

Expert Clinicians' Prototypes of an Adolescent Treatment: Common and Unique Factors

Among Four Treatment Models

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Abstract

Objective: To investigate (1) whether expert clinicians within psychodynamic therapy (PDT), mentalization-based treatment (MBT), cognitive-behavioral therapy (CBT), and interpersonal psychotherapy (IPT) agree on the essential adolescent psychotherapy processes using the Adolescent Psychotherapy Q-Set (APQ); (2) whether these four session prototypes can be empirically distinguished; and (3) whether mentalization is a shared component in expert clinicians' conceptualizations of these four treatment models.

Method: Thirty-nine raters with expertise in PDT, MBT, CBT, and IPT provided ratings of the 100 APQ items to characterize a prototypical session that adheres to the principles of their treatment model. A Q-factor analysis with varimax rotation was conducted.

Results: Expert clinicians reached a high level of agreement on their respective session prototypes, which loaded onto five independent factors. The PDT session prototype straddled two different factors, suggesting more variability in PDT expert clinicians' understanding of PDT process for adolescents than in the views of the expert clinicians representing the other treatment models. Mentalization process was shared among all four session prototypes; however, the correlation between the CBT and IPT session prototypes remained significant after controlling for the MBT session prototype.

Conclusions: Researchers can now assess adherence to four adolescent treatments and identify change processes beyond these labels.

Keywords: Adolescent Psychotherapy Q-Set (APQ), psychotherapy process, session prototypes, mentalization, comparative psychotherapy

Clinical or Methodological Significance of this Article: This study composited four session prototypes of the psychotherapy process characterizing four popular adolescent treatment models—PDT, MBT, CBT, and IPT. Future researchers can use these prototypes (available from the first author) to assess session adherence to these four treatment models’ psychotherapy process and then correlate these scores with outcome data to determine the associations between prototypical process and outcomes. The findings also suggest two trajectories of success for adolescent therapy—promoting mentalization and providing support—which should stimulate further research regarding when and with which patients they should be used.

Expert Clinicians' Prototypes of an Adolescent Treatment: Common and Unique Factors Among Four Treatment Models

There is now considerable evidence for the effectiveness of psychological therapies with children and young people (Hanley & Noble, 2017). There is also research to identify what types of therapy are likely to be effective for which particular kinds of childhood disturbance (Fonagy et al., 2015), and specific evidence for different treatment approaches, such as cognitive behavioral therapy (CBT; e.g., Stallard, in press), interpersonal therapy (IPT; e.g., Gunlicks-Stoessel et al., 2010), mentalization-based treatment (MBT; e.g., Rossouw & Fonagy, 2012) and psychodynamic therapy (PDT; e.g., Midgley et al., 2021). However, despite these important advances, little is still known about the mechanisms of change in therapy for young people, or to what degree change is due to common factors or specific therapeutic techniques associated with different treatment modalities (Hayes, 2017; Hayes & Brunst, 2017). If we are to improve our understanding of what makes a therapy effective, it is essential to have reliable measures of the therapeutic process, especially ones that can be used across a range of different treatment types.

The Psychotherapy Q-Set (PQS; Jones, 2000) was developed by Enrico Jones as a way of assessing the psychotherapy process with adults. Wishing to go beyond the “horse race” approach to evaluating treatments, the PQS aims to describe psychotherapy process at the level of the individual session, to allow for a more fine-grained examination of the role of therapy technique, as well as the broader “interaction structures” that develop between a therapist and their client (Ablon, Levy, & Smith-Hansen, 2011). Working from audio- or video-recordings of a session, independent observers sort 100 items, each describing different elements of the

therapeutic interaction, into categories representing items ranging from least characteristic to most characteristic of the session. The PQS has been used in a wide range of process studies, to examine questions such as the development of the therapeutic process across time in single cases of psychotherapy, to studies exploring the therapeutic process across different types of treatment. (For a review, see Ablon et al., 2011).

