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Interaction structures between a child and two therapists in the psychodynamic treatment of a child with borderline personality disorder

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This study examined the constellation of interaction structures – repetitive patterns of interactions between patient and therapist over the course of treatment – that emerged in the psychodynamic therapy (PDT) of a child diagnosed with borderline personality disorder and treated by two doctoral student therapists. Identification of these interaction structures can inform therapists of what might be expected from patients with particular symptom or behaviour patterns and how interactions change over time. This study also examined each session's adherence to three session prototypes: PDT, cognitive-behavioural therapy (CBT) and reflective functioning (RF) process. The Child Psychotherapy Q-Set (CPQ) is a 100-item instrument that assesses the processes within a single psychotherapy session. Items reflect a wide range of therapist attitudes and behaviours, patient attitudes and behaviours and interactions between therapist and patient. Experts used the CPQ to define PDT, CBT and RF process session prototypes. The results suggested that four distinct interaction structures could be identified and that their constellations differed between the two therapists and also differed over time within each treatment. Therapists were more structured and accommodating early on in their treatments and more interpretive later. Prototypical PDT process was more prominent in the sessions than RF process, which in turn was more prominent than CBT process. Unique therapeutic processes are at work in every dyad, despite holding the patient and theoretical orientation constant. An effective treatment in one dyad might not work in another due to therapist-specific and dyad-specific effects.

Keywords: child psychotherapy; psychotherapeutic processes; treatment outcomes; treatment adherence; naturalistic study; single-case research

The psychodynamic treatment of children with borderline personality disorder

Although borderline personality disorder (BPD) is not typically diagnosed in children or adolescents (American Psychiatric Association, 2013), the *Diagnostic and Statistical Manual of Mental Disorders* does permit the diagnosis of personality disorders under certain conditions:

> Personality disorder categories may be applied with children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder. It should be recognized that the traits of a

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> personality disorder that appear in childhood will often not persist unchanged into adult life. For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year.
>
> (American Psychiatric Association, 2013: 648)

Several research groups (Bemporad *et al*., 1982; Kernberg *et al*., 2000; Westen and Chang, 2000; Fossati *et al*., 2002; Bradley *et al*., 2005; Crowell *et al*., 2012) have identified BPD criteria in children and adolescents which have been shown to predict adult BPD symptoms (Winograd *et al*., 2008), while other groups (Lofgren *et al*., 1991; Griffiths, 2011; Stepp, 2012) have challenged the homotypic continuity of BPD from childhood to adulthood. Regardless of the developmental outcomes of this population, children who satisfy BPD criteria need psychological services to help them face the challenges of affective and behavioural dysregulation and disturbed interpersonal relationships (Sanislow *et al*., 2002) and prevent potential developmental continuity into adulthood. The present study examines the psychotherapy processes that characterise the psychodynamic therapy (PDT) of a seven-year-old girl who met the criteria for BPD. A Q-sort technique for studying child psychotherapy process was used. The patient met a wide range of BPD criteria, including identity disturbance, inappropriate, intense anger, unstable and intense interpersonal relationships, impulsivity, affective instability and repeated suicidal threats.

Psychotherapeutic interventions need to be identified that help these children not only to experience symptomatic relief but also to prevent BPD criteria from returning after the therapeutic relationship is terminated. Which interventions have been shown to succeed for children diagnosed with BPD psychopathology? Only one randomised controlled trial (RCT) of PDT for children or adolescents who meet BPD criteria has been published (Midgley and Kennedy, 2011; Palmer *et al*., 2013). Forty-one adolescents meeting at least two BPD criteria were treated for 24 weekly sessions with cognitive analytic therapy (CAT), a psychodynamically-informed, integrative treatment principally used for 'complex and relational disorders, especially borderline personality disorder' (Chanen *et al*., 2008: 479). Outcome data on these adolescents were compared with outcome data collected from a sample of adolescents receiving 'standardised good clinical care', which 'used a simple problem-solving model for all participants, 25 with additional modules determined by the co-occurring problems (e.g., depression, anxiety or anger management) identified by the patient and/or therapist' (ibid.: 479). Results indicated that both groups improved symptomatically, but patients in the CAT condition improved more rapidly (ibid.). Clearly additional studies demonstrating the effectiveness of PDT for children who satisfy BPD criteria need to be conducted.

Some authors (e.g., Ablon *et al*., 2006; Goodman, 2010) have argued that studies demonstrating the effectiveness of popular treatment models offer little or no information about how these treatment models actually work. The question psychotherapy researchers need to be asking is not whether a given treatment model works but rather how therapeutic interventions within a treatment model work and for which therapist–patient dyads do they work (e.g., Blatt and Felsen, 1993; Eagle, 2006). This approach to psychotherapy research circumvents the horse-race mentality of the RCT movement and instead focuses on psychotherapy processes that work, regardless of treatment model.

The present study also provides an opportunity to examine potential common factors in the process of PDT with children, one of which is mentalization (Fonagy *et al*., 2002). Mentalization is a theory of mind construct introduced by French

psychoanalysts in the 1960s (Fain and David, 1963; Fain and Marty, 1964). Fonagy and his colleagues (Fonagy *et al*., 1991) operationalised the construct of mentalization as reflective functioning (RF), defined as interpreting the behaviours of self and others as motivated by their underlying mental states. In subsequent writings, Fonagy and his colleagues (e.g., Fonagy *et al*., 2002) relocated mentalization in the context of attachment theory as a developmental process in which the primary caregiver simultaneously communicates an empathic understanding of the child's mental states and a separateness from them that facilitate the symbolisation of emotional phenomena as mental states to be observed as well as experienced. These communications commonly take place within a secure attachment relationship in which the child feels secure in exploring his or her own mind as well as the mind of his or her primary caregiver. A capacity to mentalize well has been shown to be central to the capacity of affect regulation and to the development of a coherent self-narrative; on the other hand, deficits in this capacity have been hypothesised to create a vulnerability to psychopathology, in particular BPD, where core diagnostic features (such as affective lability, poor interpersonal relations and a fragile sense of self) can be understood as consequences of a failure in mentalization (Bateman and Fonagy, 2013).

It has been suggested that enhancing mentalization is a common process factor inherent to all effective treatment models (Allen *et al*., 2008). There is preliminary evidence from adult process research (e.g., Goodman, 2013; Katznelson, 2014) and child process research (Goodman *et al*., in press) to support this conjecture. Effective psychotherapy processes that underlie a given treatment model might differ from the processes theoretically predicted by the literature. For example, Ablon and Jones (1998) asked experts in PDT and cognitive-behavioural therapy (CBT) to rate the 100 items of the Psychotherapy Process Q-Set (PQS) to reflect the ideal psychotherapy process from their particular theoretical orientation, yielding two composited prototypical Q-sorts of PDT process and CBT process. None of the 20 most characteristic items of each theoretical orientation overlapped. Ablon and Jones (1998) then applied these two PQS prototypes to their examination of three archival psychotherapy data-sets and found that the CBT process did not predict positive symptomatic treatment outcome, whereas PDT process did predict positive symptomatic treatment outcome, in *both* PDT *and* CBT treatments.

