ISTANBUL BILGI UNIVERSITY
INSTITUTE OF GRADUATE PROGRAMS
CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

INTERACTION STRUCTURES IN ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY: PSYCHODYNAMIC TECHNIQUE IN PREDICTION OF PROBLEM BEHAVIORS

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ISTANBUL

2021

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Ergen Psikodinamik Psikoterapisinde Etkileşim Yapıları: Psikodinamik Tekniğin Sorunlu Davranışları Yordaması

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Date of Thesis Approval: 28.06.2021

Total Number of Pages: 125

Keywords (Turkish):	Keywords (English)
1) Ergen Psikoterapisi	1) Adolescent Psychotherapy
2) Psikodinamik Psikoterapi	2) Psychodynamic Psychotherapy
3) Süreç Araştırması	3) Process Research
4) Etkileşim Yapıları	4) Interaction Structures
5) Psikodinamik Teknik	5) Psychodynamic Technique

ACKNOWLEDGEMENTS

I would first like to thank the members of my jury for their contributions to my thesis. I am immensely thankful that Sibel Halfon has accepted her role as my advisor. Besides her illuminating instruction, her insight, eloquence and guidance throughout this process were indispensable and made me all the better. Alev Çavdar Sideris has always been a distinguished mentor and source of wisdom both in my studies and life; I cannot imagine my experience at Bilgi without her. I am also indebted to Nesteten Gazioğlu for graciously accepting to be a jury member at the last minute, evaluate my work and provide feedback.

Without the arduous work of my fellow research assistants, BusemKuralar, Hilmi Kaan, Selin Günkaya and Tuğba Çetin, I would not be able to conduct this study. Above that, I extend my gratitude to Busem for being an constant source of joy and motivation; Hilmi for being a kindred spirit and comrade; Selin for her selfless efforts and positive demeanor; and Tuğba for her steady and empathetic friendship. In addition, I would like to recognize the support provided by Eda Erdivanlı, who has shown that "being there" matters; Sumru Duraner, whose honest cynicism has been most refreshing; Kaan Kabukçuoğlu, whose conversations have always left me with an uplifted spirit; Ece Akten, whose jest and candor helped preserve my perspective; and Esra Akça, whose aid and mere presence have been a great blessing. I am also grateful to have a family who have been understanding of my absence but, nonetheless, have been there whenever I needed them.

Moreover, I feel obliged to state that without the instruction of my other lecturers and supervisors during my graduate studies, a substantial part of what I have read would not have made sense. In particular, I owe a lot to Elif Göcek Akdağ and Nevra Buldur for the therapeutic intuition they have provided, and to Ferhat Jak İçöz for revealing and guiding me on a path that I can better relate with.

Last but not least, I would like to express my eternal gratitude to Nesrin Dosdoğru, who has been on many an occasion the breath I need to continue and a pillar of my affective understanding, and to Ekrem Düzen, who has been the source of my ever-present faith in what I do while remaining human, all too human.

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ABSTRACT

In order to better account for the dynamics in psychotherapy processes, studies have used Q-sort instrument to identify interaction structures, which are recurring forms of interactions embedded in sessions that are brought about mutually by the therapist-patient dyad. The Adolescent Psychotherapy Q-set (APQ) has allowed researchers to extend this method to adolescent psychotherapy. Firstly, the current study aims to determine the interaction structures of adolescent psychodynamic psychotherapy sessions. Based on previous research, it is hypothesized that at least one of the interaction structures will represent the therapists' implementation of the psychodynamic technique. Secondly, it seeks to investigate therapists' techniques by examining how technique-related interaction structures change over time and are related to problem behaviors. The tentative hypotheses is that psychodynamic technique will predict a decrease in problem behavior, but will be moderated by the baseline problem severity. The study is naturalistic and is conducted with APQ coded 123 sessions selected from the treatment of 43 young people (M_{age} = 13.02, *SD* = 1.85) referred to therapy for a wide array of internalizing and externalizing problems. Baseline problem behaviors were assessed with Youth Self-Report (YSR) and process problem-assessment was measured with Brief Problem Monitor (BPM-Y) administered at least once every 10 sessions. The principal components analysis with a five-factor solution provided the interaction structures: Resistant Patient with Alliance Rupture; Demanding Patient, Accommodating Therapist; Resistant Patient with Avoidance of Negative Affect; Inexpressive Patient, Inviting Therapist; and Exploratory Psychodynamic Technique (EPT). Only the last one corresponded to therapist interventions. Through multilevel modelling (MLM), EPT exhibited a significant quadratic positive increase over time. Furthermore, although no independent effect of EPT on problem behaviors was found, the two-way interaction effect between EPT and baseline problem severity was significant; for patients with high and low baseline problem severity, higher levels of EPT predicted an increase and decrease in problem behaviors, respectively. The results of the current study are similar to those found in child psychodynamic

psychotherapy and suggest exploratory techniques may be associated with an increase in problem behavior within the treatment process.

Keywords: Adolescent Psychotherapy, Psychodynamic Psychotherapy, Process Research, Interaction Structures, Psychodynamic Technique

ÖZET

Psikoterapi süreç dinamiklerini daha iyi açıklayabilmek için bilimsel çalışmalar, seanslar içine yerleşik olarak kendini tekrarlayan ve terapist-hasta ikilisinin ortak olarak oluşturdukları etkileşim biçimlerini ifade eden 'etkileşim yapılarını' belirleyebilmek için Q-sort ölçüm araçlarını kullanmışlardır. Adolescent Psychotherapy Q-set (APQ) araştırmacılara bu metodu ergen psikoterapsinde de kullanma imkanı sunmaktadır. Bu araştırmanın ilk hedefi ergen psikodinamik psikoterapi seanslarındaki etkileşim yapılarını tespit etmektir. Önceki araştırmalara dayanarak, en az bir etkileşim yapısının terapistin psikodinamik teknik kullanımını temsil etmesi beklenmektedir. İkinci olarak çalışma, terapist tekniklerini, teknikle ilişkili etkileşim yapılarının zaman içerisinde nasıl değiştiklerini ve sorunlu davranışlarla nasıl ilintili olduklarını inceleyerek araştıştırmayı amaçlamaktadır. Bu amaç doğrultusunda deneysel hipotez, psikodinemik tekniğin sorunlu davranışlarda azalmayla ilişkili olacağı yönündedir. Bu tez, geniş çapta içselleştirici ve dışsallaştırıcı sorunlarla terapiye yönlendirilen 43 genç kişinin ($Ort_{yaş}$ = 13.02, *SS* = 1.85) tedavisinden alınmış, APQ ile kodlanmış 123 seans örneklemiyle yürütülmektedir. Tedavi öncesi sorunlu davranışlar Youth Self-Report (YSR) ile değerlendirimektedir ve süreç için sorun değerlendirmesi de en az her 10 seansta bir uygulanmış olan Brief Problem Monitor (BPM-Y) ile ölçülmektedir. Beş faktörlü temel bileşenler analizi ile etkileşim yapıları oluşturulmuştur: İttifak Kırılmalı Dirençli Hasta; Talepkar Hasta, Uyumlayıcı Terapist; Olumsuz Duygulardan Kaçınan Dirençli Hasta; Kendini İfade Etmeyen Hasta, Davetkar Terapist; ve Araştırıcı Psikodinamik Teknik (APT). Sadece sonuncusu therapist müdahalelerine tekabül etmektedir. Çok düzeyli modelleme (ÇDM) ile APT'nin zaman içerisinde anlamlı ikinci dereceden değişim göstermiştir. Ayrıca, APT'nin sorunlu davranışlar üzerinde bağımsız bir etkisi bulunamamış olsa da, APT ve tedavi öncesi sorun ciddiyeti arasında iki yönlü etkileşim etkisinin anlamlı olduğu keşfedilmiştir; yüksek ve düşük sorun ciddiyetli hastalar için, daha çok APT'nin sorunlu davranışlarda, sırasıyla, bir artış ve azalmayı öngörmüştür. Bu çalışmanın sonuçları çocuk psikodinamik psikoterapisindekilerle benzerlik göstermektedir ve

daha araştırıcı tekniklerin tedavi sürecinde sorunlu davranışlarda artışla ilişkili olabileceğine işaret etmektedir.

Anahtar Kelimeler: Ergen Psikoterapisi, Psikodinamik Psikoterapi, Süreç Araştırması, Etkileşim Yapıları, Psikodinamik Teknik

CHAPTER 1
INTRODUCTION

Child and adolescent psychodynamic psychotherapy (PDT) has long been considered to lack the rigorous, scientific evidence-base of efficacy in comparison to other approaches, especially cognitive-behavioral psychotherapy (CBT; Midgley, 2009; Reinecke & Shirk, 2007 Target & Fonagy, 1997). While still not on par with the adult PDT or its alternatives, recent additions to the research literature have shown an improvement in demonstrating the effectiveness and efficacy of PDT for child and adolescents for many different mental disorders (Abbass et al. 2013; Midgley & Kennedy, 2011; Midgley et al. 2017; Palmer et al., 2013). Furthermore, PDT researchers turned their focus away from a perspective that any particular approach could be effective in all cases for all disorders, but instead shifted it to the question of "what works for whom" (Fonagy et al. 2004, Roth & Fonagy, 2005). However, another (relatively) concurrent development in psychotherapy research was the questioning of outcome-based studies and their "golden standard" of randomized-control trials (RCT) based on being insufficient in furthering our ability to understand and improve clinical practice, requiring more diverse forms of evidence (Levy et al. 2014; Shedler, 2010). The need to answer questions pertaining to the how and why, psychotherapy leads to change, i.e., the mediating factors and mechanisms, became crucial questions. The corollary was that, in general, process research – which aims to give an empirical account of the therapist-patient interaction within the session – attained a significant place in research. In particular, those that formed a connection with outcome (process-outcome research) became all the more important (Kazdin, 2000b; Kazdin, 2007; Midgley, 2009).

Although, the progression of adolescent PDT outcome research has been even slower than that of child PDT, recent research has gone a long way to close that gap (see Midgley et al., 2017). Unfortunately, despite some promising initial studies, this accelerated development in this stage has not been reflected in process research for adolescents (Atzil-Slonim, 2019). One pivotal problem for process

research for those working in the psychoanalytic tradition has been the notion that instruments would diminish the intricacies of the therapeutic interactions (Hodges, 1999). Hence, many of the academics in PDT research have, in the start, been entrenched in trying to provide measures that would allow for empirical assessment that could compare multiple forms of psychotherapy (Midgley, 2009). The Adolescent Psychotherapy Q-set (Calderson et al., 2013) – which was derived from the Psychotherapy Process Q-set (PQS; Jones, 2000) for adult psychotherapy and the Child Psychotherapy Q-set (CPQ; Schneider, 2004) for child play therapy – provides an excellent opportunity to help fulfill this task.

Perhaps an underlying reason why research into adolescence has come later is Freud's amalgamation of this stage of development with adulthood, where puberty is merely a transition period where prior issues are worked out (Freud, 1905). Although later theoreticians in the tradition have given adolescence its due, the delayed arrival of advancements in research has followed a similar path. Today, adolescence is recognized as a distinct period with its own internal dynamics (Lanyado & Horne, 2009; Reinecke & Shirk, 2007). APQ recognizes this distinction and incorporates items that reflect the core issues of the period (Calderon et al., 2017), enabling researchers to identify rudimentary recurring, conscious or unconscious patterns of relational dynamics between the therapist and patient, i.e., interaction structures (IS) (Jones, 2000), that are unique to therapy with young people. This construct has previously been the basis on which researchers have been able to better understand the nature of the therapeutic process by analyzing the adult and child PDT sessions (with the Q-set measures CPQ and PQS, respectively) taken from both single-cases (e.g., Goodman & Athey-Lloyd, 2011; Jones et al., 1993; Ramires et al., 2020) and a multitude of cases (e.g., Halfon et al., 2018; Jones & Pulos, 1993). Moreover, within the framework of child and adult psychotherapy research, studies were consistently able to extract psychotherapy techniques in general, and psychodynamic techniques in particular as ISs within sessions from a collection of cases. This allowed them to inquire whether techniques were correlated with or predicted treatment outcome (Halfon et al., 2018 Jones & Pulos, 1993), and examine the association that psychodynamic technique has with problem

behavior in the course of treatment (Halfon, 2021). The purpose of the study is to extend the methodology and guiding question of these articles to adolescent PDT. To clarify, we would like to first attain a better understanding of the PDT process for young people through the emergent ISs from a pool of sessions selected from a wide range of cases. Secondly, our aim is to investigate the how any ISs representing techniques change over time and whether they can predict problem behaviors in the course of psychotherapy.

The introduction part of the thesis will move from the more theoretical towards the empirical. It will begin by presenting the uniting assumptions in PDT followed by a brief explanation of how past and more contemporary theories of the psychodynamic approach depict adolescence. After presenting how the theories in question are put into action by providing the empirically founded discerning qualities of psychodynamic techniques in adult psychotherapy, the potential modifications to these due to the developmental stage of the patient (i.e., adolescence) are discussed. Having completed the more theoretical dimensions, the thesis next expounds on the general changes in psychotherapy research from being outcome-centered to emphasizing the critical value of process and process-outcome works. Before the introduction examines the process / process-outcome research in adolescent PDT both with and without APQ thus far, the relevant parts of the PDT outcome research literature for young people, and the studies in child / adult psychotherapy by utilizing the Q-set measures (CPQ and PQS respectively) are outlined in order to be a background and basis for the aims and hypotheses of the current study.

1.1 BASIC ASSUMPTION OF PSYCHODYNAMIC PSYCHOTHERAPY

What constitutes as PDT is hard to pin-down because of the diversity of thoughts which emerged over time. However, such factors will be essential to delineate the aspects of the therapy that pertain to the therapist's orientation in this study. Fonagy and Target (2008) explain that, historically, the primary differentiating quality of 'dynamic' therapies is that they are "a comprehensive

account of human subjectivity that aims to understand *all* aspects of an individual relationship with their environment, external and internal" (p. 1079). In this regard, while cognitive behavioral therapists (classically) may concentrate their efforts on a specific dimension of a problem, psychodynamic approaches retain a more holistic response to the process of therapeutic change. Those in this line of thought strive to increase the patient's (or their parents') awareness of the various influences and regularities in their lives, and build on his or her capacity for managing emotional and social pressures.

Fonagy and Target (2008) propose that even though there are plenty of techniques used by therapists who practice a wide array of types of therapy, contemporary child and adolescent psychodynamic psychotherapists do share eight assumptions. Although some of these assumptions may not be unique to PDT and may be accepted by other orientations to varying degrees, as a whole they seem to delineate its difference:

(1) *Notion of Psychological Causation:* The child's mental disorders are considered to be sufficiently captured by the client's conscious and unconscious maladaptive organization that includes his or thoughts, feelings and motivations; these in turn determine how he or she perceives the external world. In other words, the emphasis is not on the genetic or arbitrary factors.

(2) *Limitations of Consciousness and the Influence of the Non-Conscious Mental States:* The psychodynamic approaches accept specific "narrative-like" experiences that play a pivotal role in later expectations and formation of the self, and that awareness of these (by the child or caregiver) is instrumental in the managing of complex emotions and behavior.

(3) *Assumption of Internal Representation of Interpersonal Relationships:* Psychodynamic therapist assume that intimate interpersonal relationships (e.g., attachment relationship) create mental schemes that later play a crucial role in formation of a person's personality; their self-other representations; organize emotional structures; and creates the patterns with which the person engages with others.

(4) *Ubiquity of Psychological Conflict:* The more dynamic notions of psychotherapy regard established conflicting (conscious and unconscious) psychic states as central to the mental distress and potential impediments to developmental achievements, seeking to illuminate them in order to relieve anxiety and smooth developmental transitions.

(5) *Assumption of Psychic Defenses:* Having its origins in classical psychoanalytic theory, therapists in this line of thought utilize defenses – i.e. mental operations that distort conscious reality in order to avert sources of anxiety – in the evaluation of mental difficulties.

(6) *Assumption of Complex Meaning:* Psychodynamic psychotherapists presume that there is an underlying meaning which is not overt in the consciousness or the behavior of the individual, and that elaboration and clarification of these meaning structures can be therapeutic in overcoming the more apparent emotional and behavioral symptoms.

(7) *Emphasis on Therapeutic Relationship:* While many different approaches accept some form of bond to be pertinent for therapeutic change, in dynamic theories the attachment relationship formed is either considered to be conducive to "transference". Transference in PDT is seen as the condition where unconscious expectations are played out and interpreted, or the experiencing of such interpersonal difficulties (based on past conflicts) with an understanding that adults have therapeutic results.

(8) *The Developmental Perspective:* Despite divergences about what they are, child and adolescent PDTs are (at least partially) geared towards achieving age-appropriate functioning and capacity.

It is perhaps prudent to reiterate that these seem to be critical issues that do not necessarily fully differentiate psychodynamic therapies individually, but are as a whole considered to be defining. Therefore, the next section will seek to illustrate how these basic tenets have been used to make sense of the adolescent experience.

1.1.1 EVOLUTION OF PSYCHODYNAMIC APPROACHES TO ADOLESCENCE

Freud's theory of psychosexual development ended with the genital phase, which starts with puberty. In the last essay of *Three Essays on the Theory of Sexuality*, Freud (1905) presents adolescence via a description of the physiological changes during puberty and the maturation of the infantile fantasy world. He contends this period is one that centers the focus of erogenous zones on the male and female genitalia, essentially separating the two sexes and transforming their aims based on the adult demands of finding new love objects that are different from the (fantasized) familial ones. In this sense, it is a transition into adulthood in the form of physical maturation. As the final stage of physiological differentiation, it conflates adolescent problem as one that prioritizes and prescribes the sexual aims of adulthood while defining the problematic aspects to be reminiscent of and framed by early childhood experiences.

Considering the downplay of puberty as a derivation of the prior and later stages and the reduction of many issues to a physiological level, it is not so surprising that Anna Freud later comments that adolescence is "a neglected period, a stepchild where analytic thinking is concerned" (Freud, 1958, p.255). After identifying this stage as such, Anna Freud (1958) continues to expound that adolescence embeds significant shifts in the youth's drives' defenses and is a stage where changes in personality may in fact vary. Anna Freud's perspective ran contrary to the conventional view that adolescence is simply a stepping-stone where difficulties pertaining to infantile sexuality take on a more mature form. She further observed that adolescents, unlike children and adults, do not respond well to the classical approaches of psychoanalytic psychotherapy. Anna Freud's position is that the challenge of teenagers derives from: (1) their tendency to remain in the conscious due to the excessive strain the unconscious material from earlier childhood presents to the defenses (2) their resistant attitude and sabotaging behavior which is founded on the young person's already existing struggle to displace their libidinal cathexis from the parents to someone else, who is not ideally

another adult. These qualities of adolescents are detrimental to the therapeutic process; blur the line between what is pathological and what is developmentally acceptable; and require the therapist to modify his or her technique so that it becomes more responsive to the patient's particular developmental needs. Nevertheless, Anna Freud insists that the anxiety-ridden emotional upheavals that characterize the breakdown of defenses, and aggression that is unleashed because of the mental restructuring, are desirable for the formation of an adaptive and harmonious psychic structure.

Such relatively slow realization of the distinctness and uniqueness of adolescence, and the difficulties it bears on psychotherapy, has led many psychoanalytic therapists to provide a depiction of this period that incorporated what they saw to be major developmental elements. Blos (1967) further develops Anna Freud's point on the shift in the cathexis by conceptualizing adolescence as a second individuation process. Unlike the first Mahlerian individuation process, which is based on physical capabilities and independence attained in early childhood, the one in adolescence can be regarded as extending from his or her social autonomy. During this juncture, the young person tries to integrate himself or herself into the adult society by trying to detach from the internalized objects (i.e. object constancy), in which he or she finds comfort, security and to which he or she was dependent on. Instead, the young person seeks to externalize and substitute this relationship by exploring objects outside of the home to cultivate new – albeit mostly transient – bonds of love and hate. This situation creates a back and forth for the adolescent where the psychic restructuring requires him or her to both reject infantile objects and (regressively) embrace the safety they provide. Such a conflict places stress on the adolescent that often results in ego regression and re-experiencing of previous unresolved dependencies.

As an extension of ego psychology, Erikson (1968) placed greater emphasis on the psychosocial aspect of the adolescents' experience. Despite the young person's need to resolve various issues that may have been left over from previous stages, Erikson's account prioritizes the development of the adolescent's personal and distinct identity at this stage. Since "in the social jungle of human existence

there is no feeling of being alive without a sense of identity" (p. 130), the challenge facing young individuals is to adapt to the enlarged spheres of issues for which they have to come to acquire and consolidate an ego identity – i.e., a continuously changing sense of self that is set forth by the achieved goals of the person. Erikson also recognizes the rejection of earlier bonds with parents but his perspective posits this as an extension of a need to distance himself or herself from prescribed ideals. Since the adolescent is bombarded by demands of a widened social circle, he or she is prone to 'identity confusion' in the cacophony. For Erikson, the degree to which this period is "stormy" or turbulent is contingent upon the congruence of the young person's capabilities to the prevailing ideals, expectations and technical developments within the culture he or she presides.

In an essay written in 1961, Winnicott (1965) touches upon similar themes as mentioned before. Winnicott recognizes the critical role played by the environment (in general) and the family (in particular) in the youth's ability to overcome the developmental stage without typical problems and illnesses that arise from the difficulties of the cultural trends of the period; he contends this obliges society to be more tolerant towards the conflicts of the youth. Winnicott recognizes that hostility and aggression are integral parts of both the adolescent's process of differentiating themselves from their parents to form an individuated form of emotional regulation capacity (Winnicott, 1975), *and* his or her insertion of himself or herself into the world where he or she (in his or her developmental trajectory) establishes relationships of loyalty and disloyalty, and love and hate, i.e. a social identity. Moreover, along the same lines as Erikson, Winnicott also views the formation of a social identity as a precondition for feeling "real" (Winnicott et al., 1986). Winnicott identifies these aggressive tendencies coupled with the immaturity of the period to be the source of a wide array of difficulties and pathologies from being suicidal (Winnicott, 1971), to confusions and problems pertaining to sexual intercourse, to antisocial tendencies (Winnicott, 1965) – especially in the absence of what he calls a (developmentally) facilitating environment.

However, despite its role in the setbacks and psychiatric illnesses that plague adolescence, Winnicott also holds the same immaturity at this stage at high regard (Winnicott, 1965; Winnicott, 1971). He considers rebellion to "[belong] to the freedom you have given your child by bringing him or her up in such a way that he or she exists in his or her own right" (Winnicott, 1971, p. 196). Thus, it becomes unacceptable to impose upon children or youth a false self in the form of false maturity, where they act as if they are adults and take on the responsibility of the long-term consequences of their actions and the surrounding (societal) suffering and evils. The adolescent confrontation of adults and the adult world in an 'immature' manner holds "the most exciting features of creative thought, new and fresh feelings, ideas for new living" (Winnicott, 1971, p. 198). In other words, efforts to curtail the (internalized and externalized) aggression in the name of making youth more amenable to societal norms and the period less turbulent also carries with it the risk of suffocating an essential element of authenticity (the True Self) which is integrated into this stage of their lives.

Despite Kohut's lack of a coherent account of adolescence (Palermo, 1983), Wolf, et al. (1972) have provided an accepted account of adolescent development using his approach. Their focus in this perspective is about the imposed disillusionment (via new experience) of the parents as idealized selfobjects and the loss of their function in the stable grandiose sense of self. As such, the young person is deprived of his or her ability to be demanding and assertive towards those around him or her and has to yield to mirroring affirmation of idealized others. This leads to a *fluctuation* of self-esteem as the adolescent seeks out other substitutes for the more archaic base (the parents) from which he or she derives his sense of self-worth. However, the response is not merely reactive. As Palermo (1983) points out, what differentiates Erikson's adaptive stance from Kohut's is that the latter conceives of normal adolescence to be constituted by a purpose to realize certain goals that may completely ignore the cost it may have in relation to how he or she is viewed by the adults around him. In this regard, normal adolescence is construed as one which deviates from childhood idealizations (ego ideals in Erikson's terms) in order to form one's values and ideals that would enable a person to cultivate his or her

internal sources of self-worth (Lapan & Patton, 1986). As such, it could be said the position of Self Psychology converges with Winnicott's outlook in that it at least equalizes (if not prioritizes) the formation of a more genuine self over the adolescent's capacity to cope with the newly emerging circumstances.