Given the very different nature of the therapeutic process when working with children, Celeste Schneider created an adaptation of the PQS for use with children to examine the child therapy process across different types of therapy (CPQ; Schneider, 2004; Schneider & Jones, 2004). This principle was continued in the development of the Adolescent Psychotherapy Q-Set (APQ; Calderón, 2014; Calderón et al., 2017). To ensure that the items included covered a broad range of therapeutic approaches, the development of the APQ included a review of published therapeutic treatment guides across a number of different therapy types commonly used with adolescents, including CBT, IPT, PDT and MBT. The wording of items was also reviewed to ensure that the wording was neutral and that specific items weren't "tagged" as belonging to a particular treatment approach, for example, by using terms such as "transference" or "cognitive restructuring" (for details of the development of the APQ, see Calderon, 2014; Calderon et al., 2017). The APQ has been used in two studies to examine the shared and nonshared components of CBT and PDT in the treatment of adolescents with moderate to severe depression (Bychkova et al., 2011; Calderón et al., 2017, 2019) and to explore the therapeutic process for adolescents with borderline features (Grossfeld et al., 2019), or those who drop out of therapy prematurely (Fredum et al., in press).

One of the great virtues of the PQS and the measures derived from it is that it allows us to examine therapy sessions as they actually happen; but the psychotherapy process Q-sets also provide an opportunity to empirically investigate what an “ideal” or “prototypical” session would look like, when conceptualised by therapists using different therapeutic approaches, and to compare these to how therapy sessions are actually delivered (e.g., Goodman & Halfon, in press). For child and adult therapies, such prototypes have been developed by inviting expert therapists to rate the appropriate psychotherapy process Q-set based on how they would expect an “ideal” session to look within their particular therapeutic modality. However, to date little is known about whether experts in their respective treatment modalities would agree on what the core components of each approach should be when working with adolescents, and there have been no empirical investigations of the common and unique features of a range of commonly used treatment modalities for this age group.

The current study aimed to address this gap by examining the way in which expert therapists from different treatment traditions conceptualize a prototypical session when working with adolescents. It also aimed to investigate the common and unique features of these different treatment approaches. Given that a focus on promoting mentalizing has sometimes been proposed as a common factor that is shared by all effective psychotherapies (e.g., Bateman & Fonagy, 2017; Goodman, 2013; Goodman, Midgley, & Schneider, 2016), this study also explored whether a focus on promoting mentalization could be a shared feature of these different ways of working.

This study investigates (a) whether it is possible for expert clinicians to agree on prototypes of CBT, IPT, PDT and MBT process in adolescent psychotherapy using the APQ; (b)

whether these four prototypes can be empirically distinguished; and (c) whether promoting mentalization is a shared component of the way expert clinicians conceptualize these four therapeutic approaches.

Method

Expert Clinicians

The purpose of this study was to recruit expert clinicians in four treatment models—PDT, MBT, CBT, and IPT—and use their expertise to determine whether expert clinicians within each treatment model can agree on the essential elements of a prototypical session of their preferred treatment model, and if so, whether they can be conceptually distinguished from each other using the 100 APQ items. In addition, this study aimed to examine whether mentalization is a common process factor in the way adolescent therapy expert clinicians conceptualize their preferred psychotherapy process.

All expert clinicians in this study were approached and selected because of their nationally or internationally recognized expertise in adolescent PDT, MBT, CBT, or IPT process. Expert clinicians were either known to the authors or referred to the authors by other internationally recognized expert clinicians. Where different traditions have developed within a particular treatment modality (e.g., the relational school and the post-Kleinian tradition within PDT, or second- and third-wave approaches within CBT), an attempt was made to ensure that the experts represented different traditions as fully as possible, by inviting contributors to a range of published treatment manuals. Regarding gender, most of the sample (71.8%; $n = 28$) were female. The percentage of female expert clinicians within each treatment model was as follows:

PDT (90%), MBT (70%), IPT (44.44%), and CBT (80%). There was no statistical association between expert clinicians' gender and their theoretical model ($X^2 [3, N = 39] = 5.31, p = .15$).

Regarding credentials, all were practicing therapists who had many years of postgraduate clinical experience (PDT: $N = 10; M = 30.10, SD = 11.68$; MBT: $N = 10; M = 17.60, SD = 10.00$; CBT: $N = 10; M = 17.20, SD = 7.50$; IPT: $N = 9; M = 16.33, SD = 5.64$). The PDT expert clinicians had significantly more years of postgraduate clinical experience than the expert clinicians representing the other three treatment models ($F(3,35) = 5.14, p = .005$). It should be noted that the differences in postgraduate clinical experience among these four groups of expert clinicians represent a potential limitation of the prototype method of construct definition.