Enhancing mentalization could be an effective change process of CBT alongside – or even as a substitute for – changing distorted cognitions. Alternatively, enhancing mentalization could be an effective change process of PDT alongside – or even as a substitute for – promoting insight. Several studies have viewed mentalization as a treatment outcome variable (for a review, see Barber *et al*., 2013), but no study to date has studied mentalization as a fluid process of psychotherapy over time.

Studying the vicissitudes of mentalization in patients who meet BPD criteria is especially vital to influencing treatment outcomes. Bleiberg argued that psychotherapy with children diagnosed with BPD often 'triggers … a retreat from reflective function [i.e. mentalization] and the activation of coercive, unreflective modes of experiencing and relating' (Bleiberg, 2001: 193). Indeed, adolescent psychiatric in-patients with BPD traits demonstrated specific mentalization deficits compared to adolescent psychiatric in-patients without such traits (Sharp *et al*., 2011). A central goal of child-focused PDT, therefore, might be the enhancement of mentalization in this diagnostic population. According to Bleiberg (2001), a child therapist who works on enhancing mentalization in such child patients must implement strategies for tolerating, containing and reflecting back the intense affects experienced in the

therapeutic relationship. Merely surviving an affective onslaught can have healing properties. A treatment model targeting the enhancement of mentalization among self-harming adolescents with BPD traits has shown promise (Rossouw and Fonagy, 2012). The present study examines the vicissitudes of mentalization (operationalised as RF) in the PDT of a 7-year-old girl who met criteria for BPD. Again, a Q-sort technique for studying RF was used.

Empirical studies of adult psychotherapy process

Several assessment instruments have been developed to study psychotherapy process empirically. The PQS was developed by Enrico Jones and his colleagues (Jones *et al*., 1988; Jones, 2000) in an attempt to develop an empirical measure of adult psychotherapy process that could produce findings generalisable to actual clinical conditions. The Q-sort technique breaks down adult therapy sessions into analysable data points through the ordering of 100 qualitative, session-specific statements. A rater arranges the items in a forced-choice normal distribution made up of nine categories ranging from 'most characteristic' to 'most uncharacteristic' (see *Measure*). These statements fall into three categories: (1) the patient's attitudes, behaviours or experience; (2) the therapist's behaviours or attitudes; and (3) the therapist–patient interaction, or the climate or atmosphere of the encounter (Jones, 2000). Items are placed not in relation to any implied norm but are based on their relative value to the other 99 items to best capture the overall 'shape' of the session. The process of therapy, therefore, is characterised by the stability or variability of items in relation to one another during one session. The arrangements of these 100 items form a session profile. These profiles can then be studied across the course of treatment. Although it is applicable to multiple-case research, the Q-sort technique is uniquely qualified to examine a single case in which the *N* value of the study is the number of treatment sessions as opposed to the number of participants.

Jones (2000) went on to investigate interaction structures with the PQS by identifying clusters of items that tended to co-occur across sessions within particular therapist–patient dyads. He used the PQS to identify dyad-specific processes or interaction structures – repetitive patterns of interaction across sessions. These interaction structures are mutually influencing; that is to say, the behaviour and experience of each member of the dyad affects the behaviour and experience of the other. Dominant patterns typically emerge between each therapist–patient pair, as evidenced by certain items consistently occurring together longitudinally.

Session prototypes, or ideal sessions of adult treatment, were also developed by two panels of PDT and CBT expert therapists (Ablon and Jones, 1998). Eleven PDT and 10 CBT expert therapists, experienced and well regarded in their fields, were asked to distribute the PQS items according to their understanding of an ideal session from their theoretical orientation. High Cronbach's alpha coefficient reliabilities were found among both the PDT ($\alpha = .94$) and CBT ($\alpha = .95$) expert therapists. The distributions loaded onto two distinct factors, one for the ideal PDT psychotherapy process in a session and the other for the ideal CBT psychotherapy process in a session (ibid.). Goodman (2013) developed a third PQS prototype that assesses the RF process in an adult psychotherapy session. An intraclass correlation (ICC) of .74 was found among the RF process expert therapists.

The Child Psychotherapy Q-Set

Drawing from a review of child psychotherapy literature and research, Schneider and Jones (2004) created the Child Psychotherapy Q-Set (CPQ), an adaptation of Jones's (2000) PQS. The authors delineated 100 items most characteristic of processes occurring in child psychotherapy across many theoretical orientations. Many of these items closely approximate items from the adult-oriented PQS; however, some items, such as those referring to the quality of the child's play, are specific to the treatment of children. In preliminary studies, the CPQ has been shown to be valid and reliable (Schneider, 2004a, 2004b; Schneider *et al*., 2009, 2010; Goodman and Athey-Lloyd, 2011). Thus far, the CPQ has not been used to study psychotherapy process with children diagnosed with BPD.

As part of the process of developing the CPQ, Goodman and his colleagues (Goodman *et al.*, in press) used the CPQ to collect 12 PDT expert prototypes, 10 CBT expert prototypes and 9 RF process expert prototypes. The child PDT expert therapists described working with affects, looking for recurrent themes and interpreting warded-off experiences as the most characteristic features of psychotherapy process from their perspective. By contrast, the child CBT expert therapists described rewarding desirable behaviours, offering reassurance, self-disclosure and exerting control over the interaction as the most characteristic features of psychotherapy process from their perspective. No items loaded significantly onto both factors – evidence of the discriminant validity of the two prototypes.

Two recent studies using the PQS and CPQ have found two quite different constellations of interaction structures between the same therapist treating two different patients (one an adult patient, the other a child patient), suggesting that interaction structures are unique to each dyad, even when only the patient is varied (Schneider *et al*., 2009; Goodman *et al*., 2014). One child study (Goodman and Athey-Lloyd, 2011) also demonstrated that the constellation of interaction structures differed in magnitude with a six-year-old boy diagnosed with Asperger's disorder treated by two different therapists in succession. The present study seeks to uncover a different constellation of interaction structures with a seven-year-old girl diagnosed with BPD treated by two different therapists in succession.

The purpose of the present study is to identify the constellations of interaction structures between a child and two therapists across the course of two years of PDT with a seven-year-old girl diagnosed with BPD, where the first therapist had to end her work with the child after one year. Coding of the video footage of the complete treatment using the CPQ yielded four interaction structures, and the independent contribution of each therapist to the psychotherapy process was assessed by comparing the degree to which the identified interaction structures were present or absent in each of the two therapists' treatments of the same child.

Hypotheses tested in the study

(1) It was hypothesised that, using the CPQ, several interaction structures could be identified that characterised the psychotherapy process of the treatment of a seven-year-old girl, C., diagnosed with BPD.
(2) It was hypothesised that some of the identified interaction structures would significantly differ between the two therapists successively treating the same

child. An independent samples *t*-test was used to test this hypothesis. It was also hypothesised that some of these interaction structures would become more or less characteristic over time. Pearson correlations were used to test this hypothesis. A within-subjects Multivariate Analysis of Variance (MANOVA) was then used to determine which interaction structures predominated in the two years of treatment. Finally, differences between the two therapists at the item level were tested using a series of Bonferroni-corrected, independent samples *t*-tests.

