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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

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In the sciences, new conjectures and theories generally do lead to innovations of method, since new means are necessary to "see" or investigate hitherto unknown entities or structures.

Galison and Stump (1996), as cited by Rustin (2001, p. 81)

Research into psychotherapy necessarily and inevitably changes the nature of the therapy it investigates.

Fonagy (2005), as cited by Pruetzel-Thomas (2006, p. 8)

Clinicians engaged in thinking about the nature of the therapeutic process in work with children frequently state concern that traditional research measures fail to do justice to the complex interactions that take place between therapist and child. The Child Psychotherapy Q-Set (CPQ; Schneider and Jones, 2004) is an instrument designed to describe psychotherapy process with children ages 3–13 in clinically meaningful ways and in a form suitable for quantitative comparison and analysis. The CPQ offers a common language to describe process and therapeutic action that could allow a mutual engagement with questions of therapeutic process and its relation to outcome for clinicians and researchers. Here we briefly describe this method and its application to study therapy process and outcome with an 11-year-old girl in psychodynamic psychotherapy.

INTRODUCTION

How can psychotherapy research help illuminate what is occurring when an adult and a child meet in a unique way we call *child psychotherapy*? More importantly, can psychotherapy research help

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us to identify what elements of the therapy process may promote change and what elements may hinder it?

In recent years there has been considerable progress in child and adolescent psychotherapy research, reflected in the quantity and quality of outcome studies and the identification of evidence-based treatments for a range of clinical problems (Midgley et al., 2009). Nevertheless, when it comes to work with emotionally disturbed children, "fundamental questions remain about therapy and its effects" (Kazdin, 2003, p. 271). In particular, most research studies to date reveal an absence of consideration of how or why certain treatments work and what aspects of the treatment tend to facilitate or inhibit therapeutic change. Yet without such an understanding of the mechanisms of therapeutic change, the accumulated findings from outcome studies will be of limited value (Kazdin and Nock, 2003).

Although child psychotherapy process research spans over a half a century, the rate of production of studies that explore mechanisms of change in child treatments amounts to less than one study every two years between 1946 and 1993 (Shirk and Russell, 1996). For many of the process studies the units of analysis used were small segments of therapy sessions and in some studies the data were aggregated within and across sessions (Lebo, 1956; Siegel, 1972; Traux et al., 1973; Howe and Silvern, 1981; Mook, 1982; Russell et al., 1993, as cited in Shirk and Russell, 1996). Though illuminating, these studies did not fully represent the richness, complexity, and continuity of entire sessions.

To address these challenges of a more objective approach to studying child therapy process, child psychotherapy process scales have been developed that rely on the subjective accounts of children and their therapists (see Smith-Acuna, Durlak, and Kaspar, 1991; Shirk and Saiz, 1992). Estrada and Russell (1999) called *in particular* for process scales that can be used by objective raters.

There have been moves in more recent years to develop process methodology aimed to tap "essential ingredients" of child psychotherapy process and its relation to outcome (for an overview, see Kennedy and Midgley, 2007; Midgley, 2009). Kernberg, Chazan, and Normandin (1998) developed an instrument that vividly captures play activity in child psychotherapy, and Foreman et al. (2000) have adapted methodology used to study therapeutic alliance and progressiveness in adult psychotherapy to examine these constructs in child treatments. Estrada and Russell (1999) developed the Child Psychotherapy Process Scale (CPPS) to objectively describe process in child treatments using Likert methodology.

In this context, the CPQ offers an objective rating methodology (Q-methodology) that draws on the rater's subjective accounts and formulations of entire psychotherapy sessions and addresses the halo effect of subjectivity that Likert methodology does not account for. It thus offers a different level of analysis of psychotherapy process with children that builds on the back and forth between objectivity and subjectivity that is characteristic of clinical reasoning.

