

# Mentalization and Play Therapy Processes Between Two Therapists and a Child With Asperger's Disorder

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*The British Association of Play Therapists (BAPT) provides a definition of play therapy (PT) that emphasizes humanistic ideals such as using nondirective play techniques to enable the child's inner resources to bring about growth and change. These therapeutic change processes have never been submitted to empirical testing, partly because of the paucity of valid, reliable instruments to assess child psychotherapy process. Identifying empirically supported change processes is crucial to discovering which change processes work for which child. For example, children with Asperger's disorder have deficits in mentalization—the ability to interpret behaviors of self and others as motivated by underlying mental states. Would a mentalization-informed PT approach or a traditional PT approach be more effective in treating such patients? The Child Psychotherapy Q-Set (CPQ) is a 100-item instrument that assesses the processes within a psychotherapy session. Items reflect a wide range of therapist attitudes and behaviors, patient attitudes and behaviors, and interactions between therapist and patient. To characterize PT process, 24 BAPT play therapists were asked to use the CPQ to rate the prototypical PT session based on their knowledge of PT operationalized by the BAPT definition. Findings indicated that according to these 24 raters, a therapist who is sensitive to the child's feelings and level of development characterizes British PT. Two therapists treating a child with Asperger's disorder over 2 years decreased their session adherence to PT*

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*while maintaining their session adherence to mentalization processes. The CPQ enables empirical treatment comparisons with the PT definition of American play therapists.*

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Play therapy (PT) is widely used to treat children's emotional and behavioral problems and is typically recommended for children ages 3 to 12 because they have not yet fully developed a capacity for abstract thought. Abstract thought is needed to express one's intentions, feelings, and thoughts linguistically. To account for their developmental level, children in PT use toys, art supplies, and sensory media such as clay and sand to communicate through action rather than words their thoughts, feelings, and experiences (Axline, 1947; Bratton, Ray, Rhine, & Jones, 2005; Kottman, 2001; Landreth, 2012; O'Connor, 2001; Schaefer, 2001). Two meta-analyses support the efficacy of PT in treating children with both externalizing and internalizing problems (Bratton et al., 2005; Leblanc & Ritchie, 2001).

## DEFINITIONS OF PT

The [British Association of Play Therapists \(1996; BAPT\)](#) website (BAPT Code of Ethics and Practice) defines PT as

the dynamic process between child and Play Therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that are effecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centred, in which play is the primary medium and speech is the secondary medium. Play Therapy encompasses many approaches but the foundation of all approaches is child-centred.

In the United States, the [Association for Play Therapy's \(n.d.; APT\)](#) website (Play Therapy Makes a Difference) defines PT as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Both definitions emphasize the relationship between the play therapist and child as well as the medium of play as central to the process of therapeutic change. What other features of PT are considered therapeutic by therapists in the field?

PT in the United Kingdom originated from the work of [Melanie Klein \(1923\)](#) and [Anna Freud \(1927\)](#), who, in their child therapy, used play in recognition of the restrictions of verbal interactions with young children. The model of PT taught and practiced by BAPT, however, is heavily influenced by humanistic psychology, specifically by person-centered therapy developed by [Carl Rogers \(1980\)](#). Virginia Axline, who was herself a student of Rogers, developed an approach to PT defined by person-centered principles and described in her account of her child patient, Dibs ([Axline, 1964](#)). These principles have since been revised and extended by [Landreth \(2012; see also BAPT, n.d.\)](#).

A child-centered play therapist does not interpret back to the child his or her play, as Klein or Freud might have done, but rather keeps the play "in the metaphor," not challenging the symbolism of the child's play. The therapist engages the child in his or

her play, and difficult feelings are expressed and safety maintained by symbolic distance. The subtleties of expression out of reach for many children in verbal communication can be communicated through play. In pretend play, the child straddles the two worlds of internal and external realities, bridging the perceptual and the imaginary. The therapist needs to stay attuned to the child and attend to his or her communications as a “total activity” (Wilson & Ryan, 2000, p. 54). Dissociated self-states can be expressed symbolically through their enactment or through projective play. Play therapists use play and playfulness as a way of encountering (engaging and connecting with) the child and play as a means of harnessing creativity to find meaning and develop resilience. By using symbolic expression, children feel safer to reveal difficult feelings to others (and often to themselves) and experience self-understanding (BAPT, n.d.; Reed, 2012).

