

The Therapeutic Process of a Child Diagnosed With Disruptive Mood Dysregulation Disorder

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It has been recognized that there is a need to make psychotherapy more effective for children with disruptive symptoms. Many studies on child psychodynamic psychotherapy have indicated its effectiveness, but do not explain how this treatment works. It is not only necessary to understand how it works, but also for which therapist—patient dyads. The Child Psychotherapy Q-Set was designed to describe the therapeutic process with children, and makes it possible to identify interaction structures (i.e., repetitive patterns of interaction) and how they change in the course of a treatment. Based on these assumptions, the aim of this study was to analyze the psychotherapeutic process of a school-aged boy who presented with disruptive behavior disorder, identifying the interaction structures in his treatment. A total of 123 sessions of his treatments were analyzed and 4 interaction structures were identified: 2 became more characteristic over the course of treatment, and 2 became less characteristic. They also varied in magnitude. The therapeutic process showed characteristics consistent with the models described as ideal for psychodynamic psychotherapy, the reflective functioning process, and cognitive-behavioral therapy, in this order of significance. The study highlighted the importance of supportive interventions alongside expressive ones in the treatment of children with disruptive behavior disorders. The results also suggested the integrationist nature of most psychotherapies, and the importance of acknowledging and understanding the effective elements, rather than treatment types that can be present within any therapeutic modality.

Keywords: child psychotherapy process, psychodynamic psychotherapy, disruptive behavior disorders, interaction structures, case study

Children with disruptive behavior disorders constitute a heterogeneous group (Eresund, 2007). Often, these children have other difficulties such as comorbid psychiatric or neuropsychiatric problems, learning difficulties, depressive feelings, problems at school, and social problems. Because of these problems, the children's behavior can affect the life of their parents, siblings, peers, and

teachers. In addition, they constitute a risk group for developing antisocial personality disorder, alcohol or substance abuse or psychiatric illness in their adult lives (Eresund, 2007; Hoffman, Rice, & Prout, 2016; Loeber, Burke, Lahey, Winters, & Zera, 2000; PDM Task Force, 2006).

The *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association [APA], 2013) describes a new diagnosis called disruptive mood dysregulation disorder (DMDD). It is characterized by chronic, severe, persistent irritability in children and adolescents, severe recurrent temper outbursts manifested verbally (verbal rages) or behaviorally (physical aggression) that are out of proportion to the situation, and persistently negative mood (irritable, angry, or sad).

DMDD cannot be diagnosed for children aged <6 years or >18 years (APA, 2013). These children exhibit low frustration tolerance and difficulties with emotion regulation, distress tolerance, and behavioral self-control. DMDD can coexist with oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD) or substance use disorder.

Intervention strategies for children with disruptive behavior disorders are still under investigation, and common treatments include pharmacological interventions and cognitive-behavioral therapy (Gilea & O'Neill, 2015). Treatments regarded as evidence-based include social skills training, parent training, and multisys-

This article was published Online First February 2, 2017.

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This work was supported by the CAPES Foundation, Ministry of Education of Brazil, under Grant BEX 2863/2015-4; and National Counsel of Technological and Scientific Development (CNPq) under Grants 471358/2014-2 and 311235/2014-0. We thank Caroline de Oliveira, Catiane Pinheiro, Cibele Carvalho, Fernanda Driemeier Schmidt, Guilherme Pacheco Fiorini, Maiara Freitas and Marina Gastaud for their participation on the coding team.

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temic therapy, which fall within the cognitive-behavioral spectrum (Eresund, 2007).

However, it is recognized that there is a need to make psychotherapy more effective for children with disruptive symptoms. Eresund (2007) explored the effectiveness of psychodynamic psychotherapy (PDT) for these children and performed an in-depth analysis of the treatments of nine boys aged 6 to 10 years diagnosed with ODD. Two boys also met the criteria for mild CD, and one for ADHD. The children were treated by psychotherapists who had extensive clinical experience and a minimum of basic psychodynamic psychotherapy training. The treatment frequency was twice weekly during the first 1.5 to 2 years, and then was reduced to once a week. The treatment duration varied between 2 and 5 years.

The treatment approach was based on the therapeutic model described by Kernberg and Chazan (1991), which encompasses supportive, expressive, and interpretive interventions (Eresund, 2007). Parents, therapists, and teachers described the boys as functioning better socially and emotionally after treatment, although the improvements were less marked when the additional diagnosis of ADHD was present. Some factors were identified by Eresund (2007) as having contributed to the effectiveness of psychotherapies: the use of supportive interventions in the initial phase, making possible the use of clarifications and interpretations later; the encouragement and facilitation of the children's expressions of feelings and thoughts; the gradual focus on awareness of intentions and behaviors; simultaneous work with parents by the therapist, and continuous contact with the children's schools.

Hoffman et al. (2016) recently published a book presenting a brief psychotherapy, based on a psychodynamic approach, for children with externalizing behaviors. They created a manual that describes the "Regulation-Focused Psychotherapy (RFP-C)" with these children. They argued that failures in implicit emotion regulation cause the disruptive behavior. Hence, the therapist must address the child's unpleasant emotions, especially their defenses, such as projection and denial, instead of addressing the child's actions and behaviors. Their oppositional or aggressive conduct, for instance, must be understood as a communication, instead of being managed. This understanding will help the child to perceive that their impulses are not so destructive, and to master more effectively their painful emotions and consequently, the disruptive behavior.

This argument leads us to consider the research on the psychotherapy process and the therapist-patient interaction. Goodman (2015) stated that it is necessary to understand how a specific psychotherapy works, and for which therapist-patient dyad, instead of asking if it works or not.

