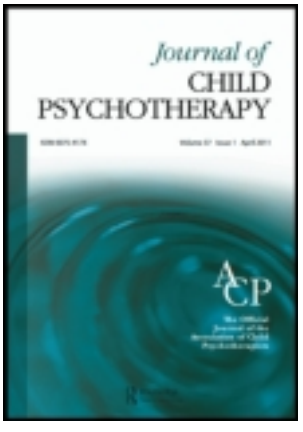

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The psychotherapy process with adolescents: a first pilot study and preliminary comparisons between different therapeutic modalities using the Adolescent Psychotherapy Q-Set

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The psychotherapy process with adolescents: a first pilot study and preliminary comparisons between different therapeutic modalities using the *Adolescent Psychotherapy Q-Set*

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An innovative methodology is presented for describing the therapeutic processes involved in five types of adolescent treatments: psychoanalysis, psychodynamic psychotherapy, cognitive-behavioural therapy, mentalisation-based treatment and interpersonal psychotherapy. Using the *Adolescent Psychotherapy Q-Set* (APQ), 18 experienced clinicians representing these different orientations were asked to rate their 'actual' and 'typical' practice as well as give feedback on the quality of the initial face validity of the APQ items. The results suggested that this new measure can be considered a meaningful tool for describing the adolescent psychotherapy process, and that it can help us identify some interesting patterns relating to it, as well as certain similarities and differences between different therapeutic approaches.

Keywords: adolescence; process research; Q-methodology; the *Adolescent Psychotherapy Q-Set* (APQ); psychotherapy process; comparisons between therapeutic modalities

Introduction

It is widely recognised that adolescence is a developmental period which is characterised by a large number of changes: biological, psychological and social. Perhaps it is the combination of these factors that makes this period so important but also challenging. It can be a time of self-discovery, turbulence and playfulness with abstract thinking, conflicts and exploration of identity, sexuality and concerns around intimacy all coming to the fore (Freud, 1958; Flavell *et al*. 1993; Rutter, 1995; Adams, 2000). Major psychotherapeutic schools offer models of treatment for adolescents who experience difficulties during this important stage of development. Each of them however, applies different psychotherapeutic techniques according to the way in which they conceptualise adolescent development, the psychotherapeutic process and the nature of adolescent disturbance.

Within the psychoanalytic/psychodynamic tradition, there exist various views as to the nature of the adolescent developmental process itself and the ways in which it can be disrupted (Perret-Catipovic and Ladame 1998; Wise, 2000). For Laufer and Laufer (1984), special emphasis is placed on pubertal changes, the adolescent's

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attitude towards the body and Oedipal issues; whereas for Blos (1967) the process of separation-individuation is seen as central to the adolescent process and failures in this process can be understood as central to adolescent disturbance. Anderson (2000) describes how such rapid biological changes in concert with shifts from dependence to inter-dependence revive intense and sometimes contradictory fantasies, feelings and processes that call for the 'revival' of containing parental figures. Thus within one theoretical modality, despite certain core shared assumptions, there exist different ideas about adolescent development and challenges that inform therapeutic technique.

Both enriching and complicating our understanding of adolescent development and psychotherapy process is that each of the other major schools of psychotherapy places an emphasis on different aspects of adolescent development when thinking about psychopathology and treatment. So interpersonal therapy (IPT) emphasises the important role of relationships in adolescent depression, and conceptualises pathology in relation to difficulties in this aspect of development. This leads to a model of psychotherapy which focuses on interpersonal stressors and applies psycho-educative, problem-solving and supportive techniques to help the adolescent improve interpersonal relationships and social skills (Mufson *et al*., 2004). Cognitive-behavioural therapy (CBT) has its own widely used techniques, with a primary focus on identifying and modifying distorted cognitive schemata which should lead to the improvement of overall functioning (Dobson, 2001; Kendall, 2006). Mentalisation-based treatment, a more recent development, draws on a specific model of the developmental process (Fonagy *et al*., 2002) to conceptualise a therapy that has the goal of helping the young person to develop the capacity to 'mentalise', that is the ability to think about one's own as well as others' mental states and to interpret as well as predict human actions on the basis of intentional mental states such as feelings, beliefs, needs, goals, purposes and reasons (Allen and Fonagy, 2006; Malberg *et al*., 2008; Midgley and Vrouva, in press).

Adolescent psychotherapy process research

Although there is now a considerable body of research assessing the effectiveness of various psychotherapies for adolescents presenting with a range of disorders (e.g. Fonagy *et al*., 2002; Kendall, 2006; Carr, 2010), relatively few studies include an analysis of the *process* of therapy or attempt to link specific processes to outcomes in relation to particular modalities of treatment. For example, Weersing and Weisz (2002) carried out an extensive review of the literature on clinical trials of empirically supported treatments for youth anxiety, depression and disruptive behaviour in order to find evidence on mediating mechanisms. They found that approximately 63% of studies included potential mediators in their designs but only 6 out of 67 actually made an attempt to use the measures in a formal mediation test. The most important fact, however, for the current study is that none of these studies used mediators that analysed psychotherapeutic process or changes in process. Although there is increasing interest in studying the therapeutic process (see Kennedy and Midgley, 2007; Midgley *et al*., 2009), there is still a clear gap in the knowledge about change mechanisms in psychotherapy with children and adolescents (Shirk and Russell, 1996).

Perhaps this gap between process and outcome research can be explained by the fact that there are only a few measures designed to quantify therapeutic processes in

child and adolescent treatments (Estrada and Russell, 1999; Weersing and Weisz, 2002; McLeod and Weisz, 2005). Most of the measures that are available focus on only one aspect of the therapeutic process, or else are designed primarily for use with younger children. For example, McLeod and Weisz (2005) used the *Therapy Process Observational Coding System—Alliance scale* (TPOCS-A) to measure parent and child-therapist alliance, whilst the *Child Psychotherapy Process Scale* (CPPS) developed by Estrada and Russell (1999) was primarily designed for studying the treatment of children younger than 12 years of age.

If research is to explore not only 'what works for whom?' but also 'how does therapy work?', then there is an urgent need for a reliable measure which would be designed specifically to: assess the adolescent psychotherapy process over the entire hour; *quantify* the therapeutic process in all its complexity and continuity; and help us to differentiate between the psychotherapy process in different types of treatment. Such a measure would allow us to begin to explore more sophisticated questions in psychotherapy research with adolescents – a process that has already begun to some degree in research looking at psychotherapy with adults. For example, one study in the field of adult psychotherapy research has suggested that psychodynamic and cognitive behavioural psychotherapy, even when equally effective overall, may promote different patterns of learning which may be more or less effective with different clients (Nilsson *et al*., 2007); another study suggested that the most effective CBT therapists working with depressed adults may be those that make use of psychodynamic techniques within their CBT therapies (Ablon and Jones, 1998). A measure of the psychotherapy process with younger people would help us to explore such important and fascinating topics in the field of adolescent psychotherapy research.