## STUDYING CHILD PSYCHOTHERAPY PROCESS

Schaefer and Drewes (Schaefer, 1993; Schaefer & Drewes, 2009, 2011) identified 25 “therapeutic powers of play,” a compendium of desirable therapeutic change processes. Schaefer (2011b) presented 17 different treatment models of PT that included empirical support for the effectiveness of each treatment model. Can all 17 treatment models be equally effective in producing desirable treatment outcomes? Might some treatment models promote these therapeutic powers of play more frequently than others or promote some therapeutic powers of play at the expense of others? Which therapeutic powers of play are effective for which patients?

In fact, surprisingly little research has been published exploring exactly *how* child treatment models work. Whereas there is increasing evidence in adult psychotherapy that there are distinct therapeutic processes in cognitive-behavioral therapy (CBT) and psychodynamic therapy (PDT; e.g., Blagys & Hilsenroth, 2000, 2002; Goodman, 2010b), Shirk and Russell (1996) found that between 1946 and 1993, child psychotherapy process research studies were published, on average, less than once every 2 years. To help address this limitation, Schneider and Jones (Schneider, 2004; Schneider & Jones, 2004) developed the Child Psychotherapy Process Q-Set (CPQ), which permits the study of child psychotherapy process within a 45-min session. Independent raters view a video-recorded child psychotherapy session and rate the 100 CPQ items on a forced-choice 9-point scale to characterize the process between the therapist and child. Therapists and researchers alike can use the CPQ to identify those therapeutic processes most strongly correlated with treatment outcomes, regardless of the treatment model used. Child psychotherapy process research can thus move beyond brand names of psychotherapy (Ablon, Levy, & Katzenstein, 2006) to identify empirically supported processes within these treatment models that actually produce change.

## MENTALIZATION AND PT PROCESSES

In addition to identifying change processes unique to a particular treatment model, the CPQ can aid in identifying change processes that underlie various treatment models. Known as common factors, these processes represent the nec-

essary conditions for effective psychotherapy such as Rogers's genuineness, empathy, and unconditional positive regard (Rogers, 1957). Allen, Fonagy, and Bateman (2008) suggested that enhancing mentalization is a common process factor inherent to all effective treatment models. There is preliminary evidence from adult process research (e.g., Goodman, 2013; Katznelson, 2014) and child process research (Goodman, Midgley, & Schneider, 2014) to support this conjecture. Fonagy, Steele, Steele, Moran, and Higgitt (1991) operationalized the construct of mentalization as reflective functioning (RF), defined as the ability to interpret the behaviors of self and others as motivated by their underlying mental states (e.g., feelings, beliefs, intentions, desires).

Fonagy and Target (2000) highlighted three aspects to enhancing mentalization in child therapy: (a) enhancing reflective processes, (b) providing opportunities for play, and (c) working in the transference (see also Bleiberg, Fonagy, & Target, 1997). Zevalkink, Verheugt-Pleiter, and Fonagy (2012) later expanded on these three aspects to enhancing mentalization in child therapy. First, the therapist can comment on the mental content of the play characters. The therapist can also comment on the mental content that the therapist infers from the child's behavior or play, or an alternative mental content not already available to the child. Second, the therapist can identify mental states as motivators of the child's behavior or play. The therapist can also verbalize the wishes or intentions of the play characters or significant others in the child's life, such as parents, or reflect on the uniqueness of the child's mental world.

PT processes are inherent to mentalization-based therapy (MBT) processes for children, but there are differences. As described earlier, PT processes in the United Kingdom focus on facilitating the child's self-exploration and restoration of healthy emotional development. MBT for children is play-based but focuses specifically on enhancing reflective processes in the child's perceptions of self and others. An MBT child therapist might conclude that effective child psychotherapy is PT plus something more: the enhancement of a child's mind-reading ability—both his or her own mind and others' minds.

Effective psychotherapy processes that underlie a given treatment model might differ from the processes theoretically predicted by the literature. For example, enhancing mentalization could be an effective change process of CBT alongside—or even as a substitute for—changing distorted cognitions. Moreover, enhancing mentalization could be an effective change process of PT alongside—or even as a substitute for—promoting self-exploration and the restoration of healthy emotional development. Several studies have viewed mentalization as a treatment outcome variable (for a review, see Barber, Muran, McCarthy, & Keefe, 2013), but no study to date has studied mentalization as a fluid process of psychotherapy over time.

