Discovering New Ways of Seeing and Speaking about Psychotherapy Process: the Child Psychotherapy Q-Set

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The only true voyage of discovery…would not be to visit strange lands but to possess other eyes, to behold the universe through the eyes of another, of a hundred others, to behold the hundred universes that each of them beholds, that each of them is.

Marcel Proust, (1942) Remembrance of Things Past

Can psychotherapy research illuminate and offer clinicians insight about this complex and unique way people meet that we call psychotherapy? Transformative meaning can be derived through history, feeling, words, silence, intuition, play, gesture, gaze; the poetry and poignancy of experience, and can take various shapes and form in the imaginative lives of therapist and child. Yet, in the minds of many clinicians, the concept of ‘psychotherapy research’ is likely to conjure associations to scientific evidence-based models emphasizing randomized clinical trials, replication, controlled setting, randomly assigned client population, and manualisation of treatment; very different bases for evidence of clinically significant experience.
Michael Rustin (2001) highlights the way in which clinicians reflexively discount the work they do as research, reminding us of alternative ways of considering what features we deem ‘evidence’, and by implication the research designs we then construct. Speaking about the field of psychotherapy research, Alan Kazdin (2003:17) points out that despite the considerable progress made in psychotherapy outcome research with children, we are faced with significant gaps in our understanding:

> Despite the progress fundamental questions remain about therapy and its effects…a great deal of concern in contemporary research focuses on the extent to which treatment effects obtained in research generalize to practice. Because we do not understand why or how most treatments work, we do not know which facets of treatment are particularly important to clinical practice.

> Kazdin 2003:17

Because of the pressure to ‘prove’ the effectiveness of treatments by means of outcome studies, researchers have been led to answer assumed questions regarding ‘what works for whom’ (Paul, 1967), before sufficiently understanding the pathways to those conclusions. This consequentialist (Fonagy, Target et al., 2002) trend has led to validation and comparison of ‘brand name’ therapies (Shirk and Russell, 1996) leading us far from the experiences in many consulting rooms, especially those of clinicians practicing child psychotherapy and psychoanalysis, so creating serious gaps between the efforts, experience and discoveries of clinicians and researchers.
It appears that a critical reading of this predominant and influential ‘evidence-based’ paradigm is called for within the context of psychotherapy research, and for psychotherapists and psychotherapy researchers to gather various kinds of evidence, and methods that move beyond a constricted version of the scientific method (Midgley, 2004). Empirical methodologies employed in outcome research may bolster our conceptual landscape by generating shared discourse, systematic inquiry and the recognition of patterns otherwise neglected, but they are often lacking means to make room for the creative and intuitive dimensions of our work. Worse, they may unknowingly constrict intuition at the very core of its epistemology. If we are to strive for methodological rigour and generalizability we must retain the subtleties and appreciation of the unknowable, and the patience needed to truly learn from, rather than about, experience. The Child Psychotherapy Q-Set (CPQ), described herein, is a methodology and an instrument developed with the above proposition in mind.

**HISTORY OF Q-METHODOLOGY**

Q-methodology is a general scaling technique used to provide convenient ways of organizing data in terms of their representativeness of a particular construct, person, or situation being described. Q-technique refers to the research instrument developed for Q-methodology. William Stephenson (1935, 1953) is recognized as the person who did most to develop Q-methodology. Originally trained as a quantum physicist, Stephenson forged his way through the tensions between classical Newtonian physics, based on
sense perception and observables, and quantum theory, which is based on the behaviour of subatomic particles involving complex structures and systems of states not amenable to direct observation (Goldman, 1999). Stephenson applied these interests to the field of experimental psychology while under the mentorship of Charles Spearman at University College London, a period during which he was also nominated by Ernest Jones for psychoanalysis with Melanie Klein (Brown, 1991). Central to his theory is that factor theory in psychology and quantum theory in physics have parallel mathematical and statistical foundations.

Jack Block (1961, Block and Haan, 1971), a personality psychologist known for his extensive elaborations and applications of Q-methodology elaborated Stephenson's techniques and principles. He developed observer-rating procedures utilizing Q-methodology, the California Q-Set, and the California Child Q-Set (Block, 1969). Block’s work facilitated communication among research psychologists about how commonly used psychological terms, labels, and constructs are understood and what they mean to the individuals using them.