Experience was also accounted for by the experts' involvement in supervision, teaching, training, and publication concerning the theoretical orientation from which they practice. All 10 PDT experts reported that they teach; eight train and have published work on their theoretical orientation; and seven supervise. Regarding the MBT experts, all 10 reported that they supervise; nine teach; eight train students; and seven have published work. The nine IPT experts reported they supervise and teach; eight train students; and six have published. Finally, all 10 CBT experts reported they supervise; nine teach and train; and six have published work in their theoretical orientation.

Procedure

Expert clinicians were contacted by e-mail. Participants were told that the aim of the project was to further the development of "prototypes", or good examples of psychotherapy with adolescents, from their theoretical point of view using the APQ. They were provided with a brief description of the APQ and requested to rate the 100 APQ items relevant to the psychotherapy

process—as they see this process occurring within a prototypical adolescent psychotherapy session from *their* theoretical perspective. Expert clinicians were asked to rate each of the 100 items on a Likert-type scale from -4 (most uncharacteristic of a typically conducted therapy session within their treatment model) to +4 (most characteristic of such a session). A rating of 0 indicates that the item is neither characteristic nor uncharacteristic or not applicable. Instructions included a description of these positive, negative, and neutral ratings.

Expert clinicians were also asked to complete a brief survey of their professional experiences and were paid honoraria for their participation in this Institutional Review Board-approved study (\$150 USD).

The expert clinicians' prototypical APQ ratings within each treatment model were composited, converted to *z*-scores, and used in all statistical analyses.

Measure

The APQ (Calderón, 2014; Calderón et al., 2017) is a 100-item instrument that assesses the processes of therapeutic change within an entire video or audio-recorded adolescent psychotherapy session. The APQ items were developed to parallel the PQS and CPQ items but significantly adapted to assess the psychotherapy process in sessions with adolescents ages 12-18 years. Approximately one-third of the APQ items were designed to capture aspects of the therapist's actions and attitudes, one-third designed to capture aspects of the adolescent's attitude and behavior or experience, and one-third designed to capture aspects of the interaction of the therapist-adolescent dyad, or the climate or atmosphere of the encounter (Calderón, 2014; Calderón et al., 2017). A report on the early development of the APQ, face validity, and item coverage can be found in Bychkova et al. (2011). During the following three years, the APQ

went through six iterations, which included analysis of experts' qualitative feedback from many therapeutic traditions and the coding and analysis of 27 psychotherapy sessions from different therapists, young people, and therapeutic approaches.

In the only aggregate study conducted using the APQ, coders reached consistent interrater reliability (ranging from ICC = .44–.88) on adolescent therapy session audio-recordings (Calderón et al., 2017, 2019). Convergent and discriminant validity with the Comparative Psychotherapy Process Scale (CPSS; Hilsenroth et al., 2005) was also established (Calderón et al., 2017).

When used to rate video or audio-recordings of adolescents, all 100 Q-sort items are sorted into nine piles in a forced-choice, ipsative procedure ranging from most uncharacteristic (pile 1) to most characteristic (pile 9) of the session being rated. This procedure forces raters to place items in a normal distribution that characterizes both the high and low ends of a construct (for more details, see Calderón, 2014; Jones, 2000). For this study, the traditional Q-methodology was modified to capture a “prototype” session from the theoretical vantage points of expert clinicians. To this end, raters were asked to rate each APQ item on a scale from -4 to +4, according to how characteristic it is of a typically conducted adolescent session from their theoretical vantage point.

Data Analysis

First, we used Cronbach's α coefficients used to test the level of agreement on what constitutes a prototypical psychotherapy session among the expert clinicians within each treatment model. Second, we used a Q-factor analysis with varimax rotation to test whether the 39 expert clinicians' prototypical APQ ratings of CBT, IPT, PDT and MBT process loaded onto

four independent factors (Ablon & Jones, 1998; Block, 1978; Goodman, 2005, 2013; Goodman et al., 2016). Third, we composited the expert clinicians' session prototypes within each treatment model by summing their ratings and dividing by the number of expert clinicians to arrive at a mean composite rating distribution for each of the four session prototypes. Fourth, a correlation matrix of Spearman-Brown correlations among the four composited session prototypes was constructed. The Spearman-Brown correlation is typically used with composited data (Block, 1978). Finally, post-hoc partial correlations were conducted, controlling for the MBT session prototype, to determine whether shared mentalization process accounted for the significant correlations among the other three session prototypes.

