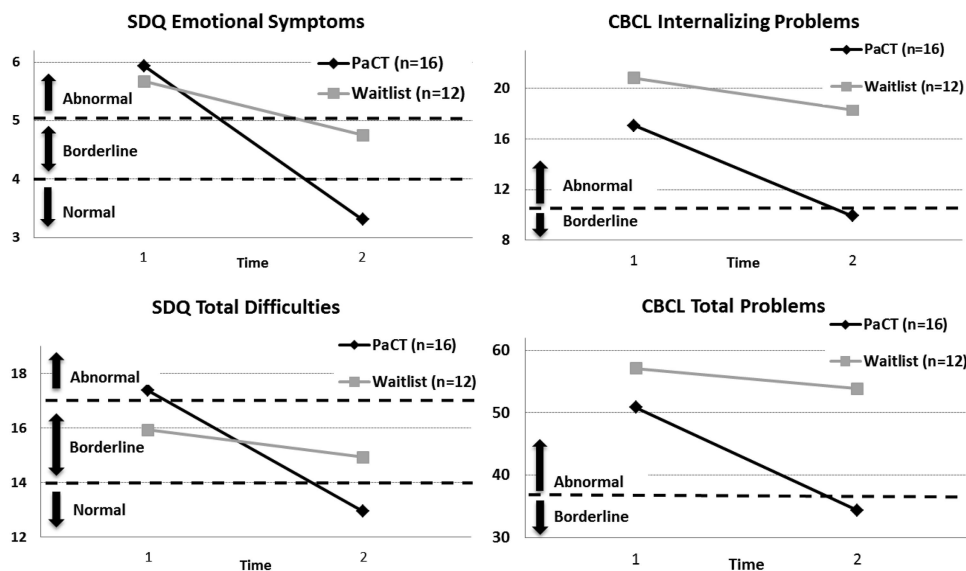
Figure 3. Interaction and main effects of primary outcome variables.

Table 2

Rates of Improvement in the Two Groups for CBCL and SDQ Syndrome Scales

	Pre M (SD)	Post M (SD)	ANOVA (df = 28)			
			Time		G × T	
			F	η_P^2	F	η_P^2
SDQ Emotional Symptoms			23.62***	.48	5.50*	.18
PaCT	5.94 (2.35)	3.31 (2.39)				
Wait-list	5.67 (2.54)	4.75 (2.20)				
SDQ Conduct Problems			2.90	.10	0.06	.00
PaCT	3.38 (2.19)	2.81 (2.29)				
Wait-list	3.50 (2.02)	3.08 (2.19)				
SDQ Total Difficulties			10.80**	.29	4.32*	.14
PaCT	17.37 (6.64)	12.94 (7.70)				
Wait-list	15.92 (6.35)	14.92 (5.55)				
CBCL Internalizing			23.50***	.48	5.43*	.17
PaCT	17.06 (8.09)	9.94 (5.52)				
Wait-list	20.83 (10.04)	18.33 (9.87)				
CBCL Withdrawn			17.17***	.40	9.24**	.26
PaCT	6.56 (3.09)	3.31 (2.58)				
Wait-list	6.17 (4.37)	5.67 (3.80)				
CBCL Anxious/Depressed			20.32***	.44	3.34 +	.11
PaCT	9.50 (5.50)	5.56 (3.52)				
Wait-list	11.83 (5.52)	10.17 (6.09)				
CBCL Externalizing			2.98	.10	5.46*	.17
PaCT	16.75 (10.66)	12.88 (9.14)				
Wait-list	17.08 (8.65)	17.67 (7.80)				
CBCL Total Problems			21.99***	.47	9.87**	.28
PaCT	50.81 (23.88)	34.38 (19.80)				
Wait-list	57.08 (26.24)	53.83 (21.91)				

Note. SDQ = Strengths and difficulties questionnaire; CBCL = Child Behavior Checklist; ANOVA = univariate analysis of variances.
$^+ p < .10.$ $^* p < .05.$ $^{**} p < .01.$ $^{***} p < .001$ (two-tailed).

significant effects after follow-up (for all *F*, *p*, and η_P^2, see Table 3).

Post to Follow-Up Results

As reported in Table 3, we conducted a repeated measures ANOVA with all relevant parent-, teacher- and child-symptom scales to test for posttreatment to follow-up differences, which did not reveal any effect of follow-up (for *F*, *p*, and η_P^2, see Table 3).

Discussion

Confirming our predictions, we found significant decreases on symptoms and diagnoses for PaCT relative to wait-list on all primary outcome measures. All effects on primary outcome measures were maintained after 6 months (clinical interviews, parent reports). We also detected significant symptom reduction for secondary outcome measures (child, teacher reports) in within-group comparisons (as no wait-list data were available for these analyses). Notably, treatment effects were evident across multiple informants (interviewers, parents, children, and teachers). All parent-reported effects on primary and secondary outcome measures remained in the moderate-to-strong range in ITT analyses, though some results merely approached significance.

