*Trends in Psychology* / Temas em Psicologia
ISSN 2358-1883 (online edition)
DOI: 10.9788/TP2018.2-07En

Article

# Interaction Structures in the Psychodynamic Psychotherapy of a Girl Diagnosed with Adjustment Disorder

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## Abstract

The scientific literature indicates the need for studies focusing on the process and outcomes of child psychodynamic psychotherapy. In addition, the relationship and the interaction structures between therapist and patient have been emphasized as an important factor of therapeutic change. The aim of this study was to analyze interaction structures in the psychodynamic psychotherapy of a child with adjustment disorder. We conducted a descriptive, longitudinal study based on the systematic case study procedure. The participants were an 8-year-old girl and her therapist. Forty psychotherapy sessions were analyzed using the Child Psychotherapy Q-Set (CPQ). Five interaction structures were identified on the basis of factor analysis of main components with varimax rotation. They describe different patterns of interaction, using supportive, directive, and interpretive approaches. The importance of interaction structures as a vector of change, therapist variables, and the trend toward integrative approaches in child psychotherapy are discussed.

**Keywords**: Child psychotherapy, single case study, process research, interaction structures.

# Estruturas de Interação na Psicoterapia Psicodinâmica de uma Menina com Transtorno de Adaptação

## Resumo

A literatura científica aponta a necessidade de estudos com foco no processo e nos resultados da psicoterapia psicodinâmica de crianças. Além disso, o relacionamento e as estruturas de interação entre terapeuta e paciente têm sido enfatizadas como importante fator de mudança terapêutica. O objetivo desse estudo foi analisar as estruturas de interação na psicoterapia psicodinâmica de uma criança com transtorno de adaptação. Realizou-se um estudo descritivo, longitudinal, baseado no procedimento de

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Support: CAPES - Coordenação de Aperfeiçoamento de Pessoal de Nível Superior; CNPq - Conselho Nacional de Desenvolvimento Científico e Tecnológico.

estudo de caso sistemático. Os participantes foram uma menina de oito anos e sua terapeuta. As 40 sessões de psicoterapia foram analisadas através do *Child Psychotherapy Q-Set* (CPQ). Foram identificadas cinco estruturas de interação, com base na análise fatorial de componentes principais com rotação Varimax. Elas descrevem diferentes padrões de interação, com utilização de abordagens suportivas, diretivas e interpretativas. A importância das estruturas de interação como vetor de mudança, variáveis do terapeuta e uma tendência de abordagens integrativas na psicoterapia de crianças foram discutidas.

**Palavras-chave**: Psicoterapia de crianças, estudo de caso único, pesquisa de processo, estruturas de interação.

## Estructuras de Interacción en la Psicoterapia Psicodinámica de una Niña con Trastorno Adaptativo

### Resumen

La literatura científica indica la necesidad de estudios con foco en el proceso y en los resultados de psicoterapia psicodinámica de niños. Además, la relación y las estructuras de interacción entre terapeuta y paciente se han enfatizado como un importante factor de cambio terapéutico. El objetivo de este estudio fue analizar las estructuras de interacción en la psicoterapia psicodinámica de una niña con trastorno de adaptación. Se realizó un estudio descriptivo, longitudinal basado en lo método de estudio sistemático de casos. Los participantes fueron una niña de ocho años y su terapeuta. Las Cuarenta sesiones de psicoterapia fueran analizadas mediante el *Child Psychotherapy Q-Set* (CPQ). Fueran identificadas cinco estructuras de interacción, con base en el análisis factorial de componentes principales con rotación Varimax. Estas describen diferentes patrones de interacción, con utilización de enfoques suportivos, directivos e interpretativos. La importancia de las estructuras de interacción como un vector de cambio, las variables del terapeuta y la tendencia de los enfoques de integración en psicoterapia de niños fueron discutidos.

**Palabras clave**: Psicoterapia de niños, estudio de caso único, proceso de búsqueda, estructuras de interacción.

Adjustment disorder (AD) in children is described as a difficulty adjusting to a new life situation, in response to an identifiable stressor, resulting in the development of emotional, somatic, and/or behavioral symptoms. The stressors may be recurrent or continuous, and may affect the individual alone or the whole family. Often, the stressors are event's in the child's daily life and the symptoms are indicative of distress out of proportion to what would be expected given the intensity of exposure, causing significant impairment in social or academic functioning. Symptoms must develop within 1 month of the stressful event (American Psychiatric Association [APA], 2013).

Three factors are essential for understanding AD: the nature of the stressor, its conscious and unconscious meanings, and the patient's preexisting vulnerability. Loss of a parent during childhood or growing up in a dysfunctional family are associated with greater susceptibility. Actual or perceived support by significant others may affect behavioral and emotional responses to stressors (Sadock & Sadock, 2007).

Psychotherapy appears to be the first-line treatment of choice for AD (Sadock & Sadock, 2007), but studies have been scarce and imprecise. Individual psychotherapy should provide opportunities to explore the meaning of the stressor and thus elaborate traumatic experiences. Psychotherapy must also help the patient adapt to stressors that are irreversible or not limited in duration. In this aspect, psychodynamic psychotherapy (PP) is particularly indicated (Kramer, De Roten, Michel, & Despland, 2009), as a process that seeks to provide patients with tools to enhance self-knowledge of their own functioning; this, in turn, leads to the use of more

mature defenses to cope with mental conflicts, improved patterns of object relations (Eizirik & Hauck, 2007), and significant improvement in symptoms (Williams, 2007).