## MENTALIZATION PROCESSES AND AUTISM SPECTRUM DISORDER

Mentalization is a particularly relevant process factor to study in children with autism spectrum disorder. Mind-blindness (Baron-Cohen, 1990, 2004) is a condition

associated with Asperger's disorder, which is classified as high functioning on the autism spectrum (see *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000). Asperger's disorder has since been reclassified as autism spectrum disorder in the fifth edition of the *DSM* (*DSM-5*; APA, 2013) in which the individual experiences deficits in empathizing with others' intentions (i.e., attributing mental states to one's own and others' behavior and generally reading other persons' minds). Thus, a treatment model that includes a focus on enhancing mentalization (or mind-sightedness) would be ideally suited to children with autism spectrum disorder such as Asperger's disorder (APA, 2000).

MBT models for children have their origins in psychoanalytic theory (Fonagy & Target, 2000; Midgley & Vrouva, 2012; Perepletchikova & Goodman, in press; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008; Zevalkink et al., 2012). Although no case study of MBT for children on the autism spectrum has been published, there is a modest, but growing, number of published case studies of effective PDT for adults (Polmear, 2004) and children (Bromfield, 2000; Josefi & Ryan, 2004; Olesker, 1999; Pozzi, 2003; Shulman, 2004; Topel & Lachmann, 2008) with a diagnosis of Asperger's disorder. The use of displacement in mentalization-informed PT might be beneficial, because children with Asperger's disorder have a greater capability for theory of mind than children with more severe autism (Dissanayake & MacIntosh, 2003). This work is quite new, however, and therefore lacks empirical validation. The current study describes an empirical investigation of the mentalization process (operationalized as RF) in PT with a 6-year-old boy diagnosed with Asperger's disorder (before the *DSM-5* was published). We wanted to identify the relative prominence of PT process and RF process between two therapists working consecutively with one child across a 2-year time span through the use of a valid and reliable measure of child psychotherapy process.

The purpose of the current study is twofold: First, we want to present the most and least characteristic features of a prototypically conducted therapy session using PT process and a prototypically conducted therapy session using RF process; second, we want to use these prototypes to determine the relative prominence of PT process and RF process in a mentalization-informed PT conducted with a child diagnosed with Asperger's disorder (APA, 2000), in which the first therapist had to end her work with the child after 1 year. Coding the psychotherapy sessions using the CPQ permitted the calculation of correlation coefficients with these prototypes that provided two distinct measures of session adherence.

### HYPOTHESES TESTED IN THIS STUDY

*Hypothesis 1:* It was hypothesized that, using the CPQ, the PT process prototype would be positively correlated with the PDT prototype.

*Hypothesis 2:* It was hypothesized that the PT process prototype would be positively correlated with the RF process prototype.

*Hypothesis 3:* As both therapists of the child diagnosed with Asperger's disorder were in training and receiving mentalization-informed PT supervision at

the time of the treatment (see Therapists section), it was hypothesized that each therapist's method of treatment would become increasingly similar to the RF process prototype and less similar to the PT process prototype over time.

*Hypothesis 4:* It was hypothesized that session adherence to the PT and RF process prototypes would not significantly differ between the two therapists.

*Hypothesis 5:* It was hypothesized that session adherence to the RF process prototype would be more prominent across both years of treatment than session adherence to the PT process prototype.

## METHOD

### Play Therapist Raters Used in Establishing the CPQ PT Prototype

An e-mail invitation was originally sent to 243 play therapists registered with the BAPT. Play therapists were asked to complete a questionnaire version of the CPQ. Raters were requested to sort the 100 CPQ items relevant to psychotherapy process—as they see this process occurring within a prototypical child psychotherapy session from their theoretical perspective.

Thirty-one of the 243 contacted play therapists responded. Two reminder e-mail messages were also sent. In addition, the second author attended a PT support group to attract further respondents. These 31 raters were asked to rate the prototypical PT session based on their knowledge of PT as operationalized by the BAPT definition. Raters were asked to rate each of the 100 items on a Likert-type scale from  $-4$  (*most uncharacteristic of a prototypically conducted therapy session within their treatment model*) to  $+4$  (*most characteristic of such a session*). A rating of "0" indicates that the item is *neither characteristic nor uncharacteristic or not applicable*. Raters were also asked to complete a brief survey of their professional experiences. The raters' prototypical CPQ ratings were composited, converted to  $z$  scores, and used in all statistical analyses. The procedure for constructing the RF process, PDT, and CBT prototypes is described elsewhere (Goodman et al., 2014).

