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Expert Clinicians' Prototype of an Ideal Treatment in Regulation-Focused Psychotherapy for Children (RFP-C)

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There are few studies of the child psychodynamic psychotherapy process. This study investigates the psychotherapy process within regulation-focused psychotherapy for children (RFP-C; Hoffman, Rice, & Prout, 2016). RFP-C is a manualized, psychodynamic treatment for children with disruptive behaviors. Three expert clinicians used the Child Psychotherapy Q-Set to develop an RFP-C prototype, which can be used in future studies to measure adherence in actual RFP-C sessions. As expected, the RFP-C prototype was associated with established prototypes of child psychodynamic psychotherapy and child-centered play therapy. There was no relationship between RFP-C and the cognitive behavior therapy process prototype. Reflective functioning was also associated with the RFP-C prototype, providing additional evidence for mentalization as a common factor in child psychotherapy. Implications for clinical practice and future research use are discussed.

Keywords: child psychotherapy, psychodynamic psychotherapy, regulation-focused psychotherapy for children, emotion regulation, Child Psychotherapy Q-Set

Regulation-focused psychotherapy for children (RFP-C; Hoffman, Rice, & Prout, 2016) is a manualized, psychodynamic play therapy for children who manifest disruptive behaviors and emotional dysregulation. RFP-C conceptualizes

children's disruptive behaviors as resulting from deficits in emotion regulation, which limit the child's ability to adaptively cope with painful emotions. Externalizing symptoms protect the child from disturbing feelings such as sadness, shame, and guilt. Through 20 sessions (16 with the child and four parent meetings), RFP-C allows the child to understand the ways distressing affects are avoided and to explore alternative ways of coping with unpleasant affect. The clinician works to increase the child's understanding that all behavior, especially oppositional and disruptive behavior, has meaning in the service of emotional and behavioral regulation. This work is also done with the parents to better support the child in achieving symptom reduction and increased emotion regulation.

Whereas there is still much work to be done in developing a strong evidence base for psychodynamic therapy for children and adolescents, the literature has grown in recent years

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(Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; Fonagy, Sled, & Baradon, 2016; Gilboa-Schechtman et al., 2010; Midgley, O’Keeffe, French, & Kennedy, 2017). There are few studies that report outcomes of psychodynamic psychotherapy for children with disruptive behavior problems (Eresund, 2007; Fonagy & Target, 1996; Laezer, 2015). Even fewer studies include empirical investigations of the mechanisms change in psychodynamic child psychotherapy (Fonagy, 2003; Goodman, Midgley, & Schneider, 2016; Shirk & Russell, 1996).

Psychotherapy process research investigates what occurs in therapy sessions and how it is connected to the outcome of the therapy (McLeod, Islam, & Wheat, 2013). Despite an increase in the number of studies on child psychodynamic psychotherapy indicating its effectiveness, the need for more research in this field remains, especially considering that therapeutic process is still poorly understood (Goodman & Athey-Lloyd, 2011; Midgley, 2007; Midgley, Anderson, Grainger, Vuckovic-Nesic, & Urwin, 2009; Midgley, O’Keeffe, French, & Kennedy, 2017; Palmer, Nascimento, & Fonagy, 2013). Analyzing the nature of therapeutic action has the potential to help identify the mechanisms of change that underlie successful clinical interventions (Fonagy, 2003; Kazdin, 2009; Midgley, 2007).

To address some of the problems of operationalization in psychotherapy, Schneider (2003) and Schneider and Jones (2009) developed the Child Psychotherapy Q-Set (CPQ), an adaptation of the Psychotherapy Process Q-Set (Jones, 1985, 2000) to empirically identify and rank components of psychotherapy process. The CPQ is pantheoretical and describes a wide range of events, interventions, and processes that may occur in child psychotherapy (Schneider & Jones, 2009). The CPQ utilizes Q-methodology, a generic scaling technique that organizes data according to their representativeness of a particular construct, person, or situation (Schneider, Midgley, & Duncan, 2010). Q-methodology calls for an ipsative sorting process, which creates a normal distribution; this forced sorting methodology is unique among child psychotherapy process measures and protects against response biases.

The CPQ has been utilized in several studies to highlight distinctions between psychody-

amic psychotherapy and cognitive behavior therapy (CBT) prototypes (Ablon & Jones, 1998; Goodman et al., 2016). A key distinction between psychodynamic and CBT for children is in their valuation of what occurs in the session versus outside the session. Psychodynamic interventions for children focus on experience-near phenomena, that is, the thoughts, behaviors, and emotions that occur during the session. In contrast, CBT with children focuses on problematic thoughts, behaviors, and emotions that take place primarily outside the therapy session. Beyond psychodynamic psychotherapy and CBT, child-centered play therapy is a nondirective approach that can be used with infants, children, and adolescents. Key aspects of child-centered play therapy include therapist sensitivity to the child’s feelings and level of development with an emphasis on fostering the ability to process, understand, and more successfully navigate emotions and conflicts (Goodman, Reed, & Athey-Lloyd, 2015).