(3) As both therapists were in training and receiving PDT clinical supervision at the time of the study (see *Participants*), it was hypothesised that session adherence to the PDT prototype would increase over the course of these two treatments, while similarities to the CBT prototype would decrease. Pearson correlations were used to test this hypothesis. It was also hypothesised that PDT session adherence would not significantly differ between the two therapists. A paired samples *t*-test was used to test this hypothesis. It was hypothesised that overall, PDT session adherence and RF process session adherence would be greater than CBT session adherence. A within-subjects MANOVA was then used to test this hypothesis.

Method

Participants

Both therapists who took part in the study were clinical psychology doctoral students participating in weekly PDT clinical supervision conducted by an experienced child clinical psychologist and candidate in a child psychoanalytic programme throughout the duration of both treatments, which took place in a university-based community mental health clinic with annual student therapist turnover. Both therapists were second-year students at the time of the treatment and each treated the patient for one year. Therapist 1 and Therapist 2, who treated the child in successive years, were females from European American backgrounds. The same experienced child clinical psychologist supervised both student therapists in weekly play-based PDT (Lopez and Kliman, 1980; Fonagy and Target, 2000; Jones, 2000; Goodman *et al*., in press; Perepletchikova and Goodman, 2014) supervision. Both student therapists and the patient's grandmother also consented for the videos of their treatments to be viewed and coded.

The child, C., began therapy as a seven year old in the second grade. She had been diagnosed with BPD by her first therapist and her clinical supervisor and lived with her paternal grandparents and a biological sister who was two years younger. The maternal grandmother was a registered nurse, while the grandfather was retired. Child Protective Services had placed C. in kinship foster care because both biological parents were neglectful of C. and her sister. C.'s father was serving a prison sentence for a drug-related offence. C. presented with behavioural and social difficulties, including difficulty following directions and routines at school, conflicts in interactions with school peers, extreme affective instability, frequent displays of temper, suicidal threats and difficulties with impulse control. In spite of these difficulties, C. appeared to be a highly intelligent child, capable of symbolic thinking. She engaged spontaneously in non-directive fantasy play but also expressed her conflicts behaviourally in the transference. Although diagnosed with BPD, C. was deemed suitable for play-based PDT. She participated in weekly 45-minute sessions across a four-year time span. The

present study investigates two of these years. C.'s assent and her grandparents' signed informed consent were obtained before videotaping her sessions.

The impressions of C.'s therapeutic gains are that throughout the course of treatment, C. became less impulsive and more tolerant of therapeutic interactions. In particular, C.'s storytelling and symbolic play became more grounded in reality-based concerns (e.g., peer interactions). She also became more cooperative with Therapist 2, with the transference interfering less with self-exploration. It is not clear whether these signs of progress resulted from the differences in clinical skill between Therapist 1 and 2 or maturational developments. Notably, C. permitted herself to feel the loss of both therapists at termination. In spite of these gains, C. still evidenced some affective lability and lack of empathy for others, especially her sister, at the end of Therapist 2's treatment. C. was then referred to another student therapist for an additional year of treatment.

Measure

The Child Psychotherapy Q-Set

The CPQ is a new and recently validated measure, adapted for use with children from the adult-oriented Psychotherapy Process Q-Set (PQS) (Jones, 2000). The 100 items were gleaned from a review of the child psychotherapy literature across theoretical orientations. A series of progressive pilot studies guided the reformulation of the items until the measure was validated successfully for 3–13 year olds of diverse symptomatology, ethnicity and socio-economic status. All 100 items were carefully rated by expert therapists according to their perceived face validity and relevance to child therapy. Pilot testing verified the measure's clinical validity, item validity and discriminant validity (Schneider, 2004b). Coders, regardless of theoretical orientation, were able to reach consistent interrater reliability (ranging from .55 to .89) on child therapy session videotapes (Schneider, 2004b; Goodman and Athey-Lloyd, 2011).

As with the PQS, the CPQ captures three domains of therapeutic process: (1) therapist attitudes, behaviour, feelings and experience; (2) child attitudes, behaviour, feelings and experience; and (3) the nature or climate of the dyadic interaction. Over the course of a treatment, these items tend to cluster together and comprise interaction structures – defined by Jones (2000) as the patterns of reciprocal interaction that go on between the therapist and patient, sometimes without their awareness (what we might think of as the transference–countertransference matrix). In a single-case research design, these interaction structures can then be correlated with weekly measures of personality or symptomatic change to determine which specific interaction structures are therapeutic.

After watching a videotape of a 45-min session, raters sort the 100 items into 9 piles in a forced-choice (ipsative) procedure ranging from most uncharacteristic (pile 1) to most characteristic (pile 9) of the session being rated. This ipsative procedure forces raters to place items in a normal distribution that characterises both high and low ends of a construct, with the majority of items placed centrally and increasingly few items placed towards each extreme.

Effort was made during development of the CPQ to reduce subjectivity of the items, instead directing coders to base their choices on observable behaviours. The language of the items is meant to be accessible to both researchers and therapists. The items were designed to demonstrate variability across sessions and across patients without significantly overlapping with other items.

The CPQ was designed to be pantheoretical; that is to say, the majority of items capture processes typical of different models of psychotherapy as well as shared qualities. During validation, feedback regarding the items was obtained from 12 PDT expert child therapists, 10 CBT expert child therapists and 9 RF process expert child therapists (Goodman *et al*., in press). The flexibility of the CPQ makes it ideal to study a session of PDT psychotherapy process, as other measures have failed to capture its complexity (Schneider, 2004b), but the CPQ also includes items that capture a session of CBT and RF psychotherapy processes.

Whereas outcome research has typically focused on a comparison of popular treatment models (Shirk and Russell, 1996), process research seeks to understand qualitatively the essential change processes of these popular treatment models. In this study, the CPQ was used to assess (1) the constellation of interaction structures across both treatments and (2) session adherence to the PDT prototype, CBT prototype and RF process prototype across both treatments. Although both student therapists conducted play-based PDT, perfect adherence to PDT process is not possible; therefore, three correlations were calculated between the independently rated, composited Q-sort of each session and the composited Q-sorts that represent the three session prototypes.

Procedure

Annually rotating clinical psychology doctoral students work under close supervision at this low-cost, university-based, community mental health clinic located in a suburb of New York City. The treatments under study were conducted in the clinic's playroom which is stocked with a large number of toys suitable for play-based PDT, including dolls, houses, vehicles, art and building supplies and a sandbox.

Forty-six treatment sessions were videotaped and coded using the 100 CPQ items. One session was not used because of technical difficulties with the video recording. The coders consisted of six trained clinical psychology doctoral students who were blind to the diagnosis of the patient and the hypotheses of this study.

The coders Q-sorted practice videos until interrater reliability consistently reached an intraclass correlation (ICC) of .70. When this benchmark was established, the coders were paired into teams of two and independently Q-sorted the sessions ($N = 46$) from the video recordings in a randomised order. After watching each session, the coders selected the most characteristic and least characteristic processes of that session, placing them into a forced-choice distribution of nine piles. The three coding teams achieved a mean interrater reliability of .74 (range: .62–.87). CPQ ratings of each session were thus made by two independent coders. These two sets of ratings were then composited by adding them together and dividing by two. Thus 46 composited CPQ ratings characterised the psychotherapy process of 46 sessions.