Psychotherapy Q-Set: a promising approach to studying the therapeutic process

The *Psychotherapy Q-Set* (PQS, Jones 2000) is as widely used measure in adult psychotherapy. In 2003, Celeste Schneider and Enrico Jones (Schneider, 2004a) developed the *Child Psychotherapy Q-Set* as an adaptation of the PQS for describing process in child treatments. The main advantage of PQS and CPQ is that they use Q-methodology which provides quantitatively analysable language for describing various aspects of the psychotherapy process with children including 'interaction structures', or complex interactions that take place between therapist and child within entire therapy hours and in clinically relevant terms. This methodology allows for empirical study of videotaped, audiotaped or transcribed verbatim transcripts of psychotherapy sessions allowing for examination of process within sessions, as well as across therapeutic modalities (Jones, 2000; Ablon and Jones, 2005). Inter-rater reliability of the PQS has shown to be high: $\alpha = 0.83$ to 0.89 for two raters and $\alpha = 0.89$ to 0.92 for three to ten raters (Jones *et al*., 1988; Jones and Windholz, 1990) with average item reliability $\alpha = 0.82$ (Jones *et al*., 1992) and satisfactory differential validity (e.g. Jones and Pulos, 1993).

In addition to the reliability and validity studies detailed above, both PQS and CPQ have been used in various research studies, proving to be reliable and meaningful tools for understanding psychotherapy process. Whilst the PQS for adult therapy is more firmly established (e.g. Jones *et al*., 1988; Jones *et al*., 1992; Jones *et al*., 1993; Jones and Pulos, 1993; Ablon and Jones, 1998; Price and Jones, 1998), there is now an emerging body of research looking at aspects of the child

psychotherapy process using the CPQ (e.g. Schneider *et al.*, 2009; Schneider *et al.*, 2010; Goodman, 2011). One of the advantages of the PQS and CPQ is that they can be used to create 'prototypes' of ideal sessions for different modalities. These can be used to make comparisons not only with each other but also with actual real-world practice (Ablon and Jones, 1998, 2002; Schneider, 2004b). For example, the PQS was used to uncover what was actually taking place in different manualised treatments (Ablon and Jones, 1998, 2002). It was found that interventions that theoretically look to be different often overlapped in 'real-world' clinical practice. For example, in one study ratings of actual psychodynamic treatments were found to adhere more closely to the 'prototype' of CBT than to the prototype of psychoanalytic treatment (Ablon and Jones, 2002).

In addition to conceptualising different types of treatments, Q-sort methodology can help the researcher to identify 'active ingredients', both specific as well as nonspecific, of psychotherapy associated with positive outcomes (Jones *et al.*, 1988; Jones *et al.*, 1992; Jones *et al.*, 1993; Jones and Pulos, 1993; Ablon and Jones, 1998; Price and Jones, 1998; Schneider *et al.*, 2009; Schneider *et al.*, 2010). Thus, Q-methodology has been shown to be a valid and reliable method for describing psychotherapeutic processes and for making process-outcome links.

Neither the PQS nor the CPQ, however, has been used on an adolescent population and it is not clear whether either measure is entirely fitting for describing the treatment of young people at this particular stage of their development. Although one attempt has been made to use the CPQ with an adolescent population (Bambery *et al.*, 2009), given the very particular issues of adolescent development described above, and the recognition of the need for significant adaptations of therapeutic technique to this population (e.g. Briggs, 2002; Mufson *et al.*, 2004; Verduyn *et al.*, 2009), the development of a version of the *Psychotherapy Q-Set* specific to this age-group is an important step in promoting research looking at adolescent therapy.

The study described in this paper therefore reports on a pilot study to develop and establish the clinical relevance of the initial 100 items of the *Adolescent Psychotherapy Q-Set* (APQ), developed by Nick Midgley and Celeste Schneider as an adaptation of the PQS and CPQ. This new measure is designed specifically to measure psychotherapeutic process with adolescents (across a range of treatment modalities) and thus fill an existing gap in process-outcome research regarding this population.

Methodology

This is the first pilot study of a larger project which aims to develop and validate the *Adolescent Psychotherapy Q-Set* (APQ) as a measure for describing psychotherapy processes with adolescents in a way suitable for quantitative analysis. The initial set of Q-items was developed by two of the authors (Celeste Schneider and Nick Midgley) through an extensive review of the relevant literature and an adaptation of two existing measures: the *Psychotherapy Process Q-Set* (PQS) designed by Jones (2000), and the *Child Psychotherapy Q-Set* (CPQ) developed by Celeste Schneider and Enrico Jones (Schneider and Jones, 2003).

The study reported here had three aims. The primary purpose of this study was to assess the face validity of the APQ items as part of the iterative process of developing the APQ itself as a valid and meaningful measure of the adolescent psychotherapy

process. (This is important as part of the on-going development of the APQ as a valid and reliable measure, but is only reported on briefly in this paper. For more detailed information please refer to Bychkova, 2010).

In addition, the study aimed to use the preliminary APQ measure to throw some light on two questions of interest to therapists working with adolescents as well as therapy researchers:

(1) What are the typical features of the psychotherapy process with adolescents generally, as well as within each specific modality of treatment?
(2) What are the main similarities and differences between the different modalities of psychotherapy with adolescents?

Participants

Twenty-eight potential participants, all of whom had significant experience of working therapeutically with adolescents using a range of treatment modalities, were contacted through e-mail and of those contacted, feedback from 18 expert clinicians was obtained: four psychoanalysts, three psychodynamic psychotherapists, three CBT, four mentalisation-based therapists (MBT) and three IPT. Ten therapists were from the United States, five from the UK, two from the Netherlands and one from Canada. Experts were identified by contacting leading figures in the fields of psychoanalysis, psychodynamic psychotherapy, cognitive behavioural therapy, interpersonal therapy and mentalisation-based therapy and asking them to recommend clinicians to contact. All participants were expert clinicians with many years of clinical and research experience working with adolescents. The average years in practice was 13.4; the average number of years working with adolescents 12.3; the age range of adolescents that they worked with was from 11 to 23 years. An attempt was made to include experts from different countries and from different traditions within each modality (e.g. among psychodynamic psychotherapists, those coming from a range of different psychodynamic schools), although overall, therapists from the United States were over-represented in the study.

Measure

The 100 items of the *Adolescent Psychotherapy Process Q-Set* (APQ) aim to provide a basic language for the description and classification of therapy processes in adolescent psychotherapy treatments. The APQ is intended to describe psychotherapy process with adolescents in a way that avoids theoretical jargon, permitting the portrayal of a wide range of events, interventions and processes. Each item describes an aspect of psychotherapeutic process in terms of linguistic and behavioural cues, the presence or absence of which can be objectively observed. In further analysis, however, certain aspects of the process (especially aspects of the therapist's technique) can be 'labelled' according to the therapeutic approach studied. For example, item 100, 'Therapist draws connections between the therapeutic relationship and other relationships', can be recognised as an item that captures a certain aspect of 'transference interpretations' as traditionally used in psychoanalytic therapy, but the language used is meant to ensure that the item could capture a behaviour seen in any type of therapy. This language not only helps to avoid

'conceptualisation biases' but also is expected to give an opportunity to non-clinicians to use this measure for rating the adolescent psychotherapy process. It is also hoped that the use of a standard language and rating procedure will provide the means for systematically characterising adolescent-therapist interactions, whilst at the same time being able to identify techniques or patterns specific to particular modalities of treatment.