Results

Internal Agreement Among PDT, MBT, CBT, and IPT Expert Clinicians

Cronbach's α coefficients used to test the level of agreement on what constitutes a prototypical psychotherapy session among the expert clinicians within each treatment model were high: .89 for the 10 PDT expert clinicians, .92 for the 10 MBT expert clinicians, .95 for the 10 CBT expert clinicians, and .93 for the nine IPT expert clinicians. These findings indicate that expert clinicians within each treatment model shared highly similar conceptualizations of the typical psychotherapy process of PDT, MBT, CBT, and IPT, respectively.

Construct Validity of PDT, MBT, CBT, and IPT Session Prototypes

A Q-factor analysis with varimax rotation was conducted to test whether the 39 expert clinicians' prototypical APQ ratings of PDT, MBT, CBT, and IPT process loaded onto four independent factors (Ablon & Jones, 1998; Block, 1978; Goodman, 2005, 2013; Goodman et al., 2016). In this statistical procedure, expert clinicians' prototypical APQ ratings were treated as

separate variables, while the 100 APQ items were treated as “subjects,” to determine how expert clinicians’ prototypical APQ ratings clustered. A five-factor solution accounted for 72.02% of the total variance. Seven of the 10 MBT expert clinicians loaded onto Factor 1, along with two PDT expert clinicians, one CBT expert clinician, and one IPT expert clinician (range of factor loadings: .52-.76). Seven of the nine IPT expert clinicians loaded onto Factor 2 (range of factor loadings: .55-.76). Nine of the 10 CBT expert clinicians loaded onto Factor 3, along with one MBT expert clinician (range of factor loadings: .51-.75). Factor 4 consisted of three PDT expert clinicians, one IPT expert clinician, and one MBT expert clinician (range of factor loadings: .57-.75). Five of the 10 PDT expert clinicians loaded onto Factor 5 (range of factor loadings: .56-.84). These results provide an indication that the prototypical APQ ratings of each expert clinician were generally consistent with the ratings of the other expert clinicians with the same treatment model. These findings also suggest that variability does exist among expert clinicians about the principles of each treatment model, especially in the case of PDT.

Similarities and Differences Among the Session Prototypes

Two hypotheses were tested: (1) the PDT session prototype would be negatively correlated with the CBT session prototype, and (2) the MBT session prototype would be positively correlated with the other three session prototypes (i.e., PDT, CBT, and IPT).

A correlation matrix of Spearman-Brown correlations was constructed. Table 1 indicates that all four prototypes were very significantly correlated with each other at the $p < .001$ level (range of correlations: .53 [between PDT and IPT] to .82 [between CBT and IPT]). Averaging the three correlations per session prototype, the MBT session prototype had the highest mean correlation ($r = .77$), while the PDT session prototype had the lowest mean correlation ($r = .61$).

To determine whether shared mentalization process accounted for the significant correlations among the other three session prototypes, post-hoc partial correlations were conducted, controlling for the MBT session prototype (see Table 2). Only the correlation between the CBT and IPT session prototypes remained significant, supporting the idea that shared mentalization process accounts for the significant positive correlations between the PDT and CBT session prototypes and between the PDT and IPT session prototypes.

Four lists of the most and least characteristic APQ items for the PDT, MBT, CBT, and IPT session prototypes are displayed in Tables 3-6. Notably, two APQ items were listed as most characteristic of all four prototypes: "Therapist works with young person to try to make sense of experience" (item 9) and "Therapist conveys a sense of nonjudgmental acceptance" (item 18). Two additional APQ items were listed as most characteristic of three of the four session prototypes: "Therapist communicates with young person in a clear, coherent style" (item 46; not IPT) and "Therapist encourages reflection on internal states and affects" (item 97; not CBT).

Two APQ items were listed as least characteristic of all four prototypes: "Young person has difficulty understanding therapist's comments" (item 5) and "Young person does not initiate or elaborate topics" (item 15). Five additional APQ items were listed as least characteristic of three of the four session prototypes: "Young person does not feel understood by therapist" (item 14; not PDT), "Young person attributes own characteristics or feelings to therapist" (item 51; not PDT), "Young person discusses experiences as if distant from his or her feelings" (item 53; not IPT), "Young person finds it difficult to concentrate or maintain attention during the session" (item 67; not IPT), and "Therapist makes definite statements about what is going on in the young person's mind" (item 89; not CBT).