1.1.2 CONTEMPORARY PSYCHODYNAMIC APPROACHES TO ADOLESCENCE

Atzil-Slonim (2019) indicates that contemporary psychodynamic (particularly relational) psychotherapy has introduced various divergences from previous theoretical approaches. Many of these seem to be shifts in emphasis rather than outright deviations from the general approach adopted by previous clinicians. For instance, her first point is that relational theories focus on the interpersonal relationship and adolescence consists of an accelerated widening of this sphere in which the young person strives to reorient themselves to the new contexts, during which he or she is preoccupied with a simultaneous process of self-discovery (cf. Winnicott, 1965). Atzil-Slonim continues by stressing the ambiguity created from and the need for maintaining a multiplicity of selves while, at the same time, striving hold together a continuity of a self that transcends pre-established patterns in the face of novel, challenging situations (cf. Palermo, 1983; Wolf, Gedo and Terman, 1972). As the person grows into adolescence, there is a further demand to overcome a plethora of negative emotions that arise from uncertainty, which can be mitigated by the caregivers' tolerant stance (cf. Blos, 1983; Winnicott, 1965). Accordingly, similar to all developmental periods, the young person is troubled with oscillations between moving forward (implying change) and asking to be treated as a child for the safety of what is known; the high levels of anxiety might prevent a healthy transition due to a divergence from the developmental trajectory (cf. Freud, 1958; Bros, 1983). Lastly, Atzil-Slonim proposes that the contemporary theory takes into account, apart from individual differences, the young person's position within a particular conjecture (e.g., race and gender) may affect where his or her experience of this period may fall within the (relatively) unhindered and turbulent axis.

Fonagy and Target (2008) also point to three outdated theories of the classical psychoanalytic approach that have widely fell out of favor by therapists. Firstly, the emphasis on uncovering repressed unconscious drives where insight is the vehicle of change has given way to the idea that insight no longer guarantees change and that most therapeutic improvements rely upon non-conscious processes taking place during the therapeutic interaction. Secondly, in spite of the tendency of (some) therapists to accept the notion that their subjective reactions allow them to indirectly access the internal representations and conflicts of the client [a transference-countertransference dynamic], the *centrality* of transference as an interpretive tool is no longer widely accepted. Lastly, the authors explain that concerns about mental coherence have replaced the unconscious as the uniform bedrock of psychodynamic understanding. This position argues that although it is possible for the presentation of unconscious material to the client may yield actions towards greater coherence, in some situations it may also confuse and instill negative feelings towards himself or herself.

While such changes in theoretical approaches should not be regarded as insignificant and it is important to acknowledge the redundancy of certain aspects of the approach, there seems to be a continuity of the awareness and an evolution of understanding about adolescence among the various clinicians.

1.2 PSYCHODYNAMIC TECHNIQUES IN ADULT THERAPY

Unlike the theoretical plurality, the more observable techniques PDT has adopted have been more consistent. Two articles by Blagys and Hilsenroth (2000, 2002) have been instrumental in determining defining elements of psychodynamic-interpersonal techniques and differentiating them from cognitive-behavioral techniques. The authors explain that unlike previous reviews that targeted *theoretical* factors for change in therapy, they seek to look into the "techniques, processes, activities and interventions" (Blagys & Hilsenroth, 2000, p.168) which sets the two orientations apart based on the empirical literature, many of which are

based on the PQS (the adult version of APQ) research. They are able to draw-out seven of these:

(a) *Focus on Affect and Expression of Patient Emotion:* The psychodynamic method prioritizes not only the expression of the patient's (especially uncomfortable) conscious and unconscious emotions to a greater degree, but also seeks to explore and create associations between them and the situations in which they are experienced. Furthermore, therapists are inclined to work towards a greater understanding, discernment and acceptance of these emotions, rather than their control or reduction.

(b) *Exploration of Patient's Attempts to Avoid Topics or Engage in Activities that Hinder the Progress of Therapy:* PDT, unlike cognitive therapy, dwells upon provocative or non-cooperative acts of the patient (e.g., remaining silent, refusing to speak about certain issues, arriving late) that disrupt the routine progression of therapy. The purpose is to unravel the conscious or unconscious meaning behind them within the scope of the therapeutic relationship.

(c) *Identification of Patterns in Patient's Actions, Thoughts, Feelings, Experiences, and Relationship:* While the cognitive-behavioral approach confronts and seeks to alter patterns in thought or action, psychodynamic therapists tend to view similar experiences, generalized beliefs or recurrence in interpersonal relationships as things to be brought to awareness and understood.

(d) *An Emphasis on Past Experiences:* Contrary to the cognitive-behavioral stance that present belief systems affecting future functioning, the psychodynamic tradition tends to focus on earlier periods to clarify how unresolved conflicts and prior relationships influence the present-day choices of the patient.

(e) *Focus on Patient's Interpersonal Experience:* The propensity of psychodynamic theory to see the source of the patient's problems to lie at the junction of past and present interpersonal conflict lead to the exploration of interpersonal dynamics as opposed to the patient's intrapsychic thoughts and expectations. Hence, in spite of the fact that other orientations also taking into account the relational conflicts of the patient, psychodynamic therapy makes it

more a more salient aspect of its process and seeks to help the patient become aware of the adaptive and maladaptive attitudes he or she may have towards others.

(f) *An Emphasis on Therapeutic Relationship:* Although, the therapeutic alliance remains a core issue for all orientations, the PT uses the relationship not only to recognize problems and conflicts that regularly emerge between the patient and significant others but view the therapist-patient relationship itself as a space in which change can occur.

(g) *An Exploration of Patient's Wishes, Dreams and Fantasies:* While the authors admit there have been few academic inquiries on this topic, they do find that theoretically one of the most distinguishing elements of psychodynamic therapy is its approach to wishes, dreams and fantasies as being channels to understanding the unconscious mind. Thus, therapists regularly use interpretations in sessions that explore these experiences.

Blagys and Hilsenroth (2000) account of psychodynamic psychotherapy might seem contextually inappropriate given it is based on adult psychotherapy and research. Nonetheless, it remains relevant to this study because the sessions included in the research are instances of talk therapy as is the sample of the current study and adolescence is generally regarded as lying at the crossroads between childhood and adulthood (Horne, 1999). Perhaps more importantly, the Adolescent Psychotherapy Q-set (APQ; Calderon et al., 2017) used in this study uses Comparative Psychotherapy Process Scale (CPPS; Hilsenroth et al., 2005), which is based on the Blagys & Hilsenroth (2000, 2002) articles' conclusions, to establish the discriminant validity of the measure. Midgley et al. (2018) also used CPPS in its evaluation of treatment fidelity in the Improving Mood with Psychoanalytic and Cognitive Behavior Therapy (IMPACT) RCT and APQ was developed using this studies sample. Nonetheless, psychodynamic techniques have had some variations that sets them apart from an adult version.

1.3 CONTEMPORARY PSYCHODYNAMIC TECHNIQUES IN ADOLESCENT PSYCHOTHERAPY

The differentiating elements of the adolescent stage brings with it a series of characteristics of the young person that we would expect are typically observable within the therapeutic process. Since for a psychodynamic therapist the description of this period of development is based on his or her approach, any modifications on technique the therapist makes would (at least in part) take into account the theoretical representation of the adolescent and the aims he or she retains according to the said approach. Jones (2000) states, with regards to the development of the PQS (and by extension the APQ), that one of the primary purposes of the measure was to operationalize accepted psychodynamic concepts such as "intersubjectivity, transference-countertransference enactments, and role responsiveness" (p. xvi). Jones believes these constructs do have observable aspects, which can be captured by the ISs. Delineating how these apply specifically to the adolescent stage would help make sense of the milieu from which the pattern of items emerge.

The overall purpose of psychodynamic psychotherapy can be found when it is appropriate to end the process. In principle, psychodynamic psychotherapy (for children and adolescents) is concluded when intra- or extra-familial relationships become manageable; any traumatic experiences the young person has suffered have been addressed; emotional regulation reaches a level conducive for the patient to function in an age-appropriate fashion; a more integrated and future-oriented self is formed; the anxiety level of the patient decreases with a reduction of an appeal to maladaptive defenses; and an overarching improvement in the mentalizing capacity of the patient (Lanyado & Horne, 2009). In this regard, psychodynamic therapy aims to assist the adolescent through its *developmental process*, which presents its series of challenges. Due to the changes each young individual is going through concerning its standing vis-à-vis home, career and intimate relationships, adolescent psychotherapy has to tackle difficulties of dealing with multiplicity of actors at a junction in the young person's life where he or she has to both bears the burden of acute change with a corresponding possibility for personal growth; such

qualities makes the whole transition process ambivalent and mentally arduous (Briggs, Maxwell & Keenan, 2015).

The formation of a *therapeutic relationship* that addresses the distinctive aspects of the adolescent stage has been an issue since the beginning of the psychodynamic theory. For Anna Freud (1958) it was the reemergence of primitive anxieties that was an impediment on a cooperative and continuous engagement of the young person, while Lampl-DeGroot (1960) emphasizes the realization of adults in the non-ideal form brings with it a type of cynicism towards the guidance and affection of new love objects such as the therapist. Furthermore, in many cases the youth do not come to psychotherapy on their own accord and are brought by other adults, making them more resistant to the therapeutic process as the young person and the referrers (parents or otherwise) have differing agendas in mind (Kazdin, 2004; Mishne, 1996). The ambivalence and turbulence experienced by the adolescent in the world reflects back into the therapy room making dropouts more likely (Kazdin, 2004; Briggs et al., 2015). Thus, various authors have sought to make specific alterations of technique that would enable the therapist to consolidate a more functioning relationship with the young person, especially in more challenging cases (Lanyado & Horne, 2009). For instance, to avoid the triggering of rejection and abandonment issues the young person frequently experiences during this time, it is suggested that the therapist refrains from being analytically neutral or maintaining long silences (Giovacchini, 1973, as cited in Mishne, 1996; Horne, 2001; see also Atzil-Slonim, 2019). Similarly, an empathetic attitude, tolerant of any selfobject transferences as well as an acceptance of the idealizing and devaluing of patients, is advocated in lieu of a confrontational or interpretive stance (Gedo & Goldberg, 1973; see also Fonagy et al., 2002). Parallel to these deviations from the prior analytical approaches, Mishne (1996) proposes the therapy room must be a space that can foster an alliance which is different from its classical variant. She suggests, "[t]he therapist must always draw on a reservoir of empathy to offer him or herself the context of establishing an alliance and providing a safe and secure holding environment in therapy" (p. 149); this implies a medium

of non-judgement where the therapist cultivates genuine respect towards the young person and acts as a vessel of consistency and structure.

However, Mishne (1996) also recognizes that the corollary to this understanding is that the therapist is self-aware and has insight into his or her own biases and value system in addition to their origins. She draws attention to the potential for the client to exhibit more primitive acting-out and unstable reactions, which may elicit countertransference that is intense and sometimes (potentially) hostile. The psychodynamic approach views the *transference-countertransference relation* is an invaluable resource that can facilitate the adolescent to carry his or her negative feelings and challenging conflicts into the relationship, and supply the therapist information about the client's conscious and unconscious world via the therapist's exploration of his or her own countertransferential responses (Atzil-Slonim, 2019). However, Anastasopoulos, and Tsiantis (1996) also point out that the due to a wide range of typical adolescent demeanors – from acting out to passive or active resistance – hand-in-hand with the therapist's cultural stereotypes of adolescents or competence-based anxieties (as a therapist), the swift affective transitions and narcissistic disposition of the young people tend to draw out hard to control and burdening countransferential reactions.

Another aspect of adolescent psychodynamic psychotherapy is the rather common view that adults who are significant in the young person's life be integrated into the therapeutic process. Briggs (2002) also advocates this view, emphasizing the importance of caregivers in the young person's life. Extending Bion's theory of container and contained – originally intended to depict (infantile) early development – to the adolescents, he claims that the containers (the mother and the therapist) act as spaces in dyadic communication in which unconscious, non-verbal mental elements or emotions of the contained (the infant or the client) find meaning. Briggs infers that "being held in the mind" of the therapist – albeit important – is inadequate since the turbulence of the stage is contingent upon the containment of the transition as a whole. That is to say, "the adolescence's quest for identity is undertaken in close relationship with others" and the parent's role is quintessential how well he or she is able to cope with the intense fluctuation of

anxiety (p. 24). (cf. Winnicott, 1965) While Briggs does not propose or deem it possible for therapists to replace parents, he does believe they do play a similar role, and the therapist's accommodating stance needs to be transferred to the parents themselves. In this sense, many therapists still maintain that one of the dimensions of adolescent psychotherapy that takes a toll on the therapist remains the need in many cases for continual relationship and alliance with the parents and other potential parties of interest. Since the young person tends to be at odds with these parties, it brings with it an additional layer of possible negative responses and contertransferential frustrations (Mishne, 1996).

The overarching theme seems to be a recognition and response by therapists to the latent and intense anxieties specific to adolescence that need to be addressed in relation to how they manifest themselves in therapy. These anxieties may derive from physiological change, the pressure to acquire a new identity, the demand for the young person to reorient himself or herself vis-à-vis both old relationships and new ones in his or her new social sphere or a yearning for intimacy (Atzil-Slonim, 2019). Clinicians who have accepted these developmental distinctions have aimed to structure their sessions in order to further age-appropriate outcomes (Briggs et al., 2015). These may imply certain deviations from more traditional or rigid techniques. The principle seems to be to supply an attuned, containing environment in which these anxieties by being moderated, verbalized and made sense of (Horne, 2001).

This attitude is considered especially important in instances where the cases are more severe as the aggressive drives become more intense and the therapist has the tendency to shy away from the young person because he or she identifies with his or her earlier destructive tendencies (Lampl-DeGroot, 1960). Winnicott (1994) was one of the first to realize that 'borderline' patients have the tendency to elicit (a countertransferential) hatred from the therapist – which was not something to be shunned but should be viewed as conducive to love. Parsons and Dermen (1999) appeal to the very same idea and explain how the therapist is stuck in a dilemma. On the one hand the therapist is faced with primitive anxieties of the patient that are likely to trigger his or own (particularly in the form of narcissistic vulnerability),

which he has to be receptive of in order to understand the patient's needs and be open to in order not to further provoke aggression. Horne (2001) builds on this notion and suggests, in a Winnicottian fashion, for therapy to be more 'holding' in a network of communication that encompasses all aspects of the young person's life and communication channels are open.

While clinical experiences have great value in theory development (Midgley, 2009), how these have translated into scientific / empirical research is another matter entirely. After all, an essential factor in how research is shaped arises from methodological concerns and societal demands. The following section will try to delineate the recent developments in research of child and adolescent psychotherapy that form the basis of this study.

1.4 EMPIRICAL RESEARCH IN CHILD AND ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY

Understanding much of the discussion that has revolved around the research in psychodynamic psychotherapy requires the distinction between outcome and process research, where an impasse in the former by researchers in the initial stages has affected how they positioned the evidence in support of the psychodynamic approach. Outcome research tries to answer the question of 'does therapy work?', which can more formally be described as "[addressing] modifications within those specific domains (affective, cognitive-behavioral etc.), which represent the target of the intervention and occur as the effect of the therapeutic process." (Omar & Manzo, 2015, p. 248). In contrast, process research "[concerns] the content of psychological therapy sessions and the mechanisms through which client change is achieved, both in single sessions and across time" (Llewelyn & Hardy, 2001, p. 2).

In this sense, while process research is conceptually tied to outcome in that it tries to determine the resultant changes which occur throughout the interaction between the therapist and client, such a limited notion of change remains only one of its explicit aims. Hardy & Llewelyn (2015) explain that process research seeks to improve the quality of therapy by identifying critical elements within the process

for change (e.g., self-disclosure and its influence on the formation of therapeutic alliance), develop theory and its underlying rationale in the hopes of inferring what can be more effective forms of intervention (e.g., the role and quality of intervention in affecting change), and the formation of better training in light of the finding of the other two aims. From a different perspective, process research can be categorized based on the research designs. Apart from *hypothesis testing*, i.e., linking therapeutic interaction with the outcome, process research includes *descriptive studies* which seek to give a depiction of the therapist-client interaction, i.e., "behavior, language, thoughts, and feelings" (Llewelyn & Hardy, 2001, p. 3) as well as *change theory linked process change* that acts on the assumption that "further progress [in theory] will only be made if it is based more soundly theory about how change is possible for *different clients at different times*" (p.12, italics added).

A comparative study among the various types of psychotherapy conducted by Luborsky et al. (1975) provided a great challenge for outcome research for psychotherapy, especially PDT. In the article, Luborsky and colleagues draw several conclusions from their comparison of articles concerning a diverse set of psychotherapy approaches ("schools") called the 'dodo verdict'[1]. The most important of these was that all types of psychotherapy yielded significant benefits of approximately equal effects, signaling they all embedded common aspects that were a lot more effective than specific differences. The only exceptions where comparisons including treatments revealed to have varying results were in the conditions: pharmacology versus psychotherapy, comorbid treatment versus single treatments (only pharmacology or only psychotherapy), and psychotherapy versus control groups; the first of each comparison were demonstrated to be more effective. Furthermore, they suggested that many editors were unsure when it came

[1] The metaphor is taken from Lewis Carroll (1960) *Alice's Adventure in Wonderland*. In the story, the dodo is asked to reach a decision on a chaotic race among animals as to who had won. Since there was no rules in the race to start with the dodo says "*Everybody* has won, and *all* must have prizes". (p. 31) In the same regard, Luborsky etl al. (1975) conclude that in the races between "group vs. individual psychotherapy, time-limited vs. time unlimited psychotherapy, client-centered vs. other traditional psychotherapies, and behavior therapy vs. other psychotherapies" (p. 1003) there are no winner because all were shown to be equally effective.

to disseminating the results of some studies because their discoveries revealed there were no significant differences between the schools of psychotherapy. In a later study, Lubosky et al. (1999) also supported a hypothesis they formulated in their 1975 article. They found that a large correlation between the allegiances of the authors to a particular type of psychotherapy and favorable outcome results for that particular form of treatment.

The ramifications of these developments eventually led to a shift in research to a new direction in which outcome studies no longer focused on approaches, but rather on the question of when and who benefits from the particular the particular types of therapy (Midgley, 2009). In publishing their book *What works for whom?*, Fonagy et al. (2004) (the first edition published in 2002) sought to delineate the evidence-based findings for various disorders in children and adolescents as well as provide guidelines for effective psychotherapy research. Along with a later publication that is not centered on a child and adolescent approach (Rother & Fonagy, 2005) these books included a variety of contemporary studies with the overall purpose of setting up dialogue and discussion that would specify what groups of patients benefitted from what types of interventions.

However, the perspective bore with it not only the realization that research in child and adolescent psychotherapy can be considered as falling behind adult research, making it hard to make recommendations as to how to proceed in many circumstances (Target & Fonagy, 2005), but also that psychodynamic psychotherapy was unable to provide relatively equivalent evidence attained from outcome research by other treatment models; especially the absence of adequate and well-designed randomized control trials (RCT) (Fonagy & Target, 1997; Reinecke & Shirk, 2007; Shirk & Russell, 1992). Hodges (1999) extends the Fonagy and Target (1997) assertion that the underlying reason behind why more generalizable methods have not been adopted by the psychodynamic approach was the tradition of psychoanalytic clinicians relying on successful case described as the preferred manner in which outcome is evaluated.

Hodges (1999) names three factors that have been influential in the lack of scientific research into the effectiveness of psychoanalysis: (1) *ethos* (among

practitioners) (2) *problems of operationalization* and (3) *institutional structures.* She defines the first factor as being a result of a belief among therapists that the intricacies of the psychoanalytic process and the individual cases will be overshadowed by the codification systems used in research to attain more encompassing representations. Hodges believes this point is partially justified by the second factor that the existent outcome measures were prepared with other orientations in mind, making them seem crude and overly simplified in the eyes of psychoanalysts. Nevertheless, she insists that clinical psychologists still need to demonstrate effectiveness on some form of equal grounds. Lastly, the third dimension is that much of psychoanalytic clinical child psychology training and practice is based in institutions that, unlike universities, do not require lecturers or those who participate in engaging in or have the necessary skill set for empirical research.

The general approach accepted evaluation of scientific research in the reviews and discussion is based on a "hierarchy of evidence" that does not evaluate the quality of research (Midgley & Kennedy, 2011), but rather categories the studies "according to their susceptibility to bias" (Roth & Fonagy, 2004, p.18). Roth and Fonagy (2004) explain that the order starts from Level 1, which are RCTs representing the "gold standard", down to the lowest levels that involve subjective observations and opinions or uncontrolled studies. The main axis of evaluation in the hierarchy arises from the distinction between efficacy and effectiveness.

Roth and Fonagy (2004) explain that this dichotomy arises from a concern for internal validity derived from a research setting in the case of 'efficacy' and the external validity attained within the context of routine clinical practice for the evaluation of the 'effectiveness' of certain intervention. For the efficacy to be established, procedures such as manualized treatments and checks to whether the application of the treatment complies with the prescribed protocols; large randomized groups because studies with smaller (20-30 people) groups would inevitably lead to significant difference both between and inside the assigned groups; determination of what constitutes a control group since the ideal 'no treatment' controls present ethical difficulties; homogeneity of problem in order to

ascertain what disorder the treatment targets. Effectiveness studies on the other hand would leave out one or more of these criteria to draw conditions closer to normal practices enabling greater generalizability at the expense of accuracy. For instance, there might not be a manualized treatment or the cases studied may include a variety of patients with mixed or more complex disorders. Thus, Roth and Fonagy conclude that the resultant condition in psychotherapy is one of a perpetual dilemma since any move to relocate the research to a clinical setting would inevitably draw risks to the internal validity of the study. In this sense, when researchers alluded to the lack of systematic, evidence based studies in PDT, they are usually referring to the sparsity of higher level research.

Hence, the reviews that have systematically analyzed a variety of studies which support the effectiveness and efficacy of PDT for a multitude of psychological disorders both for adult (Levy et al., 2014; Shedler, 2010) and child and adolescent cases (Abbass et al, 2013; Midgley & Kennedy, 2011; Midgley et al., 2017; Palmer et al., 2013) also carry with them a series of caveats. Midgley and Kennedy (2011) state that one of the major limitations of their review was their relatively more inclusive criteria. As such, the studies covered were in fact small-scale, and did not possess the foundations for conducting additional follow-up studies that would allow the formation of a cumulative and systematic evidence. In their subsequent review, Midgley et al. (2017) emphasized that despite serious advancements in the field especially with regards to the increase in RCTs, many of them still worked with relatively smaller sample sizes. Similarly, Abbass et al. (2013) meta-analysis pointed to the variation in quality and technique, and the heterogeneity in the categories of the RCT's they incorporated. Thus, they also had to be less inclusive in order to be able to perform the study. Even with regards to adult research, Shedler (2010) has also recognized the comparatively smaller number of and greater scientific rigor in RCTs of other psychotherapies – mainly cognitive-behavioral therapy.

Although there is a deficit concerning such outcome studies, psychodynamic psychotherapy seems to have some advantages when it comes to process research. As Midgley (2009) indicates, outcome studies do not actually

explain the why and how therapy leads to change, which requires an integrated form of research that ties the processes to the outcomes of therapy – i.e., process-outcome studies. Kazdin (2007) explains that area inquiries focus on the mechanisms and the associated mediators that interact to create the intended outcome. These complicate the issues of outcome considerably. In the same article, Kazdin provides examples like single mechanisms can be the cause of multiple outcomes; multiple mechanisms can operate in tandem to produce a single outcome; there can be non-linear relationships where a mediator may influence the mechanism to actually make it effective when there is no overall effect; or the effects of the mechanisms may show variation in time.

Without such knowledge, the outcome does little to increase our understanding that we could transfer to improve clinical practice, making purely outcome research merely exploratory in nature (Midgley, 2009). From the perspective of process research, despite child process research still lagging behind their adult counterpart, Midgley (2009) also identifies the clinical single case-studies as a form of process research theory development – albeit unreliable. Hardy and Llewelyn (2015) make a very similar assertion by stating that many different approaches including psychodynamic psychotherapists have had an interest in process research unlike cognitive behavioral researchers who are stuck by the robust outcome inquiries. Roth and Fonagy (2006) also go as far as to say that, if done with a strong methodology, single-case studies may actually serve to be a compromise for the conflicting aims of internal and external validity.

Another line of criticism that has been directed towards outcome studies, and manualized RCTs is their lack of what Stiles et al. (1998) refers to as *responsiveness,* which is a concept based on account of the therapist-client relationship being dynamic where both sides mutually affect each other and create feed-back loops. Thus, every interaction is considered unique, as is implied in certain concepts of therapy (e.g., countertransference), and cannot be prescribed by manuals training. They contend that since this is the basic nature of the practice, many types of interventions (e.g., interpretations or therapist characteristics like level of experience) which clinicians expect to be influential in the outcome have

not consistently shown links. However, because of the implicit expectation of those who enter therapy to achieve a positive outcome (e.g., reduction of stress or the ailments of their disorder), Stiles et al. posit that *appropriate responsiveness* are those responses that are conducive to change in this direction. In this regard, the therapist should work "to monitor the situation and to choose a treatment that is appropriate for the client's problems, follow a strategy that is appropriate for the client's capacity, and intervene with techniques that are appropriate for the client's current state" (Stiles et al., 1998, p. 440). Stiles (2009) contends not only that responsiveness inescapably transgresses on the RCTs claim for independent, standardized treatment being administered by the therapist (see also, Krause & Lutz, 2009) – instead proposing continuous mutual therapist-patient influences – but also the therapists' struggle for appropriateness takes its cue from the proposed dependent variable, i.e., therapeutic change. To clarify, the author's point is that a competent therapist would be expected to modify his or her intervention depending upon the changes in the emotional, cognitive, and social well-being of the patient and whether or not these improvements or deteriorations are being incorporated into the process for beneficial outcome throughout the process itself.