Clinicians reflect on, struggle with, and write prodigiously and richly about process and change, the poetry and poignancy of experience of therapy with children. As noted by Rustin (2001), this vast body of work and evidence is considered by many clinicians to be categorically different from the evidence provided by psychotherapy research, so the divide between consulting room and laboratory may be a consequence of how research is conceptualized in each domain. Finding a common language between clinicians and researchers that could allow a mutual engagement with the questions of process and change should ultimately be of benefit to clinicians and researchers alike (Midgley, 2004, 2006).

In this article, we look at one effort to facilitate an empirical discourse between researchers and clinicians about what is occurring in child therapy, in order to further our understanding of how clinicians can be of most help to children in treatment. We suggest that research utilizing the CPQ (Schneider, 2004a, 2004b; Schneider and Jones, 2004) offers a new stream of discourse about psychotherapy process. Such research goes beyond mere description of themes or activities and provides a focus on aspects of clinical interaction that structure and generate the "surface" (Spence, Mayes, and Dahl, 1994) of therapeutic process in such a way that the depth of meaningful therapeutic experience is also engaged.

THE CHILD PSYCHOTHERAPY Q-SET

Q-methodology is a general scaling technique used to provide convenient ways of organizing data in terms of their representativeness of a particular construct, person, or situation being described. (For a more detailed description of the Q-methodology, see Schneider, 2004a.) The CPQ, an instrument designed to describe psychotherapy process with children ages 3–13, makes use of such a scaling technique, and offers a language and a rating procedure that provides researchers, clinicians, and clinical supervisors with a vantage point for locating themes and patterns embedded in child psychotherapy process. Given the diverse and sometimes competing schools of thought in psychotherapy, the CPQ favors a "basic language" approach (Jones, 2000, p. 257) over theory-based terminologies and so can assess the psychotherapeutic process across and between theoretical schools. It therefore offers a descriptive portrait that can unveil patterns of interaction, which then can be viewed in light of how they support or are obscured by preexisting theoretical assumptions.

The CPQ is an adaptation of the Psychotherapy Process Q-Set (PQS; Jones, 1985, 2000), recognized for its effectiveness in capturing the complexity of adult psychotherapy process and its relationship to outcome. The instrument consists of 100 cards representing a selection of statements about possible significant features of the therapy process. These statements had been culled from a pool of items collected from an extensive review of child psychotherapy literature that included research on empirically validated treatments and psychoanalytic literature, as well as existing process instruments and adaptations from the PQS (Jones, 2000). As a full set, the items represent a broad range of child and therapist characteristics:

1. Items describing child's attitudes, feelings, behavior or experience. Example: CPQ Item 29—The quality of child's play is fluid, absorbed versus fragmented or sporadic.
2. Items reflecting the therapist's actions and attitudes. Example: CPQ Item 12—Therapist models unspoken or unelaborated emotions.
3. Items attempting to capture the nature of the interaction of the dyad or climate of the atmosphere of the encounter. Example: CPQ Item 45—Therapist tolerates child's strong affect or impulses.

After studying videotapes of child therapy and arriving at some formulation of the material, the 100 CPQ cards are sorted into one of nine categories, placing at one end those cards believed to be most characteristic or salient of the material and at the other end cards that are believed to be most saliently uncharacteristic. A fixed number of items is placed in each category, with more items placed centrally, and those items in the middle (category five) are the ones that are determined to

be neither characteristic nor uncharacteristic. As originally described by Block (1961), this forced distribution obliges the rater to assess the relative significance of each item to this particular therapeutic hour and avoids the well-known halo effect, by which raters tend to avoid using the two extremes of a rating scale.

Using the 100 Q-items, the rater engages in a meta-analytic process that necessarily moves between intuitions, conceptualizations, and objective cues within the session. Though each item is rooted in observable behavior and is defined very precisely, it is the rater's necessary movement between formulation and observation that goes beyond the mere identification of behavior to emphasize and deemphasize certain elements. This process allows for the emergence of therapeutic patterns that may not have been explicit in either the researcher's or the clinician's formulation.