The MBT session prototype had the most matches with the other three session prototypes on the most and least characteristic APQ items: only the MBT least characteristic item “Young person blames others or external forces for difficulties” (item 34) did not match with the other three prototypes. The PDT and IPT session prototypes had the most non-matches with the other two prototypes on the most and least characteristic APQ items: seven items each.

Discussion

We constructed four new session prototypes of four widely used treatment models with adolescents: PDT, MBT, CBT, and IPT. We showed that expert clinicians within each of these four treatment models were able to use the APQ to mostly agree with each other on the essential therapeutic processes that capture each of these four treatment models. By reverse-engineering (Q-factor analysis), we learned that, for the most part, the 39 expert clinicians’ prototypical APQ ratings fell into these four treatment models. The PDT session prototype, however, straddled two different factors, suggesting more variability in PDT expert clinicians’ understanding of PDT process for adolescents than in the views of the expert clinicians representing the other three treatment models. Finally, we also demonstrated that mentalization process (as represented in the MBT session prototype) is a shared component of the way expert clinicians conceptualize the other three treatment models. Post-hoc analysis also showed that mentalization process accounted for the significant positive correlation between the PDT and CBT session prototypes and the PDT and IPT session prototypes; however, the correlation between the CBT and IPT session prototypes was not related to mentalization process.

In spite of the shared components among all the treatment models, some APQ items uniquely characterized these four treatment models. The PDT session prototype uniquely

emphasized therapist's drawing attention to young person's characteristic ways of dealing with emotion (item 60), identifying a recurrent pattern in young person's behavior or conduct (item 62), and linking young person's feelings or perceptions to situations or behavior of the past (item 92). The CBT session prototype uniquely emphasized therapist's encouraging the young person to reflect on symptoms (item 39), encouraging the young person to discuss assumptions and ideas underlying experience (item 68), and adopting a psychoeducational stance (item 33), as well as the young person achieving a new understanding (item 32), and material is discussed from a prior session (item 56). The IPT session prototype uniquely emphasized therapist's encouraging the young person to try new ways of behaving with others (item 85) and encouraging the exploration of the potential impact of the young person's behavior on others (item 69), as well as the young person's discussing and exploring current interpersonal relationships (item 63) and describing emotional qualities of the interactions with significant others (item 6). Finally, none of the most characteristic items of the MBT session prototype were unique. Only one item among the least characteristic items of the MBT prototype was not found in the least characteristic items for other prototypes: the young person's blaming others or external forces for difficulties (item 34).

As one might expect, based on these item constellations, three of these treatment models, in spite of their considerable conceptual overlap, nevertheless reflect divergent treatment philosophies. Adolescent PDT highlights working with the adolescent's underlying emotions, while adolescent CBT emphasizes working with the adolescent's thoughts and symptoms. Adolescent IPT prioritizes working on relationships. Adolescent MBT, however, has virtually no unique therapeutic processes; the most characteristic APQ items completely overlap with the

other three treatment models. This finding supports previous research with the CPQ (Goodman et al., 2016) and PQS (Goodman, 2013) that demonstrated that mentalization principles are at the core of all treatment models. Bateman and Fonagy (2004a) first proposed that enhancing mentalization is “central to therapy...[and] may unify numerous effective approaches” (p. 49; see also Bateman & Fonagy, 2004b). It appears that adolescent expert clinicians similarly consider their respective treatment models to consist of therapy processes that aim to promote the capacity to mentalize, although there could be some differences in how each treatment model accomplishes this task (see below).

We hypothesized that the PDT and CBT session prototypes would not be positively correlated with each other, but the findings did not wholly support this hypothesis. Based on studies using the adult and child versions of the psychotherapy Q-set, Goodman and his colleagues (2016) suggested that “PDT and CBT processes for children are more similar than PDT and CBT processes for adults because child psychotherapists share a humanistic approach to relationship building and an implicit emphasis on promoting mentalization” (p. 597). Adolescence spans the years between childhood and adulthood, and we expected that the shift from play therapy techniques to more adult-like “talk therapy” beginning in the adolescent years would have resulted in a greater technical divergence among theoretical orientations. The findings of adolescent expert clinicians using the APQ, however, demonstrate that adolescent therapy process is more similar than different across these four treatment models; thus, adolescent therapy process still behaves more like child therapy process than adult therapy process. Thus, common factors of therapy (Wampold, 2001; Wampold et al., 1997; Weinberger,

1995, 2002) seem to play a greater role in the adolescent therapy process than they do in the adult therapy process.