The first stage of analysis was to identify the most and least characteristic items of the CPQ as a way of identifying the overall 'tone' of the therapy. For the second stage of analysis, we submitted the 46 composited Q-sorts to a principal components factor analysis with varimax rotation (using SPSS, Version 18), yielding four factors, or interaction structures, present across two years of treatment. The principal components factor analysis meant that strongly intercorrelated CPQ items could be clustered together into four process-oriented patterns (see *Results*). For the third stage of analysis, the 46 independently rated, composited CPQ ratings of psychotherapy process were used to calculate prototypical process scores – the Pearson correlation coefficients between each of the three composited CPQ prototypes and the 46 composited CPQ

ratings. Higher correlations indicate greater adherence to that treatment model's prototypical process.

Results

Detailed tables of results are set out in Appendix 1. An examination of the most and least characteristic CPQ items across all 46 sessions appeared to capture the overall tone of the treatment quite clearly. A look at the items with the highest and lowest means (Tables 1 and 2) suggests that this PDT-supervised treatment was characterised by two exploratory, non-judgmental therapists who demonstrated sensitivity and attunement and who placed particular emphasis on the child's affective states and helped with verbalising these, rather than on actively rewarding her. The most distinctive characteristics of the child included communicating using a wide range of feelings and making little effort to restrain or regulate them as well as not gleaning much insight during the treatment.

In the second stage of the analysis, the principal components factor analysis of the CPQ data yielded four conceptually distinct factors.

Interaction structure 1: 'sensitive, non-judgmental therapist with motivated, insightful, admiring child' (α = .91)

This interaction structure reflects that the therapist's sensitive, non-judgmental attitude towards the child coincided with the child's admiration for the therapist, feeling understood by the therapist and willingness to explore her mental states and relationships with significant others.

Interaction structure 2: 'interpretive therapist with passive-aggressive child' (α = .90)

This interaction structure reflects that the therapist's interpretation and verbalisation of the child's unacceptable feelings and wishes coincided with the child's unspontaneous play, lack of curiosity, and passive, non-compliant attitude.

Interaction structure 3: 'humorous, confident therapist with animated, playful child' (α = .90)

This interaction structure reflects that the therapist's self-confidence and use of humour coincided with the child's animated, cheerful, playful attitude and effective sense of self.

Interaction structure 4: 'structuring, accommodating therapist with difficult, angry child' (α = .84)

This interaction structure suggests that when the child expressed anger or became difficult in her interaction with the therapist, the therapist behaved in a didactic, planful manner with the child and accommodated her demands, directly rewarding her for desirable behaviours.

We also examined trends of the four interaction structures such as their relative importance to the treatment over time and their relative importance to each of the two therapists' treatment years. The independent contribution of the therapist to the process of psychotherapy was assessed by comparing the relative degree to which the four

identified interaction structures contributed to each of the two therapists' treatments of this same child.

We found that for Therapist 1, who conducted the first year of treatment, interaction structure 2 ('*interpretive therapist with passive-aggressive child*') became more characteristic across the year, $r = .54$, $p < .01$, while interaction structure 4 ('*structuring, accommodating therapist with difficult, angry child*') became less characteristic across the year, $r = -.45$, $p < .01$. We also found that for both Therapists 1 and 2 across both years of treatment, interaction structure 2 ('*interpretive therapist with passive-aggressive child*') became more characteristic, $r = .39$, $p < .01$, while interaction structures 3 ('*humorous, confident therapist with animated, playful child*') and 4 ('*structuring, accommodating therapist with difficult, angry child*') became less characteristic, $r = -.43$, $p < .01$, and $r = -.56$, $p < .001$, respectively. Furthermore, the magnitudes of interaction structures 1 ('*sensitive, non-judgmental therapist with motivated, insightful, admiring child*'), 3 ('*humorous, confident therapist with animated, playful child*') and 4 ('*structuring, accommodating therapist with difficult, angry child*') were significantly higher for Therapist 2 than for Therapist 1, $t(44) = -5.40$, $p < .001$; $t(44) = -5.02$, $p < .001$; and $t(44) = -3.44$, $p < .01$, respectively. These results confirm the hypothesis that the constellation of these interaction structures fluctuated over time within treatments and differed across therapists treating the same child. These findings suggest that the therapist makes an independent contribution to the process of psychotherapy when we hold the patient constant.

A within-subjects MANOVA followed by Sidak pairwise comparisons between every pair of the four interaction structures indicated that interaction structure 4 ('*structuring, accommodating therapist with difficult, angry child*') was more prominent across both years of treatment than interaction structures 1 ('*sensitive, non-judgmental therapist with motivated, insightful, admiring child*'), 2 ('*interpretive therapist with passive-aggressive child*') and 3 ('*humorous, confident therapist with animated, playful child*'), $p < .001$. In spite of both treatments being overtly labelled as PDT, the most prominent interaction structure identified by the CPQ suggests that both therapists favoured a more structured therapeutic approach when treating an overtly angry child.

We also examined significant differences in each therapist's treatment at the item level. We found that the two therapists significantly differed on 19 individual CPQ items (using a Bonferroni correction, $p < .0005$). To summarise these differences, Therapist 2 was rated as more self-confident and emphasised the child's current life situation more than Therapist 1. Therapist 2 was also rated as more likely to help the child manage her feelings and plan her behaviour outside the session than Therapist 1, and material from Therapist 2's sessions was rated as more meaningful and relevant to the child's conflicts than material from Therapist 1's sessions. Coincident with these therapist differences, the child was rated as more socially inappropriate, wary and fragmented in her play in Therapist 1's sessions than in Therapist 2's sessions. Furthermore, the child was rated as feeling less understood by Therapist 1 and more likely to ignore or reject the comments of Therapist 1 than Therapist 2. The child was also more likely to explore relationships with significant others in sessions with Therapist 2 than Therapist 1 (for interpretation of these findings, see *Discussion*).

We next turned to exploring the hypothesis that each therapist's method of treatment would become increasingly similar to the prototype of PDT process as the year went on. As explained above, the CPQ was designed to be pantheoretical; that is to say, the majority of items capture both shared and distinct process characteristics typical of different theoretical orientations. PDT, CBT and RF process prototypical

distributions were developed for the CPQ based on the ideal session hour Q-sorted by expert therapists representing each theoretical orientation (Goodman *et al*., in press). We correlated the 46 CPQ session Q-sort ratings for the two years of treatment with the PDT, CBT and RF process prototypical distributions to determine session adherence to each prototype. In both years of treatment, all three prototypes increased over time (PDT adherence: $r = .53$, $p < .001$; CBT adherence: $r = .49$, $p < .01$; RF process adherence: $r = .52$, $p < .001$). Therapist 2 also demonstrated higher adherence to PDT, CBT and RF processes than Therapist 1 (PDT adherence: $t(44) = -3.05$, $p < .01$; CBT adherence: $t(44) = -6.92$, $p < .001$; RF process adherence: $t(44) = -5.63$, $p < .001$). Finally, a within-subjects MANOVA followed by Sidak pairwise comparisons between every pair of the three session prototypes indicated significant mean differences in this order: PDT adherence > RF process adherence > CBT adherence, $p < .001$. In other words, PDT session adherence was more prominent across both years of treatment than RF process session adherence, which was in turn more prominent than CBT session adherence.

