Practice Parameter for Psychodynamic Psychotherapy With Children

This Practice Parameter describes the principles of psychodynamic psychotherapy with children and is based on clinical consensus and available research evidence. It presents guidelines for the practice of child psychodynamic psychotherapy, including indications and contraindications, the setting, verbal and interactive (play) techniques, work with the parents, and criteria for termination. J. Am. Acad. Child Adolesc. Psychiatry, 2012;51(5): 541–557. **Key Words:** Practice Parameter, child psychodynamic psychotherapy, indications, psychotherapeutic processes, parent work.

Psychodynamic psychotherapy is a basic skill and training requirement in adult, child and adolescent psychiatry.[1] To some, this basic skill is endangered.[2,3] Individual psychodynamic psychotherapy, alone or in combination with other treatments, is used to treat child and adolescent disorders. Derived from a rich clinical tradition, psychodynamic psychotherapy is gaining evidence-based research data supporting its effectiveness.[4,5]

The practice of psychodynamic psychotherapy provides an essential, developmental perspective on normality and pathology, applicable to the individual child and his family. This therapy addresses components of psychological functioning beyond diagnostic categories to facilitate optimal development and adaptive resilience vis-à-vis stressors and trauma.

The recommendations in this parameter are limited to children ages 3 to 12. Unless otherwise noted, the term 'parents' refers to the child's primary caregivers, irrespective of their biological relationship to the child.

METHODOLOGY

The literature search was conducted in October 2011 using MEDLINE, EBM Reviews (evidence-based medicine), PubMed, PsycINFO, ERIC (education), Social Work Abstracts, and PEP-WEB (psychoanalytic electronic publications). The search in MEDLINE combined the search terms: "child OR "youth" AND "psychodynamic psychotherapy" OR "psychoanalytic psychotherapy" OR "psychoanalysis" yielding 10454 results which totaled 7530 when the search was limited to English language. These results were further limited to "human", child (2-12 years), "review articles" yielding 47 results. When limited to "core clinical journals", 2 results were retrieved. The search was repeated in PsycINFO and yielded 56159 results which totaled 41395 when the search was limited to English language. These results were then limited to "human", "child (2-12 years)", "peer reviewed articles" yielding 518 results. When limited to "reviews", 2 results were produced. The search was repeated in the EBM Reviews (evidence-based medicine database) resulting in 0 articles, in ERIC (education) yielding 119 results and in Social Work Abstracts yielding 82 results. The PEP-WEB (psychoanalytic electronic publications) was searched in English language for "child" AND "psychodynamic psychotherapy" or "psychoanalytic psychotherapy" or "psychoanalysis" resulting in 603 results. These results were further limited to "articles" yielding 485 results and to the Psychoanalytic Study of the Child producing 13 results.

The PubMed database was searched independently to benefit from the use of the MESH term database. In PubMed, MESH terms were used to narrow the search results. The MESH term "psychodynamic psychotherapy" was used, and the results were limited to "children (3-12 years)", "human" and "English" yielding 140 results. When those were limited further, 1 result was found for "meta-analyses," 6 for "randomized controlled trials," 25 for "reviews" and 0 for "practice guidelines." Continuing in PubMed, a

search using the MESH term "psychoanalytic psychotherapy" yielded 346 results when restricted to "children (3-12 years). When the results were limited to "English," "meta-analyses," "randomized controlled trials," and "reviews and practice guidelines", 46 results were identified (5 rcts and 41 reviews). The same search for the MESH term "psychoanalysis," limited to children from age 3-12 years, yielded 524 results. When the results were limited to "English," "meta-analyses," "randomized controlled trials," and "reviews and practice guidelines", 51 results were identified (51 reviews).

The PsycINFO database was searched independently for the benefit of the specific subject headings used in the database. In PsycINFO the "psychodynamic psychotherapy" or "psychoanalysis" subject headings were combined with the subject heading of "mental health disorders" and limited to "English", "human" and "children (2-12 years)," yielding 8 results. The subject headings "psychodynamic psychotherapy" or "psychoanalysis" AND "psychotherapeutic processes" were combined, and yielded 572 results using the same limits. The subject headings "psychodynamic psychotherapy" or "psychoanalysis" AND "treatment termination" yielded 44 results when limited to the 2-12 years old population.

Abstracts selected from the searches were studied to select material for the parameter. The reference sections of review articles were searched for material not included in the search. The review articles that addressed psychodynamic psychotherapy or psychodynamic psychotherapy were initially reviewed. In addition, topics addressing indications and clinical processes including termination and work with parents were examined.

Individual child psychodynamic psychotherapy for 3-12 years old children was the specific basis for consideration in the literature review. Some interventions historically developed for psychoanalytic treatments were included based on their application in the psychodynamic psychotherapy context.

DEFINITIONS

Psychodynamic psychotherapy is based on the core propositions of psychoanalytic theory[6-9] derived from clinical observations. Research in experimental psychology and cognitive neuroscience provides the empirical foundation for these postulates.[10-13] Foremost amongst these propositions are:

1. Complex, unconscious mental processes determine conscious ideation and purposeful behavior.
2. Internal representations of experience with significant persons and the real world shape the individual's basic assumptions and expectations.
3. Observable thoughts and behaviors, including symptoms, are over-determined, i.e. they arise from more than one unconscious source. Communications have multiple meanings.
4. Psychic conflict is ever present and part of normal development. External conflicts occur between the individual and the social or physical environment when the needs of one conflict with the other. Internal conflicts occur within the mind. Most typically, internal conflicts occur when the individual's urges, impulses and desires come into conflict with internalized societal, especially parental, prohibitions.
5. Defenses are unconscious mental mechanisms that reduce anxiety and maintain psychological homeostasis. Defenses are transformed in the course of development from primitive, immature defenses to more flexible, mature defenses. Rigidly held defenses may become maladaptive and interfere with further development.
6. Resistance to psychological change serves to maintain psychic stability although it slows the therapeutic process.
7. Transference, namely the repetition or re-enactment in the therapist-patient interaction of the internalized relational patterns of past experiences with parents or other significant persons, provides an opportunity to observe, understand and revise these internalized relational patterns.
8. Therapist neutrality, the cultivation of a nonjudgmental, respectful, empathic, supportive attitude toward the patient, establishes a secure relational setting for therapy. Therapist neutrality aims to foster free expression by the patient. The therapist seeks to follow the child's lead.
9. The therapist's emotional responses to the patient (countertransference) are important for the therapist to recognize and understand. The therapist may gain insight into the child's internalized conflicts from the feelings the child induces in the therapist. The therapist must also be aware of times when the child stirs up the therapist's own internalized conflicts lest these conflicts undermine the therapist's neutrality.