Importantly, as our treatment was trialed within a routine child psychiatric setting, we targeted anxiety in young children with a high degree of depressive and externalizing comorbidity—a clinically relevant group that has proven especially difficult to treat

(Rapee et al., 2013). While theory (Barrett, 2000) and meta-analytic data (Reynolds, Wilson, Austin, & Hooper, 2012) suggest that effectiveness of CBT protocols increase with age as children cognitively mature or by mediation of effects through caregivers in younger cohorts (Waters, Ford, Wharton, & Cobham, 2009), the PaCT protocol stipulates no such prerequisites. PaCT may thus potentially broaden the profile of available empirically based interventions by means of child-directed, emotion-based intervention strategies tailored to preschool and school-age children.

The rate of diagnostic remission (66.67% of children) after PaCT was high and comparable with rates reported in current CBT trials (Hirshfeld-Becker et al., 2010), extending to comorbid depressive disorders. Parents, teachers, and children consistently rated symptomatic improvement with moderate to large effect sizes. Parent reports on relevant internalizing symptoms scales revealed large effects from pre- to posttreatment relative to wait-list, suggesting that spontaneous remission is an unlikely source of bias. Treatment effects generalized to externalizing symptoms, replicating broadband effects for psychodynamic treatments documented elsewhere (Abbass et al., 2013; Muratori et al., 2003; Palmer, Nascimiento, & Fonagy, 2013).

At follow-up, diagnostic and symptom improvement was maintained on clinician-, parent-, and teacher reports. We did not document further improvement in the follow-up interval (sleeper effects), as reported by other studies of psychodynamic treatments (e.g., Muratori et al., 2003; Trowell et al., 2007). This may suggest that immediate effects of psychodynamic treatment are more readily obtained in younger cohorts. By contrast, our strong initial effects may

Table 3

Mean Pretreatment, Posttreatment, and Follow-Up Data in the Complete Pre-, Post-, and Follow-Up Sample

	Pre-	Post-	Follow-up	ANOVA			
	M (SD)	M (SD)	M (SD)	Time comparison	F	p	η_p^2
Parent Ratings							
SDQ Emotional Symptoms	5.48 (2.34)	3.41 (2.04)	3.00 (2.13)	T1 → T2[a]	22.23	<.001	.46
				T2 → T3[b]	1.44	.243	.06
				T1 → T3[b]	20.79	<.001	.49
SDQ Conduct Problems	3.26 (2.19)	2.74 (2.07)	2.43 (1.64)	T1 → T2[a]	3.87	.060	.13
				T2 → T3[b]	0.75	.396	.03
				T1 → T3[c]	7.05	.014	.24
SDQ Total Difficulties	16.52 (6.24)	12.85 (6.60)	11.57 (6.35)	T1 → T2[a]	18.95	<.001	.42
				T2 → T3[b]	1.61	.217	.07
				T1 → T3[b]	26.68	<.001	.55
CBCL Internalizing	17.42 (8.69)	10.69 (5.27)	9.32 (6.52)	T1 → T2[d]	25.10	<.001	.50
				T2 → T3[e]	1.65	.214	.08
				T1 → T3[f]	27.19	<.001	.56
CBCL Withdrawn	6.27 (3.30)	3.65 (2.64)	3.26 (2.82)	T1 → T2[d]	20.76	<.001	.45
				T2 → T3[f]	2.87	.105	.12
				T1 → T3[b]	36.35	<.001	.62
CBCL Anxiety/Depression	9.65 (5.78)	6.42 (3.47)	4.91 (3.97)	T1 → T2[d]	13.50	.001	.35
				T2 → T3[f]	2.60	.122	.11
				T1 → T3[b]	23.14	<.001	.51
CBCL Externalizing	17.12 (9.52)	12.77 (8.04)	12.09 (9.21)	T1 → T2[d]	17.90	<.001	.42
				T2 → T3[f]	0.28	.604	.01
				T1 → T3[b]	6.74	.017	.23
CBCL Total Problems	51.19 (22.11)	34.35 (16.71)	32.13 (19.95)	T1 → T2[d]	41.63	<.001	.63
				T2 → T3[f]	1.06	.316	.04
				T1 → T3[b]	38.44	<.001	.64
Teacher Ratings							
SDQ Emotional Symptoms	3.83 (2.62)	2.38 (2.06)	2.68 (2.58)	T1 → T2[g]	8.27	.009	.26
				T2 → T3[h]	0.00	1.00	.00
				T1 → T3[c]	6.68	.019	.06
SDQ Conduct Problems	2.08 (2.30)	1.00 (1.45)	1.20 (2.29)	T1 → T2[g]	6.36	<.001	.68
				T2 → T3[c]	1.31	.268	.07
				T1 → T3[i]	1.16	.294	.06
SDQ Total Difficulties	12.63 (7.84)	8.79 (5.44)	8.11 (6.12)	T1 → T2[g]	8.13	.009	.26
				T2 → T3[h]	0.03	.869	.00
				T1 → T3[c]	9.97	.005	.36
Child Ratings							
BPI Internalizing	3.48 (.83)	3.07 (.67)	3.10 (.62)	T1 → T2[g]	5.60	.027	.20
				T2 → T3[e]	0.14	.717	.01
				T1 → T3[e]	2.17	.156	.10
BPI Externalizing	2.65 (.70)	2.41 (.47)	2.41 (.60)	T1 → T2[g]	3.91	.060	.15
				T2 → T3[e]	0.14	.712	.01
				T1 → T3[e]	1.60	.219	.07