The fact that psychotherapeutic modalities play such an important role in management of AD highlights the importance of research into the treatment of these disorders, especially regarding the active ingredients of therapeutic change (Midgley, 2007). Using these premises as a foundation, the present study reports an empirical investigation into the psychodynamic psychotherapy process in an 8-year-old girl diagnosed with AD, with particular emphasis on the interaction structures established between the patient and her therapist. This study addresses the need for empirical research to demonstrate the effectiveness of psychodynamic treatment in children.

## *The Psychodynamic Psychotherapy Process in Children and Interaction Structures*

Although into the psychotherapy process in children has grown in recent years, very few studies have explored mechanisms of change. The available studies studies have covered and discussed outcome measures such as child behavior, play, defenses, object relations, and the therapeutic relationship, but have failed to capture the process of the therapeutic encounter in its full complexity (Midgley, 2007; Midgley & Kennedy, 2011).

In response to this need for a better understanding of the nature of psychotherapeutic action and of the therapy process itself, Jones (2000) developed, based on Q methodology (Couto, Farate, Ramos, & Fleming, 2011), the Psychotherapy Process Q-Set (PQS). The PQS was developed for use in empirical studies involving adults, and is considered a particularly useful instrument because it enables qualitative and quantitative description of the therapy process (Jones, 1988, 2000).

Jones (2000) used the PQS to analyze interaction structures (ISs) within the therapeutic relationship: repetitive patterns of interaction that occur between patient and therapist, sometimes unconsciously. This concept is framed within a line of thought that emphasizes interaction as the driving force behind therapeutic change, whereby interpersonal factors and the patient–therapist dyad may help the patient resume emotional development. Jones (2000) argues that only research into these specific interaction processes will be able to identify the ingredients that produce therapeutic change, and that gaining insight into these structures can help psychotherapists in clinical practice; therapists with such knowledge can know what to expect from patients experiencing certain symptoms and exhibiting certain behaviors, and understand how interactions may change over time (Goodman & Athey-Lloyd, 2011).

Study of ISs aids in the understanding of intersubjective aspects, transference and countertransference, and acting out, among other phenomena inherent to the therapeutic process, by revealing the patient's conflicts and the therapist's reactions and interventions in response thereto. Thus, experiencing the therapeutic relationship and understanding the meaning of ISs constitute important active components of comprehending the active ingredients and change mechanisms of psychodynamic psychotherapies (Jones, 2000). Changes in these interactions over time were associated with changes in the psychological structure of patients and improvement in their symptoms (Ablon & Jones, 2005; Jones, 2000).

Following in the footsteps of Jones (2000), several authors addressed the topic of the therapeutic process and ISs in adult patients with a wide range of conditions (Ablon & Jones, 2005; Coombs, Coleman, & Jones, 2002; Goodman, Edwards, & Chung, 2014; Jones, 2000; Jones & Pulos, 1993). In this direction, faced with a growing need for more in-depth studies into child psychotherapy, Schneider and Jones (2004) used the PQS to develop the Child Psychotherapy Q-set (CPQ), an equivalent instrument which allows description of the therapeutic process in children (Schneider, 2004; Schneider & Jones, 2004, 2012). Several studies using this instrument have since been conducted in the field of child psychotherapy (Goodman & Athey-Lloyd,

2011; Ramires, Carvalho, Schmidt, Fiorini, & Goodman, 2015; Schneider, 2004; Schneider, Midgley, & Duncan, 2010; Schneider, Pruetzel-Thomas, & Midgley, 2009).

The CPQ has thus allowed study of the therapeutic process in children and analysis of ISs. Schneider et al. (2009) analyzed four psychodynamic psychotherapy modalities and two cognitive-behavioral therapies. Patients were aged 8 to 12 years and were being treated for symptoms of anxiety and/or depression. The results obtained with the CPQ were consistent with similarities between the psychotherapy process in children with the same type of complaint, even when treated by different therapists. Conversely, when the same therapist treated different children with distinct difficulties, interaction patterns were different. In both treatments, psychodynamic and cognitive-behavioral, the CPQ items related to the child were quite similar, which shows that the children presented themselves homogeneously, perhaps because of their age, type of disorder and degree of difficulty presented were similar. As for therapist-related items, a negative correlation was found, which suggests that the techniques that characterize PP were strikingly absent from cognitive-behavioral therapy and vice-versa.

Later, Schneider et al. (2010) described the therapeutic process in an 11-year-old girl referred for psychotherapy with DSM-IV diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Panic Disorder, and Avoidant Disorder of Childhood. Therapy lasted 3 years, four times a week. Interaction structures were identified and the outcome described. Nine sessions (three each from the beginning, middle, and end periods of treatment) were used for analysis of the therapeutic process. Three ISs were identified: 1 – *Bringing out the withdrawn child*, 2 – *Working with states of anxiety and resistance*, and 3 – *Coming out of the shell*. According to the authors, a combination of interpretative and empathic interventions led to improvement in the patient's symptoms.