Discussion

This study represents a first attempt at identifying specific interaction structures in the treatment of a child diagnosed with BPD conducted by two different therapists. Four different interaction structures were identified. None of these four interaction structures conceptually overlaps with the interaction structures identified in the treatment of a child diagnosed with Asperger's disorder (see Goodman and Athey-Lloyd, 2011: 324–6). Taken together, these two sets of data suggest that fundamentally different interaction structures develop between different therapists and patients. Patient diagnosis might account for some of these differences. A child diagnosed with Asperger's disorder behaves differently and is likely to arouse a different set of behaviours from his or her therapist than a child diagnosed with BPD. Therapists need to be aware of these shifts in interaction structures between patients diagnosed with different forms of psychopathology. This finding should dispel any expectation that all therapeutic relationships should look and feel alike. Because two different therapists treated the same child, any differences between these two treatments in the constellation of interaction structures would implicate the therapist's characteristics (or the unique reciprocal interaction between the child's characteristics and the therapist's characteristics) as the driving force behind these differences. When the child was held constant (i.e., the same person participated in both treatments), the constellation of interaction structures across these two therapists nevertheless varied. Simply stated, this child formed two different therapeutic relationships.

In truth, the child's different responses to these two therapists could have just as significantly originated in different aspects of her own personality, elicited by each therapist's different interaction patterns. Therapists need to be aware that transferences that emerge are unique to the therapeutic dyad and might not have emerged with another therapist. This finding lends empirical support to the old psychoanalytic idea that different analysts can bring out different transference reactions from the same analysand. A child treated by Melanie Klein or Paula Heimann might behave quite differently in session from the same child treated by Virginia Axline or Margaret Lowenfeld. One can draw the conclusion that one therapist cannot successfully treat every aspect of a child's personality. To paraphrase McDougall (1992), I am making a plea for a measure of humility in our field.

Because variables other than psychiatric diagnosis might also account for the differences in the constellations of interaction structures between these two patients (e.g., personality organisations of participating therapists, age, gender and racial differences between the two patients), further research will be required to determine the aetiology of these differences in interaction structures. For example, the treatments of a sample of child patients diagnosed with a particular form of psychopathology such as BPD could be coded using the CPQ, with each patient's sessions being factor analysed for interaction structures and then compared with the interaction structures of all the other patients in the sample. This aggregation of single-case studies could help answer whether interaction structures that develop between a therapist and patient are unique to that dyad or share common features with other patients who share the same psychiatric diagnosis.

Paradoxically, in spite of the conceptual differences in the constellation of interaction structures between the child diagnosed with Asperger's disorder in the study by Goodman and Athey-Lloyd (2011) and the child diagnosed with BPD in the present study, the therapist interventions captured by the CPQ between these two patients are quite similar (see Tables 1 and 2). Seven of the 10 most characteristic items and six of the 10 least characteristic items overlap between these two treatments. This finding suggests that the four therapists treating these two patients intervened in similar ways. Looking more closely at the content of these overlapping CPQ items, they seem to emphasise a non-judgmental acceptance of and sensitivity to the patient's feelings. These overlapping items could also characterise two of the three basic ingredients of Rogerian therapy (Rogers, 1957): empathy and unconditional positive regard. Thus, the data suggest that these therapists were implementing what are known as common factors of psychotherapy process rather than sophisticated psychoanalytic techniques. Indeed, a comparison of child PDT and CBT prototypes also found some unexpected overlap in the CPQ items used to characterise these two prototypes (Goodman *et al.*, in press). The authors concluded:

> The unique developmental features of working with children might require affective engagement, a nonjudgmental approach, as well as linguistic and affective attunement, across all child treatment models, to a greater degree than one might find in adult treatment models.
>
> (Goodman *et al.*, in press: 16–17)

The results of this study reflect a similar preference for non-specific modes of intervention in the actual practice of play-based PDT. Notably, however, the two therapists in the present study also characteristically drew the patient's attention 'to feelings regarded by the child as unacceptable', which is a distinctly PDT interpretive strategy. Thus, a combination of humanistic and PDT interventions were implemented in this child's two years of treatment. Future researchers need to correlate specific therapeutic processes with specific treatment outcomes to determine which processes are influencing which outcomes.

In summary, the three hypotheses were partially supported. As previously discussed, four empirically derived interaction structures were identified from the 46 sessions of the treatment of C., which, when taken together, were able to describe the 'shape' of this treatment (hypothesis 1). It was also found that these interaction structures fluctuated over time and that interaction structures 1, 3 and 4 were more prominent in Therapist 2's work than in Therapist 1's work, replicating Goodman and Athey-Lloyd's (2011) finding that the therapist makes an independent contribution to the formulation of an interaction structure (hypothesis 2). These therapist differences

also existed at the CPQ item level. Hypothesis 3 was not supported. Although PDT session adherence did increase over time, similarities to the CBT prototype did not decrease over time. In fact CBT session adherence actually increased over time as well as RF process session adherence. Therapist 2's session adherence to all three prototypes was higher than Therapist 1's session adherence. PDT session adherence was more prominent across both years of treatment than RF process session adherence, which was in turn more prominent than CBT session adherence.

Notably, three of the four identified interaction structures were more prominent in Therapist 2's treatment than in Therapist 1's treatment. One theory to account for these differences between the two years of treatment is that the child's behaviour significantly differed between the two years under study, prompting a different array of therapist–patient interactions specific to each therapeutic dyad. As the CPQ item analysis indicates, the child was more socially inappropriate, wary and fragmented in her play in Therapist 1's sessions and was more likely to ignore or reject Therapist 1's comments. By the time the child began therapy with Therapist 2, she might have been more aware of treatment expectations and had benefited from Therapist 1's treatment sufficiently to engage in interaction structures 1, 3 and 4 more prominently in Therapist 2's treatment. In other words, treatment with Therapist 1 might have enabled C. to take better advantage of the therapeutic process by the time she began treatment with Therapist 2.

Another explanation is that the child's process of maturation across the two years permitted greater prominence of interaction structures 1, 3 and 4 in her treatment with Therapist 2 than in her treatment with Therapist 1. In other words, because of this maturation process, C. could be more motivated, insightful, admiring, animated, playful and even more openly difficult and angry in her treatment with Therapist 2 than in her treatment with Therapist 1. These behaviours with Therapist 2 in turn would more likely catalyse a more sensitive, non-judgmental, humorous and confident therapist who could actively structure and accommodate the child when necessary. Notably in both treatments, the therapist needed to rely less on structuring and accommodating strategies as C. became less difficult and angry and instead began to rely more on interpretation later. This finding might constitute preliminary evidence for the effectiveness of these traditional CBT intervention strategies in diminishing a child patient's difficult, angry affective displays, replaced later by PDT intervention strategies only after he or she feels contained. Goodman and his colleagues (Goodman *et al*., 2015) reported a similar finding in a small sample of adult patients diagnosed with BPD (see later). Only time series analysis (a powerful statistical technique that provides a temporal ordering of data points) can settle the question of the direction of causality.