Process and Interaction Structures in Child Psychodynamic Psychotherapy

Despite the increase in studies indicating the effectiveness of child PDT, the need for more research in this field remains, especially considering that the therapeutic process is still poorly understood (Goodman & Athey-Lloyd, 2011; Midgley & Kennedy, 2011; Palmer, Nascimento, & Fonagy, 2013). Analyzing the nature of therapeutic action has the potential to help identify the mechanisms of change that underlie a successful clinical intervention (Kazdin, 2009; Midgley, 2007).

There are two main lines of thought on the nature of the therapeutic action: (1) the mutative effect of interpretation and (2) interpersonal interaction. In the first case, the emphasis is on patient self-knowledge and insight. Interactive models, on the other hand, emphasize interpersonal and relationship factors such as empathy, sense of security, continuity, the holding environment, and the therapeutic alliance (Ablon & Jones, 2005; Jones, 2000; Luyten, Blatt, & Mayes, 2012).

According to Luyten et al. (2012), the therapeutic relationship is central in treatment, and the therapeutic change process may be conceptualized as a series of compatible and incompatible experiences in this relationship, and frustration and gratification both inside and outside the therapeutic relationship. For the authors, the therapeutic relationship can be seen not only as the vehicle of change but should also be considered to contain potential iatrogenic effects.

In the same direction, Jones (2000) developed the concept of interaction structures (IS), which are "repeated, mutually influencing interactions between analyst and patient that are a fundamental aspect of therapeutic action" (p. xv) and can be positive or negative (Ablon & Jones, 2005). Interaction structures have been successfully studied in treatments with adults (Ablon & Jones, 2005; Goodman, Edwards, & Chung, 2014; Jones, 2000) and with children (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Ramires, Carvalho, Schmidt, Fiorini, & Goodman, 2015; Schneider, Midgley, & Duncan, 2010).

The studies focusing on IS have used Q-methodology. Jones (2000) developed the Psychotherapy Process Q-Set (PQS) based on Q-methodology, which provides a basic language for description and classification of the therapeutic process in a form suitable for quantitative analysis. Later, Schneider (2003) and Schneider and Jones (2006, 2012) developed the Child Psychotherapy Q-Set (CPQ), a pantheoretical procedure equivalent to the PQS, which aims to describe the psychotherapy process between children and therapists (see Measures section). These procedures permit to capture the therapeutic relationship and offer a framework to analyze and understand the characteristics of the psychotherapy process.

Jones (2000) believed that the recognition, interpretation, and understanding of interaction patterns are important components of the change process. He described studies with adult patients in which the understanding and interpretation of the IS were accompanied by their improvement. Conversely, when the IS were not sufficiently understood by the therapist, patient improvements were not significant.

The psychotherapeutic process and the interaction structures were studied in child PDT, using the CPQ. These children were diagnosed with Asperger's disorder, borderline personality disorder, adjustment disorder and depressive and anxiety disorders (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Ramires et al., 2015; Schmidt, 2015; Schneider et al., 2010). Based on systematic case study designs, these investigations identified the IS that characterized the treatment of children aged between 6 and 11 years old. Table 1 summarizes these results.

The duration of these psychotherapy treatments varied from 1 year (Schmidt, 2015) to 3 years (Schneider et al., 2010). The frequencies varied from four sessions (Schneider et al., 2010) to one session per week (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Schmidt, 2015).

Table 1
Interaction Structures and Their Internal Consistency in Child PDT

IS	Girl, age 11, diagnosed with major depressive disorder, generalized anxiety disorder, panic disorder, and avoidant disorder of childhood (Schneider et al., 2010)
IS 1	Bringing out the withdrawn child ($\alpha = .91$)
IS 2	Working with states of anxiety and resistance ($\alpha = .93$)
IS 3	Coming out of the shell ($\alpha = .92$)
Boy, age 6, diagnosed with Asperger's Disorder (Goodman & Athey-Lloyd, 2011)	
IS 1	Reassuring, supportive, nondirective therapist with a compliant, curious child building insight and positive feelings ($\alpha = .91$)
IS 2	Helpful, mentalizing, confident therapist with expressive, comfortable, help-seeking child ($\alpha = .92$)
IS 3	Judgmental, misattuned therapist with distant, emotionally disconnected, misunderstood child ($\alpha = .88$)
IS 4	Accepting therapist with playful, competitive child ($\alpha = .82$)
Boy, age 8, diagnosed with Asperger's Disorder (Ramires et al., 2015)	
IS 1	Active, confident and lively child, competing with connected, mentalizing and accepting therapist ($\alpha = .91$)
IS 2	Withdrawn and defensive child with uncertain, unresponsive and didactic therapist ($\alpha = .92$)
IS 3	Accepting therapist with demanding, provocative and hostile child ($\alpha = .84$)
IS 4	Reassuring, supportive, nondirective therapist with compliant and unspontaneous child ($\alpha = .87$)
Girl, age 7, diagnosed with Borderline Personality Disorder (Goodman, 2015)	
IS 1	Sensitive, non-judgmental therapist with motivated, insightful, admiring child ($\alpha = .91$)
IS 2	Interpretive therapist with passive-aggressive child ($\alpha = .90$)
IS 3	Humorous, confident therapist with animated, playful child ($\alpha = .90$)
IS 4	Structuring, accommodating therapist with difficult, angry child ($\alpha = .84$)
Girl, age 8, diagnosed with Adjustment Disorder (Schmidt, 2015)	
IS 1	Attuned and interpretive therapist with active, expressive and demanding child ($\alpha = .81$)
IS 2	Sensitive and supportive therapist with withdrawn and distant child ($\alpha = .85$)
IS 3	Didactic and directive therapist with aggressive and defensive child ($\alpha = .83$)
IS 4	Directive and limiting therapist with dependent, resistant and ashamed child ($\alpha = .78$)
IS 5	Receptive and supportive therapist with anxious child ($\alpha = .76$)

Note. PDT = Psychodynamic Psychotherapy; IS = Interaction Structure.