Goodman and Athey-Lloyd (2011) analyzed whether ISs differ when the patient remains the same but the therapist changes during the course of treatment. To that end, they analyzed the 2-year PP of a 6-year-old diagnosed with Asperger's disorder. In each year, the child was treated by a different therapist. Analysis of the therapeutic process was based on the CPQ. Four ISs were identified: 1 – *Reassuring, supportive, nondirective therapist with a compliant, curious child, building insight and positive feelings*; 2 – *Helpful, mentalizing, confident therapist with expressive, comfortable, help-seeking child*; 3 – *Judgmental, misattuned therapist with distant, emotionally disconnected, misunderstood child*; and 4 – *Accepting therapist with playful, competitive child.* The magnitude of each IS varied among therapists and over time during each year of treatment. The results of the study confirmed the authors' hypothesis that ISs would not only fluctuate over time, but also differ between two therapists treating the same child.

Goodman (2015) examined ISs during PP of a child diagnosed with borderline personality disorder and treated by two therapists. Again, four ISs were identified: 1 – *Sensitive, non-judgmental therapist with motivated, insightful, admiring child*; 2 – *Interpretive therapist with passive-aggressive child*; 3 – *Humorous, confident therapist with animated, playful child*; and 4 – *Structuring, accommodating therapist with difficult, angry child*. The structures varied in magnitude between the two therapists and over time with each treatment. The author notes that what is effective in one dyad may not work in another, due to therapist-specific and dyad-specific features.

Ramires et al. (2015) have also analyzed ISs in the psychodynamic therapy of a boy with Asperger's disorder, as well as possible changes in his psychic organization. Approximately 30 months of psychotherapy were analyzed using the CPQ. Four ISs were identified: 1 – *Active, confident, and lively child, competing with connected, mentalizing, and accepting therapist;* 2 – *Withdrawn and defensive child with uncertain, unresponsive, and didactic therapist;* 3 – *Accepting therapist with demanding, provocative, and hostile child;* and 4 – *Reassuring, supportive, nondirective therapist with compliant and unspontaneous child.* Two ISs varied over time.

One IS was similar to one identified by Goodman and Athey-Lloyd (2011).

The study of ISs during child psychodynamic therapy has been contributing to a greater understanding of this therapeutic process in children with a wide range of clinical problems. The need for studies in the field of child psychotherapy that take the outcomes and process of therapy into account has also been widely recognized. Within this context, the present study sought to describe and analyze the therapeutic process in a girl diagnosed with AD by identifying and understanding the ISs established over the course of her treatment.

## Method

### *Participants*

"Alice" was an 8-year-old third-grader at the start of her psychotherapeutic process. She had received a DSM-5 diagnosis of with AD with anxiety (309.24), established by her therapist and by the case supervisor. Alice lived with her mother and sister. Six months before she presented, her father had died suddenly and unexpectedly. Consequently, several changes in family structure occurred; both girls had to change schools and their mother had to spend more time at work. Alice was very attached to her father, and vice-versa. She had been referred for psychotherapeutic care after being taken by her mother to a pediatric neurologist due to migraines, crying spells, and stomachaches, for which no organic cause was found. Alice claimed to dislike going to school and was unable to make friends. According to her mother and her teacher, Alice was a kind, caring perfectionist who did not tolerate mistakes and became anxious when told off. The therapist agreed with this description and noticed on several occasions during therapy that the girl aimed to please and wished to be complimented and loved. In session, Alice demonstrated reflective capacity and creativity during play and engaged in make-believe. The child and her mother agreed to take part in the study and provided consent for video recording of sessions.

At the time of presentation, the psychotherapist had 10 years of clinical experience. She had specialist training in child PP and had completed a doctoral degree in the field. She was the clinical supervisor for the case reported herein and was undergoing personal therapy, and had previously agreed to take part in the study.

During the psychotherapy process, the therapist became pregnant and had a child. When the therapist returned from maternity leave after 2 and a half months, Alice's mother requested that Alice be discharged from care, as she believed her daughter was better and was having trouble continuing treatment. A close relative, who was part of her support network, had become gravely ill, and she felt overwhelmed by her commitments and demands. Alice had indeed overcome the symptoms that had led her to seek psychotherapy, but had started to develop some obsessive traits, which, in the therapist's opinion, warranted additional attention. Alice herself wished to continue treatment, but stated she felt better. In her own words: "*Now, I'm able to let out the things I feel. When I got here, I was like a bird in a cage. Now, it's like I've come out*". In light of this response and of the mother's difficulties, an agreement was reached whereby sessions would continue every other week, for approximately 2 months, to wind down the psychotherapy process.

### *Study Design*

This was a naturalistic, descriptive, longitudinal investigation, based on the systematic case study (SCS) design (Edwards, 2007). The SCS method is used to conduct an in-depth study of a single case. It is based on procedures developed in a clinical or naturalistic setting, and seeks to understand those factors that contribute to a change in the psychotherapy project and to the outcomes of clinical interventions.

### *Instruments*

*Child Psychotherapy Q-Set* (CPQ; Schneider & Jones, 2012). The CPQ was originally based on the PQS (Jones, 2000) and has been

translated and adapted into Brazilian Portuguese (Ramires & Schneider, 2016). It is designed to analyze the psychotherapy process in children aged 3 to 13. It is composed of 100 items consisting of statements that describe three domains of the therapeutic process: 1 – Items describing the child's attitudes, feelings, behavior, or experience; 2 – Items reflecting the therapist's actions and attitudes; and 3 – Items attempting to capture the nature of the interaction of the dyad. During the course of therapy, these items tend to cluster, and, as such, describe repetitive interaction structures (Jones, 2000).

