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Assessing levels of similarity to a “psychodynamic prototype” in psychodynamic psychotherapy with children: a case study approach (preliminary findings)

Avaliação dos níveis de adesão ao “protótipo psicodinâmico” na psicoterapia psicodinâmica com crianças: um estudo de caso (resultados preliminares)

Marina Bento Gastaud,¹ Cibele Carvalho,² Geoff Goodman,³ Vera Regina Röhnelt Ramires⁴

Abstract

Objective: To analyze the degree of similarity to a “psychodynamic prototype” during the first year of two children’s once-weekly psychodynamic psychotherapy.

Methods: This study used a longitudinal, descriptive, repeated-measures design based on the systematic case study method. Two male school children (here referred to as Walter and Peter) and their therapists took part in the study. All sessions were video and audio recorded. Ten sessions from each case were selected for analysis in this preliminary study. Trained examiners (randomly selected in pairs) independently and blindly evaluated each session using the Child Psychotherapy Q-Set (CPQ). Experts in psychodynamic therapy and cognitive behavioral therapy from several countries rated each of the 100 CPQ items with regard to how well it characterized a hypothetical ideal session of either treatment modality. A series of paired *t* tests comparing analogous adherence scores within each session were conducted.

Results: There were no significant correlations between time elapsed and adherence to the prototypes. Walter’s treatment adhered to both prototypes and Peter’s treatment did not adhere to either prototype.

Conclusion: Child psychotherapy theory and practice are not absolutely coincident. Real psychotherapy sessions do not necessarily resemble the ideal prototypes.

Keywords: Psychodynamic psychotherapy, children, case study.

Resumo

Objetivo: Analisar o grau de adesão a um “protótipo psicodinâmico” durante o primeiro ano de psicoterapia psicodinâmica de duas crianças tratadas uma vez por semana.

Método: Trata-se de um estudo longitudinal, descritivo, com desenho de medidas repetidas baseado no método de estudo de caso sistemático. Participaram do estudo dois meninos em idade escolar (aqui referidos como Walter e Peter) e seus terapeutas. Todas as sessões foram gravadas em vídeo e áudio. Foram selecionadas 10 sessões de cada caso para análise neste estudo preliminar. Examinadores treinados (aleatoriamente selecionados em pares) avaliaram de forma independente e cega cada sessão utilizando o Child Psychotherapy Q-Set (CPQ). Especialistas experientes em terapia psicodinâmica e terapia cognitivo-comportamental oriundos de diversos países pontuaram cada um dos 100 itens do CPQ em relação ao grau em que o item caracterizava uma sessão ideal hipotética de cada modalidade de tratamento. Foi realizada uma série de testes *t* pareados comparando os escores de aderência análogos a cada sessão.

Resultados: Não houve correlações significativas entre a passagem do tempo e a aderência aos protótipos. O tratamento de Walter aderiu a ambos os protótipos e o tratamento de Peter não aderiu a nenhum dos protótipos.

Conclusão: A teoria e a prática da psicoterapia de criança não são absolutamente coincidentes. Sessões reais de psicoterapia não necessariamente se assemelham aos protótipos ideais.

Descritores: Psicoterapia psicodinâmica, crianças, estudo de caso.

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Introduction

Many clinicians consider the vast body of theory and clinical evidence in psychotherapy to be categorically different from the evidence provided by empirical research.¹⁻³ We need to find a common language for communication between clinicians and researchers that allows for mutual engagement in child psychotherapy.