These developments have made process research all the more vital, but the extent to which it can link processes to outcome also varies. Similar to the differentiation between 'efficacy' and 'effectiveness' in outcome research, for process research there is also an important axis, the one between descriptive and exploratory research. Kazdin (2000a) expounds that there is a continuum in which these two types are at each end. The former seeks to provide a good account of the existent therapeutic relationships with very little interest in providing the mechanisms that influence the intended problem or qualities in question – which is the task of the latter. In spite of his admission that every well-written descriptive study bearing some explanation, Kazdin insists the move from description to explanation should be based on theory. However, he is quick to note that an approach is not equivalent to a theory. Each approach embeds a multitude of theories that seek to explain change and theories of change can in fact be shared by several approaches.

To sum up, there seems to be two trends that are in effect simultaneously, up-down and bottom-up. On the one hand more rigorous outcome research can better contribute to specifying groups and disorders on which various interventions have positive effects (up-down), while on the other hand, more generalizable, theory-based, hypothesis testing process research can allow for explanations which can help shift clinical practice (bottom-up). Hence, Levy et al. (2014) accept RCTs as an important standard in effecting practice, but the shortcomings of this method also imply RCTs are not the only standard. Their suggestion is that further evidence from naturalistic, process and meta-analyses studies is necessary to generalize, explain and support RCT findings. That is to say, only a convergence among the discoveries made by multiple methodologies can provide what they call the "platinum standard" of research.

In the following sections, I will try and explain how these trends in psychotherapy research apply to the domain of adolescent psychodynamic psychotherapy.

1.5 OUTCOME RESEARCH IN ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY

Much like its belated development in psychoanalysis literature, empirical outcome research for adolescents seems to have fallen back. However, in recent years this has changed quite dramatically. In their 2011 review, most of the articles Midgley and Kennedy use in their work are about child psychotherapy, and when an adolescent sample was included, the sample generally also included children. In the follow-up review, there was a reversal of this situation. Only six of the 23 articles lacked an adolescent sample (Midgley et al., 2017). As Midgley et al. (2017) emphasize, many of these studies continue to be *naturalistic* and test effectiveness rather than efficacy. Still some of them had a substantial number of participants (Edlund & Carlberg, 2016) and others used waitlist or treatment-as-usual controls to benefit from some aspects of RCTs (Salzer et al. 2014).

In spite of the current study being a part of process research, some of the findings of outcome research still may be pertinent to the study at hand. One of the most influential earlier studies that included adolescents was Fonagy and Target's retrospective study of 763 cases from the archives of the Anna Freud center, which led to a series of papers (Fonagy & Target, 1994; Fonagy & Target, 1996; Target & Fonagy 1994). Some of the most relevant conclusions that were drawn from these studies were in regards to adolescents. In general, younger children (under the age of 11) benefited more from psychoanalytic psychotherapy than older, and therapy with patients suffering from emotional (internalizing) problems as opposed to disruptive (externalizing) problems usually got better results. In fact, in mixed cases (patients with emotional and disruptive symptoms), psychoanalytic therapy was more effective for those who suffered from anxiety at the emotional level. For those over the age of 12, one interesting discovery that they reported was that non-intensive therapy created either equal or better results. However, for more severe and complex disorders with both emotional (especially anxiety) and disruptive components, even if frequency did not help, the length of therapy (Fonagy & Target, 1994).

Although the efficacy and effectiveness of psychodynamic psychotherapy on adolescence has greatly been challenged both for short-term and long-term interventions (Midgley & Kennedy, 2011, Midgley et al., 2017; for example, Baruch & Fearson, 2002; Edlund & Carlberg, 2016; Kronmüller, 2002; Stefini et al., 2016) results about the discrepancy of the outcome when it came to internalizing and externalizing disorders were usually confirmed in the earlier studies on children and adolescents (Midgley & Kennedy, 2011). In addition, children and young people with disruptive disorders have been found to have greater attrition (Baruch & Fearson, 2002; Fonagy & Target, 1994; Midgley & Kennedy, 2011). A potentially significant contribution to process research may be that Baruch et al. (1998) realized that a supportive approach rather than an interpretative approach was more instrumental in keeping adolescents in therapy, with lower dropout rates.

The results of one recent study by Gatta et al. (2019) showed an interesting pattern which may lead to a closer look at the discrepancy of the internalizing / externalizing divide. This included two groups of a 12-month treatment: The first one (G1) was comprised of children and adolescents who received individual psychodynamic therapy and the second one (G2) was only comprised of adolescents who received the same individual psychodynamic therapy with the addition of parental support for their parents. While this work did not challenge the norm that the psychodynamic approach was less effective for externalizing disorders for the entire sample, this was only true for self-reported Youth Self Report and *not* the parent reported Child Behavior Checklist (CBCL) where all problem areas (internalizing, externalizing and total problems) showed a decrease. However, the research also showed that there was a decrease in all problem areas for *both* measures for G2 (the group with parental support). Thus, although the authors recognized that G2 had initially higher levels of externalizing problems, which may have been the reason behind the greater drop, it also raises the questions regarding why psychodynamic psychotherapy fails for externalizing problems – e.g., parental involvement may be critical – and who is the assessor in reaching this conclusion.

Severe or challenging cases have also been increasing the target of inquiry in recent years. Salzer et al. (2014) conducted an RCT with a sample of co-morbid adolescents who showed signs of borderline personality disorder. After a manualized treatment that incorporated both individual and group therapy (but did not have a fixed length), the patients showed significantly greater improvement than the control group. Another RCT was also conducted by Cropp and colleagues (2019) by the same group of researchers. The patients had complex mental disorders and were treated again with a mixture of both individual and group therapy. The study checked for both improvements in reflective functioning (RF) and improvement in symptoms. Significant improvement in both RF and symptoms were observed but there was no interaction effect found between the two variables. In addition, although there was an in RF post-treatment, the overall RF scores were still considerably low. Both these studies involved relatively intensive treatments with 30 minute sessions three times a week and a 45 minute group therapy sessions

once a week. Undoubtedly there would be divergences between the modes of therapy used by the therapists in the Anna Freud Center (Fonagy & Target, 1996) and those employed here. Nevertheless, these studies do put into question as whether intensity of treatment *per se* constitutes a problem for the improvement of adolescent mental disorders, particularly in more complex cases; the real issue may be the theories of change PDT transfers into the techniques.

Perhaps more importantly, one of the most extensive and well formulated RCTs thus far, i.e., IMPACT, with an initial 540 participants who were randomized into three groups (cognitive behavioral therapy, short-term psychodynamic psychotherapy, and specialist clinical care – the last being the control group) was about adolescents whose ages ranged between 11 and 17 years old (Goodyer et al., 2011). As results came in from this study, short-term psychodynamic psychotherapy (STPP) did seem to outperform brief psychosocial intervention (BPI) and cognitive behavioral therapy (CBT) in the 50 weeks later follow-up after 36 weeks of treatment. More specifically, only 15% of those young people who received STPP were still diagnosed with major depressive disorder, compared to 27% and 25% of young people for BPI and CBT respectively (Goodyer et al., 2017).

1.6 PROCESS AND PROCESS-OUTCOME RESEARCH IN ADULT AND CHILD PSYCHODYNAMIC PSYCHOTHERAPY USING Q-SET MEASURES AND CPPS

The Psychotherapy Process Q-set (PQS; Jones, 2000) was developed for the purpose of determining which crucial features (represented in its 100 items) of the psychotherapeutic process were characteristic or uncharacteristic in any given hypothetical or actual session, or collection of sessions. Despite being designed by psychodynamic researchers, the measure itself sought to be “pantheoretical” and encompass aspects of any given approach (“school”) or its subgroup. The main principle behind the instrument was to enable theoretical constructs to find empirical footing, and research questions pertaining to the process to be operationalized. Smith-Hansen et al. (2012) explain that the underlying impetus

behind Jones' development of PQS was both his belief that outcome-based competition of psychotherapies had run its course and would not provide the type of knowledge needed to advance psychotherapeutic practice, and his confidence in the effect of certain techniques on outcomes.

PQS enabled a plethora of research into the adult therapy processes since its advent in the mid-1990s (see Smith-Hansen et al., 2012 for review). However this measure was not adapted to child play therapy, Child Psychotherapy Q-set (CPQ) until 2004 by Schneider and Jones. Around the same time, much of the research using PQS came to an end and process research on psychodynamic technique in adult PDT was centered around the use of CPPS (Hilsenroth et al., 2005). The active implementation of APQ came much later on with a recent validation study (Calderon et al., 2017). These three subsections will try to explain some of the main studies that PQS, CPQ and CPPS have been used in and for what purposes. The aim is not to be exhaustive but rather to delineate some of the basic methods researchers of chosen and their discoveries that are relevant to the current study, and to demonstrate the versatility of the Q-set instruments.

1.6.1 Psychotherapy Process Q-set (PQS) and Adult Psychodynamic Psychotherapy

All Q-set measures, including PQS have the same basic coding system of Q-sort (for a summary of how the coding system works exemplified by APQ, see Chapter 2.6). As the first of its kind, studies have implemented PQS: (1) to determine ideal prototypes; (2) to identify interaction structures both in sessions from a single-case or a collection of cases; (3) to develop profiles of the most characteristic items in certain samples; and (4) to analyze specific items in their change over time or relation to certain constructs.

The first inquiry into ideal prototypes for PQS was conducted by Ablon & Jones (1998) where the make-up of ideal prototypes of PDT and CBT were established by collecting data from expert practitioners of the respective approaches. This was done via the clinicians rating the items according to how

characteristic they would be in an ideal session (forgoing the regular requirement for forced distribution). Any given session can then be correlated with the compiled weighted Q-ratings taken from the experts in order to determine how much that particular session adheres to the principles of a given approach congealed in the prototype. In principle, a session can have multiple adherence scores based on the number of ideal prototypes a researcher has.

In the case of Ablon and Jones (1998), these adherences were then utilized to determine how much they can predict outcome in sessions taken from three different clinics, two practicing PDT and the other CBT. Three interesting results were revealed in the research. Firstly, it was found that, despite still adhering more to the PDT prototype, the two clinics where PDT was practiced still revealed substantial adherence to the CBT prototype. This was in stark contrast to the clinic in which CBT was practiced, where there was an overwhelming adherence to the CBT prototype with a negative correlation to the PDT prototype. The inference made by the authors was the therapy used in the former two clinics were a lot more flexible in their choice of technique. Secondly, another striking result the research discovered was that in the CBT clinic, sessions' adherence to the PDT prototype predicts the positive outcome better than their adherence to the CBT prototype. Lastly, in one of the clinics that practiced PDT where post-traumatic stress disorder (PTSD) was treated, adherence to neither approach could predict positive outcome. The crucial observation made by authors was that the attitude of the (psychodynamic) therapists here transformed their technique to be more supportive (less neutral and more structuring), indicating that perhaps "[a] prototype of supportive psychodynamic therapy for PTSD might have better accounted for positive patient change" (p. 80); the main point being that the ideal prototypes did embed a particular aspect of the approaches themselves.

Perhaps most relevant utilization of ideal prototypes to the current study was the analysis of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, a large scale RCT which incorporated a CBT and Interpersonal Psychotherapy (IPT) groups in order to compare the effectiveness of the two approaches (Ablon & Jones, 2002). Much like it was done

in the Ablon and Jones (1998), the authors again formed an ideal prototype for CBT and IPT and then correlated them with the positive outcome; the CBT prototype exhibited more consistent correlations with the outcome measures than did the IPT prototype. However, the more unexpected finding was that while the CBT group of sessions adhered quite rigidly to the CBT prototype, the IPT session in fact adhered more to the CBT prototype than they did the IPT prototype – despite there still being more adherence to the IPT prototype than the CBT group. This indicated that although the IPT sessions comprised of more diverse techniques, they still could be described better in terms of the expert-based construal of what a CBT session would look like. Hence, the author's conclusion was that the "brand names" (CBT and IPT) did little to determine what was actually happening in the therapy process, and the very similar outcomes of the two forms of psychotherapy were in fact based on very similar practices. The conclusion that the authors drew from this striking result was very similar to the point made about Stiles (2009) about responsiveness in RCTs. They found the general assumption that the therapist's adherence to the manualized techniques independent of other contextual factors which assumed the therapist as the unidirectional cause of change was essentially flawed.

The discovery was in fact consistent with a previous study on the same sample (Ablon & Jones, 1999). The mean Q-rating analysis here revealed that in spite of the significant overlap between the most and least characteristic items of the two therapy types (CBT and IPT)[2], the therapists in the two groups still consistently abided by the techniques and stance prescribed by their respective approaches. However the items that correlated with positive outcome did not concern the therapists and their actions but rather the patients' in-session characteristics. Namely, it was when the patients had a positive attitude towards to their capacities and sense of self, and when they were able to idealize their therapists that there was a decrease in their symptoms. Using the same method, in a another inquiry, the researchers had found correlation between PQS items and therapeutic

[2] Ablon and Jones (1999) took the mean of the items from the sample sessions for both CBT and IPT and used the ten most and least characteristic items in each sample to represent the general profile of interactions in CBT and IPT.

alliance (Price & Jones, 1998). Based on the conclusions drawn there, Ablon and Jones (1998) concluded that the patient's in-session behavior was a manifestation of the alliance formed. In combination with the findings, Ablon and Jones (2002) were able to support the notion that "the nature of therapeutic process is inherently interactional [where] patient and therapist mutually affect one another and the nature of what occurs in the treatment process" (p. 781). In this instance, it was not the IPT therapists' deviations from the manualized protocols, but rather their reaction to the patient's attitude, progress and needs that led them to adapt their own techniques, shifting the interactions in the sessions closer to the CBT ideal prototype.

The second procedure commonly used in the Q-sort measures is the determining common ISs from sample sessions. In the words of Jones (2000), interaction structures are "repeated, mutually influencing interactions between analyst and patient that are fundamental aspect of therapeutic action" (p. xv), which either party may or may not be aware of. Despite the use of the term "analyst" in this context, Jones is in fact referring to therapists in general, which becomes apparent from the fact that PQS is used to study therapy processes outside the psychoanalytic tradition. The statistical method of extracting these interaction structures has been the use of factor analysis (or principal components analysis) of the items of the coded / rated sessions. Much like prototypes, the procedure can be applied to a sample of sessions coming from both single-cases or a collection of cases.

The first and quite comprehensive single case study with PQS was a long-term PDT of a patient with depression that lasted two and half years (Jones et al., 1993). The analysis that set the framework for the article was the determination of the ISs from a sample of 53 sessions. The authors were able to extract four ISs – Therapist Acceptance/Neutrality, Therapist Interactive, Psychodynamic Technique, and Patient Dysphoric Affect – from 28 items after which they tracked the time series trajectory of each and associated them with the symptomatic change they measured using outcome measures. The time-based directionality of the data provided some support that lower Q-ratings of Therapist Acceptance/Neutrality

preceded symptom improvement and before a self-reported decrease in symptoms the patient exhibited lower levels of Patient Dysphonic Affect. However, perhaps the more intriguing aspect of the study was that they were able to infer the uni-bidirectional relations between the ISs due to the temporal nature of the study. Lastly, the study also investigates how some items associated with expressive techniques and supportive techniques[3] relate to Patient Dysphoric Affect (in sessions) and find both bidirectional influences as well as unidirectional two-way effects (the supportive stance predicts the IS Patient Dysphoric Affect and IS predicts the therapist's interpretations regarding the patient's use of defenses). Taken together, the conclusion is that the dynamic over time is one of mutual influence further consolidating the notion of therapy as a process of reciprocal effects.

In spite of the detail with which a single-case study can (more reliably) illustrate the therapeutic process through the lens of impartial observers with ISs expressing the comparable patterns of interaction, the external validity of the findings are still quite limited. Furthermore, research that focus on sessions with a collection of cases is more in line with the current study. The Jones and Pulos (1993) article is the first to implement principle components analysis on a the PQS ratings of sample sessions from a collection of cases from two clinics that used the psychodynamic and cognitive behavioral approaches. In running a factor analysis on the sample sessions (from both clinics), the authors were able to extract IS that contained key items that define both the psychodynamic and cognitive-behavioral technique. In addition, they also found two other factors that mostly described patient attitudes and behavior: Patient Resistance and Patient Negative Affect. In the next step, researcher tried to find the correlation between these ISs and outcome using 5 different measures for the CBT sample . The result was that patients whose sessions showed higher psychodynamic technique scores in the 1st, 5th and 10th sessions, show negative correlations in 4 of the 5 outcome measure *of the CBT*

[3] The two items used to represent expressive techniques were, "Therapist draws connections between the therapeutic relationship" and "Therapist points out patient's use of defensive manoeuvres", while the two items indicating a supportive technique were, "Therapist adopts supportive stance" and "Therapist is directly reassuring".

sample (meaning the cases showed improvement as the psychodynamic technique score increased), whereas cognitive-behavioral technique was correlated to none of them. Ironically, despite the psychodynamic technique scores were still negatively correlated with the four outcomes scores of the PDT therapy sample, these were only nearly significant. Cognitive behavioral technique scores performed poorly and even positively correlated with one of the outcome measures. Patient Resistance was usually associated with significantly worse outcome and Patient Negative Affect related to improvement in one of the outcome measures of the CBT sample, in contrast to having a negative (significant) correlation with one of the outcome measures of the PDT sample. While these do not imply a causal relationship between the use of technique and the outcome of the therapy as the authors would themselves attest to, the study did make two substantial contributions to process research. Firstly, it demonstrated that methodologically factor analysis was able to extract the techniques which the therapists consistently implement as a form of recurrent interaction that could then be quantified. Secondly, the study provided further evidence that factors (in this case, techniques) that therapists may not necessarily intend to be the main means of change may in fact be more associated with the outcome than one would expect.

The IS study with PQS (Jones & Pulos, 1993) does not include a discussion of the techniques that the psychodynamic approach adopts but rather names the factor Psychodynamic Technique based on usual practices. However, an inspection into the content of the IS in question reveals that it includes descriptors that would be coupled with the more expressive techniques previously mentioned in the single-case study (Jones et al., 1993). Furthermore, within the analysis of the association between ideal prototypes and positive outcome, there is mention that another prototype which describes "supportive psychodynamic therapy" may be more instrumental in understanding the sessions with PTSD patients (Ablon & Jones, 1998). Although, researchers never developed such a prototype, and studies using PQS never did extract an IS that would represent the more supportive techniques in the psychodynamic approach, the authors in these two studies are in fact responding an examination of sample of sessions taken from patients whose stress-related

symptoms arose from traumatic events (Jones et al., 1988). After the coding of the sessions with PQS, the authors of the study seek to identify the process factors that predict outcome separately for those patients with high and low pretreatment disturbance levels. The combination of items that they are able to draw out as the best predictors for the two groups are quite different and correspond to what they characterize as supportive (for those with high distress severity) and expressive (for those with low distress severity) treatments. Thus, the therapists who were more successful were those that aptly assesses the difficulties of their patients and adapted their treatments accordingly. In this respect, it is also possible to conclude that PQS (as a Q-set measure) also carries the potential to discern different theories of change within the same approach.

1.6.2 Comparative Psychotherapy Process Scale (CPPS) and Treatment Adherence Research in Adult Psychotherapy

After the death of Enrico Jones, who developed PQS and was an integral part of all the studies with the measure, except for a few notable exceptions (e.g., Goodman, 2013) much of the research with PQS stopped. After that, another group of academics, in a sense, took over the process research for adult PDT. However, instead of PQS they conducted their studies with the aforementioned CPPS (see Chapter 1.2; Hilsenroth et al., 2005), CPPS is measure composed of 20 Likert-type items that evaluate the behavior and techniques of therapists, which can be rated by the therapists, patients or independent observers. It is possesses two 10 item subscales (CPPS-CB and CPPS-PI), which indicate how characteristic the therapists' actions are of either cognitive behavioral (CB) or psychodynamic-interpersonal (PI) treatments (based on the conclusions drawn from Blagys & Hilsenroth, 2000, 2002). The researchers involved in this domain of inquiry, seek to utilize CPPS to discover 'treatment adherence', i.e., "the degree to which therapist-client dyad participate in the specified approach" (Owen & Hilsenroth, 2014, p. 280). This modified construct is based on 'therapist adherence' that is used in RCTs or process research to identify how consistently therapists are

implementing the techniques and the interventions prescribed by the theory they are ascribing to (Webb et al., 2010). Unlike the therapist-centered understanding of the latter, which tries to determine the therapists' fidelity to a given approach holistically, the former is based on a more interactionist framework where the researchers ask questions regarding the within-client or between-client variability, relating them to changes in adherence across time and therapists (Owen & Hilsenroth, 2014).

An initial set of studies that this perspective drew support from were centered around the relationship between technique and therapeutic alliance – i.e., the therapist-client consensus on the goals of the therapeutic process, and commitment to the means of achieving those goals, in addition to the affective and relational bonds that form the basis for a collaborative interaction (Bordin, 1979). The first of these found (in a clinic that provided adult PDT) that although alliance was an independent positive predictor of symptomatic improvement, the interaction between PI techniques (as rated by independent clinicians) and alliance was a stronger one (Owen & Hilsenrother, 2011). When the CPPS-PI slopes were analyzed for those patients whose treatment involved one standard deviation above and below the mean of therapeutic alliance, they found that relative to the patient group that was exposed to less PI techniques, the group whose CPPS-PI scores were higher revealed less improvement in situations where the patients' perceived alliance was low, but better outcome when the alliance ratings increased – *even when* controlled for pretreatment case severity and the therapist effect is accounted for.

In the next study, the authors added the CB techniques measure from CPPS (this time CPPS rated by the patients) as another variable and to account for the responsiveness of the therapists in a PDT process (Owen et al., 2012; see Chapter 1.5 for elaboration on responsiveness). Once again, the multilevel model (this time including the CB) revealed an independent significant predictive role of alliance, along with an interaction effect between alliance and PI from the patient's perspective as well. However, in this instance there was a three-way interaction as well, including the CB variable. Hence, the analysis was carried over within six

groups in a matrix of high and low levels of alliance, PI and CB techniques (+/- 1 SD in alliance, CPPS-PI and CPPS-CB) in the sessions. The conclusion drawn was that patients whose process included high levels of PI techniques exhibited improvement that increased with the better alliance *irrespective* of the level of CB techniques used. However, those that had higher levels of CPPS-CB scores along with higher CPPS-PI scores did do better. On the other hand, the fewer use of both techniques showed no association with outcome even when the level of alliance was high. Interestingly, for those patients that reported high CB but low PI, the ones with lower alliance showed better symptomatic improvement. Overall, these two articles enabled process research to reveal the association between various techniques within a context of the dyadic relationship. In this respect, technique is not taken as an independent causal variable but rather one that is moderated by quality of the relationship and the responsive modification of his or her technique by the therapist.

These studies laid the groundwork for the study into "adherence flexibility", which indicates that, despite the therapist's general adherence to a particular approach and its respective theories, he or she remains responsive by employing a wider range of techniques/interventions throughout the treatment process according to the reactions, motivations and needs of the particular client, environmental changes, and the demands of the intended goals (Owen & Hilsenroth, 2014). The variability *per se* in the sessions does not of course need to be beneficial insofar as the outcome is concerned. As the authors recognize, such variations may be due to a variety of factors that may have implications that can be negative (e.g., lack of therapist experience), neutral (e.g., response to transient environmental factors) or positive (e.g., responses to the severity or demands of the client). As such, Owen and Hilsenroth (2014) adopt the within-treatment (comprised of the client-therapist dyad) variability in adherence to PI techniques as an independent variable to test whether it has any influence on the outcome. Their results reveal that, even when factors such as the therapist based variability, therapeutic alliance and the general amount of PI techniques observed in the therapy session are controlled, adherence variability still accounts for a significant variability (10-11%) of improvements in

both the symptoms and the general functioning of the patients. While the exact source of why this variability is predictive of outcome is not clear, the authors suggest that if it was because of lack of technical skill on the part of the therapist, then a negative relation with outcome would be expected. Hence, they propose this may be due to a variety of reasons that would shift the practice of diverse techniques based on developments in the process (e.g., forming an alliance or alliance rupture) or patient-specific factors that causes fluctuations in theory-specific techniques (e.g., the increase or decrease of symptoms or motivation), which they collectively call adherence flexibility. As it is thus defined, adherence flexibility can be seen as falling under *appropriate* responsiveness (Stiles & Horvath, 2017).