After watching video recordings of therapy sessions, trained, independent raters sort the 100 items of the questionnaire into nine categories, in a forced-choice (*ipsative*) sorting procedure, seeking to describe these items along a continuum ranging from least characteristic to most characteristic of the session being rated. This *ipsative* assessment allows judges to compare items among themselves and place these items on a normal distribution, with most items at the center and fewer items at either end of the curve. Ipsative methods have benefits for psychological assessment, because the forced choice reduces the influence of social desirability and the bias of uniform response in the results (Cheung & Chan, 2002; Christiansen, Burns, & Montgomery, 2005; Miller & Lovler, 2015).

The reliability and validity of the CPQ have been demonstrated in several distinct studies. Its discriminant validity has been established (Goodman, Midgley, & Schneider, 2015; Schneider et al., 2009), as has inter-rater reliability (Goodman & Athey-Lloyd, 2011; Goodman et al., 2015; Ramires et al., 2015; Schneider, 2004; Schneider et al., 2010). In all of these studies, independent analyses of child psychotherapy sessions by trained raters have achieved agreement coefficients above 0.70 (intraclass correlation).

## Procedures

Following the mother's search for treatment, a clinical assessment was performed to confirm the need and motivation for psychotherapy. Therapy was based on the psychodynamic approach, with an object relations perspective, and was carried out in a private office setting, in once-weekly 50-minute sessions. Overall, 40 therapy sessions were performed, filmed, and analyzed.

Each of Alice's therapy sessions was adjudged independently by two raters, in random, interchanging pairs. The team of raters was composed of six psychologists, all of whom were trained in use of the CPQ and had clinical experience with PP. Agreement between any pair of raters was at least 0.70 (Cronbach's alpha; range, 0.69–0.90; $m = 0.80$; $SD = 0.05$) over Alice's 40 sessions of therapy. The scores assigned by the pairs of raters were used to calculate a mean for each session, which yielded composite scores used for every subsequent analysis.

First, a mean of the composite scores of all 40 sessions was used to identify the overall tone of Alice's treatment, revealing the most and least characteristic items as identified by the CPQ. As a second stage, a principal components factor analysis with varimax rotation of the composite scores of the 40 sessions was performed to identify ISs. Pearson correlation coefficients were used to analyze changes in the identified ISs over time. These analyses were carried out in the SPSS 23.0 software environment.

## Results

Assessment of the mean scores assigned to the most and least characteristic CPQ items during the 40 sessions of Alice's psychotherapy provides an overview of the general characteristics of this therapeutic process. The most characteristic items referred to the therapist's behaviors and attitudes, while the least characteristic items concerned the child's behaviors and attitudes (Table 1).

Analysis of the items with the highest and lowest mean scores suggests that the therapy was indeed psychodynamic and was led by a sensitive, affectively engaged, confident therapist, attuned with the child's emotional states. The therapist did not direct or structure the session; she attempted to encourage the patient to express her feelings and sought to help the patient manage these feelings. Alice's communications were

**Table 1**
**Ten Most Characteristic and Least Characteristic CPQ Items in Alice's Psychotherapeutic Process**

| CPQ Items | Mean | *SD* |
|---|---|---|
| Most characteristic items | | |
| 31 – T asks for more information or elaboration. | 8.28 | 0.57 |
| 6 – T is sensitive to C's feelings. | 8.20 | 0.55 |
| 28 – T accurately perceives the therapeutic process. | 8.06 | 0.65 |
| 3 – T's remarks are aimed at encouraging C's speech. | 7.70 | 0.79 |
| 88 – Material of hour is meaningful and relevant to C's conflicts. | 7.56 | 0.65 |
| 76 – T makes links between C's feelings and experience. | 7.45 | 0.78 |
| 77 – T's interaction with C is sensitive to C's level of development. | 7.35 | 0.85 |
| 23 – Therapy section has a specific focus or theme. | 7.25 | 0.68 |
| 86 – T is confident, self-assured [vs. uncertain or unsure]. | 7.25 | 0.76 |
| 82 – T helps C manage feelings. | 7.16 | 0.98 |
| Least characteristic items | | |
| 9 – T is nonresponsive [vs. affectively engaged]. | 1.12 | 0.25 |
| 41 – C does not feel understood by T. | 1.62 | 0.69 |
| 40 – C communicates without affect. | 1.72 | 0.48 |
| 5 – C has difficulty understanding T's comments. | 1.73 | 0.54 |
| 18 – T is judgmental and conveys lack of acceptance. | 1.77 | 0.59 |
| 56 – C is distant from his or her feelings. | 1.91 | 0.45 |
| 17 – T actively exerts control over the interaction (e.g., structuring, introducing new topics). | 1.97 | 0.86 |
| 26 – C is socially misattuned or inappropriate. | 2.02 | 0.47 |
| 42 – C ignores or rejects T's comments and observations. | 2.15 | 0.46 |
| 58 – C appears unwilling to examine thoughts, reactions, or motivations related to problems. | 2.43 | 0.99 |

*Note*. C, child; T, therapist.

highly affectionate; she felt understood by the therapist, accepting her interventions, and proved willing to examine her thoughts and feelings.

Principal components factor analysis revealed five conceptually interpretable ISs, which explained 36.93% of treatment variance, as shown in Tables 2 and 3. This finding is consistent with previous studies (Goodman & Athey-Lloyd, 2011; Goodman et al., 2015; Ramires et al., 2015).