Psychotherapies are conducted in private settings and are strongly determined by the theoretical orientation of the psychotherapist. If the cumulative evidence regarding psychodynamic therapy (PDT) is to be increased, researchers must be able to discriminate between the roles of specific and non-specific factors in promoting outcomes. The study of adherence to ideal treatment models allows practice to inform theory and theory to inform practice in this clinical work. "Prototypes" of ideal sessions for different psychotherapy modalities can be used to make comparisons not only between different ideal sessions, but also between the ideals and actual real-world practice.⁴⁻⁶

We have based our hypotheses on two theoretical ideas: a) in PDT, some patients need a preparatory period focused on the acquisition of an introspective ability before they are capable of insight and transference⁷; b) because cognitive behavioral therapy (CBT) and PDT historically emerged from distinct philosophical and theoretical frameworks and communities, it is expected that these two therapeutic approaches are not coincident.⁸

The aim of this study was to analyze the degree of similarity to a "psychodynamic prototype" during the first year of two children's once-weekly psychodynamic psychotherapy. Our hypotheses were as follows: a) the degree of similarity to the PDT prototype would increase over time and b) the process of therapy would not be correlated with the CBT prototype at any point during the whole course of treatment.

Methods

This study employed a longitudinal, descriptive, repeated-measures design based on the systematic case study (SCS) method,⁹ in order to analyze the therapeutic process. Two male school children, hereafter referred to by the fictitious names Walter and Peter, and their therapists participated in the present study. The children were evaluated before starting psychotherapy, and were reassessed during the therapeutic process, by means of interviews with parents, the Rorschach method and diagnostic play interviews.¹⁰

1) Walter was 7 years old when his parents sought help because of relationship problems at school and

symptoms of anxiety. His therapist had 23 years of clinical experience, was a specialist in psychoanalytic psychotherapy, and held a Master's degree in Clinical Psychology. Walter exhibited few psychic resources, significant relational deficits, and poor symbolization skills and was diagnosed with adjustment disorder and dysthymic disorder.

2) Peter was 8 years old at the outset of psychotherapy and his parents had sought help because he did not perform school assignments and exhibited signs of anxiety. His therapist had less than 1 year of experience and had just started a Master's program in Clinical Psychology. Peter was a withdrawn, self-restrained boy. He played a single game throughout all sessions, the "Game of Life". He was diagnosed with Asperger's syndrome.

The treatments were conducted at psychology offices duly equipped for psychotherapeutic activities. All treatment sessions lasted 50 minutes, were scheduled on a weekly basis and were video and audio recorded.

Each child attended 52 psychotherapy sessions during their first year of treatment and 10 sessions were selected for analysis for this preliminary study: sessions 1 and 2 and two sessions from each of the third, sixth, ninth and twelfth months of therapy. Five trained examiners (randomly selected in pairs) independently and blindly evaluated each session using the Child Psychotherapy Q-Set (CPQ).¹¹ The CPQ consists of 100 items each containing a statement that describes a relevant feature of the treatment process corresponding to the child's attitudes (i.e., feelings, behaviors, or experience), the therapist's actions and attitudes, and/or the nature of the patient-therapist interactions.

After watching each session video, examiners were requested to allocate these items to nine groups ranging from the least (category 1) to the most (category 9) characteristic items, reflecting the relative degree to which each particular item characterized the therapeutic process, in comparison to all of the other items. Each session was assigned a final score, which was the average of the scores awarded by the two examiners. Inter-examiner reliability was established by calculating intraclass correlation coefficients and Cronbach's alphas. Inter-examiner reliability varied from 0.70 to 0.81 (mean = 0.75) for all of Walter's sessions and from 0.70 to 0.82 (mean = 0.74) for all of Peter's sessions. Mean CPQ scores were calculated in order to generate composite scores for use in later analyses.

The prototypes of PDT and CBT used in this research were originally developed by Goodman et al.¹² Experts in PDT and CBT from several countries rated each of the 100 CPQ items with regard to how well they characterized a hypothetical ideal session of either PDT or CBT (depending on their area of expertise).

The extent to which each session conformed to the prototypes is called the adherence score. All adherence scores were transformed from Pearson *r* scores into *z* scores to increase the normality of the data prior to statistical analysis. We conducted a series of paired *t* tests comparing analogous PDT and CBT adherence scores within each session.

All analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 21.0. This study was approved by the research ethics committee at the Universidade do Vale do Rio dos Sinos (UNISINOS), Brazil. All participants signed the informed consent document.

The text of the informed consent document clearly stated that the children, their guardians, or their therapists were entitled to withdraw from participation in the study at any time without affecting the ongoing therapy.

Results

Both psychotherapeutic processes are described in Table 1. There were no significant correlations between time and adherence to PDT or CBT prototypes during the first year of either treatment.

Table 1 - Participants' psychotherapeutic processes assessed according to the Child Psychotherapy Q-Set (CPQ) items

Walter			Peter		
Item	Score (mean)	Relation to prototypes*	Item	Score (mean)	Relation to prototypes*
Most characteristic items			Most characteristic items		
C appears unwilling to examine thoughts, reactions, or motivations related to problems	8.50	-	C appears unwilling to examine thoughts, reactions, or motivations related to problems	8.55	-
T asks for more information or elaboration	7.75	CBT	C is distant from his or her feelings	8.25	-
T's remarks are aimed at encouraging child's speech	7.70	CBT	C communicates without affect	8.05	-
T points out child's use of defenses	7.65	PDT	C's play lacks spontaneity	7.90	-
T comments on the child's nonverbal behavior (e.g., body posture, gestures)	7.55	-	The quality of C's play is fluid, absorbed (vs.; fragmented, sporadic)	7.70	-
T draws attention to feelings regarded by the child as unacceptable (e.g., anger, envy, or excitement)	7.55	-	Therapy session has a specific focus or theme	7.60	-
T is sensitive to the child's feelings	7.35	PDT	C feels shy and embarrassed (vs.; un-self-conscious and assured)	7.10	-
C ignores or rejects therapists comments and observations	7.25	-	C is competitive, rivals with the T	7.05	-
C expresses anger or aggressive feelings	7.25	-	C's aggression is directed toward self	6.85	-
T tolerates child's strong affect or impulses	7.10	PDT	T is sensitive to the C's feelings	6.75	PDT
Least characteristic items			Least characteristic items		
T is nonresponsive (vs. affectively engaged)	1.40	PDT/CBT	T interprets the meaning of C's play	2.05	-
C conveys awareness of own internal difficulties	1.90	-	T points out C's use of defenses	2.15	-
C is compliant	2.20	-	C engages in make-believe play	2.15	-
T acts to strengthen existing defenses	2.25	-	C seeks greater intimacy with the T	2.25	-
C communicates without affect	2.30	CBT	C conveys awareness of own internal difficulties	2.45	-
T actively exerts control over the interaction (e.g., structuring, introducing new topics)	2.45	PDT	T models unspoken or unelaborated emotions	2.95	-
C achieves a new understanding or insight	2.60	-	C expresses anger or aggressive feelings	3.00	-
T directly rewards desirable behavior	2.75	PDT	C is active	3.05	-
C has difficulty understanding the therapist's comments	2.85	-	T emphasizes feelings to help C experience them more deeply	3.05	-
T attempts to modify distortions in child's beliefs	2.85	-	T interprets ward-off or unconscious wishes, feelings, or ideas	3.10	-

C = child; CBT = cognitive behavioral therapy; PDT = psychodynamic therapy; T = therapist.

* This column indicates if the item also figures in the list of most/least characteristic items for the PDT or CBT prototypes.

Walter's treatment was more adherent to both prototypes than Peter's treatment:

- 1) The mean correlations between Walter's sessions and the prototypes indicated that these sessions were significantly and positively correlated with both the PDT and the CBT prototypes (PDT prototype: z score [mean \pm standard deviation] = 0.81 ± 0.16 , $p < 0.001$; CBT prototype: z score = 0.77 ± 0.52 , $p < 0.01$).
- 2) Peter's sessions were not significantly correlated with either CBT or PDT prototypes (PDT prototype: z score = -0.81 ± 0.78 , $p > 0.05$; CBT prototype: z score = -0.77 ± 0.72 , $p > 0.05$).