To facilitate greater reliability, a coding manual provides clear definitions and examples of each item, reflecting features that can be assessed using videotapes of child psychotherapy sessions. Though the CPQ is always seeking a delicate balance between that which is observable and that which has to be inferred, the instrument is designed to keep the level of inference as minimal as possible. For instance, an explanation for item 8 (i.e., "Child is curious"), may go as follows:

> Place toward *characteristic* direction if child exhibits curiosity or interest in surroundings, such as interest in toys in the room, or the thoughts, feelings, or behaviors of others, including the therapist. For example, the child asks numerous questions about other children under the therapist's care. … Place toward *uncharacteristic* direction if child does not seem curious. For example, child lacks interest in surroundings, or understanding something or someone better. [Schneider and Jones, 2004, p. 6]

The instrument development spanned 4 years and involved a recursive piloting process of item construction, piloting for clinical validity, item validity, and discriminant validity (Schneider, 2004a, b). Each of the CPQ development studies mutually informed the other, and modifications to the items and the manual were made after consideration of the results along the way. Initial studies have suggested that it is possible to achieve good interrater reliability on the instrument (Schneider, Thomas, and Midgley, 2009), even with raters who do not share the same clinical model as the therapists whose sessions are being rated.

Current and Future Application of the CPQ

Since its creation in 2003, a number of studies have used the CPQ to describe process in child psychotherapy in various ways (Schneider, 2004a, 2004b; Duncan, 2006; Preutzel-Thomas, 2006; Ruzansky, 2007; Athey-Lloyd and Goodman, 2010; Goodman & Mavrides, 2010; Thurin, 2010; Thurin and Thurin, 2010).

- The CPQ can be used to establish an empirical foundation for the differences or similarities between different modalities of child psychotherapy, such as cognitive behavioral and psychodynamic treatment. Initial studies using the CPQ to make such comparisons suggest that there are clear differences in the types of interaction that occur in these respective modalities of therapy (Schneider, 2004a; Schneider et al., 2009).
- By comparing ratings of actual psychotherapy sessions with expert therapists' accounts of ideal sessions, it is also possible to use the CPQ to investigate the relationship between what Sandler and Sandler (1994) have called the "public" and the "private" faces of various modalities of treatment. Initial studies indicated that there was not a simple,

one-to-one correlation between expert accounts and actual transcripts of child psychotherapy sessions (Schneider and Midgley, 2007; Thomas, 2006). The CPQ is presently being employed in the context of an innovative practice-based research network study currently being conducted by Jean-Michel Thurin and Monique Thurin of the Fédération Française de Psychiatrie in Paris. These researchers are gathering data from psychotherapy practices across France from 120 cases with children who have characteristics consistent with Pervasive Developmental and Autistic Spectrum diagnoses. The CPQ is utilized to describe the most salient characteristics of the treatment at 3, 6, and 12 months. The findings of the CPQ are read alongside other instruments to create a multidimensional and systematic view of both the process and the relation of process to treatment progress and outcome. The network-based study allows an aggregation of data and thus a comparative analysis of the differences and the commonalities between cases and the consideration of the individual or more general character of the outcome.