IS 1 – *Attuned and interpretive therapist with active, expressive, and demanding child* ($\alpha = 0.81$). In this interaction structure, the therapist performs an accurate analysis of the therapeutic process and the child is calm and at ease, playing fluidly during the session, competing with the therapist, and feeling accepted and welcome. Separations and breaks in treatment were discussed. This structure became more characteristic over the 40 sessions of therapy ($r = .365$, $p < .05$; Figure 1).

IS 2 – *Sensitive and supportive therapist with withdrawn and distant child* ($\alpha = 0.85$). This IS reflects an interaction sensitive to the child's level of development and needs. Alice was cautious in her relationship with the therapist, with concrete, rule-bound play. The therapist was confident and supportive. The child expressed

**Table 2**
**Interaction Structures 1, 2, and 3**

| Interaction Structure 1 – Attuned and interpretive therapist with active, expressive, and demanding child. (α = *0.81*) | |
|---|---|
| CPQ Items | Factor Loading |
| 28 – T accurately perceives the therapeutic process. | .68 |
| 72 – C is active. | .66 |
| 29 – The quality of C's play is fluid, absorbed [vs. fragmented, sporadic]. | .60 |
| 96 – C's parents are a topic of discussion. | -.59 |
| 69 – C's current or recent life situation is emphasized. | -.54 |
| 46 – T interprets the meaning of C's play. | .54 |
| 22 – C expresses fears of being punished or threatened. | -.52 |
| 75 – Interruptions, breaks in the treatment, or termination of therapy are discussed. | .50 |
| 13 – C is animated or excited. | .50 |
| 83 – C is demanding. | .46 |
| 90 – C's dreams or fantasies are discussed. | -.45 |
| 39 – C is competitive, rivalrous with T. | .45 |
| 73 – C expresses fears or displays phobic behavior. | -.43 |
| Interaction Structure 2 – Sensitive and supportive therapist with withdrawn and distant child. (α = *0.85*) | |
| CPQ Items | Factor Loading |
| 99 – T offers help or guidance. | .79 |
| 12 – T models unspoken or unelaborated emotions. | -.72 |
| 77 – T's interaction with C is sensitive to C's level of development. | .62 |
| 27 – There is a focus on helping C plan behavior outside the session. | .60 |
| 53 – C conveys awareness of own internal difficulties. | -.56 |
| 71 – C engages in make-believe play. | -.56 |
| 91 – An earlier developmental phase is a topic. | -.54 |
| 26 – C is socially misattuned or inappropriate. | -.53 |
| 81 – T emphasizes feelings to help C experience them more deeply. | -.52 |
| 54 – C is clear and organized in verbal expression. | .51 |
| 95 – C's play lacks spontaneity. | .51 |
| 44 – C feels wary or suspicious [vs. trusting and secure]. | .50 |
| 10 – C seeks greater intimacy with T. | -.48 |
| 40 – C communicates without affect. | .47 |
| 93 – T is neutral. | -.45 |
| 47 – When the interaction with C is difficult, T accommodates C. | .42 |
| 86 – T is confident, self-assured [vs. uncertain or unsure]. | .42 |

Interaction Structure 3 –
Didactic and directive therapist with aggressive and defensive (projective) child. (α = *0.83*)

| CPQ Items | Factor Loading |
|---|---|
| 34 – C blames others, or external forces, for difficulties. | .69 |
| 55 – T directly rewards desirable behaviors. | .68 |
| 66 – T is directly reassuring. | .65 |
| 85 – C's aggression is directed toward self. | -.63 |
| 65 – T clarifies, restates, or rephrases C's communications. | .59 |
| 70 – C struggles to control feelings or impulses. | -.56 |
| 87 – T informs C of the potential impact of his or her behavior on others (not including T). | .56 |
| 84 – C expresses anger or aggressive feelings. | .51 |
| 38 – T and C demonstrate a shared vocabulary or understanding when referring to events or feelings. | -.50 |
| 97 – T emphasizes verbalization of internal states and affects. | .50 |
| 82 – T helps C manage feelings. | -.48 |
| 57 – T attempts to modify distortions in C's beliefs. | .46 |
| 8 – C is curious. | -.43 |
| 51 – C attributes own characteristics or feelings to T. | .41 |

*Note*. C, child; T, therapist.

herself clearly and fluently, but did not appear to be aware of her inner difficulties. IS 2 did not change significantly over the 40-session psychotherapy period ($r$ = .061).

IS 3 – *Didactic and directive therapist with aggressive and defensive (projective) child* (α = *0.83*): In this IS, Alice demonstrated resistance, expressing and directing her anger and/or aggressive feelings outward, seemingly making no effort to contain or regulate the feelings she was experiencing and exhibiting no curiosity regarding these feelings. She attributed her characteristics or feelings to the therapist, who sought to emphasize the patient's inner states and affects in order to shed light on their meaning, encouraging the child to explore and verbalize her thoughts and feelings. In this structure, the patient blamed others for her troubles, while the therapist was directly reassuring and attempted to modify distortions in her beliefs. This IS did not change significantly over the 40-session psychotherapy period ($r$ = .190).