In total, 24 completed CPQ questionnaires were returned (9.88% response rate). Twenty-two respondents (91.67%) were female. All raters were highly qualified, having worked as play therapists between 2.5 and 25 years ( $M = 12$  years). The majority of raters described their theoretical orientation as "child-centered" or "nondirective." Only one rater (4.17%) reported that the CPQ items were "not relevant" to a PT practice (Reed, 2012). All other raters used in this study (i.e., those used to construct the PDT, CBT, and RF process prototypes) are described elsewhere (Goodman et al., 2014).

### Therapists

This study took place in a university-based community mental health clinic. Both therapists who took part in this study were second-year clinical psychology



doctoral students enrolled in the same doctoral program and participating in weekly mentalization-informed PT supervision conducted by the same experienced child clinical psychologist. The first therapist, who treated the child during the first year, was female. The second therapist, who treated the child during the second year, was male. Both were of European American background. The same experienced child clinical psychologist (also European American) supervised both student therapists. Both therapists also consented for the videos of their treatments to be viewed and coded for the present study.

### Client

The child, Stepney (a pseudonym), began therapy as a 6-year-old in the first grade. He received a *DSM-IV-TR* (APA, 2000) diagnosis of Asperger's disorder at this age by his first therapist and her clinical supervisor. Stepney lived with his biological parents and a typically developing biological brother who was 2 years younger. Both parents were upper-middle-income professionals who appeared to love each other and their two sons. Stepney presented with behavioral and social difficulties. Behavioral difficulties included difficulty following directions and routines at school, and social difficulties included failure to initiate contact or sustain interactions with peers. Stepney also manifested perseverative interests in certain TV shows and films (i.e., endlessly repetitive views of a particular children's cartoon). He had a history of developmental delay in several areas, including speech and gross motor coordination. Despite these delays, he appeared to be a highly intelligent child, capable of symbolic thinking. He engaged spontaneously in nondirective fantasy play, although often in connection with themes or characters from his perseverative interests. Although diagnosed with Asperger's disorder, Stepney was deemed suitable for mentalization-informed PT. He participated in weekly 45-min sessions across a 2-year time span. Stepney's assent and his parents' signed informed consent were obtained before videotaping his sessions.

Anecdotally, Stepney's treatment outcome was moderately successful. The therapists' and supervisor's impressions of Stepney's therapeutic gains are that throughout the course of treatment, Stepney became less impulsive and more tolerant of therapeutic interactions. In particular, Stepney's storytelling and symbolic play became not only more flexible but also less scripted and reliant on external sources (such as certain TV shows) that had initially served as perseverative material. Notably, Stepney permitted himself to feel the loss of both therapists at termination. In spite of these advances, Stepney still demonstrated social awkwardness and some affective restriction in and out of sessions at the end of these 2 years, as observed by his therapist, parents, and school teacher.

### Treatment

Annually rotating, clinical psychology doctoral students work under close supervision at this low-cost, university-based community mental health clinic located in a suburb of New York City. The treatments under study were conducted

in the clinic playroom, which is stocked with a large number of toys suitable for mentalization-informed PT.

### **Measure: The Child Psychotherapy Q-Set (CPQ)**

The CPQ is a new and recently validated measure, adapted for use with children from the adult-focused Psychotherapy Process Q-Set (PQS; Jones, 2000). The 100 items were gleaned from a review of the child psychotherapy literature across theoretical orientations. A series of progressive pilot studies guided the reformulation of the items until the measure was validated successfully for 3- to 13-year-old children of diverse symptomatology, ethnicity, and socioeconomic status. Expert therapists carefully rated all 100 items according to their perceived face validity and relevance to child therapy. Pilot testing verified the measure's clinical validity, item validity, and discriminant validity (Schneider, 2004). Coders, regardless of theoretical orientation, reached consistent interrater reliability (intraclass correlation [ICC] ranging from .55 to .89) on child therapy session videotapes (Goodman, 2014; Goodman & Athey-Lloyd, 2011; Schneider, 2004).

As with the PQS, the CPQ captures three domains of therapeutic process: therapist attitudes, behavior, feelings, and experience; child attitudes, behavior, feelings, and experience; and the nature or climate of the dyadic interaction. After watching a videotape of a 45-min session, raters sort the 100 items into nine piles in a forced-choice (ipsative) procedure ranging from most uncharacteristic (Pile 1) to most characteristic (Pile 9). The ipsative procedure used in Q-sort methodology forces raters to place items in a normal distribution that characterizes both high and low ends of a construct, with the majority of items placed centrally and increasingly fewer items placed toward each extreme.