The finding that the significant positive correlations between the PDT and IPT session prototypes and the PDT and CBT session prototypes evaporated when controlling for the MBT prototype merits further discussion. This finding is consistent with the Bateman and Fonagy (2004a) proposition that enhancing mentalization is what unifies otherwise conceptually divergent treatment models; however, it does not account for the significant positive correlation between the CBT and IPT session prototypes, even after controlling for the MBT session prototype. We are proposing that there might be two different therapeutic processes at work here—mentalization and support. Mentalization permeates the other three treatment models—PDT, CBT, and IPT, and according to Bateman and Fonagy (2004a), is what makes each of these treatment models effective. On the other hand, mentalization is not the unifying principle when examining the correlation between the CBT and IPT session prototypes. Instead, the findings from this study suggest that support is a second unifying therapeutic principle. Support is a technical term that consists of “assum[ing] a supportive, advocate-like posture toward the patient, [which] may take the form of approval of something the patient has done, or encouraging” (Jones, 2000, p. 338). Our study indicates that PDT and MBT therapists do not consider this principle to be the most characteristic aspect of their work with adolescents. It is quite possible that a more supportive therapy process unifies CBT and IPT process.

In support of this idea, CBT and IPT treatment conditions in the National Institute of Mental Health (NIMH)-sponsored Treatment of Depression Collaborative Research Program (TDCRP) systematically differed in content but shared the therapy process of an active,

authoritative therapist coaching a compliant, deferential patient to behave differently (Ablon & Marci, 2004). Further support for the idea of shared process features of CBT and IPT comes from Goodman (2010), who found that the correlation between the PQS CBT and IPT session prototypes (Ablon & Jones, 1998, 2002) was $r = .51$ ($p < .001$), suggesting that these two adult treatment models share underlying processes despite their superficial differences in technique. Thus, CBT and IPT might both be using support as a change process, whereas PDT and MBT might both be using a focus on mentalization as a change process. Of course, this hypothesis is based on clinicians' perceptions of the therapeutic process and needs to be tested in a large sample of adolescent patients. Which change process is more effective for which adolescents under which conditions?

In an interesting session adherence study using the CPQ, Goodman and Halfon (in press) found that among children diagnosed with externalizing behaviors, “two trajectories of success” (p. 19) were identified. In some of these treatments, mentalizing process—verbalizing the child's internal states and affects, commenting on changes in the child's mood, exploring relationships with significant others (Goodman et al., 2016)—resulted in greater emotion regulation and reduced the need to express dysphoric affects in oppositional and aggressive behaviors. In other treatments, however, supportive process—focusing on a specific theme, teaching the child how to manage his or her feelings, planning behavior outside session (Goodman et al., 2016)—resulted in direct containment of these undesirable behaviors. It is possible that a controlling, supportive therapist who empathizes with the patient's feelings might provide the auxiliary ego support necessary for stabilization of acute symptoms such as suicidality; however, the polarized state of the patient's self and object representations might remain untouched by this process.

Under these circumstances, therefore, symptom management would be short-lived without a continued supportive approach as found in these prototypes of CBT or IPT. Jones (2000) suggested that “changes in brief therapy brought about by supportive interventions under the rule of a positive transference are not enduring” (p. 220). On the other hand, in a sample of five adult patients diagnosed with BPD (Goodman et al., 2015), CBT process early in treatment “facilitated building of the therapeutic alliance, stabilized the patients’ symptoms and was paving the way for later ‘bread-and-butter’ PDT interventions....Treatment of severely disturbed BPD patients requires the temporary use of more supportive CBT processes...before more ambitious models...are attempted” (p. 91).

Over 100 years ago, Freud (1919/1955) foresaw that “the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion” (p. 168). The change processes of psychodynamic interpretation (a neighboring construct to mentalization) and suggestion (a neighboring construct to support) are sometimes viewed on a continuum, with varying amounts of each prescribed for specific conditions such as psychiatric diagnosis, treatment setting, therapist and patient personality structures and attachment patterns, and treatment phase (e.g., Piper et al., 2002). Perhaps both mentalizing and supportive change processes can also be brought to bear on adolescent treatments if we pay close attention to treatment phase and diagnostic distinctions.