IS 4 – *Directive therapist with dependent, resistant, and embarrassed child (α = 0.78*). In this IS, the patient resisted examining her own role in her problems and expressed mixed feelings about the therapist, despite adopting dependent behaviors. She also expressed feelings of inadequacy and inferiority, and felt shy and embarrassed. Alice rejected the therapist's remarks or interpretations, while the therapist focused more on setting limits and was less responsive. Current and past experiences were discussed, but not related. The therapist's activity during these periods did not include attempts to correlate the interpersonal aspects of therapy with experiences from other relationships, even when opportunities to do so presented themselves. This structure became significantly less characteristic over the 40 sessions of therapy ($r$ = .545, $p$ < .01; Figure 2).

IS 5 – *Accepting, supportive therapist with anxious child* (α = *0.76*). In this IS, the therapist sought information or encouraged the child to provide a more detailed description of her feelings and experiences, in an attempt to interpret the meaning of the behaviors of significant others in her life. Alice was anxious and tense, but

explored her experiences of relationships with significant others. The therapist did not focus on nonverbal and repetitive behaviors, nor on feelings and reactions that Alice had trouble dealing with. Reasons for therapy were discussed, as were separations. This IS did not change significantly over the 40-session psychotherapy period ($r$ = .208).

**Table 3**
**Interaction Structures 4 and 5**

| Interaction Structure 4 – Directive therapist with dependent, resistant, and embarrassed child. (α = *0.78*) | |
|---|---|
| CPQ Items | Factor Loading |
| 100 – T draws connections between the therapeutic relationship and other relationships. | -.63 |
| 67 – T interprets warded-off or unconscious wishes, feelings, or ideas. | -.62 |
| 32 – C achieves a new understanding or insight. | -.57 |
| 49 – C conveys or expresses mixed or conflicted feelings about T. | -.53 |
| 80 – C behaves in a dependent fashion [vs. insists on independence]. | .51 |
| 58 – C appears unwilling to examine thoughts, reactions, or motivations related to problems. | .50 |
| 92 – C's feelings or perceptions are linked to situations or behaviors of the past. | -.50 |
| 9 – T is nonresponsive [vs. affectively engaged]. | .49 |
| 42 – C ignores or rejects T's comments and observations. | .48 |
| 17 – T actively exerts control over the interaction (e.g., structuring, introducing new topics). | .47 |
| 61 – C feels shy and embarrassed [vs. un-self-conscious and assured]. | .46 |
| 74 – Humor is used. | -.45 |
| 48 – T sets limits. | .41 |
| 59 – C feels inadequate and inferior [vs. effective and superior]. | .41 |
| 45 – T tolerates C's strong affect or impulses. | -.40 |
| Interaction Structure 5 – Accepting, supportive therapist with anxious child. (α = *0.76*) | |
| CPQ Items | Factor Loading |
| 31 – T asks for more information or elaboration. | .57 |
| 2 – T comments on C's nonverbal behavior [e.g., body posture, gestures]. | -.54 |
| 4 – There is discussion of why C is in therapy. | .54 |
| 36 – T points out C's use of defenses. | -.51 |
| 79 – T comments on changes in C's mood or affect. | -.51 |
| 64 – C draws T into play. | -.50 |
| 63 – C explores relationships with significant others. | .50 |
| 50 – T draws attention to feelings regarded by C as unacceptable [e.g., anger, envy, or excitement]. | -.48 |
| 52 – T makes explicit statements about the end of the hour, upcoming weekend, or holiday. | .48 |
| 43 – T suggests the meaning of the behavior of others. | .42 |
| 7 – C is anxious and tense [vs. calm and relaxed]. | .42 |
| 16 – There is discussion or evidence of bodily functions [e.g., bowel movements]. | -.40 |

*Note*. C, child; T, therapist.