We can observe differences and some similarities in these IS across different dyads and different pathologies. We would not expect the same IS in different child psychotherapies (even with the same age or the same diagnosis), given the uniqueness of each dyad; however, it is interesting to note that for most treatments, positive and negative transference-countertransference matrices were present (Goodman & Athey-Lloyd, 2011; Ramires et al., 2015; Schmidt, 2015). In these treatments, when the child was withdrawn, defensive, resistant, distant or aggressive, the therapist seemed more directive, didactic or misattuned. Interestingly, two IS were quite similar in two studies that focused on the psychotherapeutic process of boys with Asperger's disorder: IS 4 (reassuring, supportive, nondirective therapist with compliant and unspontaneous child) in Ramires et al. (2015), and IS 1 (reassuring, supportive, nondirective therapist with a compliant, curious child building insight and positive feelings) in Goodman and Athey-Lloyd (2011). A total of nine CPQ items were the same in both of these IS.

Changes in IS over time were analyzed in all studies. The authors identified that many IS changed over time: some became more characteristic, whereas others became less characteristic. Goodman (2015) and Goodman and Athey-Lloyd (2011) identified different magnitudes in IS in their studies, with some IS being more present in the treatments than others.

The similarity of the treatments to the prototypes of psychodynamic psychotherapy (PDT), cognitive-behavioral therapy (CBT), and the reflective functioning process (RF) was also examined in some studies (see Goodman, 2015; Goodman & Athey-Lloyd, 2011; Schmidt, 2015). These prototypes depict the ideal session in each psychotherapy approach, according to the experts in these fields. Goodman, Midgley, and Schneider (2016) conducted a study to identify the prototypes of these models, using the CPQ to outline each one. They found that mentalization (i.e., the RF process) is a common factor across conceptually distinct treatment models.

These analyses provide a picture that shows whether and how therapists are actually doing what they intend to do. They also provide a framework to understand the extent to which elements from different approaches may comprise a psychotherapeutic process according to its vicissitudes and the needs of that particular patient.

In summary, analyzing the IS seems to be a promising line of research on the psychotherapy process. According to the reviewed literature, the CPQ makes it possible not only to study the IS but also the sessions' resemblance to various treatment prototypes. Its methodology also makes it possible to describe the integrative nature of most treatments. Considering what was described, the aim of this study was to analyze the psychotherapeutic process of

a school-aged boy who presented with disruptive behavior disorder, identifying the interaction structures in his treatment. The following hypotheses were tested:

1. It would be possible to identify IS in a child psychodynamic psychotherapy of a school-aged boy who presented with DMDD.
2. These IS would vary in magnitude and over time.
3. It would be possible to identify characteristics consistent with the PDT prototype, and this consistency would increase over time.
4. There would not be characteristics consistent with the CBT prototype.
5. It would be possible to identify characteristics consistent with the RF process prototype.

Method

Participants

The participants in this study were a boy aged 7 at the beginning of treatment and his therapist. His family was Caucasian, had a socioeconomic status corresponding to middle class, and his parents had high school diplomas. We call the boy “Walter” in this work. The therapist was female and had more than 20 years of clinical experience. She had training in psychoanalytic psychotherapy, which involved supervision of clinical cases, theoretical seminars, and personal treatment.

The psychotherapy took place in the therapist’s consulting room, equipped with toys, dolls, games, story books, and drawing materials. Walter was attending the first grade, and his parents sought assistance due to his relationship difficulties at school. They reported that Walter had no friends at school and that his schoolmates teased him. Walter’s mother also said, “When he’s angry, he explodes.” In his last fight at school, he pushed his desk against a boy and caught him by the neck. “First he explodes, then he weeps; he’s an impulsive child,” the mother said. Until the previous year, Walter had been victimized by his schoolmates and for that reason had been moved to another class.

Walter was an only child, and was overweight like his mother. He had childish and regressive behavior. He still used a baby bottle when he began psychotherapy and slept in his parents’ room, in a nearby bed, although he had his own bedroom.

The family lived in a house next to the maternal grandparents’ home. Walter’s mother had conflicts with her own mother. Walter’s father lost his parents as a child and was raised by older sisters, who overprotected him. He also behaved in a dependent manner, and the mother seemed to be the dominant figure in the family.

The child attended weekly 50-min sessions for 14 months. These sessions were increased to twice weekly for 2.5 years, then reduced again to one session per week. At this point, the end of the treatment was being discussed.

Walter exhibited dependent behaviors in his sessions, asking the therapist to help him take off his shoes or coat or help him go to

the bathroom. He also exhibited dominant behaviors toward the therapist, trying to give orders and make a series of demands. He expressed strong feelings of irritation, aggressive behaviors, and outbursts of anger. He also hit objects, toys, and dolls in the office and showed resistance when the therapist tried to explore his anger and feelings of irritation. Walter was diagnosed with a disruptive mood dysregulation disorder (APA, 2013). He also met the criteria for oppositional defiant disorder, but this diagnosis cannot be made in the presence of DMDD (APA, 2013). He also presented anxiety and depressive symptoms. The diagnosis was based on child and parent interviews, the Rorschach Method, the Comprehensive System (Exner, 2003), and the Child Behavior Checklist (Achenbach, 1991), answered by the mother, the father and Walter’s teacher.

His symbolic play featured content related to an infant still attached to his mother and content that was sexually oriented; however, the patient refused to explore this content during the first year of treatment. When the subject of school or his classmates was raised, he remained silent or occasionally asked the therapist to stop talking about it in an irritated manner.

Throughout treatment, it was difficult for the child to address his problems at school and speak about or recognize his feelings, especially with regard to his aggressiveness and fears. He seemed unable to handle these moments, and he asked the therapist to stop talking and hid underneath a table or behind a chair. The therapist reported countertransference feelings of irritation and discouragement about the boy’s resistance and doubts about how much she was helping him.