Enrico Jones, a psychoanalyst and psychotherapy researcher dedicated to encouraging discourse between these two fields, further extended Q-methodology in developing the Psychotherapy Process Q-Set (Jones, 1985, 2000). The PQS offers us a language and a rating procedure to draw out and describe the unique and guiding dynamics of the interplay between therapist and child. Raters undertake an evaluation of videotapes and transcripts of actual clinical experience in a Q-Sorting procedure that both identifies
salient observable themes, and gathers underlying organizing principles of a session. Theoretical terminology is kept to a minimum, allowing for theoretically ‘un-saturated’ portraits of therapist-patient interaction. Such description allows for comparison of process across various theoretical orientations and offers a closer look at what clinicians and researchers mean when referring to particular theoretical dynamics and constructs (for example see Jones and Price, 1998).

The PQS has been recognized for its effectiveness in capturing the complexity of psychotherapy process in adult treatments and has contributed valuable information about adult psychotherapy process and its relationship to outcome. The work of Jones and colleagues has challenged accepted notions about various treatment modalities, revitalized the use of single-case research design in psychotherapy research, and promoted the study of long-term psychotherapy and psychoanalysis (e.g. Jones, Cumming, & Horowitz, 1988; Jones and Windholz, 1989; Jones, Hall & Parke, 1991; Jones and Pulos, 1993, Ablon and Jones, 1998, 1999, 2002). One example is the work of Jones and Pulos (1993) who applied the PQS to compare process in psychodynamic and cognitive behavioral treatments. These researchers discovered that both CBT and psychodynamic treatments were more likely to have a successful outcome when the therapist was making greater use of psychodynamic factors.

Such findings illustrate how outcome studies focused on ‘brand-name’ treatments may fail to tell us about the significant process factors that are essential to therapeutic change and the importance of case-based research (Midgley, 2006). The Child Psychotherapy Q-
Set carries on the tradition of research set-forth by Jones in the context of child psychotherapy.

**THE CHILD PSYCHOTHERAPY Q-SET**

The development of the Child Psychotherapy Q-set (Schneider and Jones, 2004) is designed for work with children ages 3-13. To allow for greater reliability, a coding manual provides clear definitions and examples of each item reflecting features that can be assessed using videotapes of child psychotherapy sessions – always seeking a delicate balance between that which is observable and that which has to be inferred.

The instrument consists of 100 cards with statements that represent a selection from a pool of items culled from an extensive review of child psychotherapy literature (including empirically validated treatment methods, as well as psychoanalytic approaches), existing process instruments, and adaptations from the adult PQS. The instrument development project spanned four years and involved a recursive process of item construction, piloting for clinical validity, and item reconstruction. Each of the CPQ development studies mutually informed the other and modifications to the items and the manual were made after consideration of the results along the way. The initial items, culled from an extensive review of child psychotherapy literature, were reviewed by experienced clinicians representing various theoretical viewpoints (including CBT, Psychoanalytic, and Psychodynamic), who provided feedback on item clarity, redundancy, coverage, and representativeness. To establish item validity across different
children in various modes of psychotherapy, members of the Berkeley Psychotherapy Research Group used the revised CPQ to describe process in 20 videotapes of child therapy representing cognitive behavioral, psychodynamic and psychoanalytic treatments. An item correlation matrix of these ratings identified items that demonstrated little variance across cases (that is failed to differentiate across subjects) and that were redundant with other items.

As a full set, the items of the CPQ represent a broad range of child and therapist characteristics as shown in table 4.1:

The rating procedure is relatively straightforward. After studying videotapes of child therapy and arriving at some formulation of the material raters sort the 100 CPQ cards into one of nine categories, placing at one end those cards believed to be most characteristic or salient of the material, and at the other end, cards believed to be most saliently uncharacteristic. A fixed number of items are placed in each category, with more items placed centrally, reflecting less or undecriptive items than at the tails of the distribution.

Raters engage in a meta-analytic process that moves between intuition, conceptualization and objective cues within the session. It is the rater’s necessary movement between formulation and observation that offers a description of process beyond the mere
identification of behaviour. As the rater emphasizes and de-emphaizes specific items of
the CPQ to describe a session, a mosaic of therapeutic patterns begins to emerge. This
mosaic will help depict the interactive process between therapist and child in ways that
may not have been *consciously* in the mind or formulation of the therapist or the rater.