In addition to identifying attributes that distinguish one form of psychotherapy from another, the CPQ is able to identify factors that are common across various methods of psychotherapy (Goodman et al., 2015, 2016). There are several common factors that have been identified in the broader psychotherapy literature, including therapeutic alliance (Horvath, Del Re, Flückiger, & Symonds, 2011) and empathy (Elliott, Bohart, Watson, & Greenberg, 2011). The CPQ has been used more recently to highlight aspects of another common factor, reflective functioning, across child therapy approaches.

Mentalization, operationalized as reflective functioning, is the ability to identify and understand motivations of the self and others. It is thought to be a universal element of effective psychotherapy across a wide range of paradigms and populations (Bateman & Fonagy, 2004). With its roots in theory of mind and metacognition research, reflective functioning has been referred to as “thinking about feeling and feeling about thinking” (reported in Slade, 2005). Reflective functioning (RF) includes many of the processes associated with metacognition; these include the ability to detect mental states in the self and others, to understand cause and effect links between interpersonal events, internal processes, and behavior, and to be critical of one’s own beliefs in acknowledgment of different perspectives and subjective experi-

ences (Dimaggio & Lysaker, 2015; Katznelson, 2014). Whereas metacognition involves mastery by definition, RF may be present and active to varying degrees within the individual (Dimaggio & Lysaker, 2015).

Psychotherapy in general and RFP-C specifically activate the child's ability to understand underlying motivations and mental states of the self and others. Reflective functioning is considered by psychotherapists to be a key component in a wide variety of adult treatment approaches, including psychodynamic therapy, CBT, and dialectical behavior therapy (Allen, Fonagy, & Bateman, 2008; Goodman, 2013) and in adolescent psychotherapy (Bo et al., 2016; Rossouw & Fonagy, 2012); however, only one study to date has explored whether psychotherapy experts view RF as a critical and salient aspect in child psychotherapy (Goodman et al., 2016).

The Present Study

Developing psychotherapy process prototypes is a critical component of psychotherapy research; prototypes help define and operationalize therapeutic approaches and can be used to identify common factors and distinct mechanisms of action and to assess adherence and fidelity in outcome studies. This study investigates the following: (a) whether it is possible for expert clinicians to agree on a prototype of the RFP-C process using the CPQ; (b) whether this prototype can be empirically distinguished from existing prototypes for psychodynamic psychotherapy, CBT, and child-centered play therapy; and (c) whether promoting mentalization (operationalized as reflective functioning) is a shared component across all four therapeutic approaches. It is the first study to report on an empirically derived description of psychotherapy process within RFP-C and to compare it with other process prototypes of child psychotherapy. This study also examines reflective functioning as a common factor across four distinct psychotherapy process prototypes for children.

Hypotheses

The primary aim of the current study was to develop a prototype for an ideal RFP-C session using the Child Psychotherapy Q-Set. We expected that three expert raters could develop a

process prototype for RFP-C with a high degree of agreement (Hypothesis 1). This RFP-C prototype was then compared with previously established prototypes of psychodynamic psychotherapy, CBT, child-centered play therapy, and reflective functioning. Three hypotheses related to the interrelationships between these psychotherapy process prototypes were tested. Given the theoretical overlaps in the approaches, we expected that the RFP-C process prototype would be significantly positively correlated with the psychodynamic and child-centered play therapy process prototypes (Hypothesis 2). It was also hypothesized that the RFP-C process prototype would not be significantly correlated with the CBT process prototype (Hypothesis 3). Finally, because reflective functioning is understood as a common factor across all psychotherapies, we hypothesized that the RFP-C process prototype would be significantly and positively correlated with the reflective functioning process prototype (Hypothesis 4).

Method

Expert Clinicians

Following established methods for use of the CPQ (Goodman et al., 2015, 2016), we engaged three clinicians, who participated in this study because of their nationally recognized expertise in the RFP-C process. All were practicing RFP-C therapists who had many years of postgraduate clinical experience ($M = 20.33$). Data on the psychodynamic therapy, CBT, child-centered play therapy, and reflective functioning process were gathered from expert clinicians, all of whom had many years of postgraduate clinical experience in their areas of expertise (Goodman et al., 2015, 2016).

Procedure

Three expert RFP-C clinicians were contacted by e-mail and requested to rate the 100 CPQ items relevant to psychotherapy process as they saw this process occurring within a prototypical child psychotherapy session from the theoretical perspective of RFP-C. Ratings were done independently and without any communication between the raters about their responses. The expert clinicians' prototypical CPQ ratings of RFP-C process were composited, converted

to z-scores, and used in all statistical analyses. This same procedure was used to establish the psychotherapy process prototypes for psychodynamic therapy, CBT, child-centered play therapy, and reflective functioning.

Measure

The CPQ (Schneider, 2003; Schneider & Jones, 2009) is a 100-item instrument that assesses the processes of therapeutic change within a child psychotherapy session. CPQ items were developed to parallel items from the Psychotherapy Process Q-Set but were significantly adapted to assess the psychotherapy process in sessions with children aged 3–13 years. Approximately one third of the CPQ items are designed to capture aspects of the therapist's actions and attitudes, one third for aspects of the child's attitude and behavior or experience, and one third for aspects of the interaction of the therapist-child dyad or the climate or atmosphere of the encounter (Jones, 2000; Schneider & Jones, 2009). For this study, the expert clinicians used the online version CPQ, in which items are sorted into piles via computer mouse.