The theoretical approach adopted by the therapist was based on psychodynamic psychotherapy, mostly inspired by object relations theory. She also used elements of the approach proposed by Kernberg and Chazan (1991) for children with conduct disorders, which integrates supportive and expressive interventions. According to the authors, in the initial periods of treatment, interventions may be defined as mainly supportive (educative, encouraging, and empathic). Later, the expressive component becomes more important, and interpretive interventions can be used.

The same therapist conducted periodic follow-up interviews with the parents to listen to their anxieties and concerns, provide guidance with regard to how to deal with the boy and with the psychotherapy process, and collect additional information. This strategy is in accordance with Kernberg and Chazan’s (1991) approach. The therapist also kept contact with the child’s school in order to help broaden their understanding of the boy’s difficulties in that environment.

Measure

The CPQ was used in this study. It was developed by Schneider (2003) and Schneider and Jones (2006, 2012), based on the PQS (Jones, 2000). The CPQ is appropriate to describe the psychotherapeutic process among 3 to 13 year olds. It consists of 100 items, each containing a statement that describes a relevant feature of the treatment process corresponding to (a) the child’s attitudes (i.e., feelings, behaviors, or experience); (b) the therapist’s actions and attitudes; and (c) the nature of the patient—therapist interaction. To improve the instrument’s reliability, a coding manual provides clear definitions and examples of each item, with descriptions of behaviors that might be identified from session videos. Each statement receives a score ranging from 1 to 9, from least to most

characteristic of the session. A fixed number of items must be placed in each rating, resulting in a normal distribution.

The reliability and validity of the CPQ have been demonstrated by different studies. Its discriminant validity was demonstrated between two sets of PDT and CBT sessions (Schneider et al., 2009). In a second discriminant validity study, 32 experienced therapists representing different theoretical orientations (PDT, CBT, and RF process) were asked to describe an ideal session of child psychotherapy by sorting the CPQ. The resulting templates consisted of prototypes of each approach, as described earlier, whereas statistical analysis confirmed the discriminant validity of the instrument (Goodman et al., 2016).

Interrater reliability has been established by several studies (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Goodman et al., 2016; Goodman, Reed, & Athey-Lloyd, 2015; Ramires et al., 2015; Schneider, 2003; Schneider et al., 2010). In all of them, independent analyses of different sets of child psychotherapy sessions (range = 9–53 sessions) conducted by trained coders have reached agreement indices above .70 (intraclass correlation). Furthermore, the CPQ proved able to distinguish between the treatments of two different patients with the same therapist (Schneider et al., 2009) and two treatments performed by different practitioners with the same patient sequentially (Goodman, 2015; Goodman & Athey-Lloyd, 2011).

Procedure

Following the parents' request for treatment, their child was assessed to confirm the need for psychotherapy. All ethical recommendations for research were followed. The study was approved by the National Committee of Research of the country where the research took place. The therapist had previously been consulted about her availability to participate in the study. The parents and the child were also consulted. The therapist and the parents signed the consent form.

To analyze the sessions (all sessions were video-recorded), six psychologists with clinical experience were trained to use the CPQ coding system. The interrater reliability was greater than an intraclass correlation of .70 for at least 10 training sessions.

Sessions were analyzed ($N = 123$), corresponding to the period of 2 years and 8 months of treatment. At this point, therapist and patient began working toward the end of psychotherapy. The patient's symptoms presented at intake had improved, according to the parents, therapist, and teacher, and according to the outcome measures (Rorschach Method, used every 12 months, and CBCL, completed every 3 months).

Two raters were randomly assigned to and independently evaluated each session. The videos were coded in random order. The first step was to establish interrater reliability. For this purpose, intraclass correlation coefficients were calculated. Each session received a final score from the average of the two raters' ratings. The interrater reliability varied from .60 to .89 ($M = .72$, $SD = .07$) in Walter's sessions. SPSS 23.0 was used for this purpose.

The second step was to calculate the most and least characteristic items of the CPQ in the treatment as a whole and every 25 sessions, each corresponding to approximately 6 months. This analysis made it possible to identify the overall tone of the therapy.

In the third phase of analysis, the composited scores of the 123 psychotherapy sessions were submitted to a principal components

factor analysis with varimax rotation, yielding four factors, or IS (to test Hypothesis 1). These IS represent strongly intercorrelated clusters of CPQ items, that is, certain items clustered together, reflecting IS during the psychotherapy process.

In the fourth step, Pearson correlations were used to analyze changes in the resulting IS over time (to test hypothesis 2). In order to analyze differences in the magnitude of the IS, a within-subjects multivariate analysis of variance (MANOVA) was used (also to test Hypothesis 2).

In the fifth step, we also analyzed if each treatment phase presented characteristics consistent with the prototypes (PDT, CBT, and RF process). For this purpose, Pearson correlation coefficients between each of the three CPQ prototypes and the 123 composited CPQ ratings were calculated and saved as session adherence scores (in the treatment as a whole and every 25 sessions, each corresponding to approximately six months). Finally, to analyze differences in the magnitude of similarity with the prototypes, a within-subjects MANOVA was performed (to test Hypotheses 3, 4, and 5).

Results

According to the CPQ, during Walter's psychotherapeutic process it was very characteristic of the therapist to ask for more information or elaboration (Item 31). Her interventions were aimed at encouraging Walter's speech (3). She was confident and self-assured (86), and accurately perceived the therapeutic process (28). She also was sensitive to the boy's feelings (6) and development level (77).

In turn, Walter was unwilling to examine his thoughts and motivations related to his problems (Item 58), and he ignored or rejected the therapist's comments (42). Notwithstanding, the material of the sessions was usually meaningful and relevant to Walter's conflicts (88).

The least characteristic CPQ items suggest that Walter was not compliant (Item 78) and did not have difficulties in understanding the therapist's comments (5). He did not achieve new understanding (32), and he communicated with strong affect (40). The therapist was not judgmental (18) and was responsive (9). She did not act to strengthen defenses (89) or to control the interaction (17). Table 2 summarizes these results and the mean of each item.