Each of the *Psychotherapy Process Q-Sets* (adult, child and adolescent versions) are composed of 100 items with descriptions and examples in order to ensure inter-rater reliability and consist of Q-items of three different types: (1) items describing the young person's emotional states and behaviour or experience; (2) items reflecting the therapist actions and attitudes; and (3) items attempting to capture the nature of the interaction of the dyad, the climate or atmosphere of the encounter. Raters are required to Q-sort entire therapy sessions, rather than small segments of adolescent or therapist communication. The general purpose of the instrument is to provide a meaningful index of the therapeutic process with adolescents, which may be used in comparative analyses or studied in relation to pre-and post-therapy assessments.

The APQ items draw on items from both the PQS (developed for use with adults) and the CPQ (for use with younger children), alongside new items which aim to make the instrument more specific to the adolescent therapy process. Item-development for the APQ was informed by traditional and more recent empirically validated treatments for adolescents, and involved a systematic review of the literature related to the adolescent therapy process more generally, as well as that describing five specific therapeutic 'schools' that work with adolescents. The APQ development process differs from that of the PQS and CPQ (which focused on psychoanalysis, psychodynamic therapy and cognitive behavioural therapy) in that it includes items that represent mentalisation-based treatment and interpersonal psychotherapy, as well as work on the 'core qualities' of different modalities (e.g. Lemma *et al*., 2008), and on 'emergent themes' (Hilsenroth, 2002) that appear across treatment modalities. A new item that represents these influences is, for example, the following one, which draws on the literature about mentalisation-based treatment with adolescents (e.g. Rossouw, in press), as well as the cognitive-behavioural therapy literature:

Young person demonstrates capacity to link mental states of self or other with action or behaviour (APQ item no. 24)

This particular item is defined in the following way: place towards *characteristic* direction if young person is able to describe his or her states of mind or make attributions about another's and link those with action or behaviour. For example, young person ascertains that the reason why his mother stopped talking while they were arguing was probably because she was overwhelmed by her own anger or feelings of helplessness.

Place towards *uncharacteristic* direction if young person avoids or does not evidence the capacity to link mental states of self or others with action or behaviour. For example, young person explains that his best friend did not call back after an argument they had the previous day, but is not able (or willing) to think about why he might have behaved in this way.

The following item, by contrast, is closely based on a similar item in the PQS (used for studying the adult psychotherapy process), as it was considered that this item was equally relevant to the therapeutic process with adolescents:

Therapist actively exerts control over the interaction (APQ item no. 17)

This item is defined in the following way: place towards *characteristic* direction if therapist intervenes frequently, for example, structuring or introducing new topics. Do not rate on the basis of the perceptiveness or appropriateness of interventions, for example, rate as very characteristic if therapist is so active that s/he frequently interrupts or intervenes to ask questions or to make a point, or provides a good deal of direction during the session.

Place towards *uncharacteristic* direction if therapist intervenes relatively infrequently, or makes little effort to structure the interaction. For more extreme ratings, this would be the case even when the young person does not have a clear focus or is asking the therapist to give more structure.

During this first stage of development of the APQ the goal was to ensure that the initial set of Q-items is able to describe the full complexity of the psychotherapeutic process, taking into account the key aspects of psychotherapy in general as well as those specific to work with an adolescent population specifically. Further steps led to the undertaking of analysis of item validity using quantitative research methods as well as qualitative feedback from experts.

Procedure

For the current study therapists were asked to use the preliminary list of APQ items to rate their typical therapeutic practice as well as one of their own therapeutic sessions with adolescents when working with a particular modality of treatment. They were also asked to mark items that had an unclear wording and/or explanation. Finally, the expert clinicians were asked to identify with which modality/modalities they would associate each of the 100 Q-items.

Additionally, detailed written instructions were provided regarding the rating procedure. For instance, the experts were instructed to rate the items based on the absence or presence of the psychotherapeutic aspect they described rather than on how appropriate or desirable that aspect or action was.

Results

Face and content validity of the APQ

The primary aim of this study was to establish the initial face validity of the APQ (i.e. whether the instrument appears to measure what it is supposed to be measuring) and its content validity (i.e. whether the instrument appears to measure the most important facets of the particular social construct that is being studied). This is an important first step in measure development, before going on to establish the reliability of the measure, since it is important to know that the items of the APQ are appropriately focused (in their description of the therapeutic process with adolescents) and that they describe the various facets of that process (i.e. the range of features of importance to the therapeutic process with adolescents across different

treatment modalities). Before establishing other psychometric properties of the measure (e.g. whether two people can rate the same item, looking at the same therapy session, in a reliable way) it has to be ensured that the APQ is able to capture:

(a) The whole range of techniques used by psychotherapists of all five modalities under study to the same degree (that is not to be 'approach biased')
(b) The whole range of thoughts, feelings and behaviours of an adolescent client that are considered of most relevance to the therapeutic process
(c) The characteristic features of the interaction between therapist and adolescent and the therapeutic atmosphere more generally.

These questions were addressed, for example, by examining whether the same items were always coded together (which may suggest that they are two ways of describing the same thing). Such 'redundant' items when detected have to be modified as the aim is to have *one* item that describes two poles of a particular aspect of the therapeutic process.

In addition, validity was established by the detection of the items that were rarely or never used (which may suggest their irrelevance) and by asking the participants whether important aspects of the therapeutic process had not been covered adequately. A detailed account of the findings from this part of the study can be found elsewhere (Bychkova, 2010), and will be reported on in a later study outlining the full development of the APQ, so only brief headlines will be reported on here.

When each of the 100 Q-items was analysed, it was found that only seven items failed to be sensitive enough to the therapeutic aspects they described (i.e. all participants marked them as being present to the same degree in all treatments). For example, APQ item 31, 'Therapist asks for more information or elaboration', received the lowest rating of 4 and the highest of 5 on the 5-point scale that was used in the current study, suggesting that this was a feature of all therapies and that it did not differentiate between different approaches. For other items, the rating was almost always at the bottom end of the scale, suggesting that the behaviour described in that particular item was not characteristic of any of the therapies described by the experts. However, as the vast majority of these items describe therapist's technique, the result could be due not to the lack of sensitivity of these items, but because in the rated sessions these techniques were not used to a significant degree. Further research using a larger sample size will be needed to establish whether these items need to be replaced or modified.