While the CPQ can be used to provide a ‘snapshot’ of therapeutic processes, a more
dynamic portrait of therapeutic work would entail tracing factors, item clusters, or
*interaction structures* (Jones, 2000) that emerge in CPQ ratings over time using factor
analytic techniques, as evidenced in research carried out by Jones and colleagues (Jones,
Ghannam, Nigg, 1993; O’Crowley, 1999; Jones, 2000; Coombs, Coleman & Jones, 2002;
Duncan, 2006; Schneider and Midgley, 2007). Even when used in these sophisticated
way, there are of course myriad dynamics and nuances within session that Q-ratings
cannot capture. However, as another stream of clinical inference, the Q-ratings may
contribute to the complex dialogue that every case evokes and may help us towards a
systematic investigation of clinical practice as illustrated by the following example of
research conducted at the Anna Freud Centre, London.

**THE CHILD PSYCHOTHERAPY PROCESS OUTCOME STUDY (CPPOS) AT
THE ANNA FREUD CENTRE**

The Anna Freud Centre has a long history of research in the field of child therapy,
including a major retrospective outcome study and a long-term follow up (see Schachter
Child Psychotherapy and Research – Chapter 4

and Target, Chapter 14). As part of this on-going work, the Centre has built up a unique data-base – much of it yet to be analysed - providing a mass of material related to treatment, including video-tapes of clinical sessions and regular and systematic assessment data. Drawing on this gold-mine of material, the Child Psychotherapy Process Outcome Study (CPPOS) aims to explore in depth the nature of the therapy process and its relation to outcome.

The CPPOS project aims to apply a range of research methodologies - mostly developed in the field of adult psychotherapy research - to clinical work with children, in order to progress towards identifying key mechanisms involved in therapeutic change. The primary data used in this study is the video-recording and therapist process notes of a small number of psychotherapy treatments, alongside a battery of standardized measures used before, during and after the end of each treatment, which had been collected as part of a pilot project for a prospective outcome study of child analysis and psychotherapy.

As a first step in this on-going project, a selection of sessions from a number of therapies - both psychodynamic and cognitive behavioural - were coded using the CPQ. Videos of four psychodynamic treatments (two intensive, two non-intensive) and two cognitive behavioural treatments, all with children between 8 and 12 who were referred because of anxiety and/or depression, were available for use.

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1 We are grateful to the organisers of the original study – Peter Fonagy, Mary Target and Karin Ensink – for permission to use this data, as well as the therapists and families who took part in the research. This project received financial support from the Tavistock Institute of Medical Research and the International Psychoanalytical Association Research Advisory Board.
This stage of the study aimed to address the following questions:

1. What similarities or differences are there across different psychodynamic treatments, either involving the same or different therapists?
2. Is there a measurable difference between what goes on in psychodynamic child psychotherapy compared to CBT?
3. How does what takes place in psychodynamic child psychotherapy sessions relate to the ‘prototype’ of what expert clinicians believe should take place?

1) What similarities or differences are there across different psychodynamic treatments, either involving the same or different therapists?

To begin with, we were curious to know to what degree a certain therapist-child dyad had a consistent pattern of engagement during the ‘middle period’ of treatment, a stage at which one would expect the analytic process to be fully engaged. After establishing inter-rater reliability with an experienced child psychotherapist in the use of the CPQ, three sessions from the middle period of each of the four psychodynamic treatments were rated by one of the authors (APT) and correlations were measured between the three sessions within each of the treatments. (The relatively small amount of data used must be borne in mind when considering what follows). As one might have expected, highly statistically significant positive correlations were found between the three sessions within
each of the treatments studied. It therefore appears that, once therapy has been on-going for a certain period of time, there is some degree of consistency in the style of interaction within each child-therapist dyad.

When each of the four psychodynamic child treatments was compared to each other, however, the findings were somewhat different. Although the same therapist worked with two of the children, the overall correlation between these two treatments was fairly weak, suggesting that there was more difference than similarity between the patterns of interaction in these two treatments, despite the therapist being the same person. This might suggest that the range of techniques and patterns of engagement used by a child psychotherapist are a response to a particular therapist-child dyad, rather than being a ‘set’ style, characteristic of that particular therapist, which is then used across all cases.