A third explanation implicates the personality differences between Therapist 1 and Therapist 2. The clinical supervisor of both therapists observed that Therapist 1 seemed more emotionally overwhelmed by her experience with C. than Therapist 2. Thus these two therapists had completely different experiences of their relationship with C. Of course, differences in C.'s behaviour between the two treatments could account for the therapist differences in feeling overwhelmed. Again, researchers need to turn to time series analysis to determine the direction of causality. Future researchers need to explore therapist characteristics that contribute to the uniqueness of the therapeutic process as well as treatment outcome over and above the contributions of the treatment models themselves.

Regarding the vicissitudes of session adherence to PDT, CBT and RF process, we found that PDT session adherence increased over time as expected; however, so did

CBT and RF process session adherence. This finding is misleading, however. CBT session adherence increased across the two years only because Therapist 2 demonstrated higher CBT session adherence than Therapist 1. Actually, both Therapist 1 and Therapist 2 were negatively correlated with CBT session adherence over time (Therapist 1: $r = -.15$, *ns*; Therapist 2: $r = -.16$, *ns*). Thus, although CBT session adherence was significantly more prominent in Therapist 2's treatment than in Therapist 1's treatment, CBT session adherence did not increase over time *within* each treatment. Even so, hypothesis 3 was not supported because CBT session adherence had been expected to decrease significantly over time.

Why was Therapist 2's treatment more similar to the CBT prototype than Therapist 1's treatment? The clinical supervisor observed that Therapist 2, being more confident, was better able to set limits on C. and thus structure her treatment during moments of severe affective instability than Therapist 1, who, as mentioned earlier, felt emotionally overwhelmed for much of her treatment of C. In spite of the fact that both treatments were labelled PDT (verified by the finding that PDT session adherence was most prominent across both years of treatment), some CBT-like interventions were nevertheless implemented to help C. to contain her severe affective and behavioural dysregulation. Adult psychiatric in-patients diagnosed with BPD, also suffering from severe affective and behavioural dysregulation at admission, experienced the most significant distress reduction when CBT session adherence was most prominent (Goodman *et al*., 2015). These authors concluded:

> Perhaps, the treatment of severely disturbed BPD patients requires the temporary use of more supportive CBT processes early in recovery … that serve the treatment goals of alliance-building and stabilization before more ambitious treatment models … are attempted.
>
> (Goodman *et al*., 2015: 91)

Apparently C. still needed these 'temporary' supportive CBT processes even after her first year of treatment. It is possible that C. needed more frequent sessions than once per week to move away from such interventions. Alternatively, child patients diagnosed with BPD will always need some structuring therapeutic processes to contain their severe affective and behavioural dysregulation. More research is needed to examine the impact of treatment frequency on children's BPD psychopathology.

Prototypical RF process was more prominent across both years of treatment than prototypical CBT but less prominent than prototypical PDT. As a product of PDT theory, prototypical RF process would be expected to be as prominent as prototypical PDT process and more prominent than prototypical CBT process. In previous research on both adult and child prototypes, however, prototypical RF process shared a high degree of variance with both the PDT and CBT prototypes (Goodman, 2013; Goodman *et al*., in press). Thus, it is not surprising that prototypical RF process was found to be less prominent than prototypical PDT process but more prominent than prototypical CBT process. More research is needed to determine the effectiveness of this emphasis on enhancing RF on treatment outcomes in this population (Barber *et al*., 2013).

Conclusion

In summary, we hope that these findings will prove valuable to both researchers and therapists. The finding that unique therapeutic processes are in fact at work in every dyad, despite holding the patient and the theoretical orientation constant, could help

both researchers and therapists to become aware that a treatment that proves effective in one dyad might not work in another due to therapist-specific and dyad-specific effects. We also demonstrated that researchers can glean important information from comparing results from two or more single-case studies. We compared the results from the case of a child diagnosed with BPD with the previously published results from the case of a child diagnosed with Asperger's disorder and learned that while the interaction structures between the two cases conceptually differed, the therapist interventions were surprisingly similar. Child psychotherapy process research needs to continue this practice to uncover what forms of treatment work best for which patients. More research is needed to establish PDT as a first-line treatment model for children diagnosed with BPD, augmented by RF process to promote mentalization and CBT intervention strategies to contain severe affective and behavioural dysregulation.

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References

Ablon, J.S. and Jones, E.E. (1998) 'How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy'. *Psychotherapy Research*, 8: 71–83.

Ablon, J.S., Levy, R.A. and Katzenstein, T. (2006) 'Beyond brand names of psychotherapy: identifying empirically supported change processes'. *Psychotherapy: Theory, Research, Practice, Training*, 43: 216–31.

Allen, J.G., Fonagy, P. and Bateman, A.W. (2008) *Mentalizing in Clinical Practice*. Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Barber, J.P., Muran, J.C., McCarthy, K.S. and Keefe, J.R. (2013) 'Research on dynamic therapies'. In Lambert, M.J. (ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. Hoboken, NJ: Wiley.

Bateman, A. and Fonagy, P. (2013) 'Mentalization-based treatment'. *Psychoanalytic Inquiry*, 33: 595–613.

Bemporad, J.R., Smith, H.F., Hanson, G. and Cicchetti, D. (1982) 'Borderline syndromes in childhood: criteria for diagnosis'. *American Journal of Psychiatry*, 139: 596–602.

Blatt, S.J. and Felsen, I. (1993) 'Different kinds of folks may need different kinds of strokes: the effect of patients' characteristics on therapeutic process and outcome'. *Psychotherapy Research*, 3: 245–59.

Bleiberg, E. (2001) *Treating Personality Disorders in Children and Adolescents: A Relational Approach*. New York, NY: Guilford Press.

Bradley, R., Zittel Conklin, C. and Westen, D. (2005) 'The borderline personality diagnosis in adolescents: gender differences and subtypes'. *Journal of Child Psychology and Psychiatry*, 46: 1006–19.

Chanen, A.M., Jackson, H.J., McCutcheon, L.K., Jovev, M., Dudgeon, P., Yuen, H.P., Germano, D., Nistico, H., McDougall, E., Weinstein, C., Clarkson, V. and McGorry, P.D. (2008) 'Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial'. *British Journal of Psychiatry*, 193: 477–84.

Crowell, S.E., Beauchaine, T.P., Hsiao, R.C., Vasilev, C.A., Yaptangco, M., Linehan, M.M. and McCauley, E. (2012) 'Differentiating adolescent self-injury from adolescent depression:

possible implications for borderline personality development'. *Journal of Abnormal Child Psychology*, 40: 45–57.
Eagle, M.N. (2006) 'Attachment, psychotherapy, and assessment: a commentary'. *Journal of Consulting and Clinical Psychology*, 74: 1086–97.
Fain, M. and David, C. (1963) 'Aspects fonctionnels de la view onirique'. *Revue Francaise de Pychosomatique*, 27: 241–343.
Fain, M. and Marty, P. (1964) 'Perspective psychosomatique sur la fonction des fantasmes'. *Revue Francaise de Psychosomatique*, 28: 609–22.
Fonagy, P., Gergely, G., Jurist, E.L. and Target, M. (2002) *Affect Regulation, Mentalization, and the Development of the Self*. New York, NY: Other Press.
Fonagy, P., Steele, M., Steele, H., Moran, G.S. and Higgitt, A.C. (1991) 'The capacity for understanding mental states: the reflective self in parent and child and its significance for security of attachment'. *Infant Mental Health Journal*, 12: 201–18.
Fonagy, P. and Target, M. (2000) 'Mentalization and personality disorder in children: a current perspective from the Anna Freud Centre'. In Lubbe, T. (ed.) *The Borderline Psychotic Child: A Selective Integration*. London: Routledge.
Fossati, A., Novella, L., Donati, D., Donini, M. and Maffei, C. (2002) 'History of childhood attention deficit/hyperactivity disorder symptoms and borderline personality disorder: a controlled study'. *Comprehensive Psychiatry*, 43: 369–77.
Goodman, G. (2010) *Transforming the Internal World and Attachment: Theoretical and Empirical Perspectives* (Vol. 1). Lanham, MD: Jason Aronson.
Goodman, G. (2013) 'Is mentalization a common process factor in transference-focused psychotherapy and dialectical behavior therapy sessions?' *Journal of Psychotherapy Integration*, 23: 179–92.
Goodman, G. and Athey-Lloyd, L. (2011) 'Interaction structures between a child and two therapists in the psychodynamic treatment of a child with Asperger's disorder'. *Journal of Child Psychotherapy*, 37 (3): 311–26.
Goodman, G., Edwards, K. and Chung, H. (2014) 'Interaction structures formed in the psychodynamic therapy of five patients with borderline personality disorder in crisis'. *Psychology and Psychotherapy: Theory, Research and Practice*, 87: 15–31.
Goodman, G., Edwards, K. and Chung, H. (2015) 'The relation between prototypical processes and psychological distress in psychodynamic therapy of five inpatients with borderline personality disorder'. *Clinical Psychology and Psychotherapy*, 22: 83–95.
Goodman, G., Midgley, N. and Schneider, C. (in press) 'Describing child psychotherapy process in prototype sessions of cognitive-behavioral and psychodynamic therapy: is mentalization a common process factor?'. *Psychotherapy Research*.
Griffiths, M. (2011) 'Validity, utility and acceptability of borderline personality disorder diagnosis in childhood and adolescence: survey of psychiatrists'. *Psychiatrist*, 35: 19–22.
Jones, E.E. (2000) *Therapeutic Action: A Guide to Psychoanalytic Therapy.* Northvale, NJ: Jason Aronson.
Jones, E.E., Cumming, J.D. and Horowitz, M.J. (1988) 'Another look at the nonspecific hypothesis of therapeutic effectiveness'. *Journal of Consulting and Clinical Psychology*, 56: 48–55.
Katznelson, H. (2014) 'Reflective functioning: a review'. *Clinical Psychology Review*, 34: 107–17.
Kernberg, P.F., Weiner, A.S. and Bardenstein, K.K. (2000) *Personality Disorders in Children and Adolescents*. New York, NY: Basic Books.
Lofgren, D.P., Bemporad, J.R., King, J., Lindem, K. and O'Driscoll, G. (1991) 'A prospective follow-up study of so-called borderline children'. *American Journal of Psychiatry*, 148: 1541–47.
Lopez, T. and Kliman, G.W. (1980) 'The Cornerstone treatment of a preschool boy from an extremely impoverished environment'. *Psychoanalytic Study of the Child*, 35: 341–75.
McDougall, J. (1992) *Plea for a Measure of Abnormality.* New York, NY: Brunner/Mazel.
Midgley, N. and Kennedy, E. (2011) 'Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base'. *Journal of Child Psychotherapy*, 37 (3): 1–29.

Palmer, R., Nascimento, L.N. and Fonagy, P. (2013) 'The state of the evidence base for psychodynamic psychotherapy for children and adolescents'. *Child and Adolescent Psychiatric Clinics of North America*, 22: 149–214.

Perepletchikova, F. and Goodman, G. (2014) 'Two approaches to treating pre-adolescent children with severe emotional and behavioral problems: Dialectical Behavior Therapy adapted for children and Mentalization-Based Child Therapy'. *Journal of Psychotherapy Integration*, 24: 298–312.

Rogers, C.R. (1957) 'The necessary and sufficient conditions of therapeutic personality change'. *Journal of Consulting Psychology*, 21: 95–103.

Rossouw, T.I. and Fonagy, P. (2012) 'Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 51: 1304–13.

Sanislow, C.A., Grilo, C.M., Morey, L.C., Bender, D.S., Skodol, A.E., Gunderson, J.G., Shea, M.T., Stout, R.L., Zanarini, M.C. and McGlashan, T.H. (2002) 'Confirmatory factor analysis of DSM-IV criteria for borderline personality disorder: findings from the collaborative longitudinal personality disorders study'. *American Journal of Psychiatry*, 159: 284–90.

Schneider, C. (2004a) 'The development and first trial application of the Child Psychotherapy Q-set'. Web publication of the International Psychoanalytical Association. http://www.ipa.org.uk/research/schneider.asp

Schneider, C. (2004b) 'The development of the Child Psychotherapy Q-set'. (Doctoral Dissertation, Berkley: University of California, 2004). *Dissertation Abstracts International*, 65 (2–B): 1039.

Schneider, C. and Jones, E.E. (2004) *Child Psychotherapy Q-Set Coding Manual*. Unpublished manuscript. Berkley: University of California.

Schneider, C., Midgley, N. and Duncan, A. (2010) 'A "motion portrait" of a psychodynamic treatment of an 11-year-old girl: exploring interrelations of psychotherapy process and outcome using the Child Psychotherapy Q-Set'. *Journal of Infant, Child and Adolescent Psychotherapy*, 9: 98–111.

Schneider, C., Pruetzel-Thomas, A. and Midgley, N. (2009) 'Discovering new ways of seeing and speaking about psychotherapy process: the Child Psychotherapy Q-Set'. In Midgley, N., Anderson, J., Grainger, E., Nesic-Vuckovic, T. and Urwin, C. (eds) *Child Psychotherapy and Research: New Approaches, Emerging Findings*. New York, NY: Routledge.

Sharp, C., Pane, H., Ha, C., Venta, A., Patel, A.B., Sturek, J. and Fonagy, P. (2011) 'Theory of mind and emotion regulation difficulties in adolescents with borderline traits'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50: 563–73.

Shirk, S.R. and Russell, R.L. (1996) *Change Processes in Child Psychotherapy: Revitalizing Treatment and Research*. New York, NY: The Guilford Press.

Stepp, S.D. (2012) 'Development of borderline personality disorder in adolescence and young adulthood: introduction to the special section'. *Journal of Abnormal Child Psychology*, 40: 1–5.

Westen, D. and Chang, C.M. (2000) 'Adolescent personality pathology: a review'. *Adolescent Psychiatry*, 25: 61–100.

Winograd, G., Cohen, P. and Chen, H. (2008) 'Adolescent borderline symptoms in the community: prognosis for functioning over 20 years'. *Journal of Child Psychology and Psychiatry*, 49: 933–41.

Appendix 1

Table A1. Ten most characteristic CPQ items across 46 sessions.