An analysis of all 100 items in terms of their wording and/or explanation revealed that only two items were identified by four or more therapists as requiring modifications of their descriptions. For example, item 90, 'Young person's dreams, wishes or fantasies are discussed', the qualitative feedback from one participant was that there was confusion between the item title and the item description, as it was not clear whether this should be rated based on this occurring, or on the basis of the therapist inviting such a focus; whilst a second participant asked: 'Do fantasies/ wishes mean hopes for the future? Or pure fantasy that can't be realised?' Such qualitative feedback indicates ambiguities in the item that may make it hard to rate reliably. All such qualitative feedback will be reviewed as part of the next stage of refining and developing the APQ items.

In order to avoid two or more items describing very similar characteristics of the therapeutic hour, *Spearman's Rank Correlations* were run (i.e. ratings of each of the 100 items were compared among all the raters). Coefficients found seven pairs of items with strong correlations. This means that these items had some overlap and thus were probably describing very similar aspects of the therapeutic action. All these items, having been identified, will need further modification or replacement in the next stage of the development of the APQ.

Furthermore, as the APQ is a measure designed to be able to capture features which are characteristic of adolescent psychotherapy in general as well as the aspects specific to each modality, an analysis of the number of 'trans-theoretical' and 'modality specific' items was performed. The results showed that there seems to be an adequate number of both trans-theoretical and modality-specific items. This implies that at this stage, the APQ can be considered sensitive enough to capture 'specific' as well as 'non specific' factors of the adolescent psychotherapy process. Further analysis of the APQ's 'theoretical neutrality' revealed that although a slightly greater number of items were found to be associated with psychoanalytic/psychodynamic modalities, this was probably related to a greater familiarity with psychodynamic work among some of the participants in the study who, for example, were less familiar with IPT or MBT, and so rated fewer items as characteristic of these modalities of treatment. These findings will again be taken into account in the next stage of the development of the APQ, as will the qualitative feedback from participants in the study about their experience of using the APQ and any aspects of the therapeutic process which they felt it had not fully captured.

What are the typical features of the psychotherapy process with adolescents generally, as well as within each specific modality of treatment?

One of the goals of the current study was to use the preliminary version of the APQ in order to explore what it can tell us about the psychotherapy process within each of the five modalities of treatment as well as about the adolescent psychotherapy process in general. To explore this, the means of all 100 Q-items, as rated by the participants in this study, were calculated. The ten most and least characteristic items are presented and summarised below (see Appendix: Tables 1–6). It is important to note that the authors obtained and analysed all 100 items and an absence of an item in the top/bottom 10 does not necessarily reflect irrelevance or neutrality.

Findings from this pilot study are inevitably provisional, not only because of the relatively small sample size, but also because some items on the APQ will need to be revised in the light of the findings reported above, before we can be fully confident that it is capturing all of the important features of the adolescent psychotherapy process.

As illustrated in Table 1, psychotherapy with adolescents, regardless of the particular modality of treatment being used, seems to be characterised by a focus on affects (97, 96) and an exploration of the characteristic ways of dealing with them (60) and exploring their origins (9). The therapist appears to take a non-judgmental stance (18), being calm when faced with the young person's strong affects (58) and trying to facilitate exploration and communication (31, 3, 65) whilst usually avoiding taking control over the interaction (17) or making absolute statements about the young person's thoughts and feelings (89). In addition, the young person's attitude

to therapy, based on the ratings of the expert therapists who participated in this study, appears to be mostly positive, with little indication of feeling misunderstood, being suspicious or finding it difficult to maintain attention during the sessions (67, 44, 49, 52, 87).

As Table 2 illustrates, psychoanalysis with adolescents appears to be characterised by a focus on internal states and affects (item 97) with a special attention to unacceptable or painful feelings (e.g. unconscious feelings, item 50). A lot of attention also seems to be paid to the exploration of interpersonal relationships, both within and outside the therapy, as well as to the exploration of the connections between the two (i.e. transference interpretations, items 98, 100). In addition, the therapist tends to draw attention to patterns of coping with emotions (item 60) and to encourage exploration of experiences that might have caused troubling emotional reactions (item 9). At the same time the therapist appears to be neutral (item 93), non-directive (items 27, 85, 89), non-judgmental (item 18) and calm and thoughtful when faced with the young person's strong affects (i.e. 'survives' the patient's powerful states, item 58) as they present themselves in the here and now (therapist attends to young person's current emotional states, item 96). Also, it seems to be uncharacteristic for the therapist to exert control over the interaction (item 17) or to self-disclose (item 21); whilst for the young person it is characteristic to understand the therapist as well as to feel understood and to concentrate and communicate with the therapist clearly (items 5, 41, 67, 49). Moreover, it seems to be uncharacteristic for the young person to have a problem with ending the sessions (item 52).

Psychodynamic psychotherapy with adolescents (Table 3) seems to be characterised by the therapist's focus on the adolescent's emotional states and affects (items 96 and 97) and attempts to help the young person to gain insight and understanding about the nature and patterns of his or her difficulties (item 9, 62). Special attention seems to be given to the exploration of the influence of interpersonal relationships, emotional states and exploration of the impact that his or her own behaviour can have on others (31, 63, 6). At the same time the therapist appears to avoid taking an active stance in the interaction with the young person (items 65, 3, 18, 21, 89, 27, 17) or disclosing the rationale behind his or her therapeutic approach (item 57). In addition, it appears that the young person in psychodynamic psychotherapy does not always demonstrate a clear commitment to the work of therapy (item 36), or speak with certainty about his or her thoughts and feelings (item 30), although on the whole there is a sense of communication being clear between the young person and the therapist (items 5), and the young person characteristically feels understood by the therapist (item 41).

Cognitive-behavioural therapy with adolescents (Table 4) seems to be characterisd by the therapist's challenging of the young person's views (items 71, 99), making problem-solving suggestions (items 85, 82), using clarifications and restatements of the young person's communication (item 65). In CBT it appears that the therapist encourages the adolescent to focus on his or her current emotional and somatic states (items 77, 96) and patterns of behaviour (item 62), while actively avoiding making past-present links (items 92, 88). At the same time it appears to be uncharacteristic for the young person to discuss issues related to separation or sexuality, and the young person is not typically controlling of the therapeutic interaction (items 29, 11, 87). Instead the interaction of the dyad appears to be charged with positive feeling, collaboration and mutual understanding (items 95, 74, 44, 1, 42, 5, 41).

Mentalisation-based treatment (Table 5) appears to be characterised by the exploration and understanding of mental states of the young patient as well as others (items 86, 97, 96) and an exploration of the impact of emotions and mental states on both the self and others (items 69, 60). In addition the therapist seems to attempt to communicate with clarity and to help the young person to be clear about their own thoughts and feelings (items 31, 65, 46). The therapist offers a setting of non-judgmental acceptance (item 18), whilst actively avoiding being directive or suggestive (items 17, 27, 89, 82). For the young person it is unlikely for them to discuss material from previous sessions (item 56), sexuality-related issues (item 11), or to be controlling or demanding (items 87, 83).