Other studies have been conducted taking this notion and the CPPS as a stepping stone to determine why and when certain techniques are conducive to outcome. One of the areas they have focused on is how integration of techniques are related to alliance. Initially, Goldman et al. (2013) found that although the integration of CB techniques with PI techniques in early sessions of short-term PDT did not predict the level of alliance in general, they did find it was associated with certain alliance subscales, namely Confident Collaboration (CC) and Goals and Tasks Agreement (GTA). This was especially true in cases with low CPPS-PI scores. The authors later examined how PI and CB technique integration and alliance related to outcome in broader sample. Similarly, the integration of the two techniques together did not have any direct relation to the global outcome scales but did show interaction effects with the CC and GTA subscales; it was only under conditions where CC and GTA were high that the combination of CPPS-PI and CPPS-CB scores boosted positive outcome.

Another series of articles focused on the use of PI techniques in STPP of patients with depression. Their first discovery was that both the intense use of PI techniques in general and specific psychodynamic techniques – i.e., expressive techniques such as interpretation of recurrent patterns, drawing connections to past experiences, and those that motivating clients to express their emotions – were significantly related to decrease in symptoms of depression (Katz & Hilsenroth, 2018). However, supporting the idea of adherence flexibility, researchers also found

an interaction effect between PI and CB techniques in early sessions (3rd and 9th) in predicting outcome (Katz et al., 2019). While the CPPS-CB scores were rather low in the sample, their presence still made a contribution to outcome. Accordingly, in an article that followed right after this one, the early sessions which were classified as 'adherent to PI and somewhat flexible', outperformed the 'adherent and minimally flexible' and 'somewhat adherence and somewhat flexible' categories in creating clinically significant change (Katz et al., 2020). Despite these investigations here being homogeneous in the clinical problem the clients present, the results do seem to further support the idea that judicious flexibility can benefit the clients.

1.6.3 Child Psychotherapy Q-set (CPQ) and Child Psychodynamic Psychotherapy

One of the main measures that has greatly enhanced range of studies in child PDT has been the CPQ (Schneider & Jones, 2004). Much like its predecessor, researchers have mainly looked into ideal prototypes and interaction structures in order to come to a better understanding of the processes involved in child play therapy and draw inferential conclusions, especially using more single-case studies. Nevertheless, there have been several studies that have used sample sessions from a collection of cases and this section will focus on more on those due to their greater relevance to the current study.

Like PQS was implemented in adult psychotherapy to identify ideal prototypes (Ablon & Jones 1998), CPQ has also been employed in a similar manner. However, unlike the PQS article, Goodman et al. (2016) called on experts from three different approaches; on top of PDT and CBT, the researchers have also asked for the ratings of the items from those who were well versed in mentalization-based therapies to establish a prototype for reflective function (RF) – the operational construct of mentalization. It was hypothesized that RF would constitute a mid-way between the other two approaches, incorporating aspects of both of them. Methodologically speaking, this implied the RF prototype would be correlated to

both PDT and CBT, whereas the latter two would not be correlated with each other. However, the results of the analysis revealed that, in spite of the fact that descriptive distinction could be drawn between PDT and CBT prototypes[4] and they were more correlated with RF than each other, the two still showed a moderate correlation. Goodman et al. produced three hypotheses for why such a relationship exists: (1) They speculate that since among the most and least characteristic items of the PDT and CBT prototype the six items that overlap suggest a Rogerian treatment model, both modes may embed a core conceptual similarity that does not exist in adult therapy; (2) RF being correlated to both approaches may mean that PDT and CBT appeal to the same set of principles set in mentalization-based therapies; (3) or it may be a combination of the two where the humanistic tradition coupled with an underlying aim to foster mentalization capacities – albeit in different ways – may have drawn the otherwise discernable theoretical frameworks together. As the writers suggest, a reason behind the view that common factors extending beyond theoretical differentiations may be behind the main effectiveness of psychotherapy, can be partially illuminated by this implicit agreement among clinician on certain aspects of child play therapy made more clear though this procedure in process research.

CPQ shares with PQS the operationalization of the ideal prototype sessions in single-case and multiple case studies. An important finding using this method can be found in Goodman and Athey-Lloyd (2011), where whether the PDT prototype and CBT prototype adherence of the sessions of two different therapist working with one child with Asperger's syndrome would increase or decrease over time. On the other hand, Halfon and Bulut (2017) were able to identify the RF prototype adherence of child therapy sessions taken from 57 different children was able to predict the symbolic play and affect regulation of children. What makes this study especially intriguing is that the scores derived from CPQ were no longer associated with outcome measures, but rather with another process measure,

[4] When 10 of the most and least characteristic items were listed for the PDT and CBT prototypes, there were a substantial number of items that aided in distinguishing the ideal depiction of the two kinds of sessions. .

Child's Play Therapy Instrument (CPTI; Kernberg et al., 1998) – an instrument to track various dimensions of in-session behavioral and emotional changes in the child and the qualities of his or her play. Considering empirical studies have shown a quintessential advantage of PDT over its CBT counterparts is the sleeper-effect – that is, the continuation of the patient's response to the interventions of therapy after the treatment has come to an end – in both adult (Shedler, 2010), child and adolescent (Midgley & Kennedy, 2011; Palmer et al., 2013) PDT, associating the quality of the interactions in therapy (in this case represented by the RF prototype) with the change in mental capacities of the patient made manifest in the child's play throughout the therapeutic process is invaluable in our ability to explain such phenomena beyond theory.

Fitting of the spirit that well-formulated series of single-case studies can help bridge the game between external and internal validity in psychotherapy research (Roth & Fonagy, 2006), after the advent of CPQ there has been a plethora of IS analysis of treatment of children based on a wide-range of problems the patients suffer from and certain key features of the cases. Because CPQ does not constitute the main focus of the current study, a thorough review of these seems redundant. Nonetheless, highlighting some key features can give an impression as to the potential benefits of process research and what Q-set measures (and the concept of IS) can contribute to it therein. For instance, in the aforementioned Goodman and Athey-Lloyd (2011) study, the authors were able to demonstrate that, despite the fact the two therapists were working with the same child, different interaction structures emerged in the two dyads, showing that responsiveness and the uniqueness of interaction in each dyad are indispensable aspects of everyday clinical practice. In another recent study, Ramires et al. (2020) compared the ISs in three single case studies of children with differing mentalizing capacities and tracked the change in how characteristic the ISs became over time. Their finding showed that the child whose mentalizing capacity was highest (diagnosed with adjustment disorder) exhibited ISs that were more reflective of the PDT technique, whereas the therapists of the child with lower mentalizing capacities contained interaction structure more associated with CBT – in the case of the child with

disruptive mood dysregulation disorder – or with mentalization-oriented therapy – in the case of the child with autism spectrum disorder. While all the children included ISs where the therapist acted more directive, they differed in quality and change over time. Such a finding indicates differing approaches may appear and could be required for children that show variation in RF, further emphasizing the relevance of trying to understand 'what works for whom'.

The Halfon et al. (2018) article remains of special relevance to the present study because it is the study in CPQ where the statistical procedure to determine ISs were implemented on a sample of children who were working with psychodynamic therapists. Interestingly, the four extracted ISs showed a very similar pattern to that found in PQS (Jones & Pulos, 1993), where two interaction structures comprised of mostly items describing the therapist actions were associated with technique (named by the authors as Child-Centered Technique and Psychodynamic Technique), while the other two were made up of mostly items regarding the patients (named by the authors as Therapeutic Alliance and Children's Emotion Expression). What was especially interesting with regards to the extraction of the Child-Centered Technique IS is that it is consistent with the explanation given in the article on CPQ ideal prototypes as to what relates PDT and CBT child therapy. In this sense, it seems that Halfon et al. (2018) in fact were able to empirically validate the transfer of expert views of how mentalization-based therapy sessions should be in actual practice. Furthermore, the regularity here seems to signal the potential of determining meaningful interactions structures that correspond to issues discussed in theory and literature. The study continues by using multilevel growth modelling (MLM) to first see if RF adherence, disorder type (internalizing-only and externalizing-only) and time played a role in predicting the ISs. Their results for psychodynamic technique was that while age was negatively related, the two disorder types had a positive relation to the IS. Moreover, they determined that the use of psychodynamic technique increased linearly with time. In the next step, when they tried to find which ISs played a role in predicting outcome, psychodynamic technique was the only one that was able to do so for both the parent-report (Child Behavior Checklist; CBCL) and the therapist-report

(Child's Global Assessment Scale; CGAS) outcome measures. Another outcome related result was that child-centered technique by itself had negative relation to the CBCL outcomes. However, the authors also realized that there was an interaction effect of IS with Externalizing-only patients, where the greater use of the child-centered technique yielded better outcomes for patients with externalizing-only disorders but had the opposite effect on the other groups (i.e., internalizing-only and comorbid internalizing / externalizing patients).

This study was followed by an investigation into the effects of psychodynamic technique, therapeutic alliance and baseline problem type (i.e., internalizing, externalizing and comorbid internalizing-externalizing) on the change of problem behavior over time (Halfon, 2021). In this respect, it remains parallel to the work in adult PDT that explore the connections between therapeutic alliance, technique and outcome (Goldman et al., 2013; Goldman et al., 2018; Owen & Hilsenroth, 2011; Owen et al., 2012). Some of Halfon (2021) discoveries are similar to the adult psychotherapy, but there are also some divergences. While first article had shown a direct effect of psychodynamic technique, where it was related to less problem behavior at the end of treatment than at the beginning, in-session observations of psychodynamic technique was not predictive of total problem behavior throughout the process of therapy. Instead psychodynamic technique possessed a two-way interaction effect with therapeutic alliance, and a three-way interaction effect with therapeutic alliance and comorbid internalizing-externalizing children. The first one showed that only when the dyad exhibited high therapeutic alliance (1 SD above mean) was the more intense use of psychodynamic technique predicting lower problem behaviors. In contrast, when the alliance between the therapist and patient was lower (1 SD below means) psychodynamic technique was predicting higher (total) problem behavior. However, when the discrete internalizing and externalizing children were considered independently of the comorbid internalizing-externalizing children, a moderating effect of the latter was discovered. For the those with discrete (internalizing and externalizing) pre-treatment symptoms, in conditions of low therapeutic alliance, greater use of psychodynamic technique was associated with higher problem behaviors whereas

a high therapeutic alliance indicated that the more psychodynamic technique was observed the less the problem behavior was reported. The effect of psychodynamic technique was completely negated in the more complex cases of problem comorbidity where psychodynamic technique in sessions had no influence on the level of problem behaviors reported by the parents; rather low therapeutic alliance was simply related to higher problem behavior.

Hence contrary to the results of the adult sample (Owen & Hilsenroth, 2011), Halfon found an effect of baseline level of disturbance of children on how psychodynamic technique interacted with therapeutic alliance in predicting parent-reported problem behavior throughout the course of treatment. The most critical difference between the adult and child therapy designs was undoubtedly that Halfon (2021) was tracking the changes of problem behavior throughout the course of therapy. Thus, the author was able to make in-process recommendations regarding clinical practice, such as the pointing to literature which suggest the use of more mentalizing interventions especially in the beginning can aid in the later receptivity of the child and increase his or her therapeutic bond with the therapist based on a sense of being understood.

1.7 PROCESS AND PROCESS-OUTCOME RESEARCH IN ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY

Process and process-outcome research for adolescents continues to lag behind and can be considered in its relative infancy. Much of the research conducted thus far have not used measures that targeted specifically adolescents as a separate developmental stage with its own issues. In this section, a brief account of the process and process-outcome research will be given. On the other hand, the next section will provide an explanation regarding the development of APQ and a general overview of the limited research that has been conducted using this relatively new instrument.

A main area of focus for process-outcome in adolescent PDT has been the attempts to determine mediators for PDT that focused on mainly pre- and post-

treatment measures. For instance, Stefini et al. (2013) have looked into the relationship between attachment styles and outcome in long-term PDT in a child and adolescent sample. They were unable to find a relationship between the initial attachment styles (secure and insecure) and the success of outcome, since both groups achieved a high level of success rate (88% for secure, 71% for insecure patients). However, they opined the reason for this might be the variation in the length of therapy. Due to the significantly fewer number of sessions in the securely attached patients, they suggest – albeit inconclusively – the four attachment styles could be potential mediators for success analytic psychotherapy. Similarly, another major area of research, therapeutic alliance was also considered. Fernandez et al. (2005) explores the notion whether the therapist, parent and client perceptions of therapeutic alliance in the first three sessions of therapy is correlated with the outcome. Although, the study finds some evidence that certain initial evaluations of the therapeutic alliance is related to immediate or final outcomes, the sample size remained rather low.

Through pre- and post-treatment measures, two studies by Atzil and colleagues (2011, 2013) studied the shift in internal representations of adolescent patients[5]. In Atzil-Slonim et al. (2011), the researchers were able support the theory that certain shifts in the flexibility of interpersonal relationship patterns in relation to the parents, peers and therapist were associated to the symptomatic change in the participants. In other words, the availability of conscious or unconscious patterns of interpersonal patterns exhibited more variation in comparison to those in the beginning of therapy for the patients with symptomatic improvement. Although the second study (Atzil-Slonim et al., 2013) does not provide conclusive evidence as the causal direction of symptomatic change, the results provide an avenue of potential research for of factors that may lead to change – i.e. shifts in the internal representation of the parents throughout treatment. They found that certain clusters characterizing the qualities of the represented interaction with the parents (e.g., "close and supportive" or "emotionally painful interaction") not only distinguished

[5] Midgley (2009) also identifies this as a promising area in which theories of the psychodynamic approach about intrapsychic change can be tested.

between the clinical and community samples, but also that the changes in these clusters were correlated to the symptomatic shifts.

Despite the promising nature of these findings (Atzil-Slonim, 2019), one difficulty has always been the aforementioned problem of operationalization (Hodge, 1999; Midgley, 2009). For example, the Atzil et al. (2011, 2013) studies both employed the Core Conflictual Relationship Theme (Luborsky & Crits-Christoph, 1998), a measure originally designed for adults. This is not to say the use of the measure in the analysis of adolescent samples is not sound, but rather that the instrument was not originally intended to target this demographic. Hence it is understandable why the authors used late adolescents as their samples (15-18 year-olds). The Q-set measure described below seems to remedy that by producing a variant of the Q-sort measures that was intended specifically to incorporate the issues of the developmental stage and the concerns of the clinicians working with adolescents.

1.8 ADOLESCENT PSYCHOTHERAPY Q-SET (APQ) AND ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY

For an adolescent version of the Q-set measures, an initial attempt to construct an instrument was made by Bambery et al. (2007, 2009) who tried to transform CPQ into the Adolescent Psychotherapy Q-set (APQ) by changing the words “child” to “adolescent” and word “play” to “verbalization” in the items. However, this attempt was not all that successful and bore the problem of not recognizing the uniqueness of adolescence and the issues that surround it. Instead the finalized version of APQ (Calderon et al., 2013) emerged from the IMPACT study (Goodyer et al. 2011). Before APQ took its final form, some preliminary, pilot studies were conducted (Bychkova et al., 2011) – that utilized the measure first formulated by Bychkova (2010) – but final validation study came later on (Calderon et al., 2017).

The initial studies with preliminary APQ measure were intended to establish the prototypes but also signified a divergence from the general procedure. In

Bambery (2007, 2009), the APQ derived from the rewording of CPQ was taken as a measure to form *ideal* prototypes for PDT and CBT, but these were intended for training and were never used in research. On the other hand, Bychkova et al. (2011) was also a prototype creating article, but it reformulated the question asked. Much like the Di Lorenzo et al. (2015) and Di Lorenzo and Maggiolini (2019) articles, this study also was asking experts – 4 for psychoanalysis (PA), 3 for PDT, 3 for mentalization-based therapy (MBT), and 3 for interpersonal therapy (IPT) – the extent to which an item was present in their typical sessions and one actual session rather than whether or not they were desirable or ideally seen in their respective approaches. These prototypes also had two handicaps. The first was the relative low number of experts used and the second was that APQ at this stage was still being revised (i.e., the experts were also asked what they felt was unclear or need revision in the items) making this a pilot or preliminary study. Di Lorenzo et al. (2015) took the evaluations from experts using the revised version of APQ (Calderon et al., 2013) to identify the most characteristic items describing a typical session from experts who work in Italian Adolescent Psychoanalytic Psychotherapy (IAPP). In order to answer how IAPP differed from other approaches, the authors compared it with prototypes of Bychkova et al. (2011), pointing out the common and uncommon items from pool of the most characteristic 10 items of each approach. In their latter study Di Lorenzo and Maggiolini (2018) used a different set of experts who came from different traditions ("institutions") under the umbrella of psychodynamic psychotherapy. They were then able to find the common and distinguishing items among the most characteristic and uncharacteristic items under each institution. Despite these studies' intention to form prototypes of various approaches, no ideal prototype for psychodynamic psychotherapy for the APQ (Calderon et al., 2013) has been published yet.

In adolescent psychotherapy, the last two published studies along with Di Lorenzo and Maggiolini (2019) have all identified ISs within their data set using APQ. The only APQ IS study with session samples from a multitude of cases thus far has been Calderon et al. (2018). However, method used to identify and depict the ISs is different than the articles that have employed PQS in adult psychotherapy

and CPQ in child psychotherapy. Instead of item clustering, Calderon et al. have used the IMPACT data to find the clustering of sessions – which included a relatively equal number of STPP and CBT sessions from early/mid and mid/late stages of therapy. After that, the authors presented the most and least characteristic 10 items of each cluster as representing the IS operating within those sessions. Their analysis revealed that three session clusters provided the most elegant solution. The first of them included mostly STPP sessions (30 STPP and 6 CBT), the second exclusively CBT session (25 CBT), and the last one roughly equal number of STTP and CBT (5 STPP and 4 CBT). One interesting finding of the study was that there was significant overlap between the most and least characteristic items lists, making a few items more discerning; furthering the point that the two approaches were more similar than anticipated, they found the first cluster actually included a not so insignificant number of CBT sessions. Another discovery was that, despite the IMPACT study's therapy sessions were manualized and, in general, showed relatively good levels of fidelity to the prescribed techniques of STPP (80% of sessions adherent) and CBT (74% of the sessions adherent) (Midgley et al., 2018), the authors were able to identify a cluster where when therapists confronted a disengaged young person, they strayed away from the treatment manual and became active in trying to get the patient involved. As a result, the researchers felt that, depending on whether or not these alteration in technique was related to better outcomes or not, the manual should either advocate this form of intervention or supply different appropriate reactions to adolescents' distant demeanor. Alternatively, due to the clients' heightened expression of their symptoms, which was typical in this cluster, Calderon et al. speculate (based on past literature) that the therapists, in the face of greater painful emotion, felt it necessary to *alter modality-specific interventions* and that this was a regular practice used by effective therapists. Expressed with different terminology, the authors seem to be referring to (appropriate) responsiveness in these instances.

The other article that came out from the development of the APQ was a single-case study by Grossfeld et al. (2019) that tried to dissect the therapy process of a depressed youth with borderline personality disorder. Once again the authors

method involved the clustering of sessions with a presentation of the most and least characteristic items of each session cluster, which deviates from the original method of extracting ISs. One of the more intriguing conclusions drawn from the single-case was that many of the most characteristic (or uncharacteristic) aspects of the sessions either did not include common practices in the psychoanalytic tradition (e.g., the focus on the 'here and now' of the therapy relationship) or directly incorporated techniques seen frequently in the cognitive-behavioral approach (e.g., being more directive or problem-solving). Hence the therapist was found to be responding to the immediate needs of a at particular stages. In this respect, Grossfeld et al. (2019) found a similar trend in a single-case to what Calderon et al (2018) was able to delineate from a diverse sample.

Lastly, Di Lorenzo and Maggiolini (2019) also conducted a more unorthodox form of factor analysis, where they extracted certain interaction structures from the experts' evaluations of the items on the spectrum of being characteristic and uncharacteristic. This assessment has shown a clustering of certain items in three factors that represent a continuum of the expressive to supportive approach taken by psychodynamic therapists. In addition they able to extract two other patterns, "Alliance rupture – withdrawal" and "Wish to understand". These two, much like the factors drawn from coding of actual sessions, represented attitudes or dispositions typical of the young person. The use of factor analysis to identify ISs was previously implemented solely on coded sessions; this again reflects a novel move to determine ISs form the collective experience of experts'. The experts' evaluation of what is characteristic or uncharacteristic in their own practice with adolescents (via their Q-ratings of APQ items) forms a basis for ISs in the form of items that correlated.

The transition from 'ideal' to 'typical' prototypes is quite a significant shift. For instance, if experts were asked to rate items according to how characteristic they were of actual sessions instead of ideal ones for PQS and CPQ in creating the PDT prototypes of adult and child psychotherapy, the discussion of dreams *may* have been deemed to be less characteristic. Which of the two methods is more practical could be contingent upon research question being pursued. To exemplify,

if a researcher is trying to answer the whether a particular session is conducive to realizing the change ascribed by any given approach, then ideal prototypes may be more functional. On the other hand, if the inquiry is into how similar a certain session is to a session one would regularly observe with a therapist working with a particular approach in mind, 'typical' prototypes may be better indicators. It is apparent that there is an essential trade-off between these methods and it will likely this difference will become even more salient if one or the other proves to be of greater value.

1.9 CURRENT STUDY

To the best of my knowledge, there has only been one study that has sought to find the ISs in an adolescent sample of collection of cases. However, Calderon et al. (2018) have used hierarchical analysis / clustering which aims to group the sample sessions taken from a pool from the IMPACT study[6] according to the degree of similarity they have vis-à-vis their response profile (i.e., Q-scores of the items), thereby clustering the session based on the similarity or dissimilarity of the scores of the sessions as a whole. Once they have attained their three clusters – which they found to be the best solution – the means of the items in each cluster are taken. The authors then assume the 10 items with the highest and lowest means in each session cluster indicate the (predominate) interaction structure for those sets of sessions. Grossfeld et al. (2019) uses the same method, this time for the coded sessions of a single-case. In contrast, the principle components analysis used by Jones and Pulos (1993) and Halfon et al. (2018) for adult and child psychotherapy (respectively), tries to determine items that exhibit covariance across the all the sessions. The factors in the pattern matrixes are thought to be underlying ISs whose prevalence can vary in all the sessions of the given sample. This also allows for researchers to quantify the how characteristic this interaction is in the sessions, which can later be

[6] In forming their pool, Calderson et al. (2018) have split the sessions into four groups based on their modality (STPP and CBT) and the stage of therapy (early and middle/late). In the end they report the sample included 35 sessions from each

correlated with (Jones & Pulos, 1993) or used to predict (Halfon et al., 2018) treatment outcome.

Quite similar to the change in method of in how prototypes were formed, these two notions of ISs can also be viewed as exhibiting a diverging understanding. The method of sessions clustering seen in APQ articles thus far, enables researchers to get a better picture of what is actually definitive about each cluster of sessions since the most and least characteristic items (through their mean value) does better illustrate how one would optimally describe them. On the other hand, principle components analysis captures how some items relate to other items even if they are not the most characteristic aspect of many sessions. In other words, the ISs here are present to varying degrees of prevalence *in all sessions*, quantified in the mean value of the Q-ratings of the items involved (with some item exhibiting reverse relationships).

The first aim of this study is to attain a better understanding of the nature of PDT by seeing how associated the sample sessions are to the PDT protoype and trying to capture the processes embedded within adolescent PDT. The second is to identify how techniques used by PDT therapists in the therapy process change over time and relate to the problem behaviors of the patient. In order to achieve the first of these goals, in the absence of ideal prototypes, the current sample will be compared to the prototypes of Bychkova et al. (2011). Initially, the mean Q-ratings of all the items in the sample will be taken so as to determine the most and least characteristic 10 items within the sample. Jones & Pulos (1993) applied the same method to their sample session for PDT and CBT in adult psychotherapy to establish general profile of how the sessions proceeded and empirically establish the application of the approaches. Similarly, using APQ items, Di Lorenzo et al. (2015) compares the clinicians view on how characteristic the items are for Italian Adolescent Psychoanalytic Psychotherapy sessions and compares them to the Bychkove et al. (2011) prototypes.

For the extracting of the ISs, principle components analysis will be the preferred method – especially because the second goal cannot be achieved through session clustering. Specifically, the method bears substantial similarity to the

studies conducted by Halfon et al. (2018) and Halfon (2021) for child psychotherapy. However, unlike Halfon (2021) the present study does not possess or posit any particular technique. It instead seeks to investigate *any* IS that may represent the use of technique, analyzing its change over time and relation to problem behaviors. For example, Halfon et al. (2018) have found another IS that they saw to be representative of a child-centered technique. Similarly, the factor analysis conducted by Di Lorenzo et al. (2019) on the Q-item ratings of experts with APQ have extract three separate factors that may correspond to different techniques used in the psychodynamic approach.