DESCRIPTION OF PROCEDURE

Psychodynamic psychotherapy for children may be brief (6 to 20 sessions), moderate in length (21 to 60 sessions) or long-term (100 or more sessions). The framework of psychodynamic psychotherapy seeks to establish predictability, which is reflected by meeting at a regular time and place. Additionally, arrangements address the plans for work with the parents or caregivers, confidentiality issues, the goals of treatment and the anticipated course of the treatment. The role of other treatments or interventions, such as medication or tutoring, is discussed. The therapist needs to be able to speak and play at the child's developmental level, couching the communications the therapist wishes to make in terms the child can understand.

Psychodynamic psychotherapy progresses through three stages: the opening phase, the middle phase, and the closing phase (commonly known as the termination phase). Many psychodynamic psychotherapies are open-ended treatments in which the length of treatment is determined by the child's progress in meeting the goals of treatment and by the child's ability to maintain improvements despite on-going stressors. In long-term therapies the middle phase is significantly longer than either the opening or termination phases. In brief dynamic psychotherapies, in which the termination time is set from the start, tasks of the termination phase are addressed throughout the treatment.

Specific therapist tasks are integral to each phase. These tasks may roughly be divided between those that shape the therapist-patient relationship, those that more directly facilitate the patient's self-understanding and change, and those that pertain to the therapist's work with the parents or primary caregivers.

Classically, psychodynamic therapy emphasizes letting the child take the lead in deciding what to do in a given session. This non-directive, flexible approach is aimed at maximizing the child's self-expression and ownership of the process. The therapist seeks to join the child as an interested observer-participant. Psychodynamic theory provides a structure for the therapist's thinking and planned interventions. These interventions can be adapted to a particular patient.

Opening phase:

The opening phase includes the initial contact and evaluation, the formulation of the case,[14] and the establishment of the routines and the arrangements for the treatment. In the process of collecting sufficient information and observations to make an initial formulation of the case, develop a working diagnosis and an initial treatment plan, the therapist has the task of engaging the patient and the caregivers, laying the groundwork for a trusting, confidential relationship.[15]

Although many features of the initial contact with the caregiver and the patient may be determined by the routines of the practice in which the contact will occur, the psychodynamic therapist strives from the start to be sensitive to the subjective experience of both the child and caregiver, including attention to the developmental sensitivities and needs of the particular patient and modifying standard practices if needed. The evaluation should allow adequate time for the child to express him or herself freely in an age-appropriate, interactive setting.

The case formulation used by psychodynamic psychotherapists is biopsychosocial with particular attention to the "psychological." The psychological component of the formulation will arrange the data of the evaluation guided by psychodynamic theory to develop a hypothesis regarding the developmental and conflictual sources of the patient's difficulties. Additionally, psychoanalytic theory (e.g., ego psychology, object relations theory, attachment theory, and self psychology) organizes the information gained from the evaluation about the patient's psychological strengths and weaknesses.

The results of the evaluation are communicated to the caregiver and in an appropriate manner to the child. If psychodynamic psychotherapy is indicated, arrangements are made with respect to time, frequency and payment for visits. The opening phase transitions into the middle phase of treatment once the pattern of visits and the working alliance are established.

Middle Phase:

The task of the middle phase is to facilitate change in the child's internal world in such areas as self-regulation, internal representations of self and others, defense mechanisms and reflective function. The process of psychodynamic psychotherapy is integral to its therapeutic effect and receives as much attention from the therapist as the explicit content of the sessions. The therapist confirms the value of the child's expressions, whether through language, silences, art or the action of play, and works with the child to understand their meaning. In doing so the ther-

apist facilitates and models reflective capacity and psychological mindedness.

The therapist understands the child's expressions and behaviors in the context of the formulation of the child's difficulties.[14] The therapist identifies patterns in the play or conversations and in the transference relationship that reveal the child's internal conflicts, developmental difficulties and maladaptive relational patterns. The therapist, through conversational or play clarifications and interpretations, seeks to help the child understand the child's own feelings and internal conflicts in developmentally appropriate terms. As the child's feelings are clarified by the therapist and acknowledged by the child, the child and therapist can together think about more mature approaches to the problem. The therapist can help the child re-interpret past experiences and current difficulties. Together they can think what is within the child's capacity to do for himself and when to ask parents or others to help to relieve the child's distress and promote healthy development.

Most psychological change is gradual. In psychodynamic psychotherapy this gradual change is facilitated through a process of repetition and elaboration called working through. The intensity of the one on one experience in the therapy gives momentum to the change process. The therapist responds to as many repetitions of the child's expressions of developmental difficulties, maladaptive relational patterns, internal conflicts, and the child's attempts at new solutions as are necessary for the child to internalize the new solutions. These many repetitions allow for the elaboration of variations of the themes and for the child to actively master the past difficulties. As old patterns change the child may develop new psychological resources to begin to work on conflicts or difficulties that were deeper or pushed aside by the earlier difficulties. This potential for further issues to be uncovered means that one task of the middle phase of therapy is continual updating of the formulation of the case, continued assessment and adjustments in the therapist's and patient's thinking.

Middle phase tasks in the parent work are several. Foremost is maintaining an alliance with the parents or caregivers. The parents remain an important source of information about the child's life both at the present time and historically, providing a context for what the therapist understands in the sessions with the child. The therapist has the task of maintaining this flow of information while protecting the confidentiality of the child's communication and the child's feeling of primacy in the relationship with the therapist. Additionally, when possible, the therapist takes on the task of helping parents adapt their parenting to the changing needs of the child, thus multiplying the valuable effects of the treatment. Finally the changes in the child can set up ripple effects in the family. If the parents or other family members become more symptomatic the therapist will have to assess the need for further interventions.

Termination Phase:

Termination phase consolidates the gains made during therapy, addresses issues of dependency, separation and loss generated by the termination of the therapy for the child, the caregivers and the therapist. Any necessary plans are made for follow-up.