The authors of the CPQ made every effort during its development to reduce the subjectivity of the items, instead directing coders to base their choices on observable behaviors. The language of the items is accessible to both researchers and therapists. The design of the items demonstrates variability across sessions and across patients without significantly overlapping with other items.

Outcome research has typically focused on a comparison of "brand-name" therapies (Shirk & Russell, 1996); however, process research seeks to understand qualitatively what essential ingredients compose these brand names. In this study, we used the CPQ to define PT process and RF process prototypes and to assess session adherence to the PT process, RF process, PDT, and CBT prototypes across both treatments.

### **Procedure**

The coders viewed 54 available video-recorded treatment sessions and coded them using the 100 CPQ items. Technical difficulties with video-recording eliminated one session from coding. The coders consisted of eight trained clinical psychology doctoral students who were blind to the diagnosis of the patient and the hypotheses of this study; they Q-sorted practice videos until



interrater reliability consistently reached an ICC of .70. When this benchmark was established, the coders were paired into teams of two and independently Q-sorted the sessions ( $N = 53$ ) from the videotapes in a randomized order. After watching each session, the coders selected the most characteristic and least characteristic processes of the session, placing them into a forced distribution of nine piles. The four coding teams achieved a mean interrater reliability of  $ICC = .77$  (range = .55 to .89). Two independent coders thus made CPQ ratings of each session. These two sets of ratings were then composited by adding them together and dividing by 2. Thus, 53 composited CPQ ratings characterized the psychotherapy process of 53 sessions. The institutional review boards of Long Island University and the University of Roehampton, England, approved this study.

## RESULTS

### Cronbach's Alpha Coefficients Among the PT and RF Therapist Raters

Cronbach's alpha coefficient (used to test the level of agreement on what constitutes a prototypical psychotherapy session among the therapist raters of PT process) was high:  $\alpha = .96$  for the 24 PT therapist raters. These findings indicate that therapist raters within this group shared highly similar conceptualizations of a prototypically conducted therapy session within the PT treatment model. Cronbach's alpha coefficients for the other four prototypes were as follows: RF process,  $\alpha = .91$ ; PDT process,  $\alpha = .95$ ; and CBT process,  $\alpha = .94$  (see Goodman et al., 2014).

### Most and Least Characteristic CPQ Items for PT and RF Process Prototypes

Tables 1 and 2 display two lists of the most characteristic and least characteristic CPQ items for the PT and RF process prototypes. Notably, four CPQ items were listed as most characteristic of both the PT and RF process prototypes: "Therapist is sensitive to the child's feelings" (Item 6), "Therapist's interaction with child is sensitive to child's level of development" (Item 77), "Interruptions, breaks in the treatment, or termination of therapy are discussed" (Item 75), and "Therapist accurately perceives the therapeutic process" (Item 28). Seven CPQ items were listed as least characteristic of both the PT and RF process prototypes: "Therapist directly rewards desirable behaviors" (Item 55), "Therapist is nonresponsive (vs. affectively engaged)" (Item 9), "Therapist is judgmental and conveys lack of acceptance" (Item 18), "Therapist's emotional conflicts intrude into the relationship" (Item 24), "Child does not feel understood by therapist" (Item 41), "Child has difficulty understanding therapist's comments" (Item 5), and "Therapist is directly reassuring" (Item 66).

**Table 1.** Most and Least Characteristic CPQ Items for PT Prototype

CPQ #	CPQ item	Mean pile #
Most characteristic PT prototype		
<sup>a</sup> 6	T is sensitive to the C's feelings.	3.83
<sup>a</sup> 77	T's interaction with C is sensitive to C's level of development.	3.79
52	T makes explicit statements about the end of the hour, upcoming weekend, or holiday.	3.75
<sup>a</sup> 75	Interruptions, breaks in the treatment, or termination of therapy are discussed.	3.67
48	T sets limits.	3.63
45	T tolerates C's strong affect or impulses.	3.38
71	C engages in make-believe play.	3.29
<sup>a</sup> 28	T accurately perceives the therapeutic process.	3.21
4	There is discussion of why C is in therapy.	3.13
65	T clarifies, restates, or rephrases C's communication.	3.08
Least characteristic PT prototype		
<sup>b</sup> 55	T directly rewards desirable behaviors.	-3.71
<sup>b</sup> 9	T is nonresponsive (vs. affectively engaged).	-3.63
<sup>b</sup> 18	T is judgmental and conveys lack of acceptance.	-3.58
<sup>b</sup> 24	T's emotional conflicts intrude into the relationship.	-3.25
21	T self-discloses.	-2.79
<sup>b</sup> 41	C does not feel understood by T.	-2.71
<sup>b</sup> 5	C has difficulty understanding T's comments.	-2.50
37	T behaves in a didactic manner.	-2.50
17	T actively exerts control over the interaction.	-2.42
<sup>b</sup> 66	T is directly reassuring.	-1.75