The CPQ's reliability and validity have been demonstrated in various ways. Discriminant validity was demonstrated between two sets of psychodynamic and CBT sessions (Schneider, Pruetzel-Thomas, & Midgley, 2009). Independent raters using the CPQ established interrater reliability in two samples of 46 video-recorded sessions (intraclass correlation = .74; range: .62–.87; Goodman, 2015) and 53 video-recorded sessions (intraclass correlation = .77; range: .55–.89; Goodman & Athey-Lloyd, 2011). The CPQ distinguished between the treatments of two different patients with the same therapist (Schneider et al., 2009) and the treatments of two different therapists with the same patient (Goodman & Athey-Lloyd, 2011).

According to the CPQ methodology, all 100 Q-sort items are sorted into nine piles in a forced-choice, ipsative procedure ranging from most uncharacteristic (pile 1) to most characteristic (pile 9) of the session being rated. This procedure forces raters to place items in a normal distribution that characterizes both the high and low ends of a construct (see Schneider, 2003; Schneider & Jones, 2009). Raters in this study were asked to independently rate each

item according to how characteristic it was of an ideally conducted RFP-C session. The three sets of expert ratings were composited by adding together the three pile numbers for each item and dividing by 3. Thus, each item was assigned a mean pile number.

Data Analysis

To develop the RFP-C process prototype, interrater reliability was measured to assess for agreement among the expert RFP-C raters. Then Q-factor analysis was used to identify factors across the various process prototypes. To test the hypotheses regarding interrelationships among the process prototypes, Spearman-Brown correlations were calculated among the composited prototypes. The Spearman-Brown correlation was used because it takes into account the fact that the item distributions were composited. To conduct the post hoc analyses, Fisher r-to-z transformations were calculated. The Fisher's r-to-z transformation tests whether a significant difference exists in the magnitudes of two different correlations.

Results

Establishing an RFP-C Process Prototype

The expert raters in this study were able to develop a psychotherapy process prototype for an ideal session of RFP-C independently of one another. The Cronbach's alpha coefficient used to test the level of agreement between raters was high: .86. This provides support for the first study hypothesis that three expert raters could develop a process prototype for RFP-C with a high degree of agreement.

To provide greater detail about the RFP-C process prototype, a list of its most and least characteristic CPQ items is displayed in Table 1. Notably, five CPQ items were listed as most characteristic of the RFP-C process prototype but not most characteristic of the other four psychotherapy process prototypes (items 50, 20, 42, 52, and 34). Three CPQ items were listed as least characteristic of the RFP-C process prototype but not least characteristic of the other four psychotherapy process prototypes (items 57, 80, and 82). Two CPQ items were listed as least characteristic of the RFP-C process prototype but most characteristic of the CBT process pro-

Table 1
Most and Least Characteristic CPQ Items for RFP-C Process Prototype

CPQ number	CPQ item	Mean pile number
Most characteristic RFP-C process prototype		
36 ^a	T points out C's use of defenses.	2.17
45 ^a	T tolerates C's strong affect or impulses.	1.99
6 ^{a,b,c}	T is sensitive to the C's feelings.	1.99
50	T draws attention to feelings regarded by C as unacceptable (e.g., anger, envy, or excitement).	1.81
28 ^{b,c}	T accurately perceives the therapeutic process.	1.81
79 ^b	T comments on changes in C's mood or affect.	1.63
20	C is provocative; challenges T or rules and boundaries of the therapy hour.	1.63
67 ^a	T interprets warded-off or unconscious wishes, feelings, or ideas.	1.45
42	C ignores or rejects T's comments and observations.	1.45
76 ^{a,b}	T makes links between C's feelings and experience.	1.27
75 ^{b,c}	Interruptions, breaks in the treatment, or termination of therapy are discussed.	1.27
52	T makes explicit statements about the end of the hour, upcoming weekend, or holiday.	1.27
34	C blames others, or external forces, for difficulties.	1.27
Least characteristic RFP-C process prototype		
18 ^{d,e,f,g}	T is judgmental and conveys lack of acceptance.	-2.17
37 ^{d,f,h}	T behaves in a didactic manner.	-2.17
9 ^{d,e,f,g}	T is nonresponsive (vs. affectively engaged).	-1.99
55 ^{d,e,f}	T directly rewards desirable behaviors.	-1.99
57	T attempts to modify distortions in C's beliefs.	-1.81
24 ^{d,e,f,g}	T's emotional conflicts intrude into the relationship.	-1.63
27 ^{d,h}	There is a focus on helping C plan behavior outside the session.	-1.63
21 ^{d,f}	T self-discloses.	-1.45
41 ^{d,e,f,g}	C does not feel understood by T.	-1.45
66 ^{d,e,f}	T is directly reassuring.	-1.27
80	C behaves in a dependent fashion (vs. insists on independence).	-1.27
82	T helps C manage feelings.	-1.27

Note. T = therapist; C = child; CPQ = Child Psychotherapy Q-Set; RFP-C = regulation-focused psychotherapy-child; PDT = psychodynamic therapy; RF = reflective functioning; CCPT = child-centered play therapy; CBT = cognitive behavioral therapy.