The endpoint of therapy may be set in advance, particularly in time-limited brief therapies. When the therapy is open-ended, the decision to set an end date is optimally reached when all parties feel the patient's condition is sufficiently improved to allow the child to function at home, in school and in the community. Of particular concern to psychodynamic psychotherapists is the child's ability to make developmental progress. There are many times when external factors, e.g., the therapist leaving, the parents' inability to continue to bring the child, or a family move, may lead to setting an end-date even when one or more parties feel further treatment is warranted. In keeping with psychodynamic therapy's emphasis on respect for the active role of the child patient in the therapy, the child should, in an age-appropriate fashion, be party to the planning of the termination.

Working through in the termination phase entails some recapitulation of the issues worked on in the therapy. Frequently there is a transient return of symptoms. The therapist works with the child to consolidate the gains of the therapy.

The termination phase offers opportunity to address loss and separation. The child's feelings and experiences with losses and stresses prior to the therapy are often reactivated and can be addressed at this time. Similarly the parents/caregivers will be losing the therapist's direct support and attention. Both the real quality of this change and its ability to stir feelings from earlier life experiences must be taken into ac-

count and addressed thoughtfully. Finally the therapist's own countertransference to the losses in termination should be considered so that they can be appropriately addressed.

Follow up plans should be tailored to the particular clinical situation. The clinician should assess whether there are current requirements for continued treatment, such as medication management, and assist the family in making the necessary arrangements. Furthermore the therapist will try to alert parents to whether or not further difficulties might be expected at later stages of development.

HISTORICAL REVIEW

Little Hans, Sigmund Freud's 1909 report of a 5-year-old child who was actually treated by his own father under Freud's guidance, is the first reported psychotherapeutic treatment of a child.[16] Hermione Hug-Hellmuth[17] published the first report on therapy using play and drawings to communicate with children. Melanie Klein,[18] Anna Freud,[19] Berta Bornstein[20] and Erik Erikson[21] developed multiple conceptualizations for the use of play in the treatment of children. David Levy reported on brief, focused play therapy in 1939 to the American Orthopsychiatry Association.[22] Levy emphasized education of the parents and the treatment of the child was quite brief.

The major formative influence on child psychodynamic psychotherapy was the ego psychology of the mid-twentieth century.[15,23] Additional influences include attachment research,[24-29] cognitive and learning theory,[30,31] research on temperament,[32] and mentalization.[33]

EVIDENCE BASE FOR PRACTICE PARAMETERS

In this parameter, recommendations for best assessment and treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:

- Clinical Standard [CS] is applied to recommendations that are based on rigorous empirical evidence (e.g., meta-analyses, systematic reviews, individual randomized controlled trials) and/or overwhelming clinical consensus.
- Clinical Guideline [CG] is applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials, cohort studies, case-control studies) and/or strong clinical consensus.
- Option [OP] is applied to recommendations that are based on emerging empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but lack strong empirical evidence and/or strong clinical consensus.
- Not Endorsed [NE] is applied to practices that are known to be ineffective or contraindicated.

The strength of the empirical evidence is rated in descending order as follows:

- (rct) Randomized, controlled trial is applied to studies in which subjects are randomly assigned to two or more treatment conditions
- (ct) Controlled trial is applied to studies in which subjects are non-randomly assigned to two or more treatment conditions
- (ut) Uncontrolled trial is applied to studies in which subjects are assigned to one treatment condition
- (cs) Case series/report is applied to a case series or a case report

EVIDENCE BASE FOR PSYCHODYNAMIC PSYCHOTHERAPY

Case Studies and Meta-Analyses

For more than fifty years the evidence base for psychodynamic psychotherapy has primarily consisted of an extensive collection of case reports.[34(cs),35(cs),36(cs)] Case reports are valuable for generating hypotheses to be tested empirically and the methodology to study them is improving.[37] Case reports provide insight and guidance for clinicians in situations where no experimental data is available. Clinicians find case reports helpful because they bring theory and concepts to life with a depth of detail that aids clinicians in applying the model to their own cases. Whereas case reports were a standard of psychiatric research early in the twentieth century, by the close of the twentieth century research methods had expanded to include clinical trials.

Although researchers have been slow to undertake clinical trials of psychodynamic psychotherapy of children, initial studies and meta-analyses are promising while the optimal approach to researching the complexities of the processes of psychodynamic psychotherapy are recognized and studied.[38] A selective review (1965-2002) of 298 child and adolescent psychotherapy studies concluded that there were significant effects with all treatments.[39] The studies included psychody-

namic play therapy for anxiety and psychodynamic therapy for conduct problems.[40]

In recent years, improved research design for psychotherapy efficacy research is adding to the existing knowledge about effectiveness and efficacy.[41-47]

Studies of Time-Limited Psychodynamic Psychotherapy

According to Cicchetti et al.,[48(rct)] toddlers of depressed mothers show a higher incidence of insecure attachment. Such children who received 45 weekly sessions of therapy with a focus on changing their self and maternal representations developed secure attachments equal to those of the toddlers of non-depressed mothers. Jellinek et al., similarly demonstrated improved maternal function in traumatized parents towards their toddlers.[49(cs)]

Kernberg and Normandin[50,51] developed a manual for 30 sessions of weekly play therapy for sexually abused children. The treatment focuses on transforming the experience of trauma into a memory of trauma, facilitating reflective functioning, and transforming traumatic play into normal play. Preliminary findings indicate significant reduction of symptoms, improved relatedness, and normalization of play.

Toth et al.,[52(rct)] in a randomized controlled study of maltreated preschool children stratified into three treatments: psychodynamic preschooler-parent psychotherapy (PPP), psychoeducational home visitation (PHV), and community standard care (CS) and a comparison group of non-maltreated, normally developing children (NC), found that the PPP group evidenced a greater decline in maladaptive maternal representations and more positive expectations of the mother-child relationship.

Muratori et al.,[53(ct)] in a 2-year follow up of psychodynamic psychotherapy for internalizing disorders in children, studied the efficacy of a time-limited (11-week) combined individual and parent-focused psychodynamic psychotherapy for children compared with treatment as usual in the community. At the 2-year follow-up, the Child Behavior Checklist results indicated that psychodynamic psychotherapy acted on both internalizing symptoms and externalizing dimensions. Attention, delinquent, and aggressive scales demonstrated significantly improved mean scores for the study group relative to the comparison group. Moreover, the active treatment condition reduced comorbidity and resulted in less frequent use of mental health services than treatment as usual in the community.