- The CPQ allows the researcher to go beyond the static account of single sessions to create a dynamic portrait of therapeutic work by tracing clusters of items termed *interaction structures* (Jones, 2000; Ablon and Jones, 2005) that emerge in CPQ ratings of a single psychotherapy treatment explored over time. Recently, Athey-Lloyd and Goodman (2010) utilized the CPQ and found that interaction structures with a single child change with different therapists, suggesting that the therapist does make an independent contribution to the process of psychotherapy, holding the patient constant. In another single-case study exploring countertransference patterns using the CPQ, Goodman and Mavrides (2010) found that countertransference patterns across different therapists seem to activate corresponding interaction structures. These findings suggest that countertransference patterns and psychotherapy process are intimately connected to each other.
- Within any one modality of child therapy, the CPQ could be used to explore what constitutes successful or unsuccessful characteristics, in order to help identify which aspects of the therapeutic process facilitate change.
- The CPQ could be used to examine hypotheses about the relative significance of specific aspects of the therapeutic process, such as the therapeutic alliance or the use of interpretation, as the work by Jones and Price (1998) demonstrates using the PQS. For example, Ruzansky (2007) employed the CPQ to explore the nature of the analytic setting and how it is established in the early sessions of psychoanalytic child psychotherapy. In this study, initial sessions of four treatments were coded using the CPQ. A number of common characteristics emerged, such as encouraging children to speak or elaborate and the use of play-related interpretations. Findings also indicated that therapist style has an influence on the technique employed.
- In addition to its utility as a research instrument, the CPQ has application as a training tool for beginning therapists and their supervisors, offering a way for them to talk about their work and to explore the interactions between therapist and child in a way that facilitates clinical understanding. For example, Goodman (2007) employed the CPQ in his supervision of three clinical psychology doctoral students working with children. The students found the CPQ helpful as a tool in learning about practicing psychodynamic psychotherapy, for improving their observational skills of their patients and aspects of therapeutic interaction, and for informing and evaluating their interventions with these patients. Further, increased awareness on behalf of students and supervisor gained from using the CPQ increased the patient's awareness of self and the relationship with his or her therapist.

Strengths and Limitations of the CPQ as a Research Tool

The primary value of the CPQ is that it offers a systematic means for describing therapist–child interactions in a clinically meaningful way. The items on the CPQ are not associated with a specific theoretical orientation, and initial studies suggest that clinical researchers can achieve good reliability on the scale with appropriate training. The instrument also can be used in a way that is relatively nonintrusive in the psychotherapy process, and it is currently being developed in computerized form, which will increase its ease of use by both clinicians and researchers.

The adult version of this instrument, the PQS (Jones, 2000) has shown itself to be able to capture some of the complexity of the psychotherapy process with adults in a meaningful way, which in turn opens up such a process to systematic empirical analysis. It is anticipated that the CPQ could open up equal opportunities for research in the field of child psychotherapy.

There are, of course, myriad dynamics and nuances within sessions that Q-ratings cannot capture. The reliance on video recording of sessions itself distorts the clinical process and necessarily neglects the vital subjective experience of the session. Though this may be true in one way, the increasing emphasis on the way in which even unconscious processes are actualized on the surface of therapeutic action means that we no longer need to make a stark distinction between behavior and the internal world (Boston Change Process Study Group, 2007).

In order to illustrate the way in which the CPQ may shed light on the therapeutic encounter, we offer a brief example from the psychoanalytic treatment of an 11-year-old girl, whom we will call Helen.

EXPLORING PSYCHOTHERAPEUTIC PROCESS AND OUTCOME IN THE CASE OF HELEN

At the time of her referral, Helen was described as extremely withdrawn, lacking in self-esteem, and with difficulties in concentration. Mother reported that Helen does not feel happy or unhappy, that she does not feel anything. A teacher at school reported that working with Helen was like "working with a ball and chain."

Psychiatric assessment prior to treatment suggested that Helen met the DSM criteria for Major Depressive Disorder, Generalized Anxiety Disorder, Panic Disorder, and Avoidant Disorder of Childhood. Although clearly intelligent, the clinical assessment noted that she rarely expressed emotion, and her imagination appeared to be severely restricted. She began four-times-a-week psychoanalysis with a female child analyst just prior to her 11th birthday, and Helen's therapy continued for 3 years. Her mother was seen weekly by another member of staff.

We will illustrate how the CPQ can be used as a way of describing therapeutic process akin to a "motion portrait," in contrast to a more static approach to describing therapeutic trends. By motion portrait we refer to work in the visual arts, where a motion portrait is a method that uses computer technology to create a three-dimensional model from a single picture. In describing the case of Helen, we describe patterns, captured in discrete portraits or ratings that can be studied sequentially over time to create a more dimensional description of the therapeutic process and aspects of change, and finally we describe this material in light of information gathered about therapy outcome for Helen.