The principal components factor analysis yielded four conceptually distinct factors. These factors explained about 33% of the variance of the items, which is consistent with the literature (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Goodman et al., 2014; Ramires et al., 2015). The four factors were conceptualized as IS, which describe repetitive patterns of interaction between the therapeutic dyad. The four IS were as follows:

Interaction Structure 1

Passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist ($\alpha = .94$; eigenvalue = 12.51; % of variance = 12.51). In this IS, Walter expressed negative feelings toward the therapist, rejected her comments and observations, and was unwilling to examine thoughts, reactions, and motivations related to his problems. For example, he brought comic books for the session; he sat in a chair with his legs up and was reading. He ignored the therapist during these moments and her attempts to

Table 2
*Ten Most and Ten Least Characteristic CPQ Items Across
 123 Sessions*

Items	<i>M</i>
Ten most characteristics items	
31: T asks for more information or elaboration.	8.18
58: C appears unwilling to examine thoughts, reactions, or motivations related to problems.	7.98
88: Material for the hour is meaningful and relevant to C's conflicts.	7.50
86: T is confident, self-assured [vs. uncertain or unsure].	7.43
42: C ignores or rejects T's comments and observations.	7.24
23: Therapy session has a specific focus or theme.	7.20
3: T's remarks are aimed at encouraging C's speech.	7.13
6: T is sensitive to the C's feelings.	7.11
77: T's interaction with C is sensitive to the C's level of development.	7.11
28: T accurately perceives the therapeutic process.	6.95
Ten least characteristics items	
18: T is judgmental and conveys lack of acceptance.	3.05
78: C is compliant.	2.67
5: C has difficulty understanding the T's comments.	2.61
12: T models unspoken or unelaborated emotions.	2.55
89: T acts to strengthen existing defenses.	2.51
40: C communicates without affect.	2.39
32: C achieves a new understanding or insight.	2.37
53: C conveys awareness of own internal difficulties.	2.30
17: T actively exerts control over the interaction (e.g. structuring, introducing new topics).	2.24
9: T is nonresponsive [vs. affectively engaged].	2.04

Note. CPQ = Child Psychotherapy Q-Set; T = therapist; C = child.

communicate with him. He said he was not willing to talk, had nothing to say and that everything was very boring. The therapist thought that in these moments Walter was acting the way he felt at school, where he suffered bullying from his peers. He was provocative, challenging the therapist, and he did not engage in make-believe play. Walter presented with a negative relationship in this IS. In short, the IS was characterized by a withdrawn, depressed, resistant, and defensive child with a tolerant and not intervening therapist.

Interaction Structure 2

Accepting, supportive, accommodating, sensitive therapist with articulate child ($\alpha = .82$; eigenvalue = 8.06; % of variance = 8.06). In this IS, a positive therapeutic relationship was present. Walter was clear and organized in his expression, and he demonstrated a shared vocabulary and understanding with the therapist. The therapist was sensitive, accepting, accommodating. She did not point out Walter's use of defenses or recurrent themes. She was also supportive. For example, in Session 92 Walter asked the therapist to continue playing with the "Paper Theater." He took the envelope containing the drawings of the characters and the narrative of the story. He asked the therapist to read what was written. Then he asked her to continue writing the story about two characters who fuse and merge together and through this joining of forces they are stronger.

Interaction Structure 3

Directive, active, and reassuring therapist with blaming child ($\alpha = .81$; eigenvalue = 6.65; % of variance = 6.65). In this IS, the

therapist assumed a directive, active, and didactic stance. At the same time, Walter used defenses such as blaming others or external forces for his difficulties. For instance, at the office door the father told the therapist about a fight at school, where Walter had been called into the principal's office. During the session, the therapist tried to discuss the episode with Walter, who complained about his classmates and said he did nothing. The therapist tried to explain to Walter how his behavior made him appear to be the problematic student in the class, and how much he damaged himself by reacting in that way. Walter shouted, covered his ears and did not listen to the therapist.

Interaction Structure 4

Directive, limit-setting therapist with demanding, misunderstood child ($\alpha = .72$; eigenvalue = 5.50; % of variance = 5.50). In this IS, Walter was demanding and did not feel understood. The therapist did not interpret warded-off or unconscious content and did not accurately perceive the therapeutic process. Instead, the therapist set limits and did not discuss the therapeutic relationship. A negative therapeutic relationship was present. For instance, in Session 27 Walter had a cold and was wiping his runny nose on his clothes. The therapist offered the paper tissue box. Walter accepted, cleared his nose and then gave the dirty tissues to the therapist. The therapist asked Walter to put in the trash, he got annoyed and threw the tissues on the floor. Later, Walter chose to draw. He made two drawings, but thought they were not good and threw the drawings on the floor. He asked the therapist to get the drawings and fix what he thought was wrong. She answered that he could take his drawings and fix them. Table 3 presents the items clustered together in each is and the corresponding factor loadings.

Using Pearson correlations, changes in IS over time were observed. Two interaction structures became less characteristic over time: IS 1 (passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist; $r = -.33, p < .01$) and IS 4 (directive, limit-setting therapist with demanding, misunderstood child; $r = -.28, p < .01$). In contrast, two IS became more characteristic over time: IS 2 (accepting, supportive, accommodating, sensitive therapist with articulate child; $r = .41, p < .01$) and IS 3 (directive, active, and reassuring therapist with blaming child; $r = .62, p < .01$).

A within-subjects MANOVA followed by Sidak pairwise comparisons between every pair of the four IS was performed ($\lambda = .31, F = 88.36^A, df = 3.00, p = .000$). This indicated that IS 1 (passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist) was more characteristic over the treatment course than IS 3 (directive, active, and reassuring therapist with blaming child) and IS 4 (directive, limit-setting therapist with demanding, misunderstood child). It also indicated that IS 2 (accepting, supportive, accommodating, sensitive therapist with articulate child) was more characteristic than IS 3 and 4 and that IS 3 was more characteristic than IS 4 ($p < .05$).