Trowell et al. and Trowell et al.,[54,55(rct)] reported on a multi-center (London, Helsinki, and Athens) study of children and young adolescents (ages 9 to 15) with major depression, dysthymia or both conditions. In a comparison trial of time-limited individual psychoanalytic psychotherapy (mean of 24.7 fifty minute patient sessions plus parent sessions) and family therapy (mean of 11 ninety minute sessions), 72 patients were randomly allocated. Seventy-five percent of participants had improved in both groups at the end of treatment. Continued improvement was seen in both groups. At six-month follow-up, 100% of cases in the individual therapy were no longer clinically depressed compared to 81% in the family therapy.

Trowel et al.,[56(rct)] reported on a multi-center (UK) study of sexually abused girls (ages 6 to 14) with mental health problems. In a comparison trial of time-limited focused individual psychodynamic psychotherapy (up to 30 sessions) and psychoeducational group therapy (up to 18 sessions), 71 patients were randomly assigned. Psychopathological symptoms were substantially reduced in both groups but individual therapy led to a greater improvement in manifestations of post-traumatic stress disorder.

Studies of Open-Ended Long-Term Therapy

There is general agreement that psychotherapy is more efficacious than placebo. Meta-analytic studies beginning with Smith et al.,[57] have demonstrated that the average treated patient is approximately two thirds of a standard deviation better off than the average nontreated patient. These studies have generally been replicated in child psychotherapy.[58]

Fonagy and Target[59,60(cs)] in a systematic review of 763 records at the Hampstead Clinic, reported the efficacy of psychoanalytic treatment for children with severe emotional disorders in the anxiety and depression spectrum (three or more Axis I diagnoses). Their criteria for improvement were the relief of symptoms and the return of the child to a non clinical classification. The mean length of treatment was 14 months. Both frequency and length of treatment were important factors in outcome. Children with conduct problems responded less well to once- or twice-a-week psychodynamic psychotherapy but with greater frequency of sessions did almost as

well as children with emotional difficulties of equal severity. Children younger than 12 years made more impressive gains with intensive treatment of four to five times versus one to three times per week.

Moran et al.,[61(ct)] illustrated the positive impact of psychoanalytic psychotherapy on the regulation of blood glucose in brittle juvenile diabetics. This study compared two groups of children aged 6-18 years with brittle diabetes. Both groups manifested significant psychiatric symptoms: 73% in the experimental group and 64% in the control group. Patients in the treatment group were offered 15 weeks of psychoanalytic psychotherapy three to four times a week during their inpatient medical intervention. Intervention was highly effective in improving diabetic control as measured by HbA1c, maintained at 1-year follow-up. The comparison group, who received only the usual inpatient medical intervention, relapsed to prehospitalization levels of HbA1c within three months.

FREQUENCY OF THERAPY

Frequency of therapy may be a significant variable. Heinicke and Ramsey-Klee[62(ct)] compared children with learning problems seen four times a week for one year with children seen once a week by the same analyst. Both groups improved equally in reading and spelling, but in an 18-month follow-up the higher-frequency group demonstrated significant differences. Children seen four times weekly showed higher self-esteem and greater capacity for appropriate peer relations. They were freer to express a wider variety of affects. They were judged to be more autonomous and assertive. They had greater capacity to reflect about their behavior and motives. The defense mechanisms they used were more balanced, flexible, and mature (Table 1).[63]

RECOMMENDATIONS

Recommendation 1. Psychodynamic psychotherapy requires training in psychodynamic theory and techniques. [CS]

The therapist should be knowledgeable regarding child development and acquainted with the range of psychodynamic theories (e.g., ego psychology, object relations theory, attachment theory, and self psychology). Clinical experience should be acquired under supervision. Optimally the training experience should include children of both sexes in various developmental phases and with various psychopathologies.

The clinician tailors the psychodynamic psychotherapy to the individual patient through flexible application of generic psychodynamic principles and selection of psychodynamic techniques based on a developmentally informed, biopsychosocial formulation of the case.[14,64-68]

Recommendation 2. The clinician should understand the full spectrum of psychodynamic therapeutic interventions, from supportive to expressive modalities. [CG]

Traditionally psychodynamic psychotherapies have been conceptualized as extending along a spectrum from supportive to expressive. The more supportive therapeutic interventions are those that are meant to build on the patient's strengths and existing psychological capacities either through a positive relationship with the therapist or through therapeutic interventions, such as encouragement, suggestions, and education, that facilitate the development of adaptive capacity. The adaptive capacities affected are impulse control; tolerance for frustration, anxiety, and affect; capacity to anticipate, reflect, or sublimate; and communication through play or language. The expressive therapeutic interventions address the child's unconscious conflicts, traumatic memories, feelings, maladaptive defense mechanisms, and distortions of the relationship with the therapist (transference). The repetition of past experiences allows them to become conscious, so that their pathological residues can be worked through and resolved.

Recommendation 3. The therapist is informed about indications and contraindications for psychodynamic psychotherapy. [CS]

The use of psychodynamic psychotherapy is not diagnosis specific. It has been used effectively for internalizing disorders, externalizing disorders in the mild to moderate spectrum of severity, developmental character difficulties and maladaptive, internal responses to life events. In addition to diagnosis, consideration must be given to the child's ability to work with the therapist toward self-understanding. Psychodynamic psychotherapy is helpful in complex cases because it addresses the underlying psychological functions.