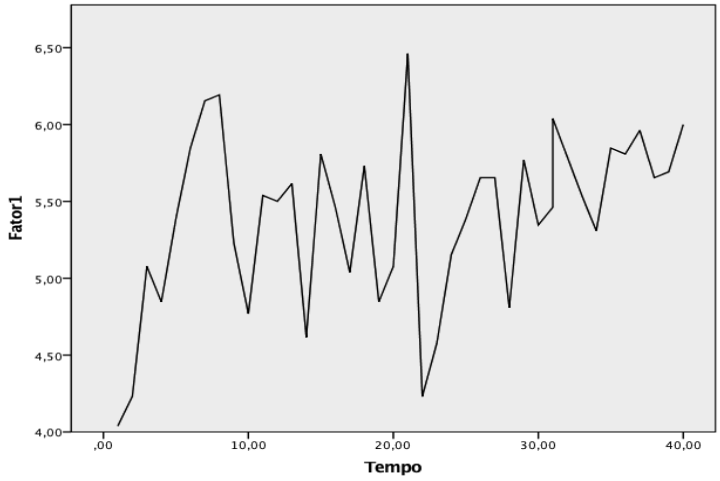


**Figure 1. Variation in Interaction Structure 1 over time (40 sessions of psychotherapy).**

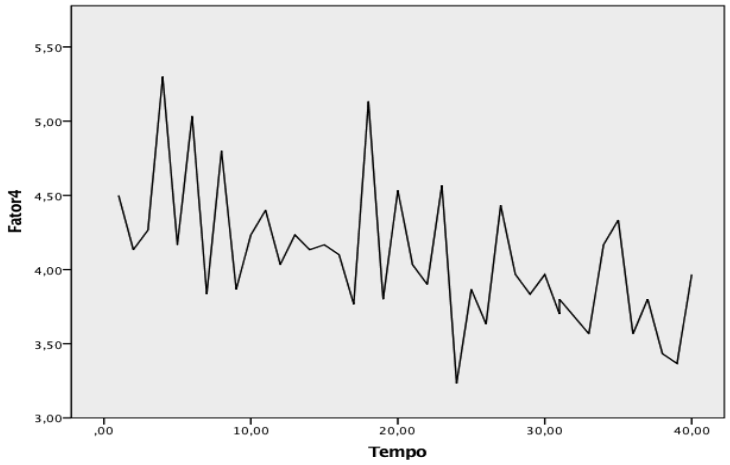


**Figure 2. Variation in Interaction Structure 4 over time (40 sessions of psychotherapy).**

## Discussion

Overall, Alice's therapeutic process was characterized by a constant attempt by her therapist to help Alice express her emotions, encouraging verbal expression and seeking to establish connections between feelings and experiences. This was done sensitively and in a manner attuned to the child's development level. It is important to note that the symptoms that led Alice to be referred for therapy included somatization, and that she was still mourning the loss of her father. When working with children, therapeutic characteristics such as affective involvement, an impartial approach, and attunement of language and affect may be needed to a greater extent than when treating adults (Goodman, 2015; Palmer, Nascimento, & Fonagy, 2013).

These intervention characteristics are consistent with the PP model (Zavaschi, Conte, Recondo, Bassols, & Ghelen, 2008). When faced with a patient experiencing difficulty coping with or expressing painful feelings, leading to somatization, one of the therapist's first tasks after forging a good connection and therapeutic alliance is to help the patient express and verbalize his emotions and affect.

Alice appears to have responded well to these interventions; according to CPQ findings, she felt understood by the therapist, took her remarks into consideration, and did not remain distant from her feelings. According to the most and least characteristic CPQ items, we hypothesize that a positive bond and a good working alliance were established between the patient and her therapist.

Principal components factor analysis identified five ISs during Alice's psychotherapy. Some are indicative of a clearly positive transference-countertransference matrix, such as IS 1, while others denote a negative transference-countertransference matrix, such as ISs 3 and 4. These findings are similar to those of other studies of ISs in child psychodynamic therapy, which also identified positive and negative transference-countertransference matrices (Goodman, 2015; Goodman & Athey-Lloyd, 2011; Ramires et al., 2015).

IS 1 revealed an attuned, interpretive therapist interacting with an active, expressive child. Separations and breaks in therapy were discussed, and the patient's play flowed well. Two important factors that affected Alice's psychotherapy must be noted: her therapist's pregnancy and subsequent unavailability during maternity leave; and the death of Alice's father (which preceded her referral for therapy). We raise the hypothesis that, over the course of therapy, these factors could be worked on whenever IS 1 made itself present more markedly, especially through the transference relationship pathway, as demonstrated by items 69 and 96 present in this interaction pattern. The importance of play is also clear in this IS (item 29). This is consistent with the child psychotherapy literature, which highlights the use of play as a means of working through the child's problems and the therapeutic relationship (Zavaschi et al., 2008). This IS increased in magnitude over the course of treatment, which is indicative of positive progress, as corroborated by Alice overcoming her presenting symptoms.

The second IS describes a relationship pattern in which the patient was more withdrawn and distant. The therapist took on a more active, supportive stance, and sought to adjust to the patient's needs. In transference, the child therapist sometimes plays a maternal role of guidance, care, and support, particularly when the child's surrounding adults are too fragile to play this role (Luz, Keidann, & Dal Zot, 2006; Zavaschi et al., 2008). One plausible hypothesis is that Alice's mother's grief over the death of her husband, compounded by her need to support her family – emotionally and financially – on her own, may have facilitated such interventions and enhanced sensitivity to the child's troubles, leading to less neutrality in these situations.

ISs 3 and 4 revealed interactions characterized by negative transference-countertransference matrices. During these period of the therapeutic process, Alice was by turns more aggressive and defensive (IS 3) or more resistant and dependent (IS 4). The therapist then took on a didactic, directive, and less neutral stance during these interactions. The expression of negative affect and aggressive impulses is part of the psychodynamic therapy process (Carlberg, 2009). In the specific case of Alice, who was mourning the loss of her father, these impulses and affects had been strongly repressed, leading to her somatic symptoms and trouble adjusting to her new school. In addition, the therapist became pregnant and moved away during psychotherapy, which may also have contributed to Alice's resistance and defensiveness.

Alice was strongly attached to her father while he was alive. His premature, sudden death may have triggered fantasies and feelings of guilt. Consequently, at school, Alice was highly anxious, perfectionist, and fearful of making mistakes. During PP, as reported by her therapist, she manifested a willingness and concern to please and be accepted, which may account for her dependent and embarrassed (IS 4), defensive (IS 3), and withdrawn (IS 2) behaviors.

Conversely, the therapist's pregnancy may have mobilized unconscious feelings of guilt regarding the fact that she had to "abandon" her little patient, who was already mourning a major loss. This may have led the therapist to be less neutral in these ISs, adopting more active and directive stances. The literature on therapist pregnancy during psychoanalytical psychotherapy suggests that this factor somehow has an impact on the therapeutic process, and can lead to changes in the therapist's attitudes and technical approach (Schmidt, Fiorini, & Ramires, 2015).

IS 4 decreased significantly over the course of therapy. We hypothesize that, to some extent, an understanding and elaboration of this interaction pattern was achieved during the therapeutic process. Jones (2000) stated that, in PP, changes

and outcomes are related to an understanding and interpretation, by both therapist and patient, of their interaction structures, particularly those that reveal patterns of conflict.