Interpersonal psychotherapy (Table 6) appears to be characterised by a focus on the emotional states of the young person as well as those of significant others (items 96, 86), and the exploration of the impact of the adolescent's actions on others (item 69). The therapist seems to take a supportive (79) and problem-solving approach (82) with a focus on changing the young person's behavioural patterns (85) and clarifying the adolescent's communication (65). At the same time the therapist appears to avoid self-disclosures (21), but stays with present behaviours and situations, not focusing on the past or trying to link it to the present (92, 88), and avoiding a focus on fantasy material (90). The young person appears to understand the therapist (item 5) and display a generally positive and receptive attitude towards the therapist and his or her comments (44, 1, 42, 83, 5). In this form of treatment the young person is likely to feel helped (95), to share his or her low mood with the therapist (94) and to share dangerous or distressing preoccupations (91).

What are the main similarities and differences between the different modalities of psychotherapy with adolescents?

The third aim of the current study was to explore what this provisional version of the APQ can tell us about the ways that different modalities of adolescent psychotherapy are similar to or different from each other, both in terms of how the therapist or the young person behaves, as well as the interaction between them. In order to assess these similarities and differences, Spearman Rank Correlations were used to correlate means of 100 Q-items among the five modalities under study. The same statistical tests were used to correlate three types of APQ items (items describing young person's behaviour or attitude ($N = 45$); therapist's behaviour or attitude ($N = 26$), and the interaction in the adolescent-therapist dyad ($N = 29$)) separately in order to identify the nature of the differences between what typically takes place in the therapeutic room in each modality. In addition, findings from correlations that were of greatest theoretical interest were analysed more closely by looking at Tables 1–6. Once again, all findings must be treated with considerable caution, considering the relatively small amount of data on which the findings are based.

Psychoanalysis and psychodynamic psychotherapy

The first discovery that deserves attention refers to the long-standing debate about the relationship between psychoanalysis and psychodynamic psychotherapy (Rangell, 1954; Alexander, 1954; Wallerstein, 1995; Kernberg, 1999). Analysis of the findings from *Spearman's Rank Correlations* revealed that therapeutic techniques used in psychoanalysis and psychodynamic psychotherapy were strongly and highly

correlated (rho (26) = 0.73, p < 0.0) which suggests a great resemblance between the two approaches, as we would expect. In addition, a close look at the most/least salient items in the typical practice of psychoanalytic and psychodynamic psychotherapies with adolescents revealed that the main similarities between these approaches were: in both approaches the therapist attends to the young person's current emotional states (item 96); the therapist works with the young person to try to make sense of his or her experience (item 9) and expresses curiosity about his or her internal states and affects (item 97). These are features that are also characteristic of adolescent psychotherapy in general (see Table 1), so they do not in themselves seem to account for what is specific about psychoanalytic and psychodynamic approaches to working with adolescents. However, it is also possible to see a number of apparent differences between these two approaches. For instance, it appears to be *more* typical in psychodynamic psychotherapy to ask the adolescent client for more information or elaboration (item 31), to clarify, restate, or rephrase (item 65) and to be supportive (items 79). Psychoanalysts, on the other hand, would typically occupy a more neutral stance (item 93) and offer more resistance and transference interpretations (items 50 and 98).

These findings seem to correspond almost exactly to the conclusions that Kernberg (1999) and others reached when comparing these two modalities, i.e. that they may be characterised by the same basic techniques but with certain modifications such as the amount of emphasis the therapist places on maintaining the condition of neutrality or offering interpretations. The psychodynamic treatments appear to be more 'supportive' and active, whereas the psychoanalytic treatment appears to be more focused on the interpretation of resistance with a focus on interpretation of the therapeutic relationship itself.

Interpersonal and cognitive-behavioural therapies

Cognitive-behavioural and interpersonal therapies, when looked at together, on the whole (N = 100) were found to be in contrast to psychoanalytic and psychodynamic treatments when looking at the typical therapeutic process. A closer look at the tables revealed that when filtering all the items that were found to be characteristic of psychotherapy in general (Table 1), the most vivid difference between the two pairs was as follows: in psychoanalysis and psychodynamic psychotherapy the therapists seem to occupy a neutral and non-directive stance (items 93, 27, 21). They focus on making resistance and transference interpretations (items 50,100) as well as identifying repeating patterns of behaviour (item 62). Cognitive-behavioural and interpersonal psychotherapists, in contrast, appear to take a much more active stance suggesting to the young person new ways of behaving (item 85) and working with the young person on finding practical solutions to his/her problems (item 82) in the context of 'here and now' (items 92, 88).

Whilst it is generally recognised that cognitive-behavioural therapy is noticeably distinct from psychoanalytic and psychodynamic modalities (Kendall, 2006), such a dramatic contrast between psychodynamic and interpersonal psychotherapy was rather surprising, considering that IPT is sometimes described as a form of psychodynamic treatment. In respect of technique, there were neither significant nor strong correlations (IPT and psychoanalysis: rho(26) = 0.25, p > 0.05; IPT and psychodynamic psychotherapy: rho(26) = 0.24, p > 0.05). Despite interpersonal psychotherapy drawing on psychodynamic theory and being defined by some as

a primarily psychodynamic approach (Kernberg, 1999), according to the clinicians' ratings, this modality's use of more supportive and didactic methods (Mufson *et al.*, 2004) suggests a greater similarity to cognitive-behavioural therapy.

The findings of this study also suggest that the distinction between CBT and IPT may not be as great in actual practice as may appear from the descriptions of their theoretical models. These findings correspond to previous research on adult psychotherapy process which illustrated that in practice, cognitive-behavioural and interpersonal psychotherapies have a great deal in common (Ablon and Jones, 2002).

Mentalisation-based treatment

Based on the data collected for this study, mentalisation-based treatment was found to have the greatest resemblance to psychoanalysis and psychodynamic psychotherapy. Interestingly, when looking overall MBT was found to be more similar to psychoanalysis ($rho(100) = 0.64$, $p < 0.01$) . However, closer exploration revealed that in respect of therapist technique it appeared to be closer to psychodynamic psychotherapy ($rho(26) = 0.65$, $p < 0.01$) than to psychoanalysis ($rho(26) = 0.60$, $p < 0.01$). This is consistent with the theoretical descriptions found in the literature about MBT which explains that, despite apparent similarity between MBT and CBT, the former does not focus on distortions of cognitive schemata and makes rather extensive use of typically psychodynamic techniques (Allen and Fonagy, 2006). Nevertheless, MBT has sometimes been described as taking a mid-point between other therapeutic modalities, and drawing on aspects of each of them; so it is interesting that this initial investigation of MBT with adolescents does not appear to bear that out. However, findings about MBT have to be treated with considerable caution, as many of the therapists who took part in this study reported that they were unfamiliar with this model of treatment, so were not able to rate the APQ items in relation to this modality of treatment. Once the APQ has been revised it will be important for it to be tested on a larger sample, including a greater number of therapists familiar with the MBT model and psychoanalysts and psychoanalytic psychotherapists from diverse schools.