TABLE 1 Hierarchy of Defense Mechanisms

NORMAL	
Humor:	I'm taking some distance to see it from different perspectives, to master it while having fun.
Anticipation:	I'll think ahead of time to be better prepared to handle it effectively.
Suppression:	I'll put it on hold for the time being, to return to it at a better moment.
Sublimation:	I'm lifting myself above the conflict, while still dealing with it.
NEUROTIC	
Repression:	As I am holding it in, I'm not looking, I'm not seeing, and I don't want to be aware of it.
Undoing:	I am placing it and then taking it away.
Projection:	I am spitting, eliminating, discarding.
Introjection:	I am mouthing, swallowing, absorbing.
Isolation:	I am separating one feeling (or idea) from another.
Somatization:	I'm expressing it in body language so as not to be aware of it.
Regression:	I am turning backward. I am going back.
Negation:	I am not seeing.
Turning into the opposite/ reaction formation:	I am turning my back. I am putting forward one side of my experience rather than the other.
Turning against the self:	I'm hitting myself. I'm destroying what I build.
Intellectualization:	I am changing my experience into one of thoughts.
Rationalization:	I'm giving possible reasons other than the real one.
BORDERLINE	
Splitting:	Two aspects of one's emotional life are experienced as independent from each other.
Denial:	"I" am closing off.
Idealization:	The object is high above, while "I" am way below.
Devaluation:	The object is down below, while "I" am way above.
Projective Identification:	The object (or experience) is outside. "I" am actively holding it at arm's length so that it does not return into "me."
Omnipotent control:	"I" must keep everything and other people in check.
Acting out:	I express it by action rather than in words.
PSYCHOTIC	
Deanimation:	It is still, not doing anything.
Animation:	It (everything) keeps moving or it will die.
Hypochondriasis:	It is taken in again (re-introjected) into the body and feels bad.
Constriction:	It must stay in one familiar focal area in the mind and at times in body movement, facial expression, and affective expression.
Dismantling:	It (everything) falls passively into bits, so no feeling or sensation is related to another. Cross-modal perception is suspended in this defense[95].
Fusion:	It (everything) gets lost in a boundlessness with everything.
Autistic encapsulation:	It is walled inside[96].
Dispersal:	It is scattered into small bits or broken pieces so it cannot hurt me anymore.

Note: These are defined operationally as narratives for easier recognition through verbal communication and through play themes. For classical definitions, refer to Moore and Fine.[94] Source: Kernberg P. Mechanisms of defense: development and research perspectives. Bull Menninger Clin. 1994;58:55-87.[63] Copyright Guilford Press. Reprinted with permission of The Guilford Press.

Brief, time-limited, individual psychotherapy is indicated with children who are in acute, situational distress such as grief, separation anxiety, sleep problems, or acute anxiety. There is an agreed-upon focus of treatment and an agreed-upon point of termination, which brings momentum to the process. The treatment goals aim at increasing adaptive behaviors, gaining symptomatic improvement, and enhancing adaptation to family, school, and peers.

Long-term, open-ended psychotherapy is indicated when the biological or social factors destabilizing the child's adaptation and development are chronic, or the psychological difficulties due to comorbidities are complex, or entrenched conflicts and developmental interferences are present. In addition to the goals sought in brief therapy, long-term psychodynamic psychotherapy aims at redressing maladaptive personality traits, reworking conflicts to relieve constricting

defensive and relational patterns, lifting of unnecessary inhibitions, development of flexible thinking and access to fantasy life. It stabilizes psychological functioning by increasing freedom of expression through play and words rather than through impulsive actions. It develops the flexible use of defenses and age appropriate assessment of realities of the child's life. It enhances the capacity for pro-social activities, age-appropriate autonomous functioning in school, and an age-appropriate sense of identity including sexuality and positive self-regard.

For severely organically impaired children, those with significant mental retardation, psychosis, or severe pervasive developmental disorders and for severe conduct disorder without guilt or remorse, expressive psychodynamic psychotherapy is usually contraindicated. In contrast, supportive psychodynamic psychotherapy can be usefully tailored to each of these conditions.[65,66]

Recommendation 4. The therapist is informed about potential complications and adverse effects of psychodynamic psychotherapy. [CS]

In some instances there may be transitory deteriorations (regressions) in the level of functioning, such as acting-out behaviors or exacerbation of parent-child conflict. In addition complications may arise in the relationship between the parents and the therapist. Common examples include excessive dependence of the parents on the therapist, and threats of treatment disruption if the parents feel criticized by the therapist or resent the therapist's close relationship with the child. In very difficult cases consultation with a colleague can be beneficial to the therapist. Additionally, obtaining a second opinion can be useful in difficult cases.

Recommendation 5. When indicated, the clinician will combine individual psychodynamic psychotherapy with other treatments such as group therapy, family therapy or psychopharmacology. [CG]

The psychodynamic psychotherapist, working within a biopsychosocial model, may recommend treatments in addition to the individual therapy. Group psychotherapy may be appropriate for addressing difficulties with peer relationships. Family therapy may be indicated to address family dysfunction.[67]

Medication may be used adjunctively to relieve symptoms and facilitate the patient's ability to work in therapy. The therapist must take into account the possible meanings that the child or the family may assign to taking medication. Medication and psychotherapy may require different amounts of time to reach their respective maximum effectiveness. Medication may target the symptoms while the psychotherapy is aimed at facilitating the resumption of healthy character development. If the medication is effective in relieving symptoms, the problem arises that whenever symptoms are relieved some parents may be tempted to discontinue the treatment before underlying issues are resolved in psychotherapy. Nonadherence with medication due to fear of drug addiction or fear for the child's safety can best be addressed through the therapist's collaborative alliance with the parents.[68-70]

Recommendation 6. The clinician formulates a psychodynamic understanding of the child and family and communicates it to the family within the context of a biopsychosocial treatment plan. [CG]

Formulation is the process by which the clinician organizes the clinical data obtained from the evaluation and the ongoing work with the patient and caregivers.[71,72] The formulation gathers together the biological information about the child (e.g., genetics and epigenetic influences, temperament, physical development and intelligence), the psychological data (e.g., developmental history, emotional development, personality style, self-esteem, conscience, theory of mind, defenses and coping skills, object representations and relational patterns and evidence of internal conflicts) and sociological information (e.g., assessment of the family and the child's place in it, peer relations, school functioning, cultural and spiritual traditions).

The psychodynamic psychotherapist uses psychoanalytic theory (e.g., ego psychology, object relations theory, attachment theory, self psychology, and developmental theory) to relate the biopsychosocial data to the presenting symptoms and the diagnosis. Diagnosis may be both a DSM diagnosis[73] and a Psychodynamic Diagnostic Manual (PDM) Diagnosis.[74] The psychodynamic therapist considers the precipitating events that brought the child to treatment at this time in the context of developmental theory asking "what developmental challenge may have precipitated the child's symptoms at this time?"

Once the therapist has integrated the available information into a psychodynamic understanding of the patient's condition the therapist turns to the treatment planning aspect of formulation. Considering the severity of the patient's difficulties, the impact on the child's development, and the patient's and family's strengths and weaknesses, the therapist gauges the child's needs in terms of frequency of sessions for both the child and the parents and the duration of treatment. The formulation guides the therapist's recommendations of other treatment modalities. The therapist must translate the formulation and recommendations into terms the parents can understand and, when speaking to the child, in terms appropriate to the child's development and capacity to understand.