Helen—A Motion Portrait of the Child Psychotherapy Process

By all accounts, Helen's psychoanalytic treatment was a successful one. When treatment concluded, it was reported that Helen was engaging in activities and schoolwork and taking a lively interest in her world. Though still somewhat reserved, Helen had begun to be social and make friends. Further, she and was more expressive about her needs and feelings. Her relationship with her mother had improved, and her mother spoke of her delight at seeing Helen smile, take enjoyment in things, and show some humor. The therapist felt that Helen had moved from a "cold blank" to being able to assert and express her feelings, instilled with the awareness that thoughts and feelings really do matter.

When looked at in terms of an entire range of validated measures, Helen's improvement could be validated in a number of different ways. On the Child Depression Inventory, for example, Helen's score dropped from a high clinical range at the start of treatment to a subclinical range by the end of treatment.

On a more global measure, the Child Behavior Checklist (CBCL; Achenbach, 1991), as rated by the mother, the decrease in the total score was again highly significant (see Figure 1). When broken down into different components, one can see that Helen was initially rated in the high clinical range for every aspect of internalizing problems—she was withdrawn, anxious, and depressed and suffering from somatic complaints. She also had a clinical level of attention problems. At each subsequent yearly administration of the CBCL, these scores dropped, so that by the end of treatment Helen still showed a degree of anxious and withdrawn behavior but was within the high end of the normal range for these areas (see Figure 2).

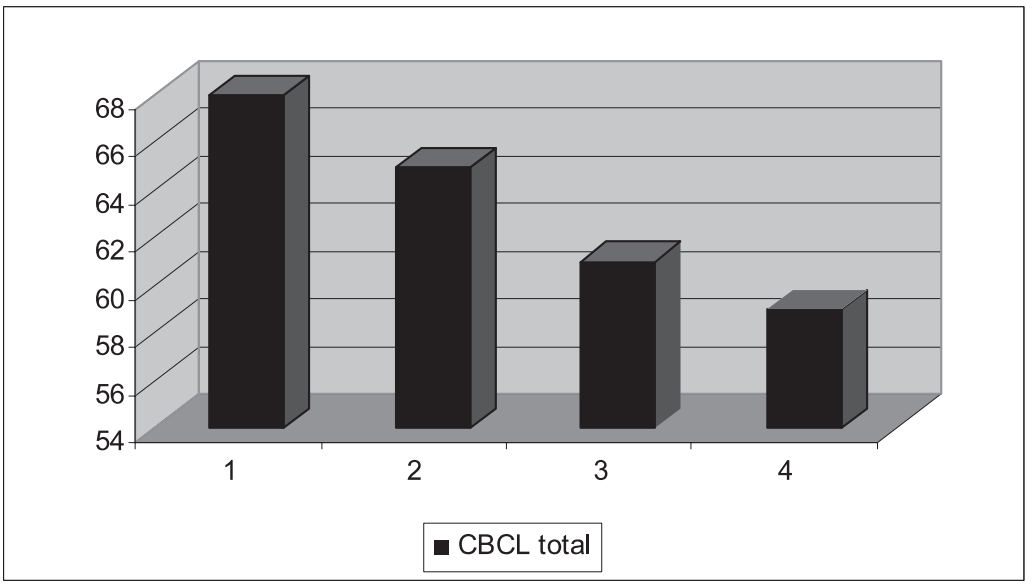

FIGURE 1 Helen—Outcome Measures.