CPQ item (T: therapist, C: Child)		Mean
Item 31*	T asks for more information or elaboration	8.01
Item 6*	T is sensitive to C's feelings	7.63
Item 97*	T emphasises verbalisation of internal states and affects	7.45
Item 28*	T accurately perceives the therapeutic process	7.18
Item 3*	T's remarks are aimed at encouraging C's speech	7.17
Item 77*	T's interaction with C is sensitive to C's level of development	7.12
Item 81*	T emphasises feelings to help C experience them more deeply	6.88
Item 50	T draws attention to feelings regarded by the child as unacceptable	6.78
Item 88	Material of hour is meaningful and relevant to C's conflicts	6.68
Item 52	T makes explicit statements about the end of the hour, upcoming weekend or holiday	6.66

*Also listed as one of the 10 most characteristic CPQ items in the treatment of a six-year-old boy diagnosed with Asperger's disorder (see Goodman and Athey-Lloyd, 2011).

Table A2. Ten least characteristic CPQ items across 46 sessions.

CPQ item		Mean
Item 18†	T is judgmental and conveys lack of acceptance	1.86
Item 89†	T acts to strengthen defences	2.39
Item 9†	T is non-responsive (vs. affectively engaged)	2.45
Item 37†	T behaves in a didactic manner	2.69
Item 40	C communicates without affect	2.80
Item 61	C feels shy and embarrassed	2.87
Item 55†	T directly rewards desirable behaviours	2.88
Item 32†	C achieves a new understanding or insight	2.96
Item 5	C has difficulty understanding T's comments	2.97
Item 70	C struggles to control feelings or impulses	3.11

†Also listed as one of the 10 least characteristic CPQ items in the treatment of a six-year-old boy diagnosed with Asperger's disorder (see Goodman and Athey-Lloyd, 2011).

Table A3. Sensitive, non-judgmental therapist with motivated, insightful, admiring child (α = .91).

CPQ item		Factor loading
Item 58	C appears unwilling to examine thoughts, reactions, or motivations related to problems	−0.73
Item 41	C does not feel understood by the T	−0.73
Item 63	C explores relationships with significant others	0.71
Item 42	C ignores or rejects T's comments and observations	−0.66
Item 32†	C achieves a new understanding or insight	0.66
Item 88*	Material of hour is meaningful and relevant to C's conflicts	0.65
Item 1	C expresses negative feelings (e.g. criticism, hostility) towards T [vs. expresses approval or admiration]	−0.64
Item 20	C is provocative; tests limits of the therapy relationship	−0.59
Item 53	C conveys awareness of own internal difficulties	0.59
Item 96	C's parents are a topic of discussion	0.57
Item 51	C attributes own characteristics or feelings to the T	−0.57
Item 33	C expresses feelings about needing someone or being close to someone	0.56
Item 6*	T is sensitive to the C's feelings	0.55
Item 69	C's current or recent life situation is emphasised	0.55
Item 49	C conveys or expresses mixed or conflicted feelings about T	−0.54
Item 26	C is socially misattuned or inappropriate	−0.51
Item 22	C expresses fears of being punished or threatened	0.50
Item 18†	T is judgmental and conveys lack of acceptance	−0.44
Item 79	T comments on changes in C's mood or affect	−0.43
Item 68	Real rather than fantasised meanings of experience are actively differentiated	−0.43
Item 66	T is directly reassuring	−0.43
Item 34	C blames others, or external forces, for difficulties	−0.41

*One of the 10 most characteristic CPQ items across 46 sessions.
†One of the 10 least characteristic CPQ items across 46 sessions.

Table A4. Interpretive therapist with passive–aggressive child ($\alpha = .90$).

CPQ item		Factor loading
Item 67	T interprets warded-off or unconscious wishes, feelings or ideas	0.77
Item 78	C is compliant	−0.72
Item 95	C's play lacks spontaneity	0.66
Item 72	C is active	−0.63
Item 52*	T makes explicit statements about the end of the hour, upcoming weekend or holiday	−0.63
Item 50*	T draws attention to feelings regarded by the C as unacceptable (e.g. anger, envy, or excitement)	0.63
Item 81*	T emphasises feelings to help C experience them more deeply	0.63
Item 8	C is curious	−0.62
Item 77*	T's interaction with C is sensitive to C's level of development	−0.62
Item 71	C engages in make-believe play	−0.58
Item 43	T suggests the meaning of the behaviour of others	0.52
Item 4	There is a discussion of why C is in therapy	0.52
Item 76	T makes links between C's feelings and experience	0.52
Item 97*	T emphasises verbalisation of internal states and affects	0.51
Item 92	C's feelings or perceptions are linked to situations or behaviour of the past	0.50
Item 19	C asks for advice or information	−0.50
Item 80	C behaves in a dependent fashion [vs. insists on independence]	−0.49
Item 25	C has difficulty leaving the session	−0.45
Item 46	T interprets the meaning of C's play	0.45
Item 62	T points out a recurrent theme in C's experience or conduct	0.41
Item 45	T tolerates C's strong affect or impulses	−.41

*One of the 10 most characteristic CPQ items across 46 sessions.

Table A5. Humorous, confident therapist with animated, playful child (α = .90).

CPQ item		Factor loading
Item 94	C feels sad or depressed [vs. cheerful vs. joyous]	−0.83
Item 13	C is animated or excited	0.83
Item 7	C is anxious and tense [vs. calm and relaxed]	−0.65
Item 59	C feels inadequate and inferior [vs. effective and superior]	−0.65
Item 61†	C feels shy and embarrassed [vs. unselfconscious and assured]	−0.62
Item 74	Humour is used	0.59
Item 29	The quality of C's play is fluid, absorbed [vs. fragmented, sporadic]	0.58
Item 44	C feels wary or suspicious [vs. trusting and secure]	−0.57
Item 64	C draws T into play	0.57
Item 86	T is confident, self-assured [vs. uncertain or unsure]	0.56
Item 12	T models unspoken or unelaborated emotions	0.54
Item 35	C's self-image is a theme	0.53
Item 70†	C has difficulty controlling feelings or impulses	−0.50
Item 17	T actively exerts control over the interaction (e.g. structuring, introducing new topics)	−0.50
Item 5†	C has difficulty understanding T's comments	0.46
Item 3*	T's remarks are aimed at encouraging C's speech	−0.45
Item 28*	T accurately perceives the therapeutic process	−0.44

*One of the 10 most characteristic CPQ items across 46 sessions.
†One of the 10 least characteristic CPQ items across 46 sessions.

Table A6. Structuring, accommodating therapist with difficult, angry child (α = .84).

CPQ item		Factor loading
Item 27	There is a focus on helping C plan behaviour outside the session	0.73
Item 37†	T behaves in a teacher-like, didactic manner	0.69
Item 98	The therapy relationship is discussed	−0.64
Item 93	T is neutral	0.56
Item 55†	T directly rewards desirable behaviours	0.55
Item 56	C is distant from his or her feelings	−0.52
Item 82	T helps C manage feelings	0.52
Item 47	When the interaction with C is difficult, T accommodates C	0.48
Item 15	C makes physical contact with T	0.47
Item 9†	T is non-responsive [vs. affectively engaged]	0.46
Item 89†	T acts to strengthen defences	0.45
Item 84	C expresses anger or aggressive feelings	0.45
Item 36	T points out C's use of defences	−0.42

†One of the 10 least characteristic CPQ items across 46 sessions.