As discussed in the introduction, although diverse techniques have been extracted using factor analysis, much of the literature have more closely examined and reported findings on psychodynamic technique. With regards to the change of psychodynamic technique over time, the child psychotherapy literature has found that PDT sessions in collection of cases shows linear increase as the treatment progresses. Similarly, in the single-case study of an adult patient, Jones et al. (1993) observes the same trend. However, the literature on the early adult STPP sessions also reveal some therapists integrating CB techniques in the context of general PI adherence (Katz et al., 2019, 2020), which interact with therapeutic alliance (Goldman et al., 2016). Thus, both linear and quadratic models will be checked. In addition, the literature in adult psychotherapy has discovered that psychodynamic technique correlates with symptomatic and functional improvement across outcome measures (Jones & Pulos, 1993) and when implemented in earlier sessions (Katz & Hilsenroth, 2018). Halfon et al. (2018) has also revealed a parallel relation in child psychotherapy where the psychodynamic technique has predicted positive treatment outcome in both therapist- and parent-reported measures. Furthermore, as a follow-up, Halfon (2021) has investigated psychodynamic technique in relation problem behavior in the course of treatment for the sample of child PDT sessions. Here no direct effect of technique was found to predict problem behaviors. Its positive associations were predicated with high therapeutic alliance for the sample in general, baseline internalizing and externalizing patients in particular. In contrast, for comorbid internalizing-externalizing children technique had no effect.

The review of the empirical, practical and theoretical literature has led us to form certain expectation but, due to the novelty of the analysis with an adolescent sample, the hypotheses formed are tentative and exploratory. Of the five hypotheses, the first three are more descriptive in nature while the other two fall under process-outcome research:

(1) We expect the most and least common items of the sample to be more related to those of the PDT prototype, than the prototypes of other approaches (see Bychkova et al., 2011).

(2) Based on prior findings of the statistical analysis on sample sessions of PDT, we could expect an IS that reflects the psychodynamic technique (Halfon et al., 2018; Jones & Pulos, 1993). However, both these studies have been done with alternative measures and samples of patients at different developmental stages – namely CPQ with child samples and PQS with adult samples. Despite similarities in the items, there are substantial differences as well.

(3) As the treatment progresses, therapists will use more psychodynamic techniques.

(4) The IS which represents psychodynamic technique will negatively predict patients' total problem behaviors over time.

(5) Baseline problem behavior will moderate the association between the psychodynamic technique IS and patients' total problem behavior, in which increased use psychodynamic technique on high baseline problem severity patients will be associated with increased total problem behaviors.

CHAPTER 2
METHOD

2.1 DATA

The current study uses data collected and processed by Istanbul Bilgi University Psychotherapy Process Research Laboratory taken from clients and

parents of those receiving low-cost psychodynamic psychotherapy from Istanbul Bilgi University Psychological Counselling Center (BUPCC). Child and adolescent patients are referred to the BUPCC by health professionals, school counsellors, teachers or the parents. Applicants are evaluated and screened by a licensed clinic psychologist before they start therapy. Criteria for exclusion include the following: (1) presence of psychotic symptoms (2) current drug use (3) immediate and significant suicidal risk and (4) primary eating disorders. If an applicant is excluded they are referred to another institution, psychologist or psychiatrist. Participation to the research project is voluntary and is not requirement for receiving therapy. Neither is there any additional incentive provided for partaking in the research. Before therapy begins, the young people and their parents are informed about the aims of the research conducted at the laboratory. Special care is taken to emphasize that not volunteering for the project will not affect the therapy process in any way. They are also notified of the confidentiality of the data and the anonymity of the participant in published work. Lastly, the participants are told they can withdraw from the study at any point if they so wish and can request the disposal of any data collected up to then. In the case of adolescents, written consent is given by both the patient and the parents.

2.2 PARTICIPANTS

For the demographic information of the participants can be seen in Table 2.1. Data from 43 young individual was collected for this study. The ages of the participants range from 11 years old to 17 years old at the beginning of their therapy (M_{age} = 13.02 years old, *SD* = 1.85); nearly four fifths of these fell under the category of early adolescence (11-14 years old), while the rest were mid or late adolescents (depending on the definitions, 15-18 years old). Slightly more than a third of the youth were referred to or applied for internalizing reasons such as depression or anxiety, close to a quarter for externalizing behavioral problems, i.e., aggressive or rule-breaking behavior. Other reasons for application included school or learning, adjustment, and somatic difficulties.

All except one of the participants were administered *Youth Self-Repor*t (YSR; Achenbach, 1991; Achenbach, 2001) before the intake sessions. The young people's self-report on their various difficulties yielded T scores for externalizing problems ranging from 39 to 82 (M = 63.86, SD = 10.87), for internalizing problems ranging from 34 to 73 (M = 54.31, SD = 9.80), for total problems ranging from 36 to 79 (M = 60.55, SD = 10.76). The T-score cutoffs for YSR are 60 for borderline cases (60 ≤ T-score < 65) and 65 is the cutoff for clinical cases (65≤ T-score). As such, internalizing and total problems mean T-scores lie in the borderline range, whereas externalizing problem mean T-score for externalizing problems is within the non-clinical range. When the sample young people are distributed into ordinal groups according to whether or not the particular young person has a borderline score and above in the internalizing and externalizing problem levels, there is a relatively even divide in the sample among the non-clinical patients, the discrete internalizers and the comorbid internalizers-externalizers; no discrete-externalizers were present in the sample according to YSR.

Table 2.1 Demographic Information of Sample (N = 43)

Variables	Categories	N	%
YP's Age	11-12	22	51.2
	13-14	12	27.9
	15-17	9	20.9
Gender	Female	20	46.5
	Male	23	53.5
Application Reasons	Aggressive Behavior	10	23.3
	Anxiety	13	30.2
	Depression	3	7.0
	Somatic Problems	1	2.3
	School and Learning Problems	9	20.9
	Adjustment Problems	4	9.3
	Other	3	7.0
YP's Clinic Characteristics (YSR)	Non-clinical	13	30.2
	Internalizing	17	39.5
	Comorbid	12	27.9
	Missing	1	2.3
Parents' Marital Status	Married	35	81.4
	Other	8	18.6

Socioeconomic Status	Low	5	11.6
	Low-Middle	8	18.6
	Middle	9	20.9
	Middle-High	3	7.0
	Not Reported	18	41.9
Mother's Age	30-39 years old	17	39.5
	40-49 years old	20	46.5
	Over 50 years old	3	7.0
	Missing	3	7.0
Father's Age	30-39 years old	9	20.9
	40-49 years old	24	55.8
	Over 50 years old	8	18.6
	Missing	2	4.7
Mother's Education Level	Elementary School	10	23.3
	Middle School	12	27.9
	High School	9	20.9
	University (4 year program)	9	20.9
	Missing	3	7.0
Father's Education Level	Elementary School	8	18.6
	Middle School	7	16.3
	High School	15	34.9
	University (4 year program)	9	20.9
	Master's / PhD	2	4.7
	Missing	2	4.7
Mother's Working Status	Employed	14	32.6
	Unemployed	28	65.1
	Missing	1	2.3
Father's Working Status	Employed	1	2.3
	Unemployed	41	95.3
	Missing	1	2.3

Notes: YP = Young Person; Cutoff criteria for YSR = T-score < 60 Non-clinical, 60 ≤ T-score Borderline or Clinical Range.

2.3 THERAPISTS

The 29 therapists were second and third year master's students in clinical psychology program at Istanbul Bilgi University working at BUPCC and training to be child and adolescent psychotherapists. There were comprised of 24 females

(82.8%) and 5 males (17.2%) whose ages are between 23 and 37 (M = 25.76, SD = 3.20). They all had nearly no prior experience before they started their internship. Each treated between 1 to 3 patients with most treating one or two. All had completed courses focusing on psychodynamic psychotherapy. Each received at least three hours of group supervision and one hour of individual supervision for one year from licensed clinicians with a minimum of 10 years of experience.

2.4 TREATMENTS

Although not manualized the standard treatment at BUPCC is on the basis of psychodynamic psychotherapy principles parallel with those explained by Blagys & Hilsenroth (2000). The first year course curriculum is structured around providing trainees with solid foundation in psychodynamic theory and basic assessment skills. During the second internship period of one year, which can be extended two years, therapists are given supervision by therapists with strong psychodynamic backgrounds.

After the assignment of the cases to the therapists, a relatively standardized assessment procedure is followed. The first intake session involves an semi-structured interview with both the young person and the family, both together and separately. Depending on the age, nature of the problem and the familial interpersonal dynamics, there may be various alterations to the length of each segment. The cultivation of a therapeutic bond with the patient is of special consideration. This is followed by two sessions with the parents or caregivers if possible. However, in order to establish a continuity of the process, these were regularly scheduled in a manner that did not lengthen the period in between the sessions with the adolescent. The main task at this stage is to take a developmental history of the patient as well as attaining an understanding of the parents' past with their own parents. This is followed by approximately three individual sessions with the young person to arrive at a case formulation, at which point there is a feedback session that informs patient and the parents about the therapist's findings and the intended trajectory of the therapeutic process.

After the feedback, the most common frequency of sessions were once a week with the adolescent. Parental work – with or without the teenager in the therapy room – was a common practice among therapists. It is at the therapist's discretion to do parental work or not, but this decision is not made individually. Not only are the supervisors consulted, but the patient's own views about the issue is also taken into account. The adolescent is regularly assured of client confidentiality and no specifics of the sessions are discussed with the parents and if certain topics are transferred from client sessions, these are not done without the client's prior approval. The parent sessions did not usually replace the sessions with the client, which protected its general course. In the current sample, 7 of the clients have ended their process after the feedback. Among the remaining 36 cases, only 9 (25%) of them did not involve parent or family sessions at all, or occurred during the assessment period or only before termination. The frequency of those that included parental therapy was determined on a case-by-case basis and according to need. Despite also being contingent upon the parents and their engagement, the institutionally accepted approach was directed towards increasing the parent's reflective function both towards the young person and themselves in relation to the child.

Play was also incorporated into some sessions, especially for younger teenagers. Although therapy with adolescents (unlike children) did not embrace an immediate exposure to the toys and games, therapists provided the option to the relatively younger patients and prepared board and other alternative rule-based games to be presented in case it was demanded. In this context, games were usually *primarily* regarded as a means to building therapeutic alliance and commonly also involved talk that did not pertain to play.

Patients are given the option of continuing their therapy process after the internship of the therapist has ended at BUPCC, either with their existing therapist in another institution, or with a new therapist at BUPCC. For those cases that chose to continue at BUPCC, the client's longer treatment was included into the study. 11 of the clients were continuing their therapy process in 2020 and because of the Covid-19 pandemic their sessions had to be continued online. The online sessions

were excluded from the data set due to the change in the medium of the therapy. As a result 123 sessions were included into the analysis from the 43 participants. The lengths of treatments that were incorporated into the analysis for each participant (when the online sessions were taken out) ranged between 5 to 60 (M = 24.49, SD = 13.13).

2.5 MEASURES

2.5.1 Background Information Form

Before the start of therapy, all patients were given a form where they provided a background about the young person and his or her family. This included demographic information about the age and education of the family members (including siblings) and the marital and socioeconomic status of the parent, along with a developmental history of the patient.

2.5.2 Process Measure

The *Adolescence Psychotherapy Q-set* (Calderon et al., 2013) is adapted from PQS and CPQ, which are used, respectively, to code adult and child (play) therapy sessions. In contrast to these measures, APQ aims to enables the coding therapy sessions for process research for 12 to 18 year-olds incorporating the elements that are typical to and distinctive of adolescence. Like its predecessors, the APQ is composed of 100 items that all describe a certain feature of a session that relates to three aspects of any therapeutic process: (1) the emotional, experiential and behavioral characteristics of the young person (e.g., item 13: "Young person is animated or excited"); (2) the therapist's dispositions and behavior (e.g., item 17: "The therapist actively structures the session"); (3) the attributes of the dyadic interaction (e.g., item 12: "Silences occur during the session"). In spite of the fact that APQ retains or rephrases many of the items of PQS and CPQ, it also has 33 unique items that specifically target the adolescent

process (e.g., item 35: “Self-image is a focus of the session”). In determining these items, Calderon et al. (2017) have taken care for them not to represent a single theoretical stance, making it “pantheoretical” like the PQS (Jones, 2000). In that spirit, many of the items previously used in PQS (63 items) and CPQ (49 items) were maintained. However, to account for the distinguishing dimensions of adolescents, 33 unique items were also added.

The Q-sort methodology uses forced distribution to separate the items into 9 different piles where the pile numbers correspond to their Q-ratings. These piles range from being *most uncharacteristic* (pile 1) to *most characteristic* (pile 9) features of a particular session with the middle pile (pile 5) being *relatively neutral*. The number of items place in each pile resembles a fixed normal distribution where 5 items are place on each end (piles 1 and 9); 8 items to the next piles above and below these (piles 2 and 8); followed by 12 items in piles 3 and 7; 16 items in piles 4 and 6; and 18 items in pile 5. The description of an item corresponds to where it would be placed if it is considered to be characteristic of the session (in degrees); each item also includes an instruction as to when it should be placed towards the uncharacteristic side of the spectrum. Going by one of the examples above, to the extent that a rater would use the young person being “animated and excited” (item 13) in qualifying that particular session, they would place it further along the characteristic side of the distribution (piles 6 through 9). On the other hand, to the extent that the young person being “dull, bored or lifeless” is relevant in the depiction of the session, the item would move more down to the extremely uncharacteristic end (piles 4 through 1). If the young person is neither of the two or exhibits both qualities roughly equally the item would be placed in pile 5. Since there is a forced distribution, in coding any session, all items must me thought in relation the position to the other items. As such, even if the young person being “animated and excited” is extremely salient in a session, if five other items are more defining of it, then item 13 would be placed in pile 8 instead of pile 9.

APQ has shown adequate interrater reliability in the previous research with interclass correlations (ICC) means over 0.70 (Calderon et al., 2017; Calderon et al. 2019). Using a sample of sessions from the IMPACT (Goodyer et al., 2011) study,

the ICCs of the double-coded sessions showed small changes according to the type of sessions (STPP and CBT) being coded with the ICCs of STPP sessions ranging between 0.44 and 0.88 (mean ICC = 0.72) and CBT session ranging between 0.65 and 0.81 (mean ICC = 0.73). For the current study 5 master's level research assistants were trained by Dr. Sibel Halfon in collaboration with Dr. Ana Calderon. All of coders had previously been trained and were coding child play therapy session with the Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2006). In this sense, they were all experienced using the Q-set method and were also familiar with many of the items. During the training they all trained initially coding the same three sessions independently, after which an interrater reliability was checked. Following a discussion for each session, the same sessions were recoded. The training required the coders to achieve an ICC above 0.70. For the current study, all sessions were double-coded with ICCs ranging from 0.57 to 0.94 (mean ICC = 0.80). 11 of the 123 sessions (8.9%) exhibited insufficient interrater reliability ICC (ICC < 0.70) and were then recoded by the same two coders together, reaching and agreement upon on a single distribution of items.

The discriminant validity of APQ was established using CPPS (Hilsenroth et al., 2005) by testing whether APQ was able to adequately represent and discern the techniques of the STPP and CBT therapists (Calderon et al., 2017). The authors use factor analysis to determine four factors; two correspond mostly to STPP sessions, one mostly to CBT sessions, and one to a relatively few number of both STPP and CBT session. The two factors that were associated with STPP sessions had high Psychodynamic-Interpersonal (PI) adherence scores on CPPS, whereas the factor related to the CBT sessions had high Cognitive-Behavioral (CB) adherence scores on CPPS. Another recent study by Di Lorenzo & Maggiolini (2019) has used APQ to differentiate between four different theoretical perspectives (or institutes) within the psychodynamic tradition in reference to the clinician evaluation of the importance of the APQ items in their practice. They were then able to describe convergences and divergences among the institutions' techniques via the shared and distinguishing items, demonstrating APQ's potential in making more nuanced distinctions even within the psychodynamic approach.

2.5.2 Outcome Measures

The *Youth Self-Report* (YSR; Achenbach, 1991) is a self-report survey given to the adolescents (ages 11-18) in order to assess whether they exhibit signs of a wide range of emotional, social and behavioral problems. It is widely used in studies on youth and it is among the ASEBA measure and is structured in a very similar manner. The questionnaire has a subscale which is intended to measure the adaptive qualities of the young individual but the main body of the instrument are composed of 112 items where the participant is asked to rate the statements within a three-point scale (0 = "not true", 1 = "somewhat or sometimes true", and 2 = "very true or often true") indicating the degree to which certain behavioral and emotional problems applies to them. These items are used in YSR to calculate eight syndromes: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule Breaking Behavior, Aggressive Behavior. The first three of these constitute the Internalizing Problems score, the last two the Externalizing Problems score, and all total of all them the Total Problems score of the measure. YSR has very good internal consistency (α = 0.83) with an acceptable test-retest reliability (r = 0.79) (Achebach & Rescorla, 2001). A Turkish version of the scale has been prepared by Erol and Şimşek (2000) in which the YSR has also shown excellent internal consistency (α = 0.89) and good test-retest reliability (r = 0.82) for the Total Problems score. In this study only the Total Problems T-score the scale will be used to assess whether the severity of problems plays a role in the prediction of time-based change of IS5 and of BPM total problems.

Brief Problems Monitor for youth (BPM-Y; henceforth BPM) is form within the ASEBA family that is a 19-item abbreviated version of the more comprehensive YSR (Achenbach et al. 2011)). BPM-Y is derived from items of YSR using item response theory and factor analysis and so it also incorporates a three-point scale (0 = not true, 1 = sometimes or somewhat true, 2 = very true or often true) (Achenbach & Rescorla, 2001). Also intended as a self-report measure

for adolescents between the ages of 11 to 18, through reduced completion time, it allows a quick assessment of the patient, with comparable T-scores. BPM-Y assesses three subareas of problems: *Internalizing Problems* (e.g., "I am too fearful and anxious"), *Attention Problems* (e.g., "I am inattentive and easily distracted") and *Externalizing Problems* (e.g., "I argue a lot"). This the total problems scale has high levels of internal consistency (α = 0.86) and test–retest reliability (r = 0.88). Additionally, internal consistency, and test-retest reliability levels of three subscales were also reported good: Internalizing Problems (α = 0.78, r = .80), Attention Problems (α = 0.74, r = .77) and Externalizing Problems (α = 0.75, r = .85).

2.6 PROCEDURE

After the client and their parents were informed about the research being conducted at the laboratories at BUPCC, they were asked to give consent for their participation in the research project. Before and after treatment, YSR was administered to the participants. After the therapy process began, the young person was asked to fill out a BPM form, at least one every tenth session. Among those who agreed to partake in the research most of them also agreed to the patient's sessions being recorded. Some participants preferred only audio recordings, whereas others accepted video recordings as well.

The pool of sessions from each treatment was then divided into time phases each composed of 10 sessions (1-10, 11-20, 21-30 etc.) and one session from each time phase was selected at random to be transcribed by research assistants. Since Calderon et al. (2017) state that APQ can best represent the interactions in sessions where the client is talking instead of drawing or playing, when the sessions of the client included these activities, an alternative session where the client was talking was chosen. The coders then rated these sessions independently and in no particular order. Since the coders were also therapists at BUPCC, in order to prevent any bias, special care was taken for them not to rate their own sessions.

Parallel to the coding, the BPM from each time phase was paired with the session. If more than one BPM for a time phase existed, the one administered after the APQ coded session was preferred to represent that time phase. If that was not available then one BPM from that time phase was chosen at random. Based on the comparability of the standardized T-scores of YSR and BPM, the post-treatment YSR total problems scores (when available) were included instead of the BPM total problems score at the last time phase of the treatment. However, due to treatment continuing online after the Covid-19 pandemic in 11 of the cases, their post-treatment YSR could not be added as the total problems T-score for the last time phase, since the sample of the session of the current study did not contain the time phase that corresponded to the end of treatment. Similarly, if a BPM score was missing from the first time phase, then pre-treatment YSR total problems score substituted the missing data.

2.7 DATA ANALYSIS STRATEGY

In order to better understand the nature of adolescence PDT, the first step will be to take the mean Q-ratings of the items in all the sample sessions and compare most and least characteristic among them to those of psychoanalysis, PDT, CBT and mentalization-based (MBT) therapy prototypes (hypothesis 1). ISs of the sample sessions will be determined through a principle components analysis of the Q-ratings of the APQ items with Oblimin rotation using SPSS23. The number of factors to be considered will be based on the Eigenvalues that are above 1.0 and the cumulative variability explained. In considering the factor solutions, items with communalities below 0.2 will first be removed after which the pattern matrix will be analyzed, discarding any items with loadings below 0.4. The solution that yields the most interpretable factors will be accepted. Within the factors, whether any of them can represent the techniques being employed in the sessions (hypothesis 2) will then be carried over to the next analysis.

To check for hypotheses 3-5, the fact that sessions (N = 123) are nested within patients (N = 43) and patients are nested within therapists (N = 123) a

multilevel modelling (MLM) needs to be used. The present study will conduct the statistical analyses using MLwiN 2.36 (Rasbach et al., 2016). First, the three-level (sessions nested within patients nested within therapists) and two-level (sessions nested within patients) empty models for the dependent variables (the ISs for hypothesis 3 and BPM Total Problems for hypotheses 4 and 5) will be examined to check the degree of interdependency. Depending on the significance of the inter-class coefficients (ICC) either the two-level or three-level model will be accepted for further analysis. To test hypothesis 3 – i.e., the change of ISs over time – a mixed-effects maximum likelihood (ML) estimation MLM will be adopted. First a time variable will be created based on the phase that each session belongs to (phase 1 = sessions 1-10, phase 2 = sessions 11-20, phase 3 = sessions 21-30 etc.). In modelling the change over time, the equation for the (two- or three-level) model will have phase (for linear change) and phase-square (for quadratic change) as main effects; along with the intercept it will included demographic variables sex, age and case-severity (reflected in 'YSR Total Problems'; the pre-treatment total problems T-score of the patient). To test hypothesis 4 and 5 – i.e., the effects of IS(s) representing technique(s) – again ML estimation MLM will be utilized. The equation created for the model will now have BPM Total Problems as the variable that is being predicted. The tested main effects will be time, the IS(s) as well as the IS(s)'s interaction with case severity. It will also include an intercept and demographic variables.

CHAPTER 3
RESULTS

3.1 COMPARING MOST AND LEAST CHARACTERISTIC ITEMS TO PROTOTYPES

The 10 most and least characteristic items can be found in Table 3.1 below. To better organize the results, a description of profile will be given, starting with

the most characteristic and continuing with the least characteristic items. Item numbers are stated in parentheses.

The therapists in the sample sessions speak in clear and coherent fashion (46), frequently asking for more information and elaboration (31) while restating and rephrasing what the young people say to clarify meaning (65), trying to make sense of the patients experience (9), and raising questions about his or her views (99). They also emphasize the young people's internal states and emotions the subjects being explored (97) and in the 'here and now' (96). Furthermore, the therapists remain non-judgmental towards the patients (18), and strive to facilitate and encourage their speech (3). The sessions are often characterized by exploration of interpersonal relationships (63).

On the other hand, the therapists are not disposed towards a more pragmatic approach, thus, not engaging in psychoeducation (33), refraining from encouraging alternative ways of relating to others (85), and not adopting a problem-solving stance (82), lacking discussion of tasks outside the sessions that the young people can perform (49). The therapists do not usually prefer to structure sessions (17) and the patients are not resistant towards initiating and elaborating upon the topics discussed either (15). In addition, the patients tend to feel understood by the therapists (14), but the therapists also avoid making definite statements about the patient's mental world (89). Lastly, the therapist cannot often be observed being supportive either through direct reassurances (66), or explicit advice or guidance (27).

In comparing the sample with the prototypes in Bychova et al. (2011), it is important to indicate that some items were replaced in the later APQ (Calderon et al., 2013). However many of them have been retained despite some changes in wording. The most characteristic items here share 8 items (3, 9, 18, 31 63, 65, 96, 97) with the PDT, 6 items (18, 31, 46, 65 96, 97) with the MBT, 4 items (9, 18, 96, 97) with the psychoanalysis, and 3 item (65, 96, 99) with the CBT prototypes. In addition of the remaining items that were not within the 10 most salient items in the current sample, but were in the prototype lists, 1 item in the PDT (6) and the MBT (60), and 2 items (50, 60) in the psychoanalysis prototypes were among the 20 most

characteristic items in the sample[7]. In addition, 2 items in the most characteristic list of the CBT prototype, were in the least characteristic list here (82, 85). On the other end of the spectrum, the least characteristic items of the sample have 3 items (17, 27, 89) in common with the PDT, 4 items (17, 27, 82, 89) with the MBT, and 4 items (17, 27, 85, 89) with the psychanalysis prototypes; there is no overlap of items with the CBT prototype. All shared items between sessions of the study and the prototypes are therapist items and MBT and psychoanalysis both have only one item that is unique to them.