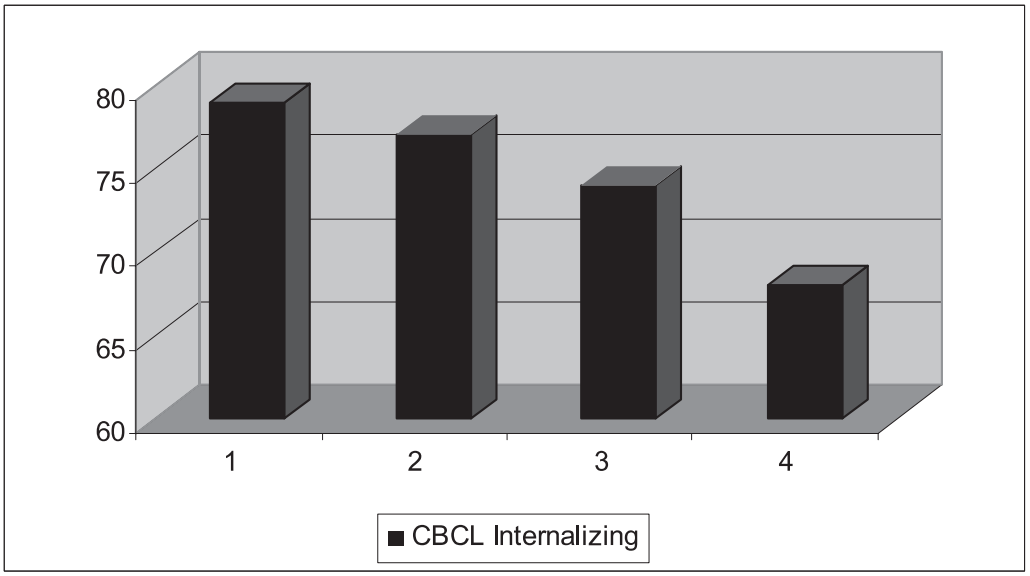

FIGURE 2 Helen—Outcome Measures (Internalizing).

Though such measures seem to confirm beyond doubt that Helen's condition improved dramatically over the period of treatment, in themselves they tell us nothing about why Helen changed or what aspects of the therapy might have contributed to such change. Longitudinal studies of childhood disturbance indicate that the normal progress of growing up cannot, in itself, be relied upon to lead to improvements in psychiatric disturbance (e.g., Klein, 1989; Birmaher et al., 1996). Even if we assume that the psychotherapy played a part in Helen's improvement, we cannot be sure what aspects of the treatment were of significance.

As a first step in trying to answer this question, we decided to use the CPQ to try to explore the development of the psychotherapeutic process across the course of Helen's treatment. Interrater reliability on the CPQ was established using a series of sample sessions, rated by two of the authors (NM and AD). Three sessions each from the beginning, middle, and end period of Helen's treatment were then coded in a random order, and patterns of therapeutic interaction were explored across time. This analysis was conducted without access to the clinical notes about the case, and the clinical notes were consulted only when the analysis was complete.

A factor analysis of the CPQ ratings for all nine of Helen's therapy sessions was conducted in order to identify the clusters of items that accounted for most variance in the treatment process. The aim was to provide a portrait of the therapy process between Helen and her therapist, namely, how Helen engaged with the work and the types of interaction structures that could be identified by the CPQ coding. Interaction structures (Jones, 2000) are clusters of items that emerge in CPQ ratings that can depict therapist and patient dynamics that occur over time using factor analytic techniques (Jones et al., 1993; O'Crowley, 1999; Jones, 2000; Coombs, Coleman, and Jones, 2002; Ablon and Jones, 2005; Duncan, 2006). The number of sessions coded was not large, so findings must be seen as very tentative but nonetheless suggestive that such an approach may have some value.

When looking at sessions across the entirety of Helen's treatment, a principal components analysis with varimax rotation produced a three-factor solution that explained 51 percent of the covariance among the 100 items of the CPQ. (The factor scales were based on those items that loaded near or above .5 and that were conceptually consistent with each other.) Each of these factors can be considered as reflecting some aspect of the interaction structures that were taking place between Helen and her therapist during the course of this child analytic treatment.

Factor One: Bringing Out the Withdrawn Child

Positive loading

- Item 80: Child behaves in a dependent fashion (vs. insists on independence).
- Item 97: Therapist emphasizes verbalization of internal states and affects.
- Item 85: Child's aggression is directed toward self.
- Item 40: Child communicates without affect.
- Item 44: Child feels wary or suspicious (vs. trusting and secure).
- Item 66: Therapist is directly reassuring.
- Item 76: Therapist makes links between child's feelings and experience.
- Item 12: Therapist models unspoken or unelaborated emotions.
- Item 47: When the interaction with the child is difficult, the therapist accommodates the child.
- Item 4: There is discussion of why the child is in therapy.