It is there concluded that neither of the study hypotheses were supported by the results.

Discussion

Unlike psychotherapy with adults, the PDT prototype was positively correlated with the CBT prototype for children's psychotherapy, with six shared items being listed as either most or least characteristic of both treatment approaches.¹² Common factors of therapeutic change might play a greater role in child psychotherapy process than they do in adult psychotherapy process.

Schneider et al.¹³ have shown that PDT and CBT were significantly differentiated in terms of items relating to therapists' technique, while the child items reflected similar child presentations in both treatments. In the present study, Walter's sessions were significantly and positively correlated with both prototypes and 7 of the 10 most characteristic items were related to the therapist. Peter's sessions were not significantly correlated with either prototype and 1 of the 10 most characteristic items was related to the therapist.

Walter's therapist is trained in and guided by the psychodynamic approach, but her work with Walter also adhered to the CBT prototype. One could argue that the items that were correlated with the CBT prototype are not specific to the CBT technique (e.g., therapist encourages child's speech and asks for more information). Although these items are quite characteristic of the CBT approach, the use of these techniques does not necessarily mean that the therapist strayed from psychodynamic approaches.

Furthermore, several unique factors related to the patients themselves can play an important role in interpretation of results. Superimposition of two psychotherapeutic procedures that are epistemologically different (such as CBT and PPD) or non-adherence to either may result from the strong contribution that both patient and therapist related

factors make to the therapeutic process.¹⁴ It is possible that Walter's characteristics and needs, such as few psychic resources, significant relational deficits, and poor symbolization skills, influenced the therapist's approach. Walter oscillated between moments of introspection and acting in, demanding great technical flexibility from the therapist. When the patient has reduced capacity for insight and abstraction or the patient's characteristics require the therapist to exercise restraint, the therapist tends to use directive or mixed techniques in his/her practice and is less restricted to the requirements of his/her theoretical model.^{15,16} Rigid and exclusive adherence to the psychodynamic model is hampered by the patient's difficulty symbolizing his feelings during some phases of the treatment.

In comparison with Walter's treatment, the first year of Peter's treatment suffered fewer oscillations, because of this patient's ritualistic features. The therapist had fewer opportunities to intervene with specific techniques and focused more on developing the therapeutic alliance and the patient's trust and reflective capacity (factors that are not specific to either approach). Peter was much more resistant, withdrawn and defensive than Walter. These traits call for caution with regard to the use of typical psychodynamic interventions, such as interpretation, because they are liable to mobilize patients' defenses and resistance and threaten their already fragile psychic balance. It is possible that treatment of patients who are so extensively impaired in terms of psychic structure requires temporary use of more supportive processes, before more ambitious treatment models are attempted. Patients first need to feel secure enough to explore the contents of their own minds.¹⁷ Peter's therapist may have responded to the feelings and behaviors that are typical of patients with Asperger's syndrome and decided that classical psychodynamic techniques would exacerbate rather than remedy these symptoms.

Additionally, Walter's therapist had greater clinical experience than Peter's therapist and this might have contributed to a more confident and self-assured posture when approaching the Walter's difficulties and resistance. This posture was reflected in the greater number of CPQ items related to the therapist.

These preliminary results involved a sample of 10 sessions for each case and only the first year of the treatments was analyzed. We intend to analyze all sessions when the treatments are complete in order to arrive at more robust analyses.

These preliminary findings suggest that: 1) CPQ is a useful tool for researching the adherence of treatments to their prototypes; 2) in practice, treatments are not necessarily coincident with their theoretical assumptions; 3) there are many factors associated with therapeutic

processes that determine the level of similarity with their ideal models; 4) patients are always coauthors and coconstructors of the treatment process; 5) there is significant overlap across theoretical models widely assumed to use distinct intervention strategies, in terms of how therapists conduct treatment in practice.

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