Conclusion

Overall, the APQ appears to be a promising measure for investigating the therapeutic process with adolescents. APQ descriptions of psychotherapy process across different modalities are largely consistent with theoretical descriptions found in the literature on adolescent psychotherapy; and qualitative feedback from this first stage of developing the APQ suggests that the items represent core aspects of the therapeutic process with this age-group well. Further work will need to be done to revise the APQ items in line with the findings of this initial study, and the revised version of the APQ will then need to be validated using a larger sample, including ratings based on video or audio tapes of actual sessions, as well as the views and opinions of expert therapists.

Although it is still early days for the APQ, some interesting preliminary findings emerged from this study. When comparing and contrasting APQ descriptions of different therapeutic approaches, analysis revealed some interesting cross-modality similarities and differences. Examination of items that represent not only expert clinical perspective on modality-specific therapist characteristics, but those of the

young person and the interaction between therapist and young person, brings these characteristics into relief with a high level of clinical detail and richness.

Nevertheless, despite the revealing findings of the current study, there are limitations which need to be considered. First of all, the sample was relatively small and not equally representative of the modalities studied. In terms of ratings, it is important to note that the sessions were Q-sorted by the therapists themselves. This contrasts with the normal usage of the *Psychotherapy Q-Set* which is typically applied to video recorded sessions by an independent rater who may or may not be a clinician. Thus, although the extent to which the coding process was influenced by ratings based on the therapists' recollections is not known, the objectivity of the results still has to be treated with caution.

Although the results reported here are provisional, and the *Adolescent Psychotherapy Q-Set* is still in the early stages of development as a reliable and valid measure of the psychotherapy process with adolescents, on the basis of this pilot study the APQ appears to be a promising tool for its description and analysis. Further work is currently underway on the development of the APQ, and a revised list of items will soon be validated using audio tapes from an on-going study of therapy with adolescents. In time, it is hoped that this measure will give researchers as well as clinicians an opportunity to gain further insight into the complexity of the therapeutic process with adolescent patients and to allow for practice to inform theory and theory to inform practice in this clinical work.

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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-behavioural therapy'. *Psychotherapy Research*, 8: 71–83.

Ablon, J.S. and Jones, E.E. (2002) 'Validity of controlled clinical trials of psychotherapy: findings from the NIMH Treatment of Depression Collaborative Research Program'. *American Journal of Psychiatry*, 159: 775–83.

Ablon, S.J. and Jones, E. (2005) 'On analytic process'. *Journal of the American Psychoanalytic Association*, 53: 541–68.

Adams, G.R. (2000) *Adolescent Development: The Essential Findings*. Oxford: Blackwell.

Alexander, F. (1954) 'Psychoanalysis and psychotherapy'. *Journal of American Psychoanalytic Association*, 2: 722–33.

Allen, J.G. and Fonagy, P. (eds) (2006) *Handbook of Mentalization-Based Treatment*. Chichester: John Wiley.

Anderson, R. (2000) 'Assessing the risk of self-harm in adolescents: a psychoanalytic perspective'. *Psychoanalytic Psychotherapy*, 14: 9–21.

Bambery, M., Porcerelli, J.H. and Ablon, J.S. (2009) 'Prototypes of psychodynamic and CBT psychotherapy with adolescents: development and applications for training'. *Journal of the American Psychoanalytic Association*, 57: 175–81.

Blos, P. (1967) 'The second individuation process of adolescence'. *The Psychoanalytic Study of the Child*, 22: 162–86.

Briggs, S. (2002) *Working with Adolescents: A Contemporary Psychodynamic Approach*. London: Palgrave.

Bychkova, T. (2010) 'Exploring the Adolescent Psychotherapy Q-Set'. *Unpublished dissertation, Master of Science in Psychoanalytic Developmental Psychology, the Anna Freud Centre and the University College London*.

CARR, A. (2010) *What Works with Children, Adolescents and Adults? A Review of the Research on the Effectiveness of Psychotherapy*. London: Routledge.
DOBSON, K.S. (2001) *Handbook of Cognitive-Behavioural Therapies* (*2nd ed.*). New York: The Guilford Press.
ESTRADA, A. and RUSSELL, R. (1999) 'The Development of the Child Psychotherapy Process Scales (CPPS)'. *Psychotherapy Research*, 9: 154–66.
FLAVELL, J.H., MILLER, P.H. and MILLER, S.A. (1993) *Cognitive Development* (*3rd ed.*). Englewood Cliffs, NJ: Prentice Hall.
FONAGY, P., TARGET, M., COTTRELL, D., PHILLIPS, J. and KURTZ, Z. (2002) *What Works for Whom? A Critical Review of Treatments for Children and Adolescents*. London: The Guilford Press.
FREUD, A. (1958) 'Adolescence'. *The Psychoanalytic Study of the Child*, 13: 255–78.
GOODMAN, G. (2011) 'Interaction structures between a child and two therapists in the psychodynamic treatment of a child with Asperger's disorder'. *Journal of Child Psychotherapy* (this issue). doi: 10.1080/0075417X.2011.614749.
HILSENROTH, M. (2002) 'Adelphi University: Psychodynamic Psychotherapy Process and Outcome Research Team'. In FONAGY, P., CLARKIN, J., GERBER, A., KACHELE, H., KRAUSE, R., JONES, E., PERRON, R. and ALLISON, E. (eds) *An Open Door Review of Outcome Studies in Psychoanalysis* (*2nd ed.*). London: International Psychoanalytical Association.
JONES, E.E., CUMMING, J.D. and HOROWITZ, M. (1988) 'Another look at the nonspecific hypothesis of therapeutic effectiveness'. *Journal of Consulting and Clinical Psychology*, 56: 48–55.
JONES, E.E., GHANNAM, J., NIGG, J.T. and DYER, J.F.P. (1993) 'A paradigm for single case research: The time series study of a long-term psychotherapy for depression'. *Journal of Consulting and Clinical Psychology*, 61: 381–94.
JONES, E.E., PARKE, L.A. and PULOS, S.M. (1992) 'How therapy is conducted in the private consulting room: a multidimensional description of brief psychodynamic treatments'. *Psychotherapy Research*, 2: 16–30.
JONES, E. (2000) *Therapeutic Action: A Guide to Psychoanalytic Psychotherapy*. London: Jason Aronson.
JONES, E.E. and PULOS, S.M. (1993) 'Comparing the process in psychodynamic and cognitive-behavioural therapies'. *Journal of Consulting and Clinical Psychology*, 61: 306–16.
JONES, E.E. and WINDHOLZ, M. (1990) 'The psychoanalytic case study: toward a method for systematic inquiry'. *Journal of the American Psychoanalytic Association*, 38: 985–1009.
KENDALL, P.C. (2006) *Child and Adolescent Therapy: Cognitive Behavioural. Procedures* (*3rd ed.*). New York: The Guilford Press.
KENNEDY, E. and MIDGLEY, N. (2007) *Process and Outcome Research in Child, Adolescent and Parent-Infant Psychotherapy*. London: North Central London Strategic Health Authority.
KERNBERG, O.F. (1999) 'Psychoanalysis, psychoanalytic psychotherapy and supportive psychotherapy: contemporary controversies'. *The International Journal of Psycho-Analysis*, 80: 1075–91.
LAUFER, M. and LAUFER, M.E. (eds) (1984) *Adolescence and Developmental Breakdown: A Psychoanalytic View*. London: Karnac Books.
LEMMA, A., ROTH, A. and PILLING, S. (2008) 'The competencies required to deliver effective psychoanalytic/psychodynamic therapy.' www.ucl.ac.uk/CORE.
MALBERG, N.T., FONAGY, P. and MAYERS, L. (2008) 'Contemporary psychoanalysis in a pediatric hemodialysis unit: development of a mentalization-based group intervention for adolescent patients with end-stage renal disease'. *The Annual Review of Psychoanalysis*, 36: 101–14.
MCLEOD, B.M. and WEISZ, J.R. (2005) 'The Therapy Process Observational Coding System Alliance scale: measure characteristics and prediction of outcome in 'usual clinical practice'. *Journal of Consulting and Clinical Psychology*, 73: 323–33.
MIDGLEY, N., ANDERSON, J., GRAINGER, E., NESIC-VUCKOVIC, T. and URWIN, C. (eds) (2009) *Child Psychotherapy and Research: New Directions, Emerging Findings*. London: Routledge.
MIDGLEY, N. and VROUVA, I. (eds) (in press) *Mentalization-based Interventions with Children, Young People and Families*. London: Routledge.