IS 5 describes an interaction pattern in which the patient was tense and anxious, while the therapist was accepting. Her interventions sought to explore content in depth, without focusing on defenses or adopting more interpretive strategies. She addressed separations (breaks and interruptions in therapy) and the child's relationship with her significant others. We hypothesize that this IS may have constituted a preparatory moment that laid the groundwork for further work, observed later during Alice's therapy, in which interpretations were employed. It is well known that the possibility of using interpretation as a resource in PP must be worked toward by the therapist and the patient; a long road is often required before this understanding is possible, and it often constitutes a natural consequence of the therapeutic process up to that point (Ferro, 1995).

Analysis of ISs in the psychotherapy of Alice and their similarity, at distinct points in the course of treatment, to different therapeutic approaches is best understood through the work of Luyten, Blatt, and Mayes (2012). These authors comprehend the therapeutic relationship as a core element of treatment and the process of therapeutic change as a series of experiences of compatibility and incompatibility in the therapist-patient relationship. Just as a mother tries to understand and respond to her infant's emotions and needs, so too must the therapist try to address the patient's demands and troubles. In this sense, Palmer et al. (2013) state that much of what they had noted as "nontraditional applications of psychoanalytic therapy may actually end up as the most commonly used methods for delivering these therapeutic ideas. And why not?" (p. 175).

Goodman (2015), in a study of ISs in the PP of a girl diagnosed with borderline personality disorder, found preliminary evidence for the effectiveness of strategies within the cognitive-behavioral therapy (CBT) to reduce the patient's rage and outbursts of temper, subsequently replacing these strategies with PP-based ones. In the therapeutic process reported herein, as in those described by Goodman (2015) and Ramires et al. (2015), some ISs proved similar to those observed in different psychotherapies of children with different diagnoses: namely, structures in which a difficult, aggressive, resistant, or distant child interacts with a directive, didactic, or otherwise less-neutral therapist. Each dyad is unique, and different therapies of children with distinct diagnoses are not expected to reveal the same ISs. What appears to be a common thread in the treatment of these children with borderline personality disorder (Goodman, 2015), Asperger's disorder (Ramires et al., 2015), and AD (present study) is a major difficulty in identifying and regulating emotions. Thus, one hypothesis that may explain the presence of interventions corresponding to different approaches is the fact that helping a child identify, understand, and regulate her emotions requires strategies other than interpretive work, at least in a preliminary stage.

Furthermore, the therapist's contribution to ISs must also be taken into account. Goodman (2015) and Goodman and Athey-Lloyd (2011) showed that the therapist contributes to interaction patterns. In their respective studies, they analyzed the sequential treatment of a child by two different therapists and found that each therapist made an independent contribution to the conformation of these structures, the magnitude of which differed between therapists. Factors such as personality, knowledge, experience, feelings toward the child, and personal therapy may affect a therapist's relationship with different patients in different ways. In Alice's case, one essential variable that must be taken into account is pregnancy, as Alice's therapist had her first child during the therapeutic process. This factor may also have contributed to the adoption of certain techniques during the therapeutic process.

After 40 sessions over approximately 15 months, Alice no longer met criteria for a diagnosis of AD. She felt more at ease at school, and the somatic symptoms that led to her referral had resolved. From a psychodynamic diagnosis standpoint, she was starting to develop obsessive

traits that, in her therapist's opinion, warranted a continuation of therapy. However, at the request of Alice's mother and justified by important objective factors, treatment was ceased. As far as the family was concerned, all treatment goals had been reached.

## Final Considerations

This study contributes to the field of research into the therapeutic process in child psychotherapy. Analysis of this process from the perspective of ISs established between patient and therapist has proven a fruitful, promising strategy, which provides information on elements to be expected from similar therapeutic processes in children of the same age group and with the same diagnosis.

Q methodology in general, and the CPQ instrument used in this study in particular, proved appropriate for analysis of the therapeutic process. Future systematic case studies exploring therapeutic action and ISs in psychotherapy of children in different age groups and with distinct diagnoses may provide additional elements with which to construct an evidence base for child psychodynamic therapy.

The use of outcome measures based on different constructs, with a focus on symptoms, defenses, and patterns of attachment, for instance, may also contribute to the development of this evidence base, as may the adoption of quantitative research designs and the conduction of randomized controlled trials. One limitation of this study was that the outcomes of psychotherapy were not analyzed through systematic application of measures designed specifically for this purpose.

Unveiling how the therapeutic process is constructed by the therapist-patient dyad is important and may help investigators and psychotherapists understand the particulars of each form of therapy. The contribution of the therapist to the process was also demonstrated clearly in this study. Although every psychotherapist adopts a given theoretical approach, it appears that, during each therapeutic relationship, the therapist's overarching allegiance should be to the patient under treatment, with attunement to the particular demands of each child. This may entail adoption of techniques that correspond, at least theoretically, to therapeutic approaches other than the therapist's own.

One trend demonstrated in the present study, as well as in previous investigations cited herein, appears to be the adoption of an integrative approach to child PP. Empirical study of interaction structures contributes to a keener understanding of what actually happens in the clinical setting of interest: it goes beyond what therapists believe they practice and instead demonstrates what they actually do in their clinical work with children.

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*Receiced: 23/09/2016*
*1st revision: 25/04/2017*
*Accepted: 27/04/2017*