^aOne of the most characteristic prototypical PDT CPQ items. ^bOne of the most characteristic prototypical RF CPQ items. ^cOne of the most characteristic prototypical CCPT CPQ items. ^dOne of the least characteristic prototypical PDT CPQ items. ^eOne of the least characteristic prototypical RF CPQ items. ^fOne of the least characteristic prototypical CCPT CPQ items. ^gOne of the least characteristic prototypical CBT CPQ items. ^hOne of the most characteristic prototypical CBT CPQ items.

prototype (items 37 and 27). These findings provide clarity about the distinctions between these psychotherapy process paradigms.

Construct Validity of the Process Prototypes

A Q-factor analysis with varimax rotation was conducted to test whether the entire set of prototypical CPQ process ratings of 49 expert clinicians (three RFP-C, 12 psychodynamic therapy, 10 CBT, and 24 child-centered play therapy) loaded onto four independent factors (Ablon & Jones, 1998; Block, 1978; Goodman, 2005, 2013; Goodman et al., 2015, 2016). In this statistical procedure, expert clinicians' prototypical CPQ ratings

were treated as separate variables, whereas the 100 CPQ items were treated as subjects to determine how expert clinicians' prototypical CPQ ratings clustered. In contrast to traditional factor analysis, which produces conceptual factors, each factor in Q-factor analysis represents a group of people.

A four-factor solution accounted for 67.36% of the total variance. Eleven of the 12 psychodynamic raters loaded onto Factor 1 (range of factor loadings: .61-.83), whereas all 10 CBT experts loaded onto Factor 2 (range of factor loadings: .71-.88). Twenty-one of the 24 child-centered play therapy experts loaded onto both Factor 3 (range of factor loadings: .53-.82) and

Factor 4 (range of factor loadings: .47–.70). The three RFP-C expert clinicians loaded onto Factor 1 (range of factor loadings: .54–.61), but they also loaded secondarily onto Factor 3 (range of factor loadings: .49–.53).

This was followed by a second Q-factor analysis with varimax rotation to determine the factor structure when all 58 expert clinicians' prototypical CPQ ratings of RFP-C, psychodynamic therapy, CBT, child-centered play therapy, and reflective functioning were entered into the analysis to determine whether RF process loads onto its own independent factor or is distributed among the other factors. A five-factor solution accounted for 69.03% of the total variance. All 10 CBT clinicians loaded onto Factor 1 (range of factor loadings: .68–.88), whereas 21 of the 24 child-centered play therapy expert clinicians loaded onto both Factor 2 (range of factor loadings: .46–.79) and Factor 3 (range of factor loadings: .49–.66). Eight of the 12 psychodynamic therapy expert clinicians loaded onto Factor 4 (range of loadings: .47–.79). The three RFP-C expert clinicians loaded onto Factor 5 (range of loadings: .60–.68). The nine reflective functioning experts did not form their own independent factor but instead were spread out across Factors 1, 2, and 3. Reflective functioning experts' mean factor loadings were .60 on Factor 1 (range of factor loadings: .47–.77), .48 on Factor 2 (range of factor loadings: .39–.58), and .64 on Factor 3 (range of factor loadings: .61–.67). This pattern of findings suggests that reflective functioning process loads onto the CBT and child-centered play therapy process prototypes but not the psychodynamic and RFP-C process prototypes. It should be noted, however, that four of the 12 PDT expert clinicians joined eight of the 24 child-centered play therapy expert clinicians and two of the nine reflective functioning expert clinicians in loading onto Factor 3 (range of factor loadings: .48–.74). None of the reflective functioning expert clinicians loaded onto Factor 5, the RFP-C process prototype.

Relationships Between Psychotherapy Process Prototypes

Spearman-Brown correlations were calculated to test hypotheses related to the interrelationships between these prototypes. The second study hypothesis, that the RFP-C process pro-

totype would be significantly positively correlated with the psychodynamic and child-centered play therapy process prototypes, was supported ($r = .55, p < .001$, and $r = .56, p < .001$, respectively). In accordance with expectations presented in the third hypothesis, the RFP-C process prototype was not correlated with the CBT process prototype, $r = .00, p = .98$. The RF process prototype was also significantly positively correlated with the RFP-C process prototype, $r = .44, p < .001$, providing support for the final study hypothesis that reflective functioning would be associated with the RFP-C process prototype because it has been identified as a common factor across all therapeutic paradigms.