In contrast, a highly significant, strong association existed across all 100 Q-items between the treatments of two other children, although they were treated by different therapists. Wanting to understand this finding better, we looked in more detail at different aspects of the CPQ. When the ‘child’ items of the CPQ were separated out for examination, a highly significant positive correlation was found between the behaviour of these two children, both of whom displayed phobic behaviour and used highly affect-laden communications. In addition, both children demonstrated ready understanding of the therapist’s comments, and were highly responsive to these. Perhaps responding to the way in which these two children engaged in therapy, there was a significant similarity in how the respective therapists engaged with these two children, and the interactive
patterns that emerged within each of these dyads had marked similarities. This finding might suggest that a particular type of behaviour on a child’s part elicits a certain kind of technique from the therapist, creating greater similarity in style and technique between two different therapists working with ‘similar’ children than between treatments in which the same therapist is working with two children who engage in therapy in very different ways.

2) Is there a measurable difference between what goes on in psychodynamic child psychotherapy compared to CBT?

A further question that this study explored was whether the CPQ could capture the difference between what goes on in a psychodynamic child psychotherapy treatment compared to cognitive behavioural therapy. Both by looking at the descriptive statistics and by examining correlations, the results would suggest that this is indeed the case.

Interestingly, a highly significant positive correlation was found between the child items for the two types of treatment, suggesting that the way in which the children presented in the two different types of treatment was quite similar. This may be due to the fact that they were matched in terms of their ages and their level and type of disturbance in the original study. However, a significant (though not strong) negative correlation across the therapist items suggests that techniques that feature highly in psychodynamic treatment were noticeably absent in the CBT treatment, and vice-versa.
These findings were echoed (and elaborated) by the descriptive statistics, which indicate that a number of items that received low ratings across psychodynamic psychotherapy treatments rated among the highest in the CBT treatments (see tables 4.2 and 4.3).

**TABLE 4.2 and 4.3 NEAR HERE**

The portrait that emerged from these findings is a psychodynamic child psychotherapy in which the therapist encourages further elaboration from the child in a sensitive manner, and attempts to verbalize the child’s feelings, including interpretations of unconscious or warded off thoughts and feelings, but does not necessarily ‘help’ the child to manage difficult feelings. Neither does the therapist behave in a didactic manner, nor attempt to teach the child to behave in a particular way; but certain areas are rarely discussed, including early developmental phases, and the reason why the child is in treatment. Interestingly, the transference relationship and its interpretation does not appear to be a central feature of the work.

In the cognitive behavioural psychotherapy, there is a much greater emphasis on the child’s current life situation, and the therapist is far more controlling of the session, setting limits, helping the child to plan behaviour outside the session, modifying distortions in the child’s thinking and directly rewarding desirable behaviours. Like the psychodynamic therapist, the therapist encourages further elaboration of the child’s
thoughts and feelings, but the focus in not on the therapeutic relationship, nor does the therapist attempt to interpret the child’s play.

At face value, these descriptions of what was actually taking place in the two types of treatment show clear differences from each other, but also seem to be recognizable to clinicians working with these respective models. But in order to explore to what degree the treatments actually reflected psychodynamic and cognitive behavioural models of what should take place, we decided to take our study one stage further.

3) How does what takes place in psychodynamic child psychotherapy sessions relate to the ‘prototype’ of what expert clinicians believe should take place?

Prior to our work on the Anna Freud Centre data, Schneider (2004) invited an international sample of 30 senior clinicians, representing cognitive behavioural and psychodynamic orientations, to rate the 100 CPQ items in terms of the extent to which they appeared characteristic (or uncharacteristic) of their ‘ideal’ practice with children.

In that study, two distinct factors emerged that exemplify an ‘ideal’ representation of psychodynamic and cognitive behavioural therapies respectively. According to these experts, the work of the psychodynamic child therapist is best captured by items on the CPQ which describe working with powerful feelings and affects, looking for recurrent themes and interpreting warded off experiences, while they felt that behaviours such as direct reassurance, helping the child plan behaviour outside the session or rewarding
desirable behaviours was not part of their approach. In contrast, the cognitive behavioural child therapists saw their role as involving precisely those features that were not deemed relevant by the psychodynamic therapists (rewarding desirable behaviours and offering re-assurance, self-disclosing, exerting control over the interaction etc.), while items which emphasize working directly with the therapeutic relationship or offering interpretations were seen as least relevant to a CBT approach.