Recommendation 7. The clinician establishes a therapeutic alliance with the child based on respect for the child's autonomy, developmental state, defensive style, and specific pathology, and attends to all aspects of the patient's communications: verbal, gestural, and symbolic (play). [CG]

The therapeutic partnership is built on respect for the child. The maintenance of confidentiality and respect for the child's autonomy, exemplified through the therapist's ability to listen to the point of view of the child, creates a safe therapeutic space. The therapist's attunement to the child's developmental status and defensive structures is also essential to the alliance.

Recommendation 8. The therapist must maintain patient confidentiality and a commitment to keeping the child's specific communications private. [CS]

Confidentiality is crucial for psychodynamic psychotherapy. The clinician must skillfully communicate dynamic understanding to parents or collaborating clinicians while protecting the child's confidential communications. The child's communications are confidential unless in the therapist's judgment they indicate potential danger to the child, to others, or to property, or the child gives permission to share the child's specific communications with the parents *and the therapist agrees*. The therapist tells the child when and what information will be shared with the parents. The parents' reports about the child or family are shared with the child when the therapist thinks it useful to do so. The therapist may become aware of a family secret or taboo. This awareness may come from the child or from the parents. The therapist must use good clinical judgment in choosing if, when, how and to whom to disclose this information.[75]

Recommendation 9. The clinician establishes an ongoing collaborative alliance with the family through which they participate as partners in the treatment. [CS]

In the collaborative alliance with the parents, the therapist must strive to maintain neutrality and not side with the parents against the child or with the child against the parents. The therapist's attitude and behavior needs to be reliable, knowledgeable, and professional. The parents' cultural and family traditions, personal style, and values should be respectfully taken under consideration.

Exchange of Information: The therapist gives information concerning the general progress of therapy without giving the specific communications of the child. The therapist discusses the course of treatment and any recommendation for additional treatment modalities. Ideally the parents will inform the therapist of changes in family circumstances and provide updates on the child's life and behavior outside the treatment setting. The therapist should avoid allowing parents to use time scheduled for the child for parent-therapist information exchange. Parent communications about the child that are made in front of the child should be limited to brief, socially appropriate exchanges of greetings in the waiting room. Occasionally the child may express a wish to bring a member of the family, friend or even a pet to the session. The therapist will use clinical judgment in determining when such inclusion will further the therapy. At other times the clinician may feel it is clinically advantageous to meet with the parent and child together. In these cases care must be taken to maintain the therapist's primary alliance and allegiance with the child.

Addressing Parents' Negative Feelings: Parents may have negative feelings about the treatment, the therapist, or the child. The roots of negative feelings are varied and include parental self-devaluation, parental competition with the therapist, or disappointment due to unrealistic expectations of the therapist or the child.

The clinician must be alert for times when the child, stimulated by difficult work in the treatment, complains to the parents or in other ways generates negative feelings in the parents about the treatment.

It is important to address negative parental feelings in order to limit parental undermining of the treatment or premature termination.

Parent Education: The therapist supports parental curiosity about the child's developmental needs, individual characteristics, and subjective experience to facilitate their parenting. The therapist supports the parents' striving to establish realistic social and academic goals for their child.

Parent Counseling: At times it is clear to the therapist that a parent's own psychological difficulties interfere with the child's progress. In this difficult situation the therapist must use clinical judgment to determine whether the parent may be referred for his or her own therapy. When the parent cannot be referred the therapist must be careful not to be the individual therapist for both the parent and the child.

Recommendation 10. The therapist should collaborate with other professionals in the treatment of the child. [CS]

With the assent and consent of the child and parents, the therapist will collaborate with other professionals involved in the case when it is appropriate.

Keeping the child's confidentiality, the therapist clarifies to other professionals the child's characteristics, ways of perceiving and reacting to situations, particular ways of responding to and communicating with others, and developmental challenges.

Recommendation 11. The clinician is knowledgeable about play and skillful at using it in the therapeutic situation. [CG]

For most children, play is a primary way of expressing feelings, impulses, fantasies, and conflicts. Erikson[21] noted that "play is the child's form of the human ability to deal with experience by creating model situations and to master reality by experimentation." In supportive psychotherapies, play is frequently a goal in itself because of its intrinsic development-promoting functions. In more expressive psychotherapies, play serves as a background activity, enabling the child to communicate verbally with the therapist. A comprehensive review of the psychological functions of play is beyond the scope of this parameter but can be found in the extensive literature on play and development.[76-86]

Children's activities in a play therapy tend to fall into the following categories: physical activities, solo imaginary play games with rules, creative projects, and imaginary play with the therapist as a participant.[50] The play therapy office must be suitably sturdy and equipped in a manner age-appropriate to the children who will be treated there. When working with young children who are struggling to control intensely messy or aggressive impulses a separate playroom is advantageous. The issue of limit setting will arise no matter how appropriately the office or playroom is outfitted. Common-sense limitations are necessary to protect the room, therapist, and child from physical damage. One way to understand the limits is to say, "When we are done I have to be able to clean up and have you, me, and the office/playroom back the way it was." The toys do not need to be numerous or elaborate. Having too many toys in the playroom can be problematic, e.g. overstimulating. It is helpful to have a deck of cards, one or two simple board games such as checkers or Trouble, a Nerf or koosh ball, paper, art supplies, a set of blocks, puppets, action figures, and dolls or animal figures. A family grouping of animals or small dolls is useful. The child can use a ferocious animal (e.g., shark, lion, or dinosaur) to express aggressive urges.

The psychodynamic play therapist develops skill at playing with the child while attending to both the content, and most importantly, the process of the play. Thus when playing a board game the therapist is keenly interested in *how* the child plays and what this manner of play reveals about the child's inner conflicts and relational patterns.[87] Additionally, the therapist is attuned to the flow of the play as a marker of the child's inner state. Does the child reach a satisfying conclusion or are there compulsive repetitions, disruptions, or interruptions?