MUFSON, L., DORTA, K.P., MOREAU, D. and WEISSMAN, M.M. (eds) (2004) *Interpersonal Psychotherapy for Depressed Adolescents*. New York: The Guilford Press.
NILSSON, T., SVENSSON, M., SANDELL, R. and CLINTON, D. (2007) 'Patients' experiences of change in cognitive-behavioural therapy and psychodynamic therapy: a qualitative comparative study'. *Psychotherapy Research*, 17: 553–66.
PERRET-CATIPOVIC, M. and LADAME, F. (eds) (1998) *Adolescence and Psychoanalysis: The Story and the History*. London: Karnac Books.
PRICE, P. and JONES, E.E. (1998) 'Examining the alliance using the psychotherapy process Q-set'. *Psychotherapy*, 35: 392–404.
RANGELL, L. (1954) 'Similarities and differences between psychoanalysis and psychodynamic psychotherapy'. *Journal of American Psychoanalytic Association*, 2: 734–44.
ROSSOUW, T. (in press) 'Self-harm in young people: is MBT the answer?' In MIDGLEY, N. and VROUVA, I. (eds) *Mentalisation-based Interventions with Children, Young People and Families*. London: Routledge.
RUTTER, M. (1995) *Psychological Disturbances in Young People: Challenges for Prevention*. Cambridge: Cambridge University Press.
SCHNEIDER, C. (2004a) 'The Development of the Child Psychotherapy Q-Set'. *Unpublished dissertation, Doctor of Philosophy in Education in the Graduate Division of the University of California, Berkley*.
SCHNEIDER, C. (2004b) '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. and JONES, E.E. (2003) *Child Psychotherapy Q-Set Coding Manual*. Unpublished manuscript, University of California, Berkeley.
SCHNEIDER, C., MIDGLEY, N. and DUNCAN, A. (2010) 'A 'motion-portrait' of a psychodynamic treatment of an eleven-year-old girl: exploring interrelations of psychotherapy process and outcome using the child psychotherapy Q-set'. *Journal of Infant, Child and Adolescent Psychotherapy*, 9: 94–107.
SCHNEIDER, C., PREUTZEL-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*. London: Routledge.
SHIRK, S. and RUSSELL, R.L. (eds) (1996) *Change Processes in Child Psychotherapy*. New York: The Guilford Press.
VERDUYN, C., ROGERS, J. and WOOD, A. (eds) (2009) *Depression: Cognitive-Behaviour Therapy with Children and Young People*. London: Routledge.
WALLESTEIN, R.S. (1995) *The Talking Cures. The Psychoanalyses and the Psychotherapies*. New Haven and London: Yale University Press.
WEERSING, V.R. and WEISZ, J.R. (2002) 'Mechanisms of action in youth psychotherapy'. *Journal of Child Psychology and Psychiatry*, 43: 3–29.
WISE, I. (2000) *Adolescence*. London: Karnac Books.

Appendix

Table 1. The 10 most/least characteristic items of adolescent psychotherapy in general.

Psychotherapy in general			
Item	Mean	Item type	Item title
			The 10 most salient items
96	4.82	I	Therapist attends to young person's current emotional states.
65	4.81	T	Therapist clarifies, restates, or rephrases young person's communication.
31	4.76	T	Therapist asks for more information or elaboration.
9	4.76	T	Therapist works with young person to try to make sense of his or her experience.
18	4.76	T	Therapist conveys a sense of non judgemental acceptance.
60	4.65	I	Therapist draws attention to young person's characteristic ways of dealing with emotion.
3	4.65	T	Therapist's remarks are aimed at facilitating young person's speech.
63	4.59	YP	Young person discusses and explores interpersonal relationships.
58	4.59	I	Therapist remains calm and thoughtful when faced with young person's strong affect or impulses.
97	4.47	I	Therapist expresses curiosity about internal states and affects.
			The 10 least salient items
67	2.56	YP	Young person appears to find it difficult to concentrate or maintain attention during the session.
44	2.50	I	Young person feels wary or suspicious of the therapist.
87	2.47	I	Young person is controlling of the interaction with the therapist.
52	2.47	YP	Young person has difficulty with ending of sessions.
49	2.41	YP	Young person's way of speaking is excessively detailed and specific.
17	2.41	T	Therapist actively exerts control over the interaction.
41	2.38	I	Young person appears to feel misunderstood by the therapist.
83	2.35	YP	Young person is demanding within the session.
5	2.12	I	Young person appears to have difficulty understanding the therapist's comments..
89	1.88	T	Therapist makes absolute statements about what is going on in the young person's mind.

Table 2. The 10 most/least characteristic items of psychoanalysis.

Psychoanalysis			
Item	Mean	Item type	Item title
			The 10 most salient items
9	5.00	T	Therapist works with young person to try to make sense of his or her experience.
98	4.75	I	The therapy relationship is a focus of discussion.
97	4.75	I	Therapist expresses curiosity about internal states and affects.
50	4.75	I	Therapist draws attention to feelings regarded by the young person as unacceptable.
100	4.50	I	Therapist draws connections between the therapeutic relationship and other relationships.
96	4.50	I	Therapist attends to young person's current emotional states.
93	4.50	T	Therapist is neutral ...
60	4.50	I	Therapist draws attention to young person's characteristic ways of dealing with emotion.
58	4.50	I	Therapist remains calm and thoughtful when faced with young person's strong affect or impulses.
18	4.50	T	Therapist conveys a sense of non judgemental acceptance.
			The 10 least salient items
67	2.50	YP	Young person appears to find it difficult to concentrate or maintain attention during the session.
52	2.50	YP	Young person has difficulty with ending of sessions.
41	2.50	I	Young person appears to feel misunderstood by the therapist.
27	2.50	T	Therapist gives explicit advice and guidance.
85	2.25	T	Therapist encourages young person to try new ways of behaving with others.
49	2.25	YP	Young person's way of speaking is excessively detailed and specific.
5	2.25	I	Young person appears to have difficulty understanding the therapist's comments.
89	1.75	T	Therapist makes absolute statements about what is going on in young person's mind.
21	1.75	T	Therapist self-discloses
17	1.50	T	Therapist actively exerts control over the interaction.