Note. Repeated measures ANOVA; *df* = 17–26.
[a] n = 27. [b] n = 23. [c] n = 19. [d] n = 26. [e] n = 21. [f] n = 22. [g] n = 24. [h] n = 18. [i] n = 20.

have placed an upward bound on any additional effects in the follow-up interval. Future research should disentangle these possibilities. Despite the fact that we detected long-term effects on parent- and teacher reports, child self-reports failed to show maintenance of effects at follow-up. Either a lack of statistical power or an actual need for additional treatment for some patients may partly account for this pattern that demands further exploration in future studies.

Finally, parents' and therapist's subjective reports of treatment success were in the good and moderate-to-good range, respectively. Video-recorded assessments of treatment integrity suggested good fit with a PaCT-adherence prototype. Contrary to widespread beliefs regarding time-intensive training in psychodynamic approaches, this suggests that the PaCT manual is suitable for relatively inexperienced clinicians following a special training package, while still representative of time-limited psychodynamic treatments, more generally.

Limitations

First, our study was conducted in a clinical setting using a quasi-experimental method. Though this design feature is thought to limit internal validity, it also enhances external validity, as data are collected under clinically representative conditions. Indeed, reviews and meta-analytic findings report comparable effects for quasi-experimental and randomized controlled trials (Leichsenring, 2004; Shadish et al., 2000). In our case, group allocation was based solely on the bottleneck presented by the limited availability of therapists in our outpatient service and therefore approximates

random allocation. The fact that no differences on outcome measures or demographics emerged between groups at baseline also supports the assumption that group assignment was unbiased. Indeed, it seems fairly implausible that our effects for PaCT relative to wait-list could be accounted for by biases in group assignment, given that we essentially replicated the treatment response in the wait-list group once they also received treatment. Nonwait-list PaCT patients thus did not appear to be at any strong advantage for remission compared with wait-listed patients before entering treatment.

Second, the length of treatment far exceeded the wait-list interval, potentially rendering spontaneous remission more likely in our treatment group. The relative brevity of control conditions compared with treatment characterizes many studies in the field using wait-list control groups (e.g., Kendall, 1994; Kendall et al., 1997; Target & Fonagy, 2005). Although our protocol does not allow session dosage to vary, there was considerable fluctuation in treatment length owing to cancelled sessions with some families (often owing to somatization). It was not possible to compensate for this by extending the wait-interval, as this would have led us to withhold treatment from patients for unethical periods of time. Still, our wait-list condition lasted considerably longer than most studies with clinically referred cases, therefore offering ample time to assess transience of anxiety disorders. Crucially, no cases in our wait-list condition remitted, which speaks to the severity and chronicity of symptoms in our sample. Moreover, treatment length (in weeks) was unrelated to any of our outcome measures, rendering a strong contribution of spontaneous remission unlikely. Although we cannot rule this factor out entirely, the literature on clinically relevant severe anxiety disorders, especially generalized anxiety (affecting >80% of our sample), has stressed their persistence and low spontaneous recovery rates (Cantwell & Baker, 1989; Cohen, Cohen, & Brook, 1993; Last, Perrin, Hersen, & Kazdin, 1996; Lavigne et al., 1998).

Third, our sample contained a low level of ethnic diversity, reflecting the population from which the sample was recruited. As such, adaptations may be necessary when implementing the protocol in other (multi-)ethnic populations. Also, owing to a limited sample size, we were only powered to find moderate-to-large effects. This gave rise to pattern of results that included moderate effect sizes, which fell below the threshold of statistical significance in conservative two-tailed intent-to-treat analyses using the last point carried forward technique. We feel that this drawback is mitigated by the fact that none of these results fell below trend level as well as the positive overall pattern of results.

Finally, owing to the inherent limitations of a wait-list control design, researchers who conducted diagnostic and symptom interviews could not be completely blind to the treatment condition. However, neither the parent nor the child interviewers formed part of the therapeutic team, nor were they informed about the course of treatment. Moreover, an interviewer bias seems somewhat unlikely, given the highly structured nature of diagnostic and symptom measures.

Conclusion

In sum, this pilot study offers preliminary support for PaCT as an age-appropriate treatment for preschoolers and young school-age children with severe anxiety disorders, also proving successful in reducing comorbid depressive and externalizing conditions. We culled support for this new protocol at a number of levels and feel that it may eventually offer an effective and potentially preferred line of treatment relative to psychotropic medication and disciplinary interventions, especially given the widely known risks of the former for young children (Gibbons et al., 2007). Pending replication, it may indeed also add to the portfolio of available well-researched cognitive–behavioral treatments owing to its child-focused and emotion-based profile. The next steps in research on psychodynamic protocols in this area call for careful randomization procedures, well-designed comparison conditions, and larger sample sizes in multicenter trials to extend these findings.

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