Study Limitations

Among this study’s limitations is the fact that the study focused exclusively on expert clinicians’ session prototypes of four treatment models of adolescent therapy, and it is an empirical question whether these prototypes reflect what takes place in actual sessions with

adolescents. It is also important to keep in mind that only therapy process was examined rather than specific content. Process rather than content was assessed to look past the superficial differences in content to the underlying features of each therapy process. In their study of CBT and IPT, Ablon and Jones (2002) concluded, “A narrow focus on the different content of these manualized treatments makes it easy to overlook the high degree of correspondence in process” (p. 781). In the present study, we wanted to look deeper than superficial content differences to identify the underlying processes both shared and unique among these four treatment models. All four session prototypes—PDT, MBT, CBT, and IPT—need further validation in actual treatment samples against other measures of adolescent therapy process. In addition, PDT expert clinicians had more professional experience than the other expert clinicians.

Some clinicians have argued that adherence to a particular treatment model is a waste of time. The relational school of the psychoanalytic community has largely embraced this point of view. Its proponents have advocated “throwing away the book” (Hoffman, 1994, p. 187) and have compared the therapeutic relationship to “a snowflake....No two are alike. Nor are any two patient-analyst pairs” (Kantrowitz, 2001, p. 403). This narrative point of view—that systematic, “objective” observation of the psychotherapy process is severely limited in its ability to teach us anything new or confirm what we already know about the psychotherapy process—itself seems severely limiting. On the other hand, previous research has shown that session adherence to a treatment manual is linked to improvements in psychological distress under certain conditions (Barber et al., 2008; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; McCarthy, Keefe, & Barber, 2016; Owen & Hilsenroth, 2014)—specifically, when session adherence is flexible (known as the “Goldilocks effect”). In fact, a meta-analytic review (Webb, DeRubeis, & Barber,

2010) that demonstrated nonsignificant session adherence-treatment outcome findings is consistent with these other studies that have suggested a curvilinear relationship between session adherence and treatment outcome.

A measure of session adherence to a treatment model is important because it can demonstrate which therapeutic techniques actually predict symptomatic or structural change. Using the PQS process prototypes as a measure of session adherence, it was discovered that CBT process was more predictive of symptomatic change in patients diagnosed with borderline personality disorder than PDT process—*early in PDT treatment* (Goodman et al., 2015). In a mixed diagnostic treatment sample, PDT process was more predictive of symptomatic change than CBT process—*in CBT treatment* (Ablon & Jones, 1998). In spite of the limitation of only 100 possible items, the APQ session prototypes presented here can facilitate adolescent psychotherapy process-outcome research, helping researchers to answer the question of what works for whom under which circumstances by assessing the level of adherence to a prototypical psychotherapy process associated with a particular treatment model.

We are not suggesting that promoting mentalization and providing support are not the only two potential common factors operating in adolescent treatment models. Other candidates such as the therapeutic alliance (Flückiger, Del Re, Wampold, & Horvath, 2018), empathy (Elliott, Bohart, Watson, & Murphy, 2018), and positive regard (Wampold, 2015) might also predict symptomatic and structural change in this population. These studies have yet to be conducted, however. It would also be interesting to determine empirically the conceptual overlap among these three constructs with mentalization and support among adolescents using a prototype methodology such as the one used in this study.

Directions for Future Research

Future researchers need to examine how session adherence to these four treatment models is associated with outcomes with actual adolescent patients with various psychiatric diagnoses and in various settings and treatment phases. Specifically, treatments of adolescent patients with various levels of disturbance or different constellations of symptoms, treatments in various settings (e.g., inpatient, day treatment, outpatient) and phases (i.e., initial, middle, endings), and treatments that systematically study pairings of therapist and adolescent attachment organizations could yield findings in which actual treatments significantly differ from their prototypes. Expert clinicians from additional treatment models also need to be solicited for their session prototypes.

The two change processes suggested in the present study—promoting mentalization and providing support—need to be the focus of future studies. Which of these two therapeutic processes is more successful with which kinds of patients in which settings and treatment phases? Can therapists who use PDT or MBT strategies be trained to use support judiciously, and can therapists who use CBT and IPT strategies be trained to use mentalization judiciously? What is the long-term effectiveness of these two change processes upon follow-up? We need to move away from brand-name labels and move toward strategically timed and implemented change processes that reflect broad empirical support.