*Note.* T = therapist; C = child; CPQ = Child Psychotherapy Q-Set; PT = play therapy; RF = reflective functioning.

<sup>a</sup> One of the most characteristic prototypical RF process CPQ items. <sup>b</sup> One of the least characteristic prototypical RF process CPQ items.

### Test of Hypotheses 1 and 2

The first two hypotheses tested were (a) the PT process prototype would be positively correlated with the PDT prototype, and (b) the PT process prototype would be positively correlated with the RF process prototype.

A correlation matrix of Spearman-Brown correlations was constructed (the Spearman-Brown correlation was used instead of the more common Pearson product-moment correlation, because the mathematical formula used in its calculation takes into account the fact that the item distributions were composited). **Table 3** indicates that the PT process prototype was significantly correlated with the RF process prototype ( $r = .76, p < .001$ ), the PDT prototype ( $r = .70, p < .001$ ), and the CBT prototype ( $r = .36, p < .001$ ).

In addition, post hoc tests determined whether there were any significant differences among these three correlations. The PT process prototype correlations with the PDT prototype and RF process prototype did not demonstrate a significant difference from each other,  $t(98) = .93, ns$ . The PT process prototype correlations with the PDT prototype and CBT prototype, however, did demonstrate a significant difference from each other,  $t(98) = 3.07, p < .01$ . Finally, the PT process prototype correlations with the RF process prototype and CBT prototype also demonstrated a significant difference from each other,  $t(98) = 4.95, p < .001$ . These findings suggest (a) that the PT process prototype is more highly correlated with the PDT and RF process prototypes than with the CBT

**Table 2.** Most and Least Characteristic CPQ Items for RF Process Prototype

CPQ #	CPQ item	Mean pile #
Most characteristic RF process prototype		
<sup>a</sup> 6	T is sensitive to C's feelings.	3.89
<sup>a</sup> 28	T accurately perceives the therapeutic process.	3.67
97	T emphasizes verbalization of internal states and affects.	3.67
<sup>a</sup> 77	T's interaction with C is sensitive to C's level of development.	3.56
38	T and C demonstrate a shared vocabulary or understanding when referring to events or feelings.	3.44
79	T comments on changes in C's mood or affect.	3.44
63	C explores relationships with significant others.	3.22
<sup>a</sup> 75	Interruptions, breaks in the treatment, or termination of therapy are discussed.	3.22
76	T makes links between C's feelings and experience.	3.22
Least characteristic RF process prototype		
<sup>b</sup> 18	T is judgmental and conveys lack of acceptance.	-3.89
<sup>b</sup> 9	T is nonresponsive (vs. affectively engaged).	-3.78
<sup>b</sup> 24	T's emotional conflicts intrude into the relationship.	-3.56
56	C is distant from his or her feelings.	-2.44
<sup>b</sup> 41	C does not feel understood by T.	-2.33
40	C communicates without affect.	-2.11
<sup>b</sup> 55	T directly rewards desirable behaviors.	-2.00
<sup>b</sup> 5	C has difficulty understanding T's comments.	-1.78
95	C's play lacks spontaneity.	-1.56
<sup>b</sup> 66	T is directly reassuring.	-1.56
44	C feels wary or suspicious.	-1.56

*Note.* T = therapist; C = child; CPQ = Child Psychotherapy Q-Set; RF = reflective functioning; PT = play therapy.

<sup>a</sup> One of the most characteristic prototypical PT CPQ items. <sup>b</sup> One of the least characteristic prototypical PT CPQ items.

prototype, and (b) that the PT process prototype significantly correlated equally with the PDT and RF process prototypes. The PT process prototype has more in common with the PDT and RF process prototypes than with the CBT prototype.