Table 3.1 10 Most and Least Characteristic Items in Sample Sessions

Items	Description	Mean
	10 Most Characteristic Items	
31	T asks for more information or elaboration	8.73
65	T restates or rephrases YP's communication in order to clarify its meaning	8.54
97	T encourages reflection on internal states and affects	8.18
9	T works with young person to try to make sense of experience	7.98
18	T conveys a sense of nonjudgmental acceptance	7.96
3	T's remarks are aimed at facilitating young person's speech	7.84
46	T communicates with young person in a clear, coherent style	7.77
63	YP discusses and explores current interpersonal relationships	7.73
96	T attends to the young person's current emotional states	7.30
99	T raises questions about young person's view	6.94
	10 Least Characteristic Items	
14	YP does not feel understood by T	3.04
85	T encourages young person to try new ways of behaving with others	2.88
15	YP does not initiate or elaborate topics	2.76
27	T offers explicit advice and guidance	2.57

[7] The two psychoanalysis items were, item 50: "Therapist draws attention to feelings regarded by young person as unacceptable" and item 60: "Therapist draws attention to young person's characteristic way of dealing with emotions". MBT shares item 60 with psychoanalysis as most characteristic. The PDT item was, item 6: "Young person describes emotional qualities of interaction with significant others".

33	T adopts a psychoeducational stance	2.32
89	T makes definite statements about what is going on in the YP's mind	2.17
17	T actively structures the session	2.05
82	T adopts a problem solving approach with YP	1.85
49	There is discussion of specific activities or tasks for the YP to attempt outside of session	1.81
66	T is directly reassuring	1.37

Notes: T = Therapist, YP = Young Person

3.2 EXTRACTING INTERACTION STRUCTURES

In the extracting the ISs for the sessions (*N* = 123) retrieved from the cases (*N = 43*), four-factor and five-factor solutions were taken to be appropriate for evaluation according to their Eigenvalues and the total variability they explained (when compared to the literature). Based on the pattern matrixes of both solutions when items below 0.4 were suppressed, the five-factor solution was found to be the more interpretable solution accounting for 43.04% of the total variance.

For the five-factor solution 19 items (items 5, 11, 16, 35, 36, 45, 50, 60, 64, 69, 71, 75, 79, 82, 90, 91, 92, 96, 98) were initially taken out of the analysis due to low communalities. The Kaiser-Meyer-Olkin measure for sampling adequacy needed to be above 0.5 in order to be acceptable (Kaiser & Rice, 1974) while Bartlett's test of sphericity needed to be significant (Field, 2017) for the sample to be suitable for factor analysis. Both conditions were met by the sample with a five-factor solution after the items were removed (KMO = 0.575, $\chi^2(3240) = 7871.418$, $p < 0.001$). An additional 13 items (items 4, 17, 19, 25, 38, 40, 56, 62, 63, 68, 70, 86) were removed due to loadings below 0.4, leaving a total of 68 items.

Each of the five factors corresponds to an IS comprised of items that strongly inter-correlate and reflect five recurrent processes in which each item shifts towards being more or less characteristic according to their loading (positive and negative loadings, respectively). The descriptive statistics for the five ISs can be

found in Table 3.2; the items numbers, their descriptions and loadings can been seen below in Table 3.3. Under the tables will be short descriptions of these IS with reference to the items each of the statements correspond to. Like before, the item numbers will be given in the parentheses; for items with a negative loading an 'r' will be added next to the number.

Table 3.2 Descriptive Statistics for the Five Interaction Structures

Factors	Number of Items	Mean Q-rating	*SD*	Variance Explained	Cronbach's alpha
IS 1	16	4.01	0.81	16.01%	0.88
IS 2	13	4.95	0.72	8.67%	0.83
IS 3	14	4.52	0.71	6.98%	0.80
IS 4	9	4.97	0.71	6.61%	0.75
IS 5	16	7.31	0.54	4.78%	0.82

Notes: IS = Interaction Structures, *SD* = Standard Deviation

Table 3.3 Five process factor solution item loading for APQ (*N*=68)

Q-items	Loading	Description
		IS 1: Resistant Patient with Alliance Rupture
15	.681	YP does not initiate or elaborate topics
7	.669	YP is anxious or tense
44	.609	YPn feels wary or suspicious of the T
30	.559	YP has difficulty beginning the session
12	.523	Silences occur during the session
20	.503	YP is provocative, tests limits of therapy relationship
1	.496	YP expresses, verbally or non-verbally, negative feelings towards the T
42	.448	YP rejects T's comments and observations
23	-.471	YP is curious about the thoughts, feelings, or behaviour of others
24	-.478	YP demonstrates capacity to link mental states with action or behaviour
28	-.482	YP communicates a sense of agency

74	-.575	Humour is used
13	-.627	YP is animated or excited
95	-.654	YP feels helped by the therapy
72	-.684	YP demonstrates lively engagement with thoughts and ideas
73	-.785	YP is committed to the work of therapy
		IS 2: Demanding Patient, Accommodating Therapist
87	.757	YP is controlling of the interaction with theT
83	.669	YP is demanding
78	.602	YP seeks T's approval, affection or sympathy
14	.528	YP does not feel understood by T
93	.501	T refrains from taking position in relation to YP's thoughts or behaviour
89	.461	T makes definite statements about what is going on in the YP's mind
47	.421	When the interaction with YPn is difficult, T accommodates in an effort to improve relations
51	.411	YP attributes own characteristics or feelings to T
37	.401	T remains thoughtful when faced with YPn's strong affect or impulses
29	-.408	YP talks about wanting to be separate or autonomous from others
80	-.439	T presents an experience or event from a different perspective
54	-.458	YP is clear and organized in self-expression
33	-.609	T adopts a psychoeducational stance
		IS 3: Resistant Patient with Avoidance of Negative Affect
58	.565	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems
53	.507	YP discusses experiences as if distant from his feelings
10	.500	YP displays feelings of irritability
67	.495	YP finds it difficult to concentrate or maintain attention during the session
2	.426	T draws attention to YP's non-verbal behavior
22	-.404	YP expresses feelings of remorse
59	-.408	YP feels inadequate and inferior
32	-.459	YP achieves a new understanding
6	-.487	YP describes emotional qualities of the interactions with significant others
94	-.504	YP feels sad or depressed
41	-.514	YP feels rejected or abandoned

9	-.525	T works with YP to try to make sense of experience
26	-.660	YP experiences or expresses troublesome (painful) affect
8	-.722	YP expresses feelings of vulnerability
		IS 4: Inexpressive Patient, Inviting Therapist
77	.501	T encourages YP to attend to somatic feelings or sensations
61	.496	YP feels shy or self-conscious
57	.430	T explains rationale behind technique or approach to treatment
100	.405	T draws connections between the therapeutic relationship and other relationships
52	-.448	YP has difficulty with ending of sessions
34	-.465	YP blames others or external forces for difficulties
88	-.539	YP fluctuates between strong emotional states during the session
55	-.641	YP feels unfairly treated
84	-.770	YP expresses angry or aggressive feelings
		IS 5: Exploratory Psychodynamic Technique
65	.632	T restates or rephrases YP's communication in order to clarify its meaning
99	.579	T raises questions about YP's view
3	.545	T's remarks are aimed at facilitating YP's speech
97	.533	T encourages reflection on internal states and affects
18	.511	T conveys a sense of nonjudgmental acceptance
39	.468	T encourages YP to reflect on symptoms
46	.452	T communicates with YP in a clear, coherent style
31	.407	T asks for more information or elaboration
66	-.408	T is directly reassuring
76	-.413	T explicitly reflects on own behavior, words or feelings
21	-.417	T self-discloses
85	-.484	T encourages YP to try new ways of behaving with others
81	-.575	T reveals emotional responses
43	-.618	T suggests the meaning of others' behavior
49	-.618	There is discussion of specific activities or tasks for the YP to attempt outside of session
27	-.626	T offers explicit advice and guidance

Notes: APQ = Adolescent Psychotherapy Q-set, T = Therapist, YP = Young Person

3.1.1 Description of Interaction Structures

IS 1: Resistant Patient with Alliance Rupture

All except two of the items described the young person. IS 1 was characterized by the young person's elevated anxiety and stress (7), generally more lifeless or somber demeanor (13r, 74r) and reduced capacity to connect behavior to mental states (24r). The client's displays attitudes towards the therapist was one that carried suspicion or distrust (44) along with non-verbally or verbally expressed negative feelings (1) and rejections of the therapist's comments and observations (42). The young person show signs that he or she is frustrated by how the therapy is proceeding (95r), communicates a lack of agency or control over his or her life (28r) and reflects this in his or her decreased willingness to fulfill the requirements of therapy (73r). Such a negative attitude towards the therapist and therapy was coupled with a disposition towards behavior that hinder the progression of the session such as not initiating topics (15, 30), showing less interest in psychology others (23r), disengagement in thoughts and ideas (72r) and provocations that test limits of therapy (20). Relatively longer and more frequent silences characterize these sessions (12).

IS 2: Demanding Patient, Accommodating Therapist

Unlike IS 1, IS 2 is composed of item types from the young person pool, the therapist pool and one from the interaction pool. It describes an interaction in which the young person is more inclined to take control of the interaction in therapy room (87) and acts in a demanding fashion towards the therapist (83). Furthermore, despite the young person's search for approval and sympathy of the therapist (78), which in line with his or her general disposition to not want to be autonomous from

others (29r), the therapist withholds his or her personal opinions from the client (93). The therapist has a tendency to make definite statements about the young person's mind (89) which are usually not psychoeducational (33r) and is less likely to present situations from a different perspectives (80r). In return the client exhibit signs he or she is not understood by (14), and projects some of his or her qualities and feelings onto the therapist (51). The session is also characterized by difficult interactions in which the young person expresses himself or herself less clearly (54r) while the therapist remains relatively thoughtful vis-à-vis the young person's strong affect and reactions (37) and seeks to accommodate them (47).

IS 3: Resistant Patient with Avoidance of Negative Affect

Except for two items that represent the therapist reactions in this interaction, all the items depict the young person acts and attitudes. In this interaction structure, the young person is more resistant and irritable towards the therapist's exploratory interventions (58, 10). The young person also acts more distant from his or own feelings (53) and expresses less emotion when describing his or her relationships with significant other (6r). Accordingly, the he or she is also less inclined to express or feel negative / anxiety-provoking emotions such as remorse (22r), inferiority / inadequacy (59r), sad or depressive feelings (94r), feelings of rejection or abandonment (41r), vulnerability (8r), and painful affect in general (26r) during the session. Hence, the client has difficulties maintaining attention (67) and is less likely to achieve a new understanding (32r). As a response the therapist is less able or inclined to work with the client to try and make sense of the young person's experience (9r) and instead shows a tendency to focus of the client's non-verbal behavior (2).

IS 4: Inexpressive Patient, Inviting Therapist

Like IS 2, IS 4 also has a mixture of types of items that describe both the young person and the therapist. In IS 4, the patient is usually more shy or self-

conscious (61) and leans towards ending the sessions with ease (52r). The young person's emotions remain relatively stable (88r) as he or she refrains from expressing anger or aggressive feelings (84r) and unfairness (55) or blaming others for his or her own difficulties (34) even if the situation being discussed calls for it. The therapist's attitude is one that can be described as an effort to draw the teenager into the process by trying to explain the rationale of therapy (57) and drawing connections between the therapeutic relationship and other relationships (100). Instead of verbal expression, the therapist is disposed to encourages the young person to somatic sensations (77)

IS 5: Exploratory Psychodynamic Technique (EPT)

IS 5 reveals a therapist who is prone to engage in an exploration of the patient internal states and affects (97) and reflection on his or symptoms (39). The therapist speaks more clearly (46), asking for greater elaboration on the issues discussed (31) and the patient's views (99), concurrently rephrasing the content to make them more meaningful (65). He or she is inclined to be more non-judgmental (18) and tries to facilitate the patient's speech (3). On the other hand, the therapist also is more likely to withhold personal information (despite requests by the young person) (21r) or emotional responses (81r), and to reflect upon his or her own behavior or speech (76r), thereby maintaining the focus on the patient. The therapist also is less disposed to provide any practical advice or engage in supportive interventions such as explicit guidance (27r); direct reassurance (66r); endorsing alternative courses of action with others (85r); suggestions concerning the meaning of others' behavior (43r); and talk about tasks and activities to be performed outside therapy (49r).

3.1.2 Descriptive Statistics for IS among Participant

In Table 3.4 the means, standard deviations and bivariate correlations of the sex, age and mean IS scores of the participants can be found. Four significant

correlations between the variables were found. The mean IS 1 ratings showed significant positive correlation with both the mean IS 3 ($p < 0.01$) and IS 4 ($p < 0.05$) ratings and a significant negative correlation with mean IS 5 ($p < 0.05$) ratings, meaning those patients who had higher IS 1 ratings were more likely to have higher IS 3 and IS 4 ratings, but lower IS 5 ratings. Additionally, the mean IS 2 score also had a significant positive correlation with IS 3 ($p < 0.05$). All the correlations were of a moderate degree.

Table 3.4 Descriptive statistics and Bivariate Correlation Between Age, Sex, and Aggregate Interaction Structures (IS) Ratings of Participants

Variables	*M*	*SD*	1	2	3	4	5	6	7
(1) Sex	0.53	0.51	-						
(2) Age	13.02	1.85	-0.22	-					
(3) IS 1	4.09	0.70	0.28	-0.12	-				
(4) IS 2	4.46	0.49	0.27	-0.25	0.26	-			
(5) IS 3	4.50	0.53	0.30	-0.25	0.41**	0.35*	-		
(6) IS 4	4.95	0.54	0.12	-0.03	0.37*	0.07	0.26	-	
(7) IS 5	7.35	0.35	0.95	-0.07	-0.30*	-0.25	-0.05	-0.23	-

*Notes: Sex was dummy coded as "0" = female, "1" = male. IS = Interaction structures. IS 1, IS 2, IS 3, IS 4, IS 5 = Mean scores of participants. * $p \leq 0.05$, ** $p \leq 0.01$*

3.2 PRELIMINARY ANALYSIS FOR MULTILEVEL MODELLING

Our first expectation was supported by the factor analysis as an IS that could be associated with a psychodynamic technique (PT) was found. IS 5 seems to be a good representation of the expressive techniques used in PDT (see Chapter 4.1 for discussion and elaboration). Hence, the current study will analyze its change over time (hypothesis 3) and see whether it has any (direct or moderated) association with problem behaviors (BPM Total Problems). Accordingly an "empty" multilevel

models with EPT and BPM Total Problems were formed. The therapist-level ICCs for the two variables were 0.05, *ns.* and 0.00, *ns.* (respectively), implying that variance in the dependent variables are not significantly attributable to the therapists. On the other hand, the patient-level ICCs was 0.00, *ns.* for EPT and 0.67, $p < 0.01$ for BPM Total Problems. These indicate that a significate amount of variation in BPM Total Problems is due to the inter-patient differences, whereas the patients did not account for the variation in EPT. Although a one-level model would still be acceptable for our first equation, the fact that EPT is a main effect in the second equation led to the conclusion that a two-level model would be more appropriate in for the analysis.

Once the level of analysis has been set, ML estimation was used for analyzing change in exploratory psychodynamic technique (EPT). The MLM equation included the 'phase' variable described in Chapter 2.7 and tried to predict the EPT_{ij} for patient *j* in the (time) phase *i* with all predicting variables being grand-mean centered:

$$EPT_{ij} = \beta_{00} + \beta_{10}Phase_{ij} + \beta_{20}Phase^2_{ij} + \beta_{01}Sex_j + \beta_{02}Age_j + \beta_{03}\text{YSR Total Problems}_j + e_{ij} + u_{0j}$$

The e_{ij} represents the patient-specific residuals while u_{0j} indicate the phase-specific ones. YSR Total Problems corresponds to the baseline case severity operationalized in the YSR total problems T-scores of each patient.

Similarly, both hypothesis 4 and 5 concerned the outcome variable BPM Total Problems and, thus, were included in the same ML estimation analysis. The second MLM model was tested with the following equation:

$$\text{BPM Total Problems}_{ij} = \beta_{00} + \beta_{10}Phase_{ij} + \beta_{20}EPT_{ij} + \beta_{01}Sex_j + \beta_{02}Age_j + \beta_{03}\text{YSR Total Problems}_j + \beta_{23}\text{EPT*YSR Total Problems}_j + e_{ij} + u_{0j}$$

The BPM Total Problems scores represent the report of patient *j* at (time) phase *i* represented through the BPM total problems T-scores.

3.3 DESCRIPTIVES STATISTICS AND INTER-CORRELATION

The descriptive statistics and inter-correlations between aggregate EPT and BPM Total Problems of patients, demographic variables sex and age, and the baseline symptom severity (YSR Total Problems) can be seen in Table 3.5. The only correlation found was between the baseline symptom severity (YSR-TP) and BPM Total Problems ($r = 0.94$, $p < 0.01$)

Table 3.5 Inter-correlations Between Aggregate EPT and BPM Scores, and Demographics and Baseline Symptom Severity ($N = 42$)

Varibles	*M*	*SD*	1	2	3	4	5
(1) Sex	0.53	0.51	-				
(2) Age	13.02	1.85	- 0.22	-			
(3) YSR-TP	60.55	10.76	0.00	0.26	-		
(4) EPT	7.35	0.35	0.10	- 0.07	- 0.12	-	
(5) BPM-TP	60.69	8.38	- 0.05	0.20	0.94**	- 0.07	-

Note: **p < 0.01; YSR-TP = Youth Self-Report - Total Problems, EPT = Exploratory Psychodynamic Technique, BPM-TP = Brief Problem Monitor - Total Problems.

3.4 CHANGE OVER TIME OF EXPLORATORY PSYCHODYNAMIC TECHNIQUE

The results of the first MLM equation are presented in Table 3.6. Both the main effects phase and phase-squared were found to be significant after the effects of the individual patients, their initial symptom severity and demographic variables sex and age were controlled. The effect of (time) 'phase' signals to a linear decrease in EPT use ($\beta = 0.102$, $SE = 0.047$, $t = -2.170$), whereas a positive 'phase-squared' relationship indicates a curvilinear progression over time ($\beta = 0.043$, $SE = 0.022$, t

= 1.954), where an initial decrease of EPT is followed by an increase. To determine whether the linear model or the quadratic model is to be retained, a difference test of the deviance statistics was conducted and found to be significant, [$\chi^2(1) = 3.99$, $p < 0.05$], showing the quadratic model was a better account of the trajectory of change. Hypothesis 3 expected that there would be an increase in the use of EPT as the treatment progressed. This partially confirmed by the analysis since, even though there was a long-term increase in EPT, it was preceded by an initial decrease.

Table 3.6 Summary of Multilevel Multivariate Model Predicting EPT by Sex, Age, YSR Total Problems, Time (linear) and Time^2 (quadratic)

	EPT		
Intercept and Predictors	B	SE	t-ratio
Intercept (β_{00})	7.171	0.082	87.451**
Sex (β_{01})	0.103	0.100	1.020
Age (β_{02})	-0.003	0.030	-0.100
YSR Total Problems (β_{03})	-0.004	0.005	-0.800
Phase (linear) (β_{10})	-0.102	0.047	-2.170*
Phase^2 (quadratic) (β_{20})	0.043	0.022	1.954*

Note: * $p < 0.05$; ** $p < 0.01$. EPT = Exploratory Psychodynamic Technique, YSR Total Problems = Pre-treatment Youth Self-Report total problems T-score.

3.5 PROCESS-OUTCOME ANALYSIS

Hypothesis 4 expected a direct effect of EPT on the total problems of the child where an increase in EPT would be predict a decrease in problem behaviors. However no significant direct effect of EPT on BPM Total Problems was found ($p = 0.921$; see Table 3.7). Nevertheless, the hypothesis that there would be a two-way interaction effect (hypothesis 5) between baseline case severity and EPT was supported by the findings ($\beta = 0.174$, $SE = 0.088$, $t = 1.977$). As can be seen in

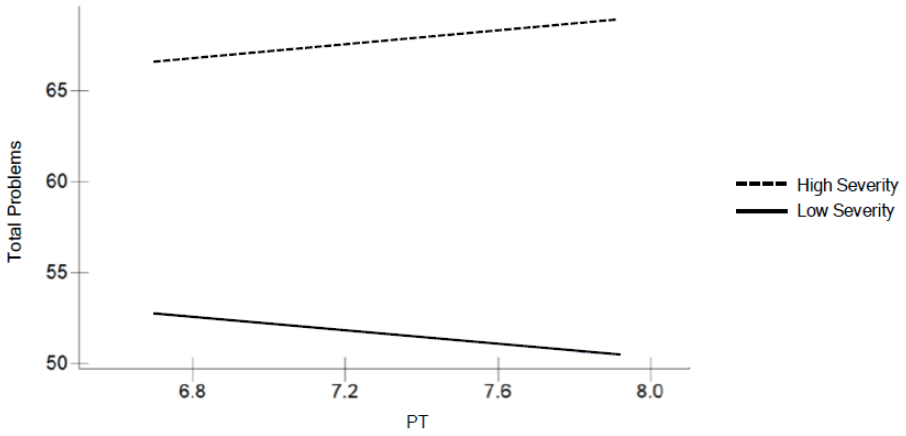
Figure 3.1, higher intensity of EPT predicted an increase in problem behavior for the patients who reported high levels of baseline symptoms (1 standard-deviation above the mean T-scores of pretreatment YSR total problems), in contrast to a decrease in problem behavior for those patient who reported lower levels of baseline symptoms (1 standard-deviation below the mean T-scores of pre-treatment YSR total problems).

Table 3.7 Longitudinal Conditional Model with Pre-treatment Case Severity (YSR-TP), EPT and Interaction as Predictors of BPM-TP

	BPM-TP		
Intercept and Predictors	B	SE	t-ratio
Intercept (β_{00})	60.163	0.705	85.338**
Sex (β_{01})	- 1.490	0.951	- 1.567
Age (β_{02})	- 0.471	0.292	- 1.613
YSR-TP (β_{03})	0.736	0.046	16.000**
Phase (β_{10})	- 0.506	0.334	- 1.515
EPT (β_{20})	0.092	0.934	0.099
EPT × YSR-TP (β_{23})	0.174	0.088	1.977*

Notes: BPM = Brief Problem Monitor, EPT = Exploratory Psychodynamic Technique, TP = Total Problems, YSR = Youth Self-Report ; * $p < 0.05$, ** $p < 0.01$;

Figure 3.1 Interaction Effect of PT × YSR Total Problems in the Prediction of BPM Total Problems



Notes: PT = Psychodynamic Technique, BPM = Brief Problem Monitor, YSR = Youth Self Report; "High Severity" indicates 1 standard-deviation above, and "Low Severity indicates 1 stand-deviation below the mean of baseline problem behavior measure with pre-treatment YSR Total Problems T-score.

CHAPTER 4
DISCUSSION

The aim of the present study was, firstly, to get a better understanding of the nature of adolescent PDT by presenting the general profile of the sessions and determining the latent ISs functioning in the therapy process and, secondly, to investigate the longitudinal change and association to problem behavior of any of the ISs which could be reflective of techniques employed by the therapists. Our descriptive hypotheses that the sample sessions would be strongly associated with the PDT prototype as opposed to the others, of finding an IS that would represent the EPT and expecting its use to increase through the course of treatment was to a large extent supported. The most characteristic items in the sessions for adolescents here were a near perfect match to those of the PDT prototype, whereas it had very few items in common with CBT and some of the items were in fact reversely related. Only one of the items (99) was more associated with CBT than it as PDT.

However, there was also a strong relationship with the MBT prototype as well, but since the sample's near perfect match vis-à-vis the most salient items of PDT, the similarity between the PDT and the MBT dimensions of the sample was largely due to the overlaps between the prototypes themselves. Nevertheless, the one item (6) that was not related to PDT through the most characteristic items list but via the 20 most characteristic items of the sample still concerned emotions stating that the young person talks about the affective aspects of his or her relationship with significant others – in other words, a mentalizing activity. Furthermore, the one item that was not among the most characteristic in the sample of the current investigation but was present in the PDT and psychoanalysis lists was the one concerning the therapist's attempt to point out to the patients the patterns in their behavior and conduct. In contrast, the item about the therapist drawing the patients' attention to their typical ways of dealing with emotions in the MBT prototype's most characteristic items list (item 60), was still place as the 15th most common item in the sample. Together these seem to back the notion that the sample sessions for the thesis is in fact not just carry the brand name PDT, but are contexts where interactions are closely related to those practiced by expert clinicians.

The results of the five-factor solution to the principle components analysis revealed only one of the ISs (IS 5) to have interactional dynamics that corresponded to the what one would expect from a therapist who was employing the expressive techniques usually associated with PDT. Furthermore, despite not being linear, EPT exhibited a quadratic positive change in time characterized by an initial decrease followed by a subsequent increase in its prevalence. On the other hand, the first of hypotheses with regards to the connection of EPT to the outcome measures (fluctuations in problem behaviors) was not confirmed. In other words, EPT was not by itself an independent predictor for change of total problem behavior of the young person. However, in line with our fifth and last hypothesis, an interaction effect was discovered between the self-reported baseline case severity and EPT. By looking more closely into the association EPT had with patients whose YSR total problems T-scores were substantially higher and lower than others in the sample (1 standard-deviation above and below the mean of the same), we could observe that

EPT predicted an increase in problem behaviors for the first group, contrary to the decrease in problem behaviors in the latter group.