Post Hoc Analyses

Post hoc tests were conducted to determine whether there were any significant differences between the correlations presented in Table 2. The correlations between the RFP-C process prototype and the CBT process prototype were significantly different from the correlations between the RFP-C process prototype and the other prototypes. More precisely, the correlation between RFP-C and CBT was significantly different from the correlation between RFP-C and psychodynamic therapy, $z = 4.32, p < .001$. The correlation between RFP-C and CBT was significantly different from the correlation between child-centered play therapy and CBT, $z = -4.41, p < .001$. The RFP-C process prototype correlations with the CBT process prototype and reflective functioning process prototype were significantly different from each other, $z = -3.29, p < .001$, suggesting that the

Table 2
Spearman-Brown Correlations Among the Five CPQ Prototypes

Variables	RFP-C	PDT	CCPT	CBT	RF
RFP-C	—	—	—	—	—
PDT	.55*	—	—	—	—
CCPT	.56*	.70*	—	—	—
CBT	.00	.36*	.36*	—	—
RF	.44*	.79*	.76*	.61*	—

Note. CPQ = Child Psychotherapy Q-Set; RFP-C = regulation-focused psychotherapy-child; PDT = psychodynamic therapy; CCPT = child-centered play therapy; CBT = cognitive-behavioral therapy; RF = reflective functioning.

* $p < .001$.

RFP-C process prototype is more highly correlated with the psychodynamic therapy, child-centered play therapy, and reflective functioning process prototypes than with the CBT process prototype. These findings provide further support for the third study hypothesis, that an RFP-C process prototype would not be associated with the CBT process prototype.

Discussion

This study demonstrated that it is possible for expert clinicians to agree on a prototype of the RFP-C process using the CPQ. The RFP-C process prototype developed in this study shares many similarities with psychodynamic and child-centered play therapy prototypes and can be empirically distinguished from the CBT prototype. Results also demonstrate that promoting reflective functioning is highly characteristic of RFP-C, providing further support for reflective functioning as a common factor across many types of psychotherapy paradigms.

In a Q-factor analysis, individuals, as opposed to items, are sorted into categories or factors. The goal is to analyze similarities among individual raters so that those individuals may be clustered together. Each factor, therefore, represents clusters of individuals with similar ratings. The results of the Q-factor analysis solution yielding five factors accounted for a substantial proportion of the variance. This solution further confirmed what the correlations among the prototypes revealed: there are interrelationships between the psychodynamic psychotherapy, child-centered play therapy, and RFP-C process prototypes and few overlaps between the RFP-C and CBT process prototypes. As in a prior study (Goodman et al., 2016), reflective functioning expert ratings were spread across factors predominated by CBT and child-centered play therapy experts. The RF process was the only prototype that behaved in this way, suggesting that it is unique in its versatility across therapeutic paradigms. These findings provide further support for RF as a common factor in the psychotherapy process. It was surprising that RF experts did not load onto the same factors as the psychodynamic therapy and RFP-C expert clinicians, especially given the fact that the reflective functioning process prototype was correlated with both the psychodynamic and the RFP-C process prototypes.

This finding suggests that, even though RFP-C and RF are highly correlated with each other, they still represent two distinct therapy processes. It may be, as Goodman (2013) and Hoffman (2015) have suggested, that whereas reflective functioning is part of any good empathic technique, it is not the most salient common factor at work in RFP-C. It is also possible that RFP-C is a psychotherapeutic approach that activates the more affective and implicit aspects of mentalization but not the more cognitive components that are closely linked with theory of mind.

We hypothesized that the RFP-C psychotherapy process prototype would be associated with the psychodynamic and child-centered play therapy prototypes but not with the CBT process prototype. These hypotheses were based on the theoretical foundation of RFP-C as a wholly psychodynamic approach and the fact that it has been promoted as an alternative to current CBT approaches for disruptive and externalizing behaviors (e.g., parent management training). As expected, the RFP-C process prototype was associated with the psychodynamic and child-centered play therapy process prototypes; there was no demonstrated relationship between the RFP-C and CBT process prototypes, thus providing support for the second and third hypotheses. Post hoc analyses further highlighted that RFP-C is linked with the psychodynamic therapy, child-centered play therapy, and RF process prototypes and distinct from the CBT process prototype. This finding supports the idea that RFP-C is a treatment approach that integrates aspects of psychodynamic theory and play therapy and emphasizes emotion regulation through iterative exploration of underlying affects and motivations for behavior, also described as RF (Hoffman et al., 2016).

As expected, RFP-C and CBT were also descriptively different. RFP-C emphasizes the therapist pointing out the use of defenses (item 36), tolerating the child's strong affect or impulses (item 45), the therapist's sensitivity to the child's feelings (item 6), and drawing attention to feelings regarded by the child as unacceptable (item 50). In contrast, the CBT process prototype emphasizes modifying distortions in the child's beliefs (item 57), helping the child to plan behavior outside the session (item 27), and the therapist behaving in a didactic manner (item 37). Notably, each of these three CBT

process prototype items were rated as least characteristic of RFP-C.

In addition, there were several items that distinguished RFP-C from the other four CPQ process prototypes. The following characteristics were unique to RFP-C: the therapist drawing attention to feelings regarded by the child as unacceptable, the child being provocative and challenging rules and boundaries, the child ignoring or rejecting the therapist's comments and observations, the therapist drawing attention to the end of the hour or other upcoming separation, and the child blaming others for difficulties. Some of these items are characteristic of the population RFP-C is intended to treat, children with disruptive and oppositional behaviors. RFP-C utilizes an experience-near approach, thus necessitating and implicitly encouraging provocative behaviors to occur in session with the therapist. This is in contrast to most CBT approaches for children that rely on parent and teacher report of the child's behavior at home and school, rather than focusing on in-session, experience-near phenomena.