### Test of Hypotheses 3, 4, and 5

We next tested the hypothesis that each therapist's method of treatment would become increasingly similar to the RF process prototype and less similar to the PT process prototype as the year went on. As explained earlier, the CPQ's pantheoretical design permits the majority of items to capture both shared and distinct process characteristics typical of different theoretical orientations. PT and RF

**Table 3.** Spearman-Brown Correlations Among the Four CPQ Prototypes

	PDT	CBT	RF	PT
PDT	—			
CBT	.36*	—		
RF	.79*	.61*	—	
PT	.70*	.36*	.76*	—

*Note.* N = 100 CPQ items. PDT = psychodynamic therapy; CBT = cognitive-behavioral therapy; RF = reflective functioning; PT = play therapy.

\*  $p < .001$ .

process prototypes were developed based on the ideal session Q-sorted by therapist raters representing each treatment model (Goodman et al., 2014). We correlated the 53 CPQ session ratings across the two years of treatment with the PT and RF process prototypes to determine session adherence to each prototype. In both years of treatment, session adherence to RF process did not increase over time (RF process adherence,  $r = -.22$ , *ns*), and session adherence to PT process decreased over time (PT process adherence,  $r = -.38$ ,  $p < .01$ ). Therapist 1 also demonstrated higher session adherence to PT process than Therapist 2, whereas session adherence to RF process did not differ between them (PT process adherence,  $t[51] = 2.32$ ,  $p < .05$ ; RF process adherence,  $t[51] = 1.76$ , *ns*). Finally, a paired-samples *t* test between RF process session adherence and PT process session adherence indicated a significant mean difference,  $t(52) = 7.34$ ,  $p < .001$ . RF process session adherence was more prominent across both years of treatment than PT process session adherence.

## DISCUSSION

This study represents a first attempt at identifying the processes of therapeutic change that British play therapists consider most and least characteristic of a prototypically conducted therapy session within the PT treatment model. A therapist who is sensitive to the child's feelings and level of development and accurately perceives the therapeutic process characterizes British PT. In addition, the therapist simultaneously tolerates the child's strong affect or impulses while setting limits on the child's behavior. Therapist and child discuss the end of sessions and breaks in treatment. The child engages in make-believe play, understands the therapist's comments, and feels understood by the therapist. The therapist does not actively exert control over the interaction and is neither didactic nor judgmental. The therapist does not directly reward desirable behaviors nor provide direct reassurance. Finally, the therapist does not self-disclose nor allow his or her emotional conflicts to intrude into the therapeutic relationship. Unlike the theoretical definitions of PT provided by BAPT and APT, this definition is based on a common vocabulary of 100 statements used by 24 BAPT members to define the most and least characteristic PT processes. Future research is needed to correlate these processes with treatment outcomes (e.g., personality and symptom measures) to determine which processes are effective in treating children with which kinds of psychopathology.

This study also compared PT process characteristics with the characteristics of an increasingly popular therapeutic process—RF. The findings indicated that 11 of the 20 most and least characteristic CPQ items defining the PT process prototype overlap with the 20 most and least characteristic CPQ items defining the RF process prototype. Both kinds of therapeutic process emphasize therapist sensitivity and affective engagement, discussion of treatment breaks, and accurate therapist perception of the therapeutic process. Both also emphasize an absence of direct reassurance, rewards for desirable behavior, and judgment. None of the most characteristic items from one prototype appeared among the least characteristic items from the other prototype, and none of the least characteristic items from one

prototype appeared among the most characteristic items from the other prototype. Furthermore, a significant Spearman-Brown correlation between the two prototypes of  $r = .76$  ( $p < .001$ ) suggests that these two kinds of therapeutic process have many more similarities than differences. Therapists and researchers alike can simultaneously use both prototypes in treatment outcome studies to determine which kind of therapeutic process is more effective in treating children with which kinds of psychopathology. For example, PT emphasizing RF process might be more effective treating children with Asperger's disorder than PT as defined by BAPT play therapists. The establishment of these CPQ prototypes now makes it possible to answer these kinds of questions empirically.

As expected, the PT process prototype positively correlated with both the PDT and RF process prototypes; however, the PT process prototype correlations with the PDT and RF process prototypes were significantly different from the PT process prototype correlation with the CBT prototype. This finding suggests that the PT process prototype has more in common with the PDT and RF process prototypes than with the CBT prototype. Visual inspection of the CPQ items of the PDT (Goodman et al., 2014), PT, and RF process prototypes suggests a Rogerian thread running through them, emphasizing unconditional positive regard, empathy, and affective engagement, as well as reflecting back to the child his or her communications using the child's own linguistic mannerisms (Axline, 1947, 1964). By contrast, the CBT child therapist behaves in a didactic manner, helps manage the child's feelings, and attempts to modify distortions in the child's beliefs; the therapy session also has a specific focus or theme (Goodman et al., 2014). A thoughtful child therapist might prescribe (Schaefer, 2001, 2011a) one child with a particular diagnosis to PT because this child would be more likely to benefit from a nondirective approach. Another child with a different diagnosis might instead receive CBT because this child would be more likely to benefit from a directive approach. More research is needed to determine how to match different kinds of therapeutic processes to different kinds of psychiatric diagnoses and attachment classifications (see also Goodman, 2010a).