The therapist must be skilled at timing interventions, particularly interpretative interventions, so as not to inhibit or distort the play. The therapist is skilled at making the interventions covered below under Recommendation 12 in the context of the child's play. In expressive psychotherapy, the symbolic meanings of play are interpreted to enable the child to have contact with his/her feelings, unconscious motives, defenses, and wishes.[21,86] The therapist needs to be skilled at using the play metaphor to make verbal interventions more tolerable to the child (e.g., the therapist says "the daddy doll" not "your daddy"). This use of the metaphor created by the play is called *working in the displacement.* When the child gives the therapist a role in the play frequently the child will

create role reversals (e.g., having the therapist play the student while the child plays the teacher). This is called *turning passive to active*. The therapist needs to be skilled at enacting and commenting on the feelings and conflicts in the "child role."

Recommendation 12. The clinician is skillful in the use of the spectrum of psychodynamic verbal interventions. [CG]

1. *Ordinary Social Behavior*. Socially appropriate verbal interventions (such as conventional expression of greeting and leave-taking) are primarily supportive.
2. *Statements or Questions Relating to Treatment*. These supportive interventions convey direct information about the framework of the therapy. The therapist gives information about the structure of sessions, the behavioral limits within sessions, the therapist's role, and any other matters that need clarification.
3. *Statements or Questions Relating to the Child's Life*. The therapist asks the child for objective information in order to fill in biographical data. This request conveys to the child that he/she is an important source of information and focus of interest to the listening therapist. However, the therapist should respect a child's reticence or resistance and not become an interrogator.

   In most psychodynamic psychotherapies the therapist will use a combination of supportive and expressive interventions (see Recommendation 2). The more expressive interventions require the child to be closer to feelings, urges, and thoughts that the child may find painful or overwhelming. Whether the therapist chooses expressive or supportive interventions depends on the therapist's assessment of the child's *ego strength*. Ego strength reflects the degree to which the child has acquired psychological capacities appropriate to the child's developmental status. Such capacities include intelligence, psychological mindedness, age-appropriate reality testing, capacity for impulse control, tolerance for frustration, and the ability to manage affects. Children with good ego strength benefit from expressive therapy. In contrast, children with low ego strength benefit more from supportive, developmentally-assistive therapy.

   Thus we have a continuum of verbal interventions[40] beginning with those addressed to the conscious level, moving to interventions addressed to preconscious contents (i.e., contents that are accessible if attention is focused on them), and continuing on to interventions aimed at unconscious contents (i.e., contents not easily accessible to the child's awareness). The following interventions can be made directly or within the play metaphor.
4. *Supportive Interventions*. Supportive interventions include educational statements, suggestions, or expressions of encouragement, reassurance, and empathy.
5. *Facilitative Statements*. Through facilitative interventions the therapist initiates, enhances, or maintains the exchange with the child either through invitations to continue his/her communications or by reviewing what has transpired in the session or in previous sessions.
   a) Invitations to continue convey the therapist's emotional availability and ongoing interest. They also encourage the child to verbalize experiences and events in the session. Invitations to continue can be open-ended, or the therapist may choose a particular topic from the child's conversation and request expansion or additional information on that specific topic.
   b) In review statements the therapist paraphrases, summarizes, or integrates what the child has said or done. By mirroring back the child's experience, the therapist's verbalizations confirm and validate the child's subjective experience, model self-observation and sequential thinking, and support the integrative functions of the child's mind.
6. *Clarifications*. Through clarification the therapist expands the child's awareness into the preconscious realm (i.e., what is knowable if attention is focused on the particular topic). Clarifications consist of preparatory statements and "look at" statements.
   a) Preparatory statements focus the child's attention on the possibility of new meanings in his/her comments, affects, play, and nonverbal behaviors. The statement alerts the child to what is going on and that there may be other meanings to be discovered. The therapist provides a stimulus for self-observation and self-assessment. Subsequent interventions provide opportunities for the child to identify with the therapist's function, strengthening the child's ego so that the child acquires the capacity

to observe, assess, and reflect on his/her experience.

b) "Look at" statements specifically identify and direct the child's attention to affects, thoughts, behaviors, or play occurring within the session. These clarifications engage the child's observing ego, enhancing self-awareness. "Look at" statements can also be applied to the child's past and to previous sessions. In this way the therapist supports memory-sequencing, helping the child to integrate experiences in space and time and maintain a sense of continuity. These interactions enhance the child's feeling of being understood by the therapist. Moreover, by observing the spectrum of his/her behaviors, the child can anticipate his/her emotional reactions and potentially choose more adaptive responses, thus developing a capacity to reflect before acting.

7. *Confrontations*. This verbal intervention addresses content that is not easily retrievable—the unconscious. Confrontations involve "see the pattern" statements. The therapist identifies patterns or sequences in events, affects, behavior, or ideas that, once pointed out, permit the child to see connections between apparently disparate behaviors or events. For example, a therapist might say directly, "Have you noticed that your stomachaches almost never happen on weekends or holidays?" or "Every time we talk about me, you change the subject." Or the therapist might point out, speaking within the metaphor of the play, "No matter how many gifts the dolly gets, she's always unhappy." These interventions serve the purpose of integration and mastery by making the child aware of unconscious elements that influence his/her affects, behaviors, or ideas. This awareness helps the child develop more adaptive responses to internal conflicts.
8. *Interpretations*. Through interpretations the therapist proposes links between the behaviors, feelings, and ideas that the child is aware of and the child's unconscious (a) defenses, (b) wishes, (c) past experiences, or (d) dreams. As children become acquainted with the ways they protect themselves from unacceptable thoughts, feelings, and behaviors, they gain self-understanding and view their experiences as something within their control. They are then open to the possibility of using other, more mature and adaptive, coping mechanisms.

a) Defenses. The interpretation of primitive, maladaptive defenses can be made when the therapist assesses that the child is capable of moving to a more mature defense to manage the unacceptable thoughts and feelings the defense has covered. (Table I) It is important to address the defense [especially against painful affects] first before bringing the child's attention to the unacceptable thoughts or feelings. The therapist uses a narrative to describe how the child uses the defense in play or conversation with the therapist. For example, the therapist might say, "You wish you could be king of the world because then you would be the boss of everybody and you think no one could do anything that would hurt you, but in that way it's much harder to get along with other kids." That statement addresses the child's use of omnipotent control. The pros and cons of the defensive strategy are thus clarified.