Negative loading

- Item 20: Child is provocative; child tests limits of the therapy relationship.
- Item 13: Child is animated or excited.
- Item 84: Child expresses anger or aggressive feelings.
- Item 83: Child is demanding.
- Item 53: Child conveys awareness of own internal difficulties.

Factor one accounted for 19 percent of the covariance and consisted of 25 items with factor loadings from 0.94 to –0.54, and an alpha test conducted on these items indicated an extremely good internal consistency score of 0.91. This factor was labeled "bringing out the withdrawn child." The items suggest that this factor describes Helen as a child who shows very little animation, anger, or provocative behavior but is rather passive, communicating with very little affect, taking the lead almost entirely from the therapist and yet wary or suspicious of emotional engagement. On the therapist's side, there is an attempt to verbalize internal states and affects, to be reassuring but still make links between feelings and experience, and to model unspoken emotions. The therapist appears to be encouraging Helen to become curious about why she is in therapy and about her internal states, but the child shows little emotional engagement, although there is some indication of aggression being turned toward the self.

Factor Two: Working with States of Anxiety and Resistance

Positive loading

- Item 58: Child appears unwilling to examine thoughts, reactions, or motivations related to problems.

- Item 70: Child struggles to control feelings or impulses.
- Item 11: Sexual feelings or thoughts emerge.
- Item 50: Therapist draws attention to feelings regarded by the child as unacceptable (e.g., anger, envy, or excitement).
- Item 46: Therapist interprets the meaning of child's play.
- Item 28: Therapist accurately perceives the therapeutic process.
- Item 85: Child's aggression is directed toward self.
- Item 7: Child is anxious and tense (vs. calm and relaxed).

Negative loading

- Item 40: Child communicates without affect.
- Item 24: Therapist's emotional conflicts intrude into the relationship.

Factor two accounted for 18 percent of the covariance and consisted of 18 items with factor loadings from 0.96 to –0.51, and an alpha test conducted on these items indicated an extremely good internal consistency score of 0.93. This factor was labeled "working with states of anxiety and resistance." This factor described interactional structures in which Helen begins to find it harder to control her feelings and communicates with greater affect. Helen's anxiety and sexual thoughts emerge, but she also becomes increasingly unwilling to examine her own thoughts and continues to direct aggression toward the self. The therapist appears to be taking a more analytic stance, not becoming emotionally involved in the child's feelings but interpreting the play, commenting on the analytic process, and drawing attention to feelings regarded as unacceptable by Helen.

Factor Three: Coming Out of the Shell

Positive loading

- Item 77: Therapist's interaction with child is sensitive to the child's level of development.
- Item 72: Child is active.
- Item 69: Child's current or recent life situation is emphasized.
- Item 6: Therapist is sensitive to the child's feelings
- Item 93: Therapist is neutral.
- Item 82: Therapist helps the child manage feelings.
- Item 89: Therapist acts to strengthen existing defenses.
- Item 53: Child conveys awareness of own internal difficulties.

Negative loading

- Item 7: Child is anxious and tense (vs. calm and relaxed).
- Item 35: Child's self-image is a theme.
- Item 61: Child feels shy and embarrassed (vs. un-self-conscious and assured).
- Item 44: Child feels wary or suspicious (vs. trusting and secure).
- Item 22: Child expresses fears of punishment or being threatened.
- Item 50: Therapist draws attention to feelings regarded by the child as unacceptable (e.g., anger, envy, or excitement).

The third factor accounted for 14 percent of the covariance and consisted of 21 items with factor loadings from 0.88 to –0.77, and an alpha test conducted on these items indicated an extremely

good internal consistency score of 0.92. This factor was labeled "coming out of the shell." In sessions that showed a high score on this factor, Helen was less anxious, shy, and suspicious and better able to express her feelings. She was actively participating in the sessions, with a particular focus on current life events, but also demonstrating some awareness of her own internal difficulties. During these periods, the therapist remains neutral and nonjudgmental but sensitive to Helen's feelings. No longer focusing on the verbalization of feelings that the child is warding off or finds unacceptable, the therapist now appears to be more on the side of the ego: trying to help the child manage powerful emotions, partly through supportive work that facilitates the development of more appropriate defenses.