We believed that because the two student therapists were receiving clinical supervision in mentalization-informed PT with a child diagnosed with Asperger's disorder, their session adherence to the RF process prototype would increase over time, whereas their session adherence to the PT process prototype would decrease over time. Although session adherence to the PT process prototype did in fact decrease over time, session adherence to the RF process prototype did not increase over time, as expected. Although both therapists were doctoral students in clinical supervision, their knowledge of mentalization processes was quite sophisticated for their level of experience. The findings from the CPQ analysis suggest that they were both practicing mentalization-informed PT from the beginning of their respective treatments, with little room to grow in adherence. In other words, they had reached a ceiling effect as implicitly defined by the CPQ. Anecdotally, because of their high level of sophistication, both therapists were learning more advanced techniques in supervision, such as interpreting the patient's moment-by-moment facial expressions, behaviors, and tone of voice for clues about the transference and the patient's reactions to the therapist's verbal and behavioral interventions. Use of these advanced techniques in sessions might escape detection by the CPQ, which is a broad-based instrument designed to assess the psychotherapy process at a molar

level of investigation. Thus, both therapists might have improved in their clinical practice of mentalization-informed PT over time without detection by the CPQ.

It is also important to recognize that both therapists decreased their session adherence to PT process even though the clinical supervision they were receiving was mentalization-informed PT. The most plausible explanation is that the therapists were adjusting their interventions to “conditions on the ground” when they felt that the patient would benefit from a shift away from a traditional Rogerian approach. An awareness of the moment-to-moment shifts in the patient’s affect states from behavioral observations as well as countertransference reactions might contribute to an intuition to change course and focus instead on enhancing mentalization. Awareness of the level of instability and treatment phase (stabilization vs. exploration) is also crucial evidence used to decide which interventions to make. More research is needed to support the hypothesis that therapists tend to shift away from a traditional Rogerian approach, and instead continue practicing a mentalizing approach specifically with children with Asperger’s disorder, because they implicitly notice therapeutic changes with a mentalizing approach for this population and therefore want to continue doing what they perceive to be therapeutically effective.

Although prototypical RF process was more prominent in both treatments than prototypical PT process—suggesting that both treatments were conducted with an emphasis on mentalization processes rather than traditional Rogerian processes—Therapist 1 demonstrated higher session adherence to PT process than Therapist 2. This finding is meaningful because it demonstrates that different therapists can exert a differential impact on psychotherapy process with the same patient. Therapist effects on therapeutic processes are real and can therefore be leveraged to produce changes in the patient’s personality functioning and symptom expression.

## CONCLUSIONS

Single-case naturalistic research holds tremendous promise (Midgley, 2006). This kind of research could ultimately identify empirically derived change processes that future therapists could consider using. Working together, we could usher in a new era of best practice based on naturalistic single-case research rather than on the outdated medical randomized controlled trial model (Goodman, 2010b). When rank-and-file therapists are excluded from the process of empirical validation, empirically validated treatments become politically validated treatments (Duncan, 2002). Rank-and-file therapists need to band together to study “what works for whom” (Blatt & Felsen, 1993) in their own practice settings, using the naturalistic single-case research design recommended by the present study. We need to discover how closely rank-and-file play therapists adhere to the PT process prototype in actual therapy sessions. Through the lens of these treatment prototypes made available through the CPQ, we now have a common language with which to identify nuances in different treatment models in ways that have hitherto been difficult to characterize.

We also hope that this study will promote greater interest in process research and in the importance of linking process to outcome to identify the effective



ingredients of treatment. Perhaps this study will further interest in the development of evidence-based process research of PT and in the possibilities of effective PT for children diagnosed with Asperger's disorder. Tracking mentalization processes in PT needs to continue with children diagnosed with other psychiatric disorders. Future studies also need to include outcome data to track treatment progress and to determine whether mentalization processes are responsible.

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