b) Wishes. Through interpretations of wishes hidden in the child's play or statements, the child learns that unrecognized assumptions or urges may underlie behavior. For example, the therapist might observe, "When you get scared you'll never have enough, that's when you eat up all the cookies." Or "You wish you were my baby because you think then you could stay here with me." Or "The little girl doll wished her mother would take a trip so she and her daddy could stay home together, just the two of them." Thus the therapist makes the wishes conscious and shared between them. Together they can measure it against reality and find socially acceptable compromises for satisfying the wish.

c) Past Experiences**.** Interpretations referring to experiences from earlier in childhood permit the child to rework sequestered affects, beliefs and defenses of that earlier period with the child's current, more developed, psychological capacities. The effective use of these interpretations—also called "constructions" and "reconstructions"—depends on the degree of evidence available about the child's early childhood experiences and their possible

impact on the present. For example, a therapist might say, "When you keep playing the 'falling off the table' game, I think you're playing what you think happened to mommy when she got hurt;" or "You've been afraid that your mean wishes may come true ever since your baby brother died . . . that's why you got so scared when you wished I'd get sick and the next day I had a bad cold."

d) Dreams. The therapist understands the manifest content of the child's dream, the dream story, in the context of the child's life situation and internalized conflicts. Dream interpretations should be made working from the child's conscious associations to the dream and its relation to the child's waking awareness to elements in the dream that may reflect of the child's internal conflicts. Dream interpretations provide continuity between what the child is thinking while sleeping and what the child is thinking while awake, thus integrating the child's sense of self. The translation of dream content (primary process thinking) into logical thinking (secondary process) is supportive, especially for children who have nightmares or problems in their relationship to reality. For example, the therapist might say, "Those monsters are your own fears that you put in the dream. Let's draw them and get rid of them by putting them into the garbage can." In expressive psychotherapy the child may be encouraged to say what pops into his/her mind about a dream in order to understand its hidden or latent meaning.

Mode of Intervention

Also important to effective verbal intervention is the mode in which the therapist expresses the intervention.[88]

a) In the *direct mode* the therapist refers to the child's immediate appearance or behavior—"You look upset today."
b) In the *therapist-related mode* the therapist refers to the child's perceptions of the therapist in terms of the transferences of past relationships that the child has begun to reenact with the therapist—"I believe you are seeing me as a police officer who is going to punish you or as a daddy who is very strict."
c) In the *indirect mode* the therapist refers to the child's behavior, thoughts, and feelings through the metaphors of play, role-taking, or other people or characters. For example: "It looks like the cowboy doesn't expect he will win against the Indians; what could he do?"
d) In the *therapist's perspective mode* the therapist reflects out loud on his/her own thoughts and feelings, encouraging the child to take into account the therapist's different perspective of what is going on without imposing it on the child. By using this mode, the therapist protects the self-esteem of the child, who may feel easily criticized and turn a deaf ear to the therapist's comments. For example: The therapist is playing Monopoly™ with the child, who is cheating by taking extra properties without paying. The therapist says to himself/herself, "If I were a kid his age I wouldn't play with him anymore. It makes me mad." The child grins, as if he finally found out why other children do not want to play with him.

Recommendation 13. The clinician is skillful in monitoring change during the course of treatment and assessing readiness for termination. [CG]

Symptom reduction, achievement of normal development, age appropriate autonomy and self-reliance are indicators of readiness for terminations of psychotherapy.[23,89] These changes are not limited to the therapy setting but extend to home and community. A child may appear better outside the sessions than within the sessions, or vice versa. To consider termination, improvement should be present in both domains. Finally, the child's capacity "to reflect on his own and others' mental states as indicated by his ability to understand, predict and plan for his own and others' responses" represents a measure of resilience.[60] Scales of particular relevance to the psychodynamic clinician are now available. These include *Perceptions of Friendships and Peer Relations.*[90,91] They enable the therapist to articulate the nature and extent of changes in the child's overall functioning in addition to symptom improvement. The scales are consistent with the objectives of psychodynamic therapy and are more likely to reflect its effects. Criteria observed

within the sessions that support ending treatment are described by Kernberg.[92] Additionally clinicians use widely disseminated clinical scales such as the Global Assessment of Functioning Scale.[73]

Parents' readiness for concluding the child's treatment must also be assessed. Parents may react intensely in positive or negative ways to termination of their child's therapy. Parents need their own opportunity to elaborate on the loss of their relationship to the therapist.

Countertransference risks during termination are frequent. The therapist may experience a compelling wish to become an informal friend of the child. The therapist may be tempted to prolong treatment if the patient becomes "the ideal patient." The therapist may misinterpret adolescent interruption of treatment as an adolescent search for independence. The therapist may feel defensive in the face of parental disillusionment if all treatment goals have not been achieved.[93]

Recommendation 14. The therapist must maintain objectivity and an attitude of consistency and realistic hopefulness and neutrality. [CS]

The therapist's empathy needs to extend to each member of the family, without taking sides, so that the child does not feel scapegoated and the parents do not feel criticized by the therapist.

The therapist's capacity to maintain objectivity depends on his/her ability to be aware and keep separate his/her own personal issues. Moreover, the therapist has to be aware of how patients or parents' transferences to the therapist may elicit reactions in the therapist that may contribute to the loss of objectivity in the case.[92] Self-reflection and consultation enable the therapist to regain objectivity.

PARAMETER LIMITATIONS

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision-making. These parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care nor exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. &

This Parameter was developed by Paulina F. Kernberg, M.D., Rachel Ritvo, M.D., Helene Keable, M.D., and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI): William Bernet, M.D., Heather J. Walter, M.D., M.P.H., and Oscar G. Bukstein, M.D., M.P.H., Co-Chairs, and Valerie Arnold, M.D., Joseph Beitchman, M.D., Christopher Bellonci, M.D., R. Scott Benson, M.D., Allan Chrisman, M.D., Tiffany R. Farchione, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Jon McClellan, M.D., David Rue, M.D., Ulrich Schoettle, M.D., Jon A. Shaw, M.D., and Saundra Stock, M.D. AACAP liaisons: Kristin Kroeger Ptakowski and Jennifer Medicus.

AACAP Practice Parameters are developed by the AACAP CQI in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP Web site. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

The AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on clinical consensus. This Parameter is a patient-oriented Parameter.

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

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Correspondence to the AACAP Communications Department, 3615 Wisconsin Ave., NW, Washington, D.C. 20016.

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