The discussion part of the thesis will start off by relating the discovered ISs to the literature of adolescent PDT and the form of interaction they may be describing. The specific focus of this section will be both the technique of the therapist captured in EPT and a reflection on certain other items which may indicate various preferred and recurrent practices the therapist adopts when the dyadic interaction leans in the manner the remaining four IS describe. Next, there will be an elaboration on the research and clinical implications of the change over time of EPT and its relation to problem behaviors as well as potential avenues of further inquiry. Lastly, the discussion will assess the limitations and followed by summing up the limitations of the study as a whole.

4.1 ANALYSIS OF INTERACTION STRUCTURES

IS 5 showed many of the characteristics of the psychodynamic technique, and much like those in previous studies of adult and child psychotherapy process research, is composed solely of items describing therapist behavior and attitude. However, what aspects of the psychodynamic approach it corresponds to will be further elaborated upon later in this section. In addition, IS 2, IS 3, and IS 4 also contain actions taken by the therapist that is usually not associated with PDT. Unlike Halfon et al. (2018) and Jones & Pulos (1993), two of the ISs (IS 2 and IS 4) had more therapist item types than would be expected. In a sense this shows the process in our sample include some consistent therapist responses to some of the young person's attitudes and behavior.

IS 1 named as *Resistant Patient with Alliance Rupture* mainly based on its resemblance to the factor "Alliance Rupture – Withdrawal" in Di Lorenzo and Maggiolini (2019) and "Resistant Patient" IS in Jones and Pulos (1993). Both the ISs set by the authors were in line with the description here as they contained items that which signal the uncooperative attitude taken by the young person; the patient not only refuses to initiate or elaborate upon topics, but also acts in manner that is

an impediment to its progress, such as being provocative, expressing boredom and remaining silent. These qualities are further coupled with an increase negative attitude towards the therapist and therapeutic process. In addition, many of the items exhibited reverse loadings to those that have been shown in Price and Jones (1998) to have positive correlations with therapeutic alliance. In this sense, the merging of these factors along with the item-based (reverse) relation to therapeutic alliance helped in how the interaction in IS 1 has been characterized.

Interestingly, the IS also presents an anxious adolescent as well as tell-tale signs of a lowered mentalization capacity with a decreased interest in the psychology of others. Both of these aspects of the IS can be traced back to the literature. Messer (2002) points out that resistance in the form of not expressing one's emotional and fantasy life can create a sense of anxiety as the patient holds in what constitutes himself. Moreover, (projected) negative attitudes towards the therapist or the inability to verbalize those thoughts may foster anxious behavior because of either inhibited behavior or fear of retaliation when the negative feelings are expressed. Psychodynamic theorists remind us that therapist is an adult upon which anxieties pertaining to the individuation (or separation from the caregivers) of the young person is projected (Blos, 1967; Briggs, 2002), making the negative and distrustful attitude towards the therapist more meaningful. On the other hand, Fonagy et al. (2002) point out the link of this interaction to mentalization. They explain mentalization capacity of the adolescent is hindered by separation process (from the parents and their internal representations) and the newly developing need to make sense of a whole new range of interpersonal relations. The authors contend that these create a tendency in adolescents to shy away from the formation and elaboration of abstract thought regarding emotions and how others perceive them. Taking these factors into consideration, IS 1 dynamic may not be unique to the sample but an expected pattern for adolescents.

Unlike IS 1, the items of IS 2 are roughly equally divided between the types about the young person and the therapist. IS 2 has been named *Demanding Patient, Accommodating Therapist*, because these seem to the aspects of the interaction that better comply to the psychodynamic approach. However, some of the depictions of

the therapist's action are not only typical within psychodynamic technique, but also can be regarded as rather puzzling.

The most striking aspect of the IS is its resemblance of one of the central inner conflict that is definitive of this stage. For instance, on the one hand the young person is both demanding and controlling the relationship, an indication of the patient's disposition to have the upper hand and consolidate his individuality. However, on the other hand, the patient also wishes to gain the approval of the therapist and is disinclined to affirm his or her own autonomy and separation with others. Such an interaction is reminiscent of the second individuation, where the adolescent want to establish his or her own identity but is disinclined to do so because it would threaten the pre-establish sense of safety (Blos, 1967; Erikson, 1968). As Lampl-DeGroot (1960) points out cynicism deriving from the recently unidealized love object may have led to the therapist being yet another figure that does not understand the teenager.

The therapist's response is congruent with the expectations of psychodynamic technique. Instead of engaging in psychoeducation and trying to explain the conflicting emotions the young person is feeling, the therapist remains thoughtful and neutral, and accommodates the patient when there is difficulty the relationship. These adhere to the general idea that one of the primary tasks of the therapist is to contain unprocessed emotions of the young person (Briggs, 2002; Mishne, 1996) and accepting projections of the patient without (at least initially) confrontation and interpretation (Fonagy et al. 2002; Gedo & Goldberg, 1973). In theory, this aims to form the facilitating environment in which the adolescent can grow (Mishne, 1996; Winnicott et al., 1986).

The difficulty with making sense of the therapist's attitude is the certainty with which he or she talks about the young person's mind (89) and the lack of exploration of looking at issues from a different perspective (80r). The expression of certainty does not appear in any of the ISs found thus far, while the exploration of different perspectives in mostly positively loaded and is the most characteristic aspect of sessions from both PDT and CBT (Calderon et al., 2019) As such, it remains a matter of further inquiry why the therapist has reacted in this manner.

One possible explanation could be the need to sound authoritative to soothe the ambivalent emotional state of the young person. Alternatively, the therapist may have identified with the role of a parent projected by the patient. The less speculative reason may be a countertransferential response of therapist's need to sound more confident of his or her statements. The source of this need may have been founded on the anxieties with regards to therapist's own sense of competence when his or her sense of authority has been challenged (Anastasopoulos & Tsiantis, 1996). In any case, the rigidity with which the therapist refers to the mind of the adolescent may have at least exacerbated the patient's sense of being misunderstood.

Unlike IS 1, in IS 3, i.e. *Resistant Patient with Avoidance of Negative Affect*, the patient is so removed from negative emotions that he or she does not even reflect this back at the therapist. The resistance of the young person described when IS 3 is high seems to be passive, where feelings in general are held at a distance. The negative feelings triggered by the circumstance – these include the ones pertaining to adolescence such as rejection or abandonment and feelings of inadequacy – and attempts at exploring them are resisted, eliciting a irritability. What seems interesting is that the therapist is no longer performing one of the most fundamental activities of PDT therapists, working with the young person to make sense of the patient's experiences (see ideal prototypes in Bychkova et al., 2011). The therapist also being disposed to comment on the adolescent's non-verbal behavior may imply confrontations or an effort to talk about emotions that are generally absent from the conversation; that is, when the patient does not verbalize the negative emotions, the therapist may be pointing out contradictions or integrating emotion into talk via the non-verbal cues of the patient. IS 3, like IS 1, also shares items with the "Alliance rupture – withdrawal" factor in Di Lorenzo and Maggiolini (2019) and the third session cluster in Calderon et al. (2019); this would support the idea that aspects of this IS are commonly experienced by adolescence therapists, making it less likely that IS 3 is unique to the sample. Moreover, like IS 1, the items of IS 3 are also indicative of break in the alliance between the therapist and patient (Price & Jones, 1998), despite being less salient. Thus, these finding seem to show two different but

typical manners of patient resistance in IS 1 and IS 3. The difficulty of the young person in this IS comes not from the processing of mental states but the rather the absence of negative emotions in the talk in therapy.

The literature on adolescents frequently refer to high levels of anxiety that arises from their newly developed ambivalent attitudes towards their parents leading to disinclination to withdraw and not express themselves (Fonagy, 2002; McCarthy, 1989). However, the adolescent is also riddled with other conflicts "including the changing body, the need to redefine the sense of self and identity, the need to redefine old and present friendships, and the need to create intimacy" (Atzil-Slonim, 2019, p. 259). One way of dealing with the emergent anxiety ridden-issues is to avoid talking about their affective aspect. The absence of many therapist items seems to indicate that the way therapists approach this shows variability. While exploration of the maladaptive and more appropriate defenses is the characteristic way of approaching the situation for PDT (Atzil-Slonim, 2019; Briggs et al., 2015), the typical therapist response in these sessions was taking a step back and trying to integrate emotions into the talk.

IS 4, *Inexpressive Patient, Inviting Therapist*, gives the profile of a young person who is not only shy but also unable to express anger or object to unfairness, taking on the responsibility of the things that happen in his or her life. Unlike IS 3, the trouble with the interaction here does seem to necessitate an absence of expression of negative emotion, but the lack of appropriate responses to unjust circumstances. In this respect, the young person exhibits properties of being self-deprecating and withdrawn. The therapist's response to the patient seems to reflect an effort to engage the young person by explaining the rationale behind therapy and relating the therapeutic relationship with those in the patient's life. Amidst the lack of verbal communication, the therapist tries to connect the psychic experience to the physical body.

Explaining the rationale of technique and approach is usually practiced more often in CBT (Jones & Pulos, 1993) and is seen as being uncharacteristic for PDT but characteristic of CBT (Ablon & Jones, 1998; Bychkova, et al., 2011), and, thus, may be seen as a deviation with the psychodynamic technique. However,

Digiuseppe et al. (1996) indicate an important issue for adolescent psychotherapy. They contend that while most therapeutic alliance research has usually been about fostering a therapeutic bond (i.e., the emotional connection in the client-therapist relationship) with children and adolescents, research fails to take into account the age and developmental stage of the client. Hence, their claim is that the other two aspects of therapeutic alliance – task (i.e., mutual agreement to partake in therapy) and goal (i.e., a consensus on the aims of therapy) – may be more important in the case of adolescents. Since concerns regarding autonomy and independence are central for youth, a more overt and prior agreement on the techniques and their relevance as well as mutually agreed upon goals can be crucial. A qualitative study on the expectation of adolescent patients from therapy which came out of the IMPACT research, offer some support to this notion (Midgley et al., 2016). According to their findings, even if the patient has had previous experience with therapy, they still tend to view the process in medical terms, with the therapist viewed as a distant doctor-like figure who is there to solve their anxieties and symptoms. Such a perspective contradicts how PDT understands change and therapy. Thus, when a young person keeps his distance, the explaining of the rationale of therapy and linking the therapist-client relationship to others may potentially be an effective way to address this concern.

Despite having named IS 5, *Exploratory Psychodynamic Technique*, the psychodynamic approach relies upon a range of techniques that are utilized according to client. These techniques or therapist interventions in talk therapy are usually thought within an expressive-supportive continuum wherein a more supportive and holding relationship is viewed to be a precondition for the expressive techniques to be accepted and tolerated by the client (Gabbard, 2004; Luborsky, 1984). Luborsky (1984) explains that what makes these techniques expressive is that "through them the therapist sets the stage for the patient to express thoughts and feelings and to listen and to reflect on them, with the aim of understanding and changing what needs to be changed" (p. 90). On the expressive side of the spectrum, in which the therapist is more aptly described as exploratory, lies interventions like, (from most to least expressive) *interpretation, observation,*

confrontation and *clarification* . On the other end of the continuum of supportive interventions, where the therapist may be thought to be (anxiety) suppressive, are interventions such as (from most to least supportive) *advice and praise*, *psychoeducation*, *empathetic validation*, and *encouragement to elaborate* (Gabbard, 2004). While it is true that the more interpretation that is involved in the therapeutic process, the more expressive the therapy is thought to be, interpretation is also the less common of the interventions (Gabbard, 2004).

IS 5 can be thought to lie in the middle of the expressive-supportive continuum, leaning towards the more expressive end. Although it falls short of encompassing the interpretive practices of the psychodynamic approach, just as importantly, it excludes various supportive practices.. The exploratory character of the therapist in IS 5 could be restated as the therapist is described as someone who speaks in a clear (46) and nonjudgmental (18) manner exploring the perspective (99), feelings (97) and symptoms (39) of the patient, all the while clarifying their meaning (65) and encouraging further elaboration (3, 31). On the other hand, the exclusion of the supportive interventions[8] can be seen in the lack of guidance in making sense of the situations (43r*) and how to act (27r*, 49r, 85r*), and the absence of direct reassurance (66r*). Furthermore, the therapist refrains from divulging any information about his or herself or what he or she is feeling and thinking (21r, 76r, 81r) – paving the way to a transferential relationship and with an apparent lack of empathetic validation or praise.

However, some of the literature on ideal or actual prototypes (Bychkova et al, 2011; DiLorenzo & Maggiolini, 2019) and IS (Caleron et al., 2019) do signal the absence of certain items that are usually associated with the distinguishing affect-focus (50, 96) and interpretive (62, 98) aspect of psychodynamic technique. However, unlike these studies, the determination of IS through principle components analysis does not analyze these items in light of how common they are within the sessions but whether or not they inter-correlate with the other items. Thus, the absence of certain items within IS 5 does not refer to their variability in

[8] The items with an " * " are items that have a counterpart in PQS and are identified by Jones et al. (1988) to represent the supportive interventions of the therapist.

how characteristic they are in sessions, which constitute the context in which these interventions take place. For instance, the mean Q-rating values for items 50 ("Therapist draws attention to feelings regarded by young person as unacceptable") and item 96 ("Therapist attends to the young person's current emotional states") make them, respectively, the 13th (M = 6.80, SD = 0.93) and 9th (M = 7.30, SD = 1.10) most characteristic items within the sample sessions. However the same cannot be said about the two interpretative items that are seen integral parts of PDT. The mean Q-ratings of item 62 ("Therapist identifies a recurrent pattern in young person's behavior or conduct") – as one of the *clearest* indicators of interpretation – shows it is not as characteristic as the other items in the whole sample. Similarly item 98 ("The therapy relationship is a focus of discussion") is also relatively less characteristic (M = 5.37, SD = 0.85) in the present sessions but remains a discerning interaction for STPP and psychoanalytic therapy (Bychkova et al., 2011; Calderon et al., 2017). Putting aside the fact that some of the other items may embed interpretations – e.g., a clarification (65) or exploration of internal states (97) – the lack of items 62 and 98 in the IS 5 may be due to lack of correlation with the more exploratory items. In other words, since not being one of the more characteristic items does not presuppose that they still cannot be associated with the other items in IS 5, their absence in the IS rather shows a diverging trend that the interpretive items exhibit in relation to the more exploratory techniques employed.

It is possible to speculate as to why therapists in the current sample are less inclined to interpret pattern behaviors in patients' lives. One possible explanation may be a hesitancy and lower skills in the technique on the part of therapists due to their novice standing; it possible to imagine that they start interpreting patterns only when they are sure or feel comfortable to do so. Another reason may be that many of the aforementioned articles are about STPP and described a manualized therapeutic process that is intended to be 6 months or less. However, despite the guidance given to the therapists being in accordance with the expected shorter processes, the PDT training is not one that is exclusively directed towards ending the session at any given time frame – i.e., remain open-ended. Manuals on long-term psychodynamic psychotherapy (LTPP) have highlighted that the timing of

interventions is important in that they should be postponed if more understanding is necessary, should take into account how prepared the patient is, and should not substantially impair the supportive and holding therapist-patient relationship (Gabbard, 2004; Luborsky, 1984). Similarly, how expressive a therapy is in LTPP also depends on frequency of sessions, where "a therapy that is designed to be more expressive places greater emphasis on transference and will occur 2-3 times weekly, whereas supportive therapy can be once weekly or less" (Gabbard, 2004, p. 66). Because of a lack of standard manualized framework , these considerations may partially have come into play for this sample. Lastly, taking into account the relatively less characteristic standing of items that depict more interpretive interventions as opposed to how characteristic the affect-focused items, it is possible that the IS 5 captures the exploratory interventions of mentalization-based therapy. These techniques more often focus on exploring mental states of the patient, others and within relationship, and elaborating upon the emotions of others without attributing any emotions to the patient (Specht et al., 2016). In this respect, the context and general attitude of the therapist is more similar to MBT than psychoanalysis. Hence items that relate to the latter are less characteristic and do not appear in the same pattern as those that relate to the former.

To reiterate, taking into account the considerations above, IS 5 seems to be a good representation of the prevalence of the exploratory techniques in a particular session. These are in relation to the studies on APQ, rather than PQS for adult psychotherapy or CPQ for child psychotherapy. It would not be possible for the psychodynamic technique in APQ to resemble those extracted using the other two measures. Only 4 of the 15 child psychotherapy (CPQ) items in the IS found to correspond to psychodynamic technique by Halfon et al. (2018) are present in APQ. Similarly, a mere 3 of the 10 adult psychotherapy (PQS) items that fall under the IS for psychodynamic technique in the Jones and Pulos (1993) study are shared by the APQ. In fact, the problem of finding an IS composed of overlapping interpretive interactions arises from the more pervasive issue of APQ lacking any items that refer to "defenses" or "interpretations" directly. In other word, the fact that PQS and CPQ contain items that make greater reference to the concepts and interactions

that belong more specifically to the psychodynamic approach, their capacity to capture elements more clearly associated with PDT would undoubtedly be better. Hence, any attempts at capturing psychodynamic techniques in APQ ISs would inevitably involve more general items within a context in which prototypically PDT interaction / items have high mean Q-ratings.

However, an important aspect of IS 5 is that it also implies the absence of supportive interventions. Not only is this highlighted by the fact that many of the items negatively associated with the IS are actually explicated as a such in Jones et al. (1988), but also are viewed as being linked to CBT (Ablon & Jones, 1998; Bychkova et al. 2011). This dimension of the IS can help us to further consolidate its position as more honing in on the exploratory techniques in PDT. That is to say, as values of IS 5 increase, we will also find the therapist employing less supportive interventions that also fall under the psychodynamic approach.

4.2 CLINICAL AND RESEARCH IMPLICATIONS OF TECHNIQUE AND PROCESS-OUTCOME RESULTS

One of the main findings of the current study was quadratic change of the intensity of EPT use over time. Such a trajectory was contrary to the linear gradual increase of psychodynamic technique revealed in the sample of child PDT sessions from a collection of cases (Halfon et al., 2018) and the sample of adult PDT sessions from a single-case (Jones et al., 1993). As mentioned in the previous section, a reason behind this discrepancy may be due to the differences of measures and the content of APQ being less representative of descriptors that clearly indicate the interpretative techniques of PDT. Furthermore, the item composition of psychodynamic techniques ISs in the adult and child psychotherapy (see also Jones & Pulos, 1993) do not preclude supportive techniques as much[9]. Thus, the EPT in the adolescent sample highlights the concurrent trend of an increase of supportive interventions when the saliency of expressive technique descriptors decrease. When

[9] Quite the opposite can be seen in the factor PT of Halfon et al. (2018), which includes the item, "Therapist help child manage feeling" with a positive loading.

the general theoretical disposition of adolescent PDT to emphasize the need to support, contain and refrain from interpretation is taken into account (see Chapter 1.3), it is likely that the decrease in expressive techniques may be due to the accommodating and supporting intentions of the therapists. In this respect, the result may derive from features of adolescence itself. Another sign that this may be the case is the negative correlation EPT has with IS 1, one of the ISs that describes a resistant young person who expresses anxiety and distrust. While this study focuses on technique and has only looked into the change in time of EPT, future studies could turn their attention to the other ISs, which may help reach a fuller and potentially more supported answer as to why therapist have exhibited this response.

The question of whether this is actually beneficial to the therapeutic process is also an open question that would require more research. Considering the results of process research from adult PDT of depressed patients (Katz & Hilsenroth, 2018; Katz et al., 2019; Katz et al. 2020), the more frequent use of affect-focused psychodynamic techniques (along with others) in the beginning the therapeutic process could also be associated with positive treatment outcome in the adolescent population, or at least among certain groups of young patients. In addition, Target and Fonagy (2005) have advised the adoption of systemic and psychodynamic thinking in the initial stages of therapy based on the fact that they can provide a broader perspective as to identifying the sources of the child and young person's difficulties. On the other hand, the drop EPT intensity does not refer to any changes in the changes that occur in the interpretative techniques being employed. The concurrent shift in interpretive techniques can perhaps be an issue of further investigation by perhaps tracking changes in certain items.

The tentative hypothesis that EPT would (independently) predict a decrease in problem behavior was mostly based on presumption that PDT has demonstrated to be effective form of therapy (Midgley et al., 2017). Otherwise, most outcome studies usually employ pre- and post-treatment outcome measures, which are very different from tracking the problem behavior across time. An exception this method can be seen in Baruch and Fearon (2002), where the researchers have checked the internalizing, externalizing and total problems of the youth every three months and

identified consistent decrease in symptoms of the young people. However, the basic difference in process research and outcome research comes to the fore in such instances. While the PDT was the "brand name" of the therapy in these instances, what constituted the practice remains unknown. Accordingly, the Baruch et al. (1998) result that therapists' supportive techniques leads to less drop-outs allows us to make the inference that there is at least some flexibility in the techniques used and it is unclear how and why they achieved the results they did. Furthermore, the conclusion of greater use of EPT causing an increase in problem behavior in cases with increased severity does not contradict generally consistent finding in outcome research either (see Chapter 1.5). Although recent RCTs have shown the efficacy of PDT on challenging adolescents (e.g., Cropp et al., 2019, Salzer et al., 2014), even brief overview of the standardized treatment manual in the studies clearly depicts a more active and supportive therapist.

In this respect, the process-outcome research counterparts of the present study in child (Halfon, 2021) and adult (Owen & Hilsenroth, 2011, 2012) psychotherapy may be a better source of comparison. One differentiating factor of what was revealed in the current study and the conclusions of adult psychotherapy was that, despite EPT having an interaction effect with therapeutic alliance and the use of CB techniques, no effect of case severity was observed. In contrast, Halfon (2021) found that comorbid cases distinguished themselves in cancelling out the effect of psychodynamic technique irrespective the level of alliance. Since the relationship between technique and therapeutic alliance is absent in the current study no comparison can be made with these results. Following the lead of these articles, inclusion of therapeutic alliance as a variable in future studies on an adolescent sample seems promising.

Nonetheless, the interaction effect between baseline problem severity and EPT is parallel to that of the results of child psychotherapy and not adult psychotherapy. One of the major concerns of adolescent PDT are developmental issues particular to the period. This could potentially be an important distinction between the adult and adolescent therapies, bringing the latter closer to the child psychotherapy. Accordingly, in trying to explain why EPT did not result in problem

behavior improvement but rather deterioration for more complex cases, Halfon (2021) refers to the literature concerning ego strength, emotional regulation and symbolic play capacities of children, suggesting that without a rudimentary and adequate development in these areas, expressive or interpretative interventions can be overwhelming for children. Thus, she advises that therapists continually monitor these parameters, employ a wider range of techniques (i.e., include supportive techniques) and mentalization developing interventions – especially when it comes comorbid internalizing / externalizing children. In other words, age-related developmental concerns form the basis on which child treatment shows different results when it comes to more complex disorders.

Adolescent psychotherapy most likely converges with child play therapy at this point where the transitional context of the developmental period has its overburdening effects. Many of the pivotal points of conflict for the young person has been discussed (Chapter 1.1.1, 1.1.2) along with modifications to techniques (Chapter 1.3). Of special importance to complex cases is perhaps the acute demand from youth to respond to a sudden increase in social complexities. Fonagy et al. (2002) find the pervasiveness of withdrawal or enactments in adolescence to be partially rooted the breakdown of their mentalization capacity because of overbearing conflicts and, by extension, anxiety; the strain on social cognition; and the increased sensitivity to emotional talk and attachment related challenges. The in-session reflections of mentalizing difficulties were also observed in IS 1 and IS 3, both depicting a resistant patient. Sensitivity to these have also been the major concerns of Salzer et al. (2014) and Cropp et al. (2019) in adopting the psychoanalytic-interactional method (PIM) into their study. The proposed approach is one of an active therapist who inserts himself or herself into relationship as a proxy to the ego functions of the young person by bringing up selectively certain feelings and observations with the developmental purpose of helping the patient acquire a better and more flexible understanding of the social world and relationships. Horne (2001) builds her perspective on a very similar social foundation as the therapist acts to open up and smooths the network of communication that surround the challenging adolescent. The corollary is that the

frequently advised therapists' continuation of contact with the significant people in the adolescents' life (Briggs, 2002; Mishne, 1996; Target & Fonagy, 2005) could serve this function. A major clinical implication of this study may be the further evidence it provides towards the prior theoretical and empirical propositions for a more supportive stance being need in more severe (baseline) cases.