Having developed this portrait of various aspects of the therapeutic process that took place in Helen's therapy, we then hoped to capture a motion portrait of the treatment by investigating the movement of these factors over the course of the whole treatment. A new global score was created for each of the three factors (with negatively coded items recoded to be comparable to positively loaded items), and the movement of each of these factors was then charted across the different stages of treatment: early, middle, and end.

Figure 3 suggests how, in the first months of treatment, Helen was extremely withdrawn and the main work of the therapist was to try and bring her out of that withdrawn state. Resistance and anxiety were at their highest levels at this point, involving a combination of interpretative and empathic work on the part of the therapist. By the midpoint in therapy, Helen was far less withdrawn, and a significant decrease in the levels of anxiety and resistance was shown. But this had not yet led to any noticeable emergence from her shell. It was only by the last months of treatment that Helen was actually coming out of her shell. She was more emotionally engaged and open, and the therapist was working to support the developing ego strengths, rather than working interpretatively to access warded off feelings.

However, there was also—in what might seem a paradoxical way—a marked increase in Helen's withdrawal as well as some increase in her anxiety, although not to the levels they were at in the first few months of treatment. This might be understood in terms of the processes involved during the termination phase of treatment, in which the consolidation of changes goes alongside a revisiting of earlier anxieties as the ending of treatment approaches.

Although only provisional, this tracking of the analytic process across the course of Helen's treatment is suggestive of the poetry of experience that makes up the analytic encounter and the way in which such processes led to a successful outcome of therapy. As the outcome measures indicated, Helen was still a somewhat quiet and inhibited child at the end of treatment, with a tendency toward internalizing problems, but this behavior was approaching the normal range of such behavior, rather than the clinical levels of anxiety and depression that were noted at the time of referral.

The account of the clinical process provided by the CPQ would seem to support this view of the ways in which Helen did and did not change but also gave indications of the kind of interactional processes that took place between Helen and her therapist that led to such changes. One can clearly see a mixture of interpretative and supportive elements in the analytic work with Helen, which provides an empirical foundation to the approach to analytic work within the Anna Freud Centre known as *developmental therapy* (Hurry, 1998).

In particular, one can see how the analyst as a "new object"—modeling the child's unspoken emotions, validating the child's experience, and using interpretation to help the child to feel understood—works alongside the analyst in his or her more traditional role of interpreting warded-off

thoughts and feelings. Over the course of the treatment, there seems a clear movement from the analyst trying to interpret and elicit unwanted feelings to helping her to better *manage* those feelings.

Although there is some focus on the here and now of the analytic relationship, it is not clear from the CPQ ratings to what extent the transference relationship was a focus of the analytic work. Clearly, anxiety and resistance were interpreted, and these interpretations hint of therapeutic interaction patterns that could be traced through the factor analytic process that point to transference–countertransference dynamics. A further analysis of this treatment with a greater number of sessions, as well as other means of studying the clinical material, may be able to shed light on these dynamics. To be certain, not all the intricacies of the analytic work are captured by the use of the CPQ, but it does seem to us to be a viable step toward linking treatment outcomes with treatment processes at an empirical level.

As researchers, we are aware that many aspects of clinical reasoning and inference cannot be reduced to behavioral cues but reside in the emotional and imaginative lives of patient and therapist. But as another stream of clinical inference, alongside more traditional methods of case description, the Q-ratings may contribute to the complex dialogue that every case evokes and may be one part of a systematic investigation of clinical practice. The potential contribution of psychotherapy process research using the CPQ lies not simply in its applicability across different contexts and theoretical terrains (Schneider et al., 2009) but also in its capacity to draw out the unique guiding dynamics of specific therapeutic dyads, as we hope we have illustrated here in the case of "Helen" and her therapist.

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