To examine if each treatment phase had characteristics consistent with the prototypes (PDT, CBT, and RF process), Pearson correlation coefficients showed a significant similarity to all prototypes. Considering the entire treatment, the similarity to the PDT prototype was highest ($r = .57, p < .01$), followed by the similarity to the RF process prototype ($r = .50, p < .01$) and the CBT prototype ($r = .39, p < .01$).

Table 3
Interaction Structures Identified in Walter's Psychotherapy and Factor Loadings

Items	Interaction Structure 1: Passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist ($\alpha = .941$)	Interaction Structure 2: Accepting, supportive, accommodating, sensitive therapist with articulate child ($\alpha = .824$)	Interaction Structure 3: Directive, active, and reassuring therapist with blaming child ($\alpha = .810$)	Interaction Structure 4: Directive, limit-setting therapist with demanding, misunderstood child ($\alpha = .719$)
72: C is active.	-.81 ^a			
13: C is animated or excited.	-.76			
94: C feels sad or depressed [vs. cheerful and joyous].	.76			
1: C expresses negative feelings (e.g., criticism, hostility) toward T [vs. expresses approval or admiration].	.74			
10: C seeks greater intimacy with the T.	-.74			
42: C ignores or rejects T's comments and observations.	.68			
40: C communicates without affect.	.66			
56: C is distant from his or her feelings.	.66			
95: C's play lacks spontaneity.	.63			
58: C appears unwilling to examine thoughts, reactions, or motivations related to problems.	.63			
78: C is compliant.	-.63			
8: C is curious.	-.62			
61: C feels shy and embarrassed [vs. unselfconscious and assured].	.62			
44: C feels wary or suspicious [vs. trusting and secure].	.61			
32: C achieves a new understanding or insight.	-.60			
20: C is provocative; challenges the T or rules and boundaries of the therapy hour.	.59			
45: T tolerates C's strong affect or impulses.	.58			
71: C engages in make-believe play.	-.56			
29: The quality of C's play is fluid, absorbed [vs. fragmented, sporadic].	-.51			
53: C conveys awareness of own internal difficulties.	-.50			
70: C struggles to control feelings or impulses.	.49			
7: C is anxious and tense [vs. calm and relaxed].	.48			
74: Humor is used.	-.47			
49: C conveys mixed or conflicted feelings about the T.	.46			
15: C makes physical contact with the T.	-.46			
65: T clarifies, restates, or rephrases C's communication.	-.45			
64: C draws T into play.	-.45			
63: C explores relationships with significant others.	-.43			
77: T's interaction with C is sensitive to the C's level of development.		.65		
18: T is judgmental and conveys lack of acceptance.		-.64		
86: T is confident, self-assured [vs. uncertain or unsure].		.61		
50: T draws attention to feelings regarded by the C as unacceptable (e.g., anger, envy, or excitement).		-.61		
36: T points out C's use of defenses.		-.60		
47: When the interaction with C is difficult, T accommodates the C.		.57		
6: T is sensitive to the C's feelings.		.54		
38: T and C demonstrate a shared vocabulary or understanding when referring to events or feelings.		.53		
54: C is clear and organized in verbal expression.		.50		

Table 3 (continued)

Items	Interaction Structure 1: Passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist ($\alpha = .941$)	Interaction Structure 2: Accepting, supportive, accommodating, sensitive therapist with articulate child ($\alpha = .824$)	Interaction Structure 3: Directive, active, and reassuring therapist with blaming child ($\alpha = .810$)	Interaction Structure 4: Directive, limit-setting therapist with demanding, misunderstood child ($\alpha = .719$)
89: T acts to strengthen existing defenses.		.50		
62: T points out a recurrent theme in the C's experience or conduct.		-.47		
24: T's emotional conflicts intrude into the relationship.		-.41		
84: C expresses anger or aggressive feelings.		-.40	.69	
57: T attempts to modify distortions in C's beliefs.			.63	
66: T is directly reassuring.			.60	
87: T informs C of the potential impact of his or her behavior on others (not including the T).			.58	
27: There is a focus on helping the C plan behavior outside the session.			-.55	
3: T's remarks are aimed at encouraging C's speech.			-.54	
93: T is neutral.			.53	
55: T directly rewards desirable behaviors.			.49	
43: T suggests the meaning of the behavior of others.			.48	
34: C blames others, or external forces, for difficulties.			-.48	
12: T models unspoken or unelaborated emotions.				-.58
98: The therapy relationship is discussed.				-.57
28: T accurately perceives the therapeutic process.				.54
41: C does not feel understood by the T.				.54
83: C is demanding.				-.46
67: T interprets warded-off or unconscious wishes, feelings, or ideas.				.45
51: C attributes own characteristics or feelings to the T.				-.45
76: T makes links between C's feelings and experience.				.41
99: T offers help or guidance.				-.41
69: C's current or recent life situation is emphasized.				.41
48: T sets limits.				.41

Note. T = therapist; C = child.

^a Only items with loadings above .40 were included.

If we consider each treatment phase, we observe that characteristics consistent with the PDT prototype began higher, then they decreased and increased again from Session 76 (Session 1–25: $r = .57, p < .01$; Session 26–50: $r = .52, p < .01$; Session 51–75: $r = .47, p < .01$; Session 76–100: $r = .53, p < .01$; Session 101–125: $r = .60, p < .01$). Characteristics consistent with the RF process prototype presented a decrease between Sessions 26 and 75, but then increased again and were the highest during the last analyzed period (Session 1–25: $r = .45, p < .01$; Session 26–50: $r = .40, p < .01$; Session 51–75: $r = .38, p < .01$; Session 76–100: $r = .53, p < .01$; Session 101–125: $r = .62, p < .01$). Finally, and surprisingly, characteristics consistent with CBT prototype were significant and increased over the therapy sessions (Session 1–25: $r = .28, p < .01$; Session 26–50: $r = .26, p < .01$; Session 51–75: $r = .29, p < .01$; Session 76–100: $r = .47, p < .01$; Session 101–125: $r = .56, p < .01$). Figure 1 shows the similarity to these prototypes and their variations over time.