Curious to know how far these ‘ideal’ prototypes reflect the way that psychodynamic and cognitive behavioural therapists work in practice, a further stage of analysis was carried out by two of the authors (APT and NM). This involved a comparison of the profile of psychodynamic and cognitive-behavioural child psychotherapy that emerged from the Anna Freud Centre study with the ‘ideal prototypes’ of treatment described above. However, when comparisons were made, not a single significant correlation, positive or negative, was found between any of the experts’ ratings and the data collected in the AFC study. This would seem to imply that there is no clear association between the ‘ideal type’ of these two kinds of treatment, as described by expert clinicians, and the actual practice, as observed in the video-tapes of real treatments.

When the descriptive statistics were examined more closely to see what CPQ items occurred in both the ‘ideal’ treatment and the actual treatment sessions, it appeared that the profile of CBT, as observed on the video-taped sessions, adhered rather better to the

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2 Because the experts’ ratings did not follow the forced normal distribution, usually applied to Q-sort ratings; these were recoded and correlational comparisons used Spearman’s Rank Correlation Coefficient. Means for each of the treatment orientations were calculated and correlated with the mean ratings for the psychoanalytic psychotherapy and CBT treatments, from this study.
ideal prototype than did the psychodynamic psychotherapy data. For the latter, while there were some similarities between the most salient items, as observed in the videotaped treatments and the psychodynamic ‘ideal prototype’ (e.g. the therapist drawing attention to, and interpreting, unacceptable or warded-off feelings, whilst taking a non-didactic, non-judgmental attitude), an inverse relation between ‘actual’ sessions and ‘ideal’ sessions was found for certain items. For example, experts considered it to be characteristic of an ‘ideal’ session that the child and therapist explore an earlier developmental phase – this was found to rarely take place in practice.

Although there were some similarities to the experts’ views on what should take place in a session, overall, an absence of any significant association was more striking. One possible explanation for this lies in the fact that many of the expert clinicians who were asked to describe their ‘ideal’ prototype of treatment commented that they found this exercise at an angle to their familiar modes of conceptualizing cases. In describing their ‘ideal’, clinicians were asked to generalize across cases in their clinical experience using Likert methodology. But it may be that ‘ideal’ prototypes are like a painter’s palette, offering a range of colours with which the artist may work, but without life until the act of creation begins. Perhaps it is only once work with a particular child begins that one can discover what aspects of the technical ‘palette’ will be drawn upon, or how they will be mixed? Certainly, on-going research at the Anna Freud Centre which we hope to publish soon, using the CPQ to describe the evolution of patterns of interaction across the course of a single treatment, indicate the unique way in which the process of
psychodynamic psychotherapy evolves, and the potential of the CPQ to capture some aspect of this act of creation (Duncan, 2006; Schneider and Midgley, 2007).

CONCLUDING THOUGHTS

In sum, the Child Psychotherapy Q-Set is designed to offer a language and research vantage point on psychotherapy process. It can be used in a variety of settings and across theoretical orientation. As we hope to have demonstrated in this chapter, the Q-Set appears able to describe some clinically-relevant aspects of the clinical encounter, and differentiate between different forms of treatment, within the context of a validated, empirically-based measure.

The potential contribution of psychotherapy process research using the CPQ lies not simply in its applicability across theoretical terrains, but also in its capacity to draw out the unique, guiding dynamics that cross boundaries of theory and practice. The hope is that the CPQ may contribute to the on-going discussion of how to reach and help children in therapy. Between familiarity and discovery, spontaneity and constraint, lies the on-going tapestry of clinical work. To recall Proust, psychotherapy process research employing the CPQ has the potential to offer a ‘different set of eyes’, thus taking us on a true voyage of discovery, one in which we can find another way to observe and to learn from the work and play of children and their therapists.

REFERENCES


http://www.ipa.org.uk/research/schneider.asp