The items rated as least characteristic of the RFP-C process—"therapist attempts to modify distortions in child's beliefs" (item 57); "child behaves in a dependent fashion (vs. insists on independence)" (item 80); and "therapist helps child manage feelings" (item 82)—were not identified as least characteristic of the other four CPQ process prototypes. These differences highlight some of the ways RFP-C is distinct from other forms of psychotherapy. Treatment grounded in RFP-C emphasizes that all behavior, especially disruptive behavior, has meaning. It would be counterproductive, from an RFP-C perspective, to actively modify a child's beliefs or even to characterize them as distorted. Rather, there is an emphasis on empathic understanding and recognizing that the child's perspective has developed within a particular ecosystem and as an adaptation to deficits in implicit emotion regulation (Hoffman, et al., 2016; Prout, Gaines, Gerber, Rice, & Hoffman, 2015; Rice & Hoffman, 2014). An RFP-C clinician is more interested in the expression of feelings than in their management or suppression. Children participating in RFP-C are very unlikely to behave in a dependent fashion because that is contrary to the nature of externalizing and oppositional problems. Expressing dependency would be too dysregulating for the

child, and it is this discomfort with vulnerability that necessitates the disruptive behavior as a defense against such feelings.

The fourth study hypothesis, that the reflective functioning process would be positively correlated with the RFP-C process prototype, was supported. This finding adds further support for mentalization as a common factor across child psychotherapy treatment models (see Bateman & Fonagy, 2004; Goodman, 2013; Goodman et al., 2016). Therapists and therapies that build reflective functioning capacities are characterized by curiosity and a not-knowing stance that encourage mentalization (Swenson & Choi-Kain, 2015). The RF prototype items identified as most characteristic of RFP-C were as follows: "Therapist is sensitive to the child's feelings" (item 6), "therapist accurately perceives the therapeutic process" (item 28), "therapist comments on changes in child's mood or affect" (item 79), "therapist makes links between child's feelings and experience" (item 76), and "interruptions, breaks in the treatment, or termination of therapy are discussed" (item 75). The first two items may be, more broadly, associated with psychotherapy in general (Wampold, 2010). The second two—focusing on changes in affect and explicitly talking about interruptions in treatment—represent opportunities for the therapist to maintain a curious stance, invite the child to mentalize, and for the child and therapist to engage in reflective functioning together. Each of these four items is highlighted as critical to RFP-C in the original treatment manual (Hoffman et al., 2016). In addition, activating parental RF (as in Slade, 2005) is a key component of the parent work in RFP-C.

There are several study limitations that should be noted. Only three expert clinicians participated in developing the RFP-C prototype. Additionally, it is not yet clear whether the RFP-C prototype corresponds with what happens in actual sessions of RFP-C. Although the RFP-C prototype proved to be remarkably distinct from the CBT prototype, these distinctions may not be manifest in a comparison of actual sessions. Additionally, the results may be limited by the nonspecific nature of the CPQ items themselves. Admittedly, these items were not designed to capture psychotherapy processes specific to RFP-C. In the present study, it was shown that the CPQ could meaningfully distin-

guish prototypical RFP-C from CBT and still identify shared processes associated with the reflective functioning process prototype.

Future research could compare the prototype of RFP-C with a mentalization-based therapy for children (Midgley & Vrouvra, 2013) to distinguish the two paradigms from each another and see what points of connection and overlap exist. It will also be important to investigate adherence to the RFP-C model by using video of actual sessions and coding them with the CPQ. The current RFP-C manual presents adherence scales that reflect theoretically derived standard practices for sessions; however, these adherence scales assess whether the therapist has established fidelity to the content of the treatment model (i.e., recommended intervention strategies). The RFP-C process prototype, on the other hand, defines the psychotherapy process in a prototypical RFP-C session. The two instruments have different objectives and could be used in conjunction with each other in the treatment process and outcome studies. Process research could also examine the role of the reflective functioning process prototype within RFP-C to identify mechanisms of change that may be universal to effective treatment.

A vital next step in this program of research will be to identify which items on the CPQ are associated with positive outcomes in RFP-C treatment. As Ablon and Marci (2004) have argued, the future of psychotherapy research will benefit from an emphasis on psychotherapy process over simple symptom reduction. Adherence scales are designed only to assess interventions in isolation from other treatment processes. Prototypes like the ones detailed here allow psychotherapy researchers to identify the most and least salient aspects of therapeutic intervention. Future RFP-C research will benefit from use of the CPQ prototype to identify elements of the treatment that are uniquely psychodynamic and those that are shared with other treatment approaches.

Conclusions

In summary, it is possible, using a validated process measure, for expert clinicians to reach consensus on a prototypical session of RFP-C. The RFP-C process prototype shares some commonalities with psychodynamic therapy and child-centered play therapy process prototypes

and exhibits key differences in contrast with the CBT process prototype. The fact that expert clinicians identified an emphasis on promoting reflective functioning process in RFP-C provides further evidence that RF is a common factor across a wide range of child psychotherapy approaches. This study also offers an internally valid method for assessing treatment adherence to RFP-C. The CPQ can be utilized in the future to determine whether therapists are adhering to an RFP-C paradigm or integrating aspects of other treatment approaches into the therapeutic work. Some treatment outcome studies (e.g., Levy et al., 2006) have suffered from unknown treatment adherence and others (e.g., Giesen-Bloo et al., 2006) have been criticized for using inadequate adherence measures (Yeomans, 2007). Use of the RFP-C CPQ prototype could easily assess fidelity and adherence in future outcome studies of RFP-C.