A within-subjects MANOVA followed by Sidak pairwise comparisons between every pair of the three session prototypes was also performed ($\lambda = .44, F = 81.03^A, df = 2.00, p = .000$). It confirmed significant mean differences between them: PDT similarity > RF process similarity > CBT similarity ($p < .05$).

Discussion

Psychotherapy with children with disruptive behavior disorders poses some challenges for therapists. The mixed symptomatology, the uncontrolled behavior and lack of emotion regulation, with the presence of sad and depressed mood at times, may hinder the adoption of a line of intervention and demand the therapist's flexibility and ability to adapt to the child's needs at every stage of the therapeutic process.

The report of Walter's psychotherapy reflects these characteristics, which is consistent with the findings from the CPQ. Analyzing the IS, we observe the importance of supportive elements (e.g., educative, suggestive, encouraging, and empathic) alongside expressive ones, as recommended by Kernberg and Chazan (1991). IS 2 (accepting, supportive, accommodating, sensitive therapist with articulate child), which became more characteristic during the treatment, corroborates the simultaneous importance of these techniques and limits to the adoption of the traditional psychoanalytic technique throughout the entire course of these treatments. The factor loadings in IS 2 depict a positive therapeutic

relationship, instead of IS 1 and IS 4, which depict negative therapeutic relationships.

Nonetheless, even if IS 1 (passive, sad and anxious, hostile child uninterested in insight with affectively tolerant therapist) and IS 4 (directive, limit-setting therapist with demanding, misunderstood child) reflect negative therapeutic relationships, such interaction patterns may have been necessary to foster the expression of Walter's difficulties while providing a secure holding environment. Children with disruptive behavior disorders who present symptoms like Walter's (e.g., temper tantrums, arguing with adults, defiance of requests, blaming others, being easily annoyed by others, expressing anger and resentment) usually feel poorly understood and are not aware that they have a problem (PDM Task Force, 2006). From their perspective, the problem lies in the demands that others make on them. Consequently, social and family relationships are impaired because of the child's disruptiveness, bossiness, and oppositional behaviors. In a vicious cycle, the resulting disapproval from others leads the child to be increasingly rebellious and defiant. These children need special assistance via appropriate limits, empathetic responsiveness, and help with affect regulation and behavioral containment. Such dynamics seemed to be repeated in the therapeutic relationship, especially in IS 3 and 4. Notably, IS 1 and 4 became less characteristic during Walter's treatment, which leads us to suggest that the therapeutic work contributed to their understanding and overcoming to some extent.

In the IS 3 (directive, active, and reassuring therapist with blaming child), the therapist assumed a directive, active, and didactic stance. She was directly reassuring while Walter used mechanisms of defense such as blaming others or external forces for his difficulties. Three items present in this IS (3, 27, and 57) were also present in the CBT prototype, described by Goodman et al. (2016; see Table 3). It is not possible to establish a relationship of cause and effect in this case; it is equally plausible that the child's behavior and defenses caused a directive response from the therapist, or the therapist's stance aroused the child's defenses.

Even if IS 3 became more characteristic over time as described above, it was not the most characteristic in the entire treatment. Its magnitude was lower than IS 1 and IS 2 and only higher than IS 4. Goodman (2015), discussing the interaction structures in the psychodynamic psychotherapy of a girl diagnosed with borderline personality disorder (BPD), found preliminary evidence for the effectiveness of traditional CBT interventions strategies in diminishing the patient's angry, affective displays, replaced later by PDT intervention strategies. Therefore, we observe in the present therapeutic process, as well as in those reported by Goodman (2015); Ramires et al. (2015), and Schmidt (2015) common IS in different children's psychotherapies, with different diagnoses, in which a difficult, angry, aggressive or resistant child relates to a directive, didactic, and limit-setting therapist. What could be the common theme in these different children, diagnoses and dyads? What seems to exist in common is an important difficulty in identifying and regulating emotions. Although these treatments have a significant adherence to PDT prototype, and they are meant to be psychodynamic psychotherapies, helping a child to identify or regulate dysregulated and strong emotions demands intervention strategies other than interpretive work, at least on a preliminary basis (see Hoffman et al., 2016).

Another aspect to be regarded is the "related problem of insufficient limit-setting and structure by a parent" (PDM Task Force,

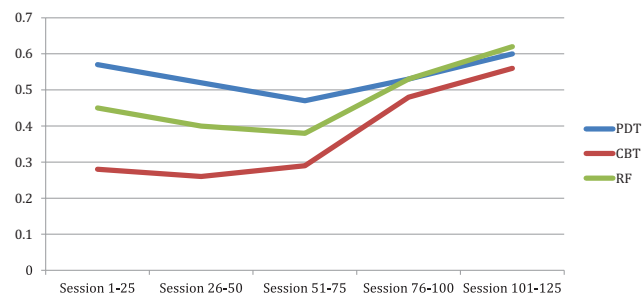


Figure 1. Similarity to prototypes over time. All correlations were significant at the .01 level (two-tailed). See the online article for the color version of this figure.

2006, p. 329). As a result, self-regulation and social problem-solving will be impaired. It is possible to identify difficulties in Walter's history that would suggest some degree of impairment in parenting coregulated reciprocal affective exchanges. Thus, self-regulation of emotions and behaviors should be explored in the therapeutic relationship. The more experiences of compatibilities and incompatibilities in this relationship, the more intense the emotionally dysregulated state. Likewise, IS in the treatment of patients who present with disruptive behavior disorders reflect the dynamics of this process.