Lastly, a critical point in interpreting these results is that EPT predicting problem behavior does not say much about the outcome of the treatment in general. Ever since Anna Freud (1958), many ascribing to PDT theory have in fact wanted the adolescent to experience the age-related conflicts and enactments within the therapy room as well. It has been seen as desirable for maturations, either to better adapt to the social world (Blos, 1983; Erikson, 1968) or establish an authentic sense of self (Palembo, 1988; Winnicott, 1971; Wolf et al., 1972). As Stiles and Horvath (2017) indicate appropriate responsiveness may require that short-term benefits may have be given up for long-term positive outcome, i.e., "a client may feel worse before he or she gets better" (p. 75). For instance, the case in the Grossfeld et al. (2019), there seemed to be no new understanding forming and the participant expressed the feeling that she was not being helped according to some ISs, but the authors still emphasized that the therapy was successful based on pre- and post-treatment outcome measures. Thus, it would be wrong to equate the outcome of the treatment as a whole with the time-related the changes in symptoms. Further examination into the relationship between these two variables much like that seen in child psychotherapy research (Halfon et al., 2018; Halfon, 2021) would be quite informative.

4.3 LIMITATIONS OF THE STUDY

Process research into adolescent psychotherapy is quite new at the time. The current study has tried to be employ APQ, as a recently validated Q-set measure that seeks to provide a comparable and reliable account of the interactions in adolescent psychotherapy considering the unique aspects of the age-group, to better understand the nature of the therapeutic process. To the best of our knowledge, the

current study remains the only one to have used APQ to extract ISs from a collection of cases using principle components analysis. Unlike the implementation of sessions clustering as seen in Calderon et al. (2019), the IS here is able to identify repeated instances of mutual dyadic influence, reflected in a form of therapist-patient interaction and which can be captured by determining correlating items irrespective of whether how characteristic they are. Hence, the understanding of adolescent PDT process provided here is not about presenting the best descriptions of the interactions seen in groups of similar sessions, but rather trying to find consistent patterns of interaction embedded in all sessions with varying degrees of prevalence. Thus, it has allowed us to find a recurrent series of therapist interventions or lack thereof, which could be considered to reflect EPT. While this method has previously been implemented to analyze the association of a Q-sort representations of psychodynamic techniques (as an IS) with outcome measures in child and adult PDT (Halfon, 2021; Halfon et al., 2018; Jones & Pulos, 1993), the present work extends this to an adolescent sample for the first time. In this respect, the current study's contribution to process research is qualified by the tentative nature of its results which need further verification. Nonetheless, its value to the literature is founded on its position as being a forerunner to future investigations. Hence, it becomes all the more important to specify the major limitations, allowing the results to be evaluated accordingly.

A clear limitation of this study is that it did not have a randomized control group. Thus, a causal inference cannot be made regarding the process-outcome results. Previous research have tried to (at-least partially) overcome the ethical dilemma of a control group where no treatment was provided to people who seem to need it, by including treatment-as-usual or wait list patients. Although it possible that no randomization will be accepted in such situations, there is still room for creating better support for a causal link between technique and problem behavior (while trying to maintain the advantages of naturalistic studies) that is open to being pursued in later studies.

Another series of prevalent methodological problems derive from the features of the sample of participants and sessions, both of which affect the degree

to which the results can be generalized. As it can be seen in Table 2.1, around half the sample is composed of adolescents that are 11-12 years old when they started therapy, and roughly 80% are 14 years old or below. In this respect, mid/late adolescents (ages 15-17) are underrepresented in the data set. The emotional development and the concerns of these subgroups may vary considerably (Horne, 1999). Hence, future inquiries that can correct this disproportionate composition can help give a more comprehensive account of this the psychotherapy processes of this developmental stage. Even greater samples can also show potential divergences in the therapy process of different age groups.

Another concern may arise from the disproportionate representation of earlier sessions in the sample. As roughly three fifths of the sessions (62%) were from the first two time phases of the treatments, the ISs found in the study may be show bias favoring ISs that frequently occur in the beginning of therapy process. A manner in which other studies have circumvented this problem was by selecting random sessions from each case (Halfon et al., 2018) or by structuring the selection of the process so that an relatively equal amount of sessions are included into the analysis from both early and mid/late sessions (Calderon et al. 2019). However, in order to abide by Jones' (2000) recommendation to include at least 50 sessions in the sample used for analysis, these procedures could not be implemented. As such, in order for there to be a more equitable selection, a larger sample size is necessary that can be remedied in other inquiries. Nonetheless, while the ISs observed in this sample cannot be generalized to all PDT processes, we can still plausibly assume they can guide therapists by providing a notion of the conditions they may confront in the first twenty to thirty sessions.

However, another difficulty which may be derived from the reason behind how such a distribution developed. As previously mentioned (see Chapter 2.6), the Covid-19 pandemic led to the discarding of the sessions from 11 of the cases. Thus, for about a quarter of the participants, a significant portion of their treatment had to be unaccounted for in this sample. Since the second portion of our analysis seeks to relate EPT with the change in problem behavior through the course of treatment, the fact that a substantial portion of the process was absent for some of the patients

may have affected the result. In this respect, the potential effect of the absence of a part of the treatments is a limitation that would make room for justified skepticism regarding the reliability of the findings.

The presence of baseline non-clinical cases can be seen as a limitation here as well, especially considering previous research has usually been on child or adult samples that either exhibited clinical level baseline problem behavior (Halfon, 2021; Halfon et al., 2018) and been given prior diagnoses (Jones & Pulos, 1993). The lack of symptoms from the self-report measure does not necessarily mean the absence of mental difficulties. Research has shown that there are discrepancies in what various informants report (e.g., patients, parents, teachers etc.) when it comes to the types of problem behavior they report and from which contexts (De Los Reyes et al., 2015). In spite of these complications there seems to be a general acceptance in adolescent psychotherapy that parents are more inclined to pass on information about externalizing symptoms whereas young people focus on internalizing issue, but the situation is even more tangled up by factors such as the mental state of the parents (e.g., mothers with depressive symptoms reported more internalizing problems) and the teenager (e.g., youth self-conscious about their bodies report more externalizing problems) (Berg-Nielsen et al., 2003). In this inquiry, the young person's self-report was chosen because he or she is the person in the interaction and, thus, the one whose perception of the symptoms are of direct consequence of therapy. Nonetheless, collecting information from multiple sources, especially when the parents are more involved in the process, can enrich the evidence and provide insight into different aspects of the change taking place. However, it is still possible in for any subsequent inquiry to incorporate some aspects of the types of problem behavior into the analysis and process outcome conclusions; namely, with a larger sample size internalizing, externalizing and more complex disorders could more closely investigated.

Lastly, the therapists in the study were (master's level) students of clinical psychology, and so many of the findings may be due to their level of experience. The most obvious of these is the deviations from EPT despite the center's training and supervision is geared towards PDT. Not only may this effect the outcome by

virtue of how skillfully and tactfully the interventions were made, but it is also not clear whether more experienced therapists would digress so consistently and in the same manner as to appears in ISs or made manifest in the decrease of EPT in the initial stages of treatment. In adult psychotherapy literature, the (therapist) adherence and competence is distinguished from each other in reference to this aspect of practice. That is, adherence is context-independent meaning it denotes the knowledge and ability to deliver a particular form of treatment, whereas competence is context-dependent characterizing the therapist's understanding of the instances when intervention is necessary or not, "predicated on a (possibly tacit) sense of appropriateness, responsiveness, good judgement, and clinical acumen" (Barber et al., 2007, p. 494). A potential effect of the novice therapists with regards to their competence is also reflected in the results. Despite having used two-level models in this study, no variability of EPT was accounted for by the patients (see Chapter 3.2). This is not to say, the therapists have made no adjustments to techniques according to patient in-session behavior and attitudes – as is made apparent in the content of the other ISs. Nonetheless, when it came to the use of EPT, the results support the idea the therapist did not adjust to the idiosyncrasies of the patients. Thus, process research with more experienced therapists could greatly contribute to the newly evolving literature on adolescent PDT in determining whether or the extent to which such fluctuations in use of EPT can be accounted for by therapist competence. Furthermore, a closer look into this lack of patient-level variability to help identify its sources and improve training.

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APPENDICES

APPENDIX A: Youth Self-Report (YSR)

ID No: Tarih:

Cinsiyeti: ___ ERKEK ___ KIZ

Yaşınız:

Doğum Tarihiniz: GÜN___AY___YIL_____

Sınıfınız: _____ Okula devam etmiyorum ____

Çalışıyorsanız, işinizi belirtiniz: _____

ANNE BABANIZIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilk okul öğretmeni, şoför, oto tamircisi, avukat gibi) EĞİTİMİ (kaç yıl okula gittiklerini yazınız)

BABANIN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

ANNENİN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

I. Yapmaktan en çok hoşlandığınız sporları a, b, c şıklarına yazınız.
Örneğin: Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme, güreş, balık tutma gibi.
___ **Hiç yok.**

Her birine ne kadar zaman ayırırsınız?

	Normalden az	Normal	Normalden Fazla
a. _____	O	O	O
b. _____	O	O	O
c. _____	O	O	O

Her birinden ne kadar başarılısınız?

	Normalden az	Normal	Normalden Fazla
a. _____	O	O	O

b. _____	O	O	O
c. _____	O	O	O

II. Spor dışı ilgi alanlarını, uğraş, oyun ve aktivitelerinizi a, b, c şıklarına yazınız. Örneğin: Bilgisayar, satranç, araba, akvaryum, el işi, kitap, müzik aleti çalmak, şarkı söylemek, resim yapmak gibi (Radyo dinlemeyi ya da televizyon izlemeyi katmayınız).

___ Hiç yok.

Her birine ne kadar zaman ayırırsınız?

	Normalden az	Normal	Normalden Fazla
a. _____	O	O	O
b. _____	O	O	O
c. _____	O	O	O

Her birinde ne kadar başarılısınız?

	Normalden az	Normal	Normalden Fazla
a. _____	O	O	O
b. _____	O	O	O
c. _____	O	O	O

III. Üyesi olduğunuz kuruluş, kulüp ya da takımları a, b, c şıklarına yazınız. Örneğin: Spor, müzik, izcilik, folklor gibi.

___ Hiç yok.

Yaşıtlarınızla karşılaştırdığınızda her birinde ne kadar aktifsiniz?

	Az Aktif	Normal	Çok Aktif
a. _____	O	O	O

b. _____	O	O	O
c. _____	O	O	O

IV. Yaptığınız herhangi bir iş ya da günlük işleri a, b, c şıklarına yazınız.
Örneğin: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri, hayvancılık, elektrik-su faturası yatırma, çocuk bakımı, sofra kurma-kaldırma, bir dükkanda çalışma gibi (ücret karşılığı ya da ücretsiz yapılan her türlü işi katınız).

___ Hiç yok.

Yaşıtlarınızla karşılaştırdığınızda her birini ne kadar planlı, düzenli yaparsınız?

	Normalden az	Normal	Normalden Fazla
a. _____	O	O	O
b. _____	O	O	O
c. _____	O	O	O

V. a. Yaklaşık olarak kaç yakın arkadaşınız var?
(Kardeşleriniz dışında)

Hiç yok	1	2 ya da 3	4 ya da fazla
O	O	O	O

b. Okul dışı zamanlarda haftada kaç kez arkadaşlarınızla birlikte olursunuz?

(Kardeşleriniz dışında)

1 den az	1 ya da 2	3 ya da daha fazla
O	O	O

VI. Yaşıtlarınızla karşılaştırdığınızda:

a. Kardeşlerinizle aranız nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşim Yok
O	O	O	O

b. Arkadaşlarınızla aranız nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir
O	O	O

c. Anne babanızla aranız nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir
O	O	O

d. İşlerinizi kendi başınıza yapmanız nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir
O	O	O

VII. 1. Okul başarınız nasıldır?

O Okula gitmiyorum. Çünkü _____

	Başarısız	Orta	İyi	Başarılı
a.	Türkçe / Türk Dili Edebiyatı	O	O	O O
b.	Hayat Bilgisi / Sosyal Bilgiler	O	O	O O
c.	Matematik	O	O	O O
d.	Fen Bilgisi	O	O	O O

Diğer dersler:

Örneğin: Yabancı dil, bilgisayar, iş meslek dersi

(Beden, resim ve müziğin dışında)

e.	_____	O	O	O O
f.	_____	O	O	O O
g.	_____	O	O	O O

Herhangi bir fiziksel hastalığınız ya da engeliniz var mıdır?

O Hayır O Evet – açıklayınız _____

Okulla ilgili herhangi bir kaygınız ya da sorununuz varsa yazınız:

Okul dışındaki alanlardaki kaygı ve sorunlarınızı yazınız:

En beğendiğiniz özellikleriniz nelerdir?

Gelecekler ilgili beklentileriniz nelerdir?

Aşağıda gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Her bir madde sizin **şu andaki ya da son 6 ay** içindeki durumunuzu belirtmektedir. Bir madde sizin için **çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0** sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 1. Yaşımdan çok daha çocuksu davranırım.

0 1 2 2. Anne babamın izni olmadan içki içerim.

(açıklayınız):

_____

0 1 2 3. Çok tartışırım.

0 1 2 4. Başladığım etkinlikleri (oyunu, dersleri, işleri) bitiremem.

0 1 2 5. Hoşlandığım, zevk aldığım çok az şey vardır.

0 1 2 6. Hayvanları severim.

0 1 2 7. Övünür, hava atarım.

0 1 2 8. Bir konuya odaklanamam, dikkatini uzun süre toplayamam.

0 1 2 9. Kafamdan atamadığım, beni rahatsız eden bazı düşüncelerim vardır (mikrop bulaşma, simetri takıntısı, okul sorunları, bilgisayar gibi) (açıklayınız):

_____

0 1 2 10. Yerimde sakince oturamam

0 1 2 11. Gereken gayreti göstermeden, sırtımı tamamen büyüklere dayayıp her şeyi onlardan beklerim.

0 1 2 12. Yalnızlık hissederim.

0 1 2 13. Kafam karışık, zihnim bulanıktır.

0 1 2 14. Çok ağlarım.

0 1 2 15. Oldukça dürüstümdür.

0 1 2 16. Başkalarına kötü davranırım.

0 1 2 17. Çok hayal kurarım.

0 1 2 18. Kendime bilerek zarar verdiğim ya da intihar girişiminde bulunduğum

olmuştur.

0 1 2 19. Hep dikkat çekmeye çalışırım.

0 1 2 20. Eşyalarıma zarar veririm.

0 1 2 21. Başkalarının eşyalarına zarar veririm.

0 1 2 22. Anne babamın sözünü dinlemem.

0 1 2 23. Okulda söz dinlemem.

0 1 2 24. Gerekenden az yerim, iştahsızım.

0 1 2 25. Başka çocuklarla pek geçinemem.

0 1 2 26. Hatalı davranışımdan dolayı suçluluk duymam, oralı olmam.

0 1 2 27. Başkalarını kıskanırım..

0 1 2 28. Ev, okul ya da diğer yerlerde kurallara uymam, karşı gelirim.

0 1 2 29. Bazı hayvanlardan, durumlardan (yüksek yerler) ya da ortamlardan (asansör, karanlık gibi) korkarım (okulu katmayınız).

(açıklayınız):

_____

0 1 2 30. Okula gitmekten korkarım.

0 1 2 31. Kötü bir şey düşünebileceğim ya da yapabileceğimden korkarım.

0 1 2 32. Kusursuz, dört dörtlük ve her konuda başarılı olmam gerektiğine inanırım.

0 1 2 33. Kimsenin beni sevmediğihissine kapılırım.

0 1 2 34. Başkalarının bana karşı olduğu, zarar vermeye ya da açığımı yakalamaya çalıştığı hissine kapılırım.

0 1 2 35. Kendini değersiz, önemsiz, yetersiz hissederim.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 36. Bir yerlerimi kaza ile sık sık incitirim.

0 1 2 37. Çok kavga çıkarırım, kavgaya karışırım.

0 1 2 38. Benimle çok dalga geçilir, bana çok sataşılır.

0 1 2 39. Başı belada olan kişilerle dolaşırım.

0 1 2 40. Başkalarının işitmediği sesler ve konuşmalar işitirim. (açıklayınız):

_____

0 1 2 41. Düşünmeden hareket ederim.

0 1 2 42. Başkalarıyla birlikte olmaktansa yalnız olmayı tercih ederim.

0 1 2 43. Yalan söyler ya da aldatırım.

0 1 2 44. Tırnaklarımı yerim.

0 1 2 45. Sinirli ve gerginimdir.

0 1 2 46. Kaslarım oynar, seğirmeler olur ve tiklerim vardır (açıklayınız):

_____

0 1 2 47. Geceleri kabus görürüm.

0 1 2 48. Başka çocuklar tarafından sevilmem.

0 1 2 49. Bazı şeyleri pek çok çocuktan daha iyi yaparım..

0 1 2 50. Çok korkak ve kaygılıyımdır.

0 1 2 51. Başım döner, gözlerim kararır.

0 1 2 52. Kendimi çok suçlu hissederim.

0 1 2 53. Çok fazla yerim.

0 1 2 54. Kendimi sebepsiz yere çok yorgun hissettiğim olur.

0 1 2 55. Fazla kiloluyum.

56. **Sağlık sorunum olmadığı halde;**

0 1 2 a. Ağrı ve sızılarım olur. (baş ağrısı ve karın ağrısı dışında)

0 1 2 b. Baş ağrılarım olur.

0 1 2 c. Bulantı, kusma duygusu olur

0 1 2 d. Gözle ilgili şikayetlerim olur (Gözlük, lens kullanma dışında) (açıklayınız):

_____

0 1 2 e. Döküntü, pullanma ya da başka cilt sorunlarım olur

0 1 2 f. Mide-karın ağrısı olur.

0 1 2 g. Kusmalarım olur

0 1 2 h. Diğer (açıklayınız):

_____

0 1 2 57. İnsanlara fiziksel saldırıda bulunur, vururum.

0 1 2 58. Derimi ya da vücudumu yolar, saç ve kirpiğimi koparırım. (açıklayınız):

_____

0 1 2 59. İyi bir arkadaş olabilirim.

0 1 2 60. Yeni şeyler denemekten hoşlanırım.

0 1 2 61. Okul ödevlerimi tam ve iyi yapamam.

0 1 2 62. El, kol, bacak hareketlerimi ayarlamada güçlük çekerim, sakarımdır.

0 1 2 63. Yaşıtlarımdan çok, kendimden büyüklerle vakit geçirmeyi tercih ederim.

0 1 2 64. Yaşıtlarımdan çok, kendimden küçüklerle vakit geçirmeyi tercih ederim.

0 1 2 65. Konuşmayı reddettiğim olur.

0 1 2 66. İstemeyerek de olsa, belli bazı davranışları tekrar tekrar yaparım (elini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi)

(açıklayınız):

_____

0 1 2 67. Evden kaçarım.

0 1 2 68. Çok bağırırım.

0 1 2 69. Sırlarımı kendime saklarım, hiç kimseyle paylaşmam.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 70. Başka insanların var olmadığına inandığı şeyler görürüm. (açıklayınız): _____

0 1 2 71. Topluluk içinde rahat değilimdir, başkalarının benim hakkımda ne düşünecekleri ve ne söyleyecekleriyle ilgili kaygı duyarım.

0 1 2 72. Yangın çıkartırım.

0 1 2 73. El becerilerim iyidir.

0 1 2 74. Gösterişten hoşlanır, maskaralık yaparım.

0 1 2 75. Çok utangaç ve çekingenim.

0 1 2 76. Diğer çocuklardan daha az uyurum.

0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyurum. (açıklayınız): _____

0 1 2 78. Dikkatim kolayca dağılır.

0 1 2 79. Konuşma problemim vardır. (açıklayınız):

_____

0 1 2 80. Haklarımı savunurum.

0 1 2 81. Evden bir şeyler çalarım.

0 1 2 82. Ev dışındaki yerlerden bir şeyler çalarım.

0 1 2 83. İhtiyacım olmadığı halde birçok şey biriktiririm.(açıklayınız):

_____

0 1 2 84. Diğer insanların tuhaf bulduğu , yadırgadığı davranışlarım vardır. (eşyaların belli bir düzende ve sırada olmasını istemem gibi). (açıklayınız): _____

0 1 2 85. Diğer insanların tuhaf bulduğu , yadırgadığı düşüncelerim vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi). (açıklayınız): _____

0 1 2 86. İnatçıyımdır.

0 1 2 87. Ruhsal durumum ya da duygularım çabuk değişir.

0 1 2 88. İnsanlarla birlikte olmaktan hoşlanırım.

0 1 2 89. Şüpheciyimdir, kuşku duyarım.

0 1 2 90. Küfürlü ve açık saçık konuşurum.

0 1 2 91. Kendimi öldürmeyi düşünürüm.

0 1 2 92. Başkalarını güldürmeyi severim.

0 1 2 93. Çok konuşurum.

0 1 2 94. Başkalarına rahat vermem, onlara sataşır, onlarla çok dalga geçerim.

0 1 2 95. Çok çabuk öfkelenirim.

0 1 2 96. Cinsel konuları fazlaca düşünürüm.

0 1 2 97. İnsanları canlarını yakmakla tehdit ederim.

0 1 2 98. Başkalarına yardım etmekten hoşlanırım.

0 1 2 99. Sigara içerim, tütün koklarım.

0 1 2 100. Uyumakta zorlanırım. (açıklayınız):

_____

0 1 2 101. Dersleri asar, okuldan kaçarım.

0 1 2 102. Fazla enerjik değilim.

0 1 2 103. Mutsuz ve üzgünüm, depresyondayım.

0 1 2 104. Başka çocuklardan daha gürültücüyüm.

0 1 2 105. Sağlık sorunum olmadığı halde madde kullanırım(içki ve sigarayı katmayınız)(açıklayınız):

_____

0 1 2 106. Başkalarına karşı dürüst olmaya çalışırım.

0 1 2 107. Güzel şakalardan hoşlanırım.

0 1 2 108. Hayatı kolay tarafından yaşamaktan hoşlanırım..

0 1 2 109. Elimden geldiğince başkalarına yardımcı olmaya çalışırım.

0 1 2 110. Karşı cinsiyetten biri olmayı isterim.

0 1 2 111. Başkalarıyla kaynaşmaktan, birlikte olmaktan kaçınırım.

0 1 2 112. Evhamlıyımdır, her şeyi dert ederim.

Lütfen yukarıdaki maddelerin dışındaki duygu, düşünce, davranış ve ilgi alanlarınızı yazınız.

APPENDIX B: Brief Problems Monitor - Youth (BPM-Y)

Bugünün tarihi: _ _ / _ _ / _ _ _ _ (gün/ay/yıl olarak yazınız)

Adız ve soyadız:

Cinsiyetiniz: O Erkek O Kız

Yaşıniz:

Doğum tarihi: _ _ / _ _ / _ _ _ _ (gün/ay/yıl olarak yazınız)

Aşağıda, gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Lütfen her maddeyi, şu anda ya da geçmiş, ____ gün içerisinde sizi tanımlayan haline göre değerlendirin. Eğer bir madde, sizin için çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değil ise 0 sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri, bildiğiniz kadarıyla, eksiksiz olarak işaretleyiniz.

0 = Doğru Değil 1 = Bazen ya da Biraz Doğru 2 = Çok ya da Sıklıkla Doğru

Yorumlar

0 1 2 1. Yaşıma göre çok daha küçük gibi davranırım. _____

0 1 2 2. Çok tartışırım. _____

0 1 2 3. Başladığım etkinlikleri (oyun, dersler vb.) bitiremem. _____

0 1 2 4. Bir konuya odaklanmakta, dikkatimi toplamakta zorlanırım. _____

0 1 2 5. Yerimde sakince oturmakta zorlanırım. _____

0 1 2 6. Başkalarına ait eşyalara zarar veririm _____

0 1 2 7. Annem ve/veya babama karşı gelirim. _____

0 1 2 8. Okulda söz dinlemem. _____

0 1 2 9. Kendimi önemsiz ya da yetersiz hissederim. _____

0 1 2 10. Düşünmeden hareket ederim. _____

0 1 2 11. Çok korkulu ve kaygılıyımdır. _____

0 1 2 12. Kendini çok suçlu hissederim. _____

0 1 2 13. Çekingen ve utangacımdır. _____

0 1 2 14. Dalgınımdır; dikkatim kolayca dağılır. _____

0 1 2 15. İnatçıyımdır. _____

0 1 2 16. Kolay öfkelenirim. _____

0 1 2 17. İnsanları zarar vermek için onları tehdit ederim. _____

0 1 2 18. Mutsuz, üzgün ya da çökkümdür. _____

0 1 2 19. Çok kaygılanırırım. _____

Yukarıdaki listede belirtilmeyen başka bir durum varsa, lütfen yazınız:

0 1 2 _____ _____

0 1 2 _____ _____

0 1 2 _____ _____

Lütfen tüm maddeleri yanıtladığınızdan emin olunuz. Teşekkür ederiz..

I. ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of the dissertation.