References

- Abbass, A. A., Rabung, S., Leichsenring, F., Refseth, J. S., & Midgley, N. (2013). Psychodynamic psychotherapy for children and adolescents: A meta-analysis of short-term psychodynamic models. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*, 863–875. <http://dx.doi.org/10.1016/j.jaac.2013.05.014>
- Ablon, J. S., & 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. <http://dx.doi.org/10.1080/10503309812331332207>
- Ablon, J. S., & Marci, C. (2004). Psychotherapy process: The missing link: Comment on Westen, Novotny, and Thompson-Brenner (2004). *Psychological Bulletin*, *130*, 664–668. <http://dx.doi.org/10.1037/0033-2909.130.4.664>
- Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in Clinical Practice*. Washington, DC: American Psychiatric Publishing, Inc.
- Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, *18*, 36–51. <http://dx.doi.org/10.1521/pedi.18.1.36.32772>
- Block, J. (1978). *The Q-sort method in personality assessment and psychiatric research*. Palo Alto, CA: Consulting Psychologists. (original work published 1961)
- Bo, S., Sharp, C., Beck, E., Pedersen, J., Gdondan, M., & Simonsen, E. (2016). First empirical evaluation of outcomes for mentalization-based group therapy for adolescents with BPD. *Personality*

- Disorders*, 8, 396–401. <http://dx.doi.org/10.1037/per0000210>
- Dimaggio, G., & Lysaker, P. H. (2015). Metacognition and mentalizing in the psychotherapy of patients with psychosis and personality disorders. *Journal of Clinical Psychology*, 71, 117–124. <http://dx.doi.org/10.1002/jclp.22147>
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy: Theory, Research, & Practice*, 48, 43–49. <http://dx.doi.org/10.1037/a0022187>
- Eresund, P. (2007). Psychodynamic psychotherapy for children with disruptive disorders. *Journal of Child Psychotherapy*, 33, 161–180. <http://dx.doi.org/10.1080/00754170701431347>
- Fonagy, P. (2003). The research agenda: The vital need for empirical research in child psychotherapy. *Journal of Child Psychotherapy*, 29, 129–136. <http://dx.doi.org/10.1080/0075417031000138406>
- Fonagy, P., Sled, M., & Baradon, T. (2016). Randomized controlled trial of parent-infant psychotherapy for parents with mental health problems and young infants. *Infant Mental Health Journal*, 37, 97–114. <http://dx.doi.org/10.1002/imhj.21553>
- Fonagy, P., & Target, M. (1996). Predictors of outcome in child psychoanalysis: A retrospective study of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44, 27–77. <http://dx.doi.org/10.1177/000306519604400104>
- Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., . . . Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: Randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry*, 63, 649–658. <http://dx.doi.org/10.1001/archpsyc.63.6.649>
- Gilboa-Schechtman, E., Foa, E. B., Shafraan, N., Aderka, I. M., Powers, M. B., Rachamim, L., . . . Apter, A. (2010). Prolonged exposure versus dynamic therapy for adolescent PTSD: A pilot randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 1034–1042. <http://dx.doi.org/10.1016/j.jaac.2010.07.014>
- Goodman, G. (2005). Empirical evidence supporting the conceptual relatedness of object representations and internal working models. *Journal of the American Psychoanalytic Association*, 53, 597–617.
- Goodman, G. (2013). Is mentalization a common process factor in transference-focused psychotherapy and dialectical behavior therapy sessions? *Journal of Psychotherapy Integration*, 23, 179–192.
- Goodman, G. (2015). Interaction structures between a child and two therapists in the psychodynamic treatment of a child with borderline personality disorder. *Journal of Child Psychotherapy*, 41, 141–161. <http://dx.doi.org/10.1080/0075417X.2015.1048124>
- Goodman, G., & 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, 311–326. <http://dx.doi.org/10.1080/0075417X.2011.614749>
- Goodman, G., Midgley, N., & Schneider, C. (2016). Expert clinicians' prototypes of an ideal child treatment in psychodynamic and cognitive-behavioral therapy: Is mentalization seen as a common process factor? *Psychotherapy Research*, 26, 590–601. <http://dx.doi.org/10.1080/10503307.2015.1049672>
- Goodman, G., Reed, P., & Athey-Lloyd, L. (2015). Mentalization and play therapy processes between two therapists and a child with Asperger's disorder. *International Journal of Play Therapy*, 24, 13–29. <http://dx.doi.org/10.1037/a0038660>
- Hoffman, L. (2015). Mentalization, emotion regulation, countertransference. *Journal of Infant, Child, and Adolescent Psychotherapy*, 14, 258–271. Presented at Wondering and Imagining: Mentalization in Clinical Practice. Section II of Division 39 of the American Psychological Association.
- Hoffman, L., Rice, T. R., & Prout, T. A. (2016). *Manual of Regulation-Focused Psychotherapy for Children (RFP-C) with externalizing behaviors: A psychodynamic approach*. New York, NY: Routledge.
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research, & Practice*, 48, 9–16. <http://dx.doi.org/10.1037/a0022186>
- Jones, E. E. (1985). *Manual for the psychotherapy process Q-set*. Unpublished manuscript, University of California, Berkeley, California.
- Jones, E. E. (2000). *Therapeutic action: A guide to psychoanalytic therapy*. Northvale, NJ: Jason Aronson.
- Katznelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review*, 34, 107–117. <http://dx.doi.org/10.1016/j.cpr.2013.12.003>
- Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19, 418–428. <http://dx.doi.org/10.1080/10503300802448899>
- Laezer, K. L. (2015). Effectiveness of psychoanalytic psychotherapy and behavioral therapy treatment in children with Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. *Journal of Infant, Child, and Adolescent Psychotherapy*, 14, 111–128. <http://dx.doi.org/10.1080/15289168.2015.1014991>

- Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 74*, 1027–1040. <http://dx.doi.org/10.1037/0022-006X.74.6.1027>
- McLeod, B. D., Islam, N. Y., & Wheat, E. (2013). Designing, conducting, and evaluating therapy process research. In J. Comer & P. Kendall (Eds.), *The Oxford handbook of research strategies for clinical psychology* (pp. 142–164). New York, NY: Oxford University Press. <http://dx.doi.org/10.1093/oxfordhb/9780199793549.013.0009>
- Midgley, N. (2007). Researching the process of psychoanalytic child psychotherapy. In E. Kennedy & N. Midgley (Eds.), *Process and outcome research in child, adolescent and parent-infant psychotherapy: A thematic review* (pp. 8–53). London, UK: North Central London Strategic Health Authority.
- Midgley, N., Anderson, J., Grainger, E., Vuckovic-Nesic, T., & Urwin, C. (Eds.). (2009). *Child psychotherapy and research: New approaches, emerging findings*. New York, NY: Routledge.
- Midgley, N., O’Keeffe, S., French, L., & Kennedy, E. (2017). Psychodynamic psychotherapy for children and adolescents: An updated narrative review of the evidence base. *Journal of Child Psychotherapy, 1*–23. <http://dx.doi.org/10.1080/0075417X.2017.1323945>
- Midgley, N., & Vrouva, I. (Eds.). (2013). *Minding the child: Mentalization-based interventions with children, young people and their families*. New York, NY: Routledge.
- Palmer, R., Nascimento, L. N., & Fonagy, P. (2013). The state of the evidence base for psychodynamic psychotherapy for children and adolescents. *Child and Adolescent Psychiatric Clinics, 22*, 149–214. <http://dx.doi.org/10.1016/j.chc.2012.12.001>
- Prout, T. A., Gaines, E., Gerber, L. E., Rice, T., & Hoffman, L. (2015). The development of an evidence-based treatment: Regulation-Focused Psychotherapy for Children with externalising behaviours (RFP-C). *Journal of Child Psychotherapy, 41*, 255–271. <http://dx.doi.org/10.1080/0075417X.2015.1090695>
- Rice, T. R., & Hoffman, L. (2014). Defense mechanisms and implicit emotion regulation: a comparison of a psychodynamic construct with one from contemporary neuroscience. *Journal of the American Psychoanalytic Association, 62*, 693–708.
- Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*, 1304–1313.e3. <http://dx.doi.org/10.1016/j.jaac.2012.09.018>
- Schneider, C. (2003). *The development of the Child Psychotherapy Q-set* (Unpublished doctoral dissertation). University of California, Berkeley, CA.
- Schneider, C., & Jones, E. E. (2009). *Child Psychotherapy Q-Set coding manual*. Unpublished manuscript, University of California, Berkeley, CA.
- Schneider, C., Midgley, N., & 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*(2–3), 94–107. <http://dx.doi.org/10.1080/15289168.2010.510979>
- Schneider, C., Pruetzel-Thomas, A., & Midgley, N. (2009). Discovering new ways of seeing and speaking about psychotherapy process: The Child Psychotherapy Q-Set. In N. Midgley, J. Anderson, E. Grainger, T. Nestic-Vuckovic, & C. Urwin (Eds.), *Child psychotherapy and research: New approaches, emerging findings* (pp. 72–84). New York, NY: Routledge.
- Shirk, S. R., & Russell, R. L. (1996). *Change processes in child psychotherapy: Revitalizing treatment and research*. New York, NY: Guilford Press.
- Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*, 269–281. <http://dx.doi.org/10.1080/14616730500245906>
- Swenson, C. R., & Choi-Kain, L. W. (2015). Mentalization and dialectical behavior therapy. *American Journal of Psychotherapy, 69*, 199–217.
- Wampold, B. E. (2010). The research evidence for the common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, M. A. Hubble, (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 49–81). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/12075-002>
- Yeomans, F. (2007). Questions concerning the randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry, 64*, 609–610. <http://dx.doi.org/10.1001/archpsyc.64.5.609-c>

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