Conversely, we should consider the contribution of the therapist to IS configurations. Goodman (2015) and Goodman and Athey-Lloyd (2011) showed that the therapist contributes to these interaction patterns. They analyzed the treatment of a child with two different therapists sequentially, and found that each therapist made an independent contribution to the formulation of the IS. Factors such as the therapist's personality, knowledge, experience, feelings toward the child, and achievements in personal treatment may affect the therapeutic relationship in different ways with different patients. In some moments of Walter's treatment, he aroused strong negative feelings in his therapist, which can also help to explain the therapist's CBT stance in the face of his intense defense mechanisms.

We found that Walter's psychotherapy showed characteristics consistent with the three analyzed models of treatment: PDT, CBT, and the RF process. Similarity to the PDT prototype was the most characteristic of the entire treatment, followed by the RF process and CBT. This trend was constant at each examined treatment phase (each set of 25 sessions, corresponding to approximately six months), inverting only in the last phase, as we see in Figure 1. At that point, the similarity to the RF process prototype was the greatest.

Enhancing mentalization is an implicit process inherent to conceptually distinct treatments like PDT and CBT (Goodman et al., 2016). Moreover, one possible explanation in this case is that the dysregulation of emotions and behavior had demanded interventions designed to help the boy to think about his behavior and feelings in order to better understand the underlying mental states. His difficulties with peer relationships, feeling isolated and rejected, also would demand the understanding of others' behaviors. Goodman (2015), analyzing the psychotherapy of a girl diagnosed with BPD, identified similar results regarding the similarity to the prototypes in that treatment. In summary, with children who present with diagnoses that imply an impairment in their behavior such as DMDD and BPD, interventions aimed at enhancing mentalization should be attempted, as observed in these studies.

We can explain the characteristics consistent with CBT in a similar way. As observed in the description of IS, Walter needed help to contain his severe affective and behavioral dysregulation. The use of interpretation or pointing out his use of defenses seems to have increased Walter's anxiety, aggressiveness, and dysregulated behavior in these moments, which in turn seems to have led the therapist to adopt more directive interventions, capable of providing the necessary support.

Someone might object that PDT is not suitable for children with such difficulties, but we would argue that the characteristics consistent with the PDT prototype were quite significant throughout the overall treatment. Like a mother trying to understand and meet her child's needs and emotions, a therapist must meet the demands and difficulties of their patient. In order to achieve this, they might

make use of different techniques, adopting an integrative approach.

The CPQ is valuable in enabling the description of the integrative nature of most treatment and we observed that in this study. The therapist combined many approaches to help her patient, and she also used supportive, cognitive, and behavioral techniques according to the child's needs and to the psychotherapy trajectory. This leads us to consider the importance of acknowledging and understanding the effective elements, rather than treatment types, that can be present within any therapeutic modality.

There was a decrease in the similarity to all three prototypes between Sessions 51 and 75 (see Figure 1) and an increase in the final analyzed phase. At that point, therapist and patient were discussing the end of the treatment, and intense separation anxiety was experienced by Walter. This dynamic explains the use of supportive and expressive interventions, in order to help the patient. A microanalysis of each session in this period, and mostly between Sessions 51 and 75, could help us to understand these variations. One possible explanation for this decrease is that it was a period characterized by strong resistance from the patient, when he did not accept any intervention, according to the therapist's reports. The patient used to ask the therapist to shut up, and she experienced intense countertransference feelings.

To sum up, Hypotheses 1 and 2 were supported in this study. It was possible to identify IS in this child psychotherapy, and the CPQ was sensitive to the characteristics of this therapeutic process. The IS varied in magnitude and over time, as expected. Hypothesis 3 was partially supported. There were significant characteristics consistent with the PDT prototype, but this similarity fluctuated over time.

Contrary to our expectations, there were significant characteristics consistent with the CBT prototype, and Hypothesis 4 was unsupported. It is possible that our assumption was inaccurate, as we expect that the adoption of a psychodynamic approach would preclude the use of CBT interventions. As the study showed, the integrative nature of the psychotherapy was its most important characteristic. Finally, Hypothesis 5 was confirmed, as characteristics consistent with RF process prototype were significant. In this case, this investigation confirmed previous studies that describe the RF process as a common factor in distinct psychotherapies.

Conclusion

This study contributes to the research on the child psychotherapy process, as it investigated the IS in the treatment of a boy diagnosed with DMDD. It highlighted the importance of the therapeutic relationship and added a description of a new psychopathological condition to the set of studies analyzing IS in child psychodynamic psychotherapy process.

Adding new systematic case studies exploring the therapeutic action and IS can help to establish an evidence basis for child psychodynamic psychotherapy. The use of outcome measures could also make a contribution. A limitation of this study is that we did not analyze outcomes; despite this we were able to depict the outcome as a process that unfolds over time.

The results of this study support the guidelines described by Kernberg and Chazan (1991) for the treatment of children with disruptive behavior disorders, highlighting the importance of supportive interventions alongside expressive ones. These results also suggest the need for an integrative approach, in accordance with

the state of dysregulation of emotions and behaviors presented by the child during the therapeutic process.

Future research could deepen the investigation of the psychotherapeutic process, both inside and outside a particular case. Microanalysis of different moments of each session, observing the fluctuations in IS, the behavior of the CPQ items in these sessions, complemented by reports of the therapist and his or her affect states in relation to the child, would help in understanding the vicissitudes of IS. Analyzing different cases with the same and with different diagnose certainly would also add valuable information.

The role of a mentalizing stance should be explored in future studies in order to understand the significant similarity to the RF process prototype that this study and other cited studies have demonstrated. Furthermore, we need to understand what distinguishes psychotherapies in everyday practice as well as in what ways they are similar in helping children with mental disorders and specifically with disruptive behavior disorders.

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