Table 3. The 10 most/least characteristic items of psychodynamic psychotherapy.

Psychodynamic psychotherapy			
Item	Mean	Item type	Item title
			The 10 most salient items
96	5.00	I	Therapist attends to young person's current emotional states.
65	5.00	T	Therapist clarifies, restates, or rephrases young person's communication.
63	5.00	YP	Young person discusses and explores interpersonal relationships.
31	5.00	T	Therapist asks for more information or elaboration.
18	5.00	T	Therapist conveys a sense of non judgmental acceptance.
97	4.75	I	Therapist expresses curiosity about internal states and affects.
62	4.75	I	Therapist identifies a recurrent theme in young person's experience or conduct.
9	4.75	T	Therapist works with young person to try to make sense of his or her experience.
6	4.75	YP	Young person acknowledges feelings aroused by interactions with significant others.
3	4.75	T	Therapist's remarks are aimed at facilitating young person's speech.
			The 10 least salient items
57	2.75	T	Therapist explains rationale behind his or her technique or approach to treatment.
36	2.75	YP	Young person is committed to the work of therapy.
30	2.75	YP	Young person speaks with certainty about his or her thoughts and feelings.
21	2.75	T	Therapist self-discloses.
41	2.67	I	Young person appears to feel misunderstood by the therapist.
53	2.33	YP	Young person displays heightened vigilance about the therapist.
89	2.25	T	Therapist makes absolute statements about what is going on in the young person's mind.
5	2.25	I	Young person appears to have difficulty understanding the therapist's comments.
27	2.00	T	Therapist gives explicit advice and guidance.
17	2.00	T	Therapist actively exerts control over the interaction.

Table 4. The 10 most/least characteristic items of cognitive-behavioural therapy.

CBT			
Item	Mean	Item type	Item title
			The 10 most salient items
99	5.00	I	Therapist challenges young person's view.
96	5.00	I	Therapist attends to young person's current emotional states.
95	5.00	I	Young person appears to feel helped by the therapist.
85	5.00	T	Therapist encourages young person to try new ways of behaving with others.
82	5.00	T	Therapist adopts a problem solving approach with the young person.
77	5.00	I	Therapist encourages young person to attend to somatic feelings or sensations.
74	5.00	I	Humour is used.
71	5.00	I	Therapist challenges over-generalised or absolute beliefs about self and other expressed by young person.
65	5.00	T	Therapist clarifies, restates, or rephrases young person's communication.
62	5.00	I	Therapist identifies a recurrent theme in young person's experience or conduct.
			The 10 least salient items
44	2.00	I	Young person feels wary or suspicious of the therapist.
29	2.00	YP	Young person talks about wanting to be separate or distant from others.
11	2.00	YP	Young person explores sexual feelings and experiences.
5	2.00	I	Young person appears to have difficulty understanding therapist's comments.
92	1.50	I	Therapist links young person's feelings or perceptions to situations or behaviour of the past or more 'childish' mental states.
88	1.50	I	An earlier developmental phase is a topic.
87	1.50	I	Young person is controlling of the interaction with therapist.
42	1.50	I	Young person ignores or rejects therapist's comments and observations.
41	1.50	I	Young person appears to feel misunderstood by the therapist.
1	1.50	YP	Young person verbalises or expresses negative feelings towards therapist.

Table 5. The 10 most/least characteristic items of mentalisation-based therapy.

MBT			
Item	Mean	Item type	Item title
			The 10 most salient items
86	5.00	T	Therapist encourages reflection on the thoughts, feelings and behaviour of significant others.
97	4.75	I	Therapist expresses curiosity about internal states and affects.
96	4.75	I	Therapist attends to young person's current emotional states.
74	4.75	I	Humour is used.
69	4.75	I	Therapist encourages the exploration of the potential impact of young person's behaviour on others.
65	4.75	T	Therapist clarifies, restates, or rephrases young person's communication.
60	4.75	I	Therapist draws attention to young person's characteristic ways of dealing with emotion.
46	4.75	T	Therapist communicates with young person in a clear, coherent style.
31	4.75	T	Therapist asks for more information or elaboration.
18	4.75	T	Therapist conveys a sense of non judgemental acceptance.
			The 10 least salient items
17	2.50	T	Therapist actively exerts control over the interaction.
56	2.25	YP	Young person refers back to material or discussions from previous sessions.
11	2.25	YP	Young person explores sexual feelings and experiences.
87	2.00	I	Young person is controlling of the interaction with therapist.
83	2.00	YP	Young person is demanding within the session.
52	2.00	YP	Young person has difficulty with ending of sessions.
49	2.00	YP	Young person's way of speaking is excessively detailed and specific.
27	1.75	T	Therapist gives explicit advice and guidance.
89	1.50	T	Therapist makes absolute statements about what is going on in young person's mind.
82	1.50	T	Therapist adopts a problem solving approach with young person.

Table 6. The 10 most/least characteristic items of interpersonal psychotherapy.

IPT-A			
Item	Mean	Item type	Item title
			The 10 most salient items
96	5.00	I	Therapist attends to young person's current emotional states.
95	5.00	I	Young person appears to feel helped by therapist.
94	5.00	YP	Young person expresses or displays sadness or low mood.
91	5.00	YP	Young person discusses behaviours or preoccupations that cause distress or risk to young person or others.
86	5.00	T	Therapist encourages reflection on the thoughts, feelings and behaviour of significant others.
85	5.00	T	Therapist encourages young person to try new ways of behaving with others.
82	5.00	T	Therapist adopts a problem solving approach with young person.
79	5.00	T	Therapist attempts to foster a sense of hopefulness/optimism.
69	5.00	I	Therapist encourages the exploration of the potential impact of young person's behaviour on others.
65	5.00	T	Therapist clarifies, restates, or rephrases young person's communication.
			The 10 least salient items
83	1.33	YP	Young person is demanding within the session.
44	1.33	I	Young person feels wary or suspicious of therapist.
21	1.33	T	Therapist self-discloses.
1	1.33	YP	Young person verbalises or expresses negative feelings towards therapist.
92	1.00	I	Therapist links young person's feelings or perceptions to situations or behaviour of the past or more 'childish' mental states.
90	1.00	T	Young person's dreams, wishes, or fantasies are discussed.
88	1.00	I	An earlier developmental phase is a topic.
68	1.00	T	Real rather than fantasised meanings of experience are actively differentiated by therapist.
42	1.00	I	Young person ignores or rejects therapist's comments and observations.
5	1.00	I	Young person appears to have difficulty understanding therapist's comments.