Relatedly, we can identify which kinds of mentalization and support are most effective under which conditions. Luyten, Campbell, Allison, and Fonagy (2020) suggested four different dimensions of mentalization: (1) implicit/explicit, (2) internal/external, (3) self/other, and (4) cognitive/affective. Different treatment models might exploit different mentalizing dimensions to effect change. Similarly, support might have its own different dimensions such as validation,

advocacy, and guidance. Measurement of these different facets of promoting mentalization and providing support in adolescent psychotherapy sessions might help to answer questions about which facets might be most effective for which adolescents under which conditions.

Researchers have also begun to explore moderators of the association of session adherence with effective treatment outcomes in children. For example, mentalization level (Ramires et al., 2020) and therapeutic alliance (Halfon, 2021) have been shown to moderate the association between adherence to the PDT session prototype and change in interaction structures and problem behaviors, respectively. The APQ session prototypes are now available to measure session adherence in similar moderator studies. In the PDT literature, many child and adolescent treatment outcome studies have suffered from unknown session adherence (Midgley et al., 2021), while others (Fonagy et al., 2015) have criticized the child and adolescent treatment outcome literature for inadequate attention to methodological issues such as session adherence. Researchers can use the process information produced by the APQ session prototypes alongside both patient and therapist factors in multiple regression analyses to identify the mediators and moderators of therapeutic outcomes occurring in therapy sessions representing various treatment models.

Although session prototypes give researchers the power to calculate the magnitude of a session's adherence to a treatment model's prototype as determined by a group of expert clinicians, another use of prototypes involves a group of expert clinicians' Q-sorting the ideal session with a patient with a particular diagnosis (e.g., Fiorini & Ramires, 2019; Kealy, Goodman, & Ogrodniczuk, 2017; Kealy, Goodman, Rasmussen, Weideman, & Ogrodniczuk, 2017). Researchers can use Q-sort methodology to explore all kinds of questions related to

psychotherapy process. The prototype method of assessing psychotherapy process, however, should never substitute for the simultaneous investigation of other treatment factors such as culture, adverse childhood experiences, or therapist attachment quality.

Conclusions

This study collected prototypical Q-sorts from four groups of adolescent expert clinicians representing four different widely recognized therapy types used with adolescents. These Q-sorts were composited into four session prototypes—PDT, MBT, CBT, and IPT—that researchers can now use to assess session adherence in adolescent treatments. The results also suggested two different trajectories of therapeutic process, in which PDT and MBT seem to employ the change process of promoting mentalization, while CBT and IPT seem to employ the change process of providing support.

As well as differences, this study helped to identify shared components of different therapeutic approaches to working with adolescents. Mentalization as embodied in the MBT session prototype was significantly correlated with the other three session prototypes, thus adding to the growing support (Goodman, 2013; Goodman et al., 2016) for Bateman and Fonagy's (2004a) proposition that promoting mentalization may be an implicit change process inherent to multiple conceptually distinct treatment models. Researchers need to investigate support as a second pan-theoretical change process as well as identify different dimensions of both mentalization and support that might enhance the effectiveness of various adolescent treatments across a wide array of treatment models. The field of adolescent psychotherapy process-outcome research can begin to move beyond brand-name labels to determine which change processes work for which therapeutic dyads under which circumstances.

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Table 1*Spearman-Brown Correlations Among the Four APQ Session Prototypes*

	PDT	CBT	IPT	MBT
PDT	--			
CBT	.54***	--		
IPT	.53***	.82***	--	
MBT	.76***	.80***	.75***	--

Note. PDT = psychodynamic therapy; CBT = cognitive-behavioral therapy; IPT = interpersonal therapy; MBT = mentalization-based treatment.

*** $p < .001$.

Table 2*Post-hoc Partial Correlations Among the PDT, CBT, and IPT Session Prototypes, Controlling for the MBT Session Prototype*

	PDT	CBT	IPT
PDT	--		
CBT	-.19	--	
IPT	-.09	.52***	--

Note. PDT = psychodynamic therapy; CBT = cognitive-behavioral therapy; IPT = interpersonal therapy; MBT = mentalization-based treatment.

*** $p < .001$.

Table 3*Most and Least Characteristic APQ Items for the PDT Session Prototype*

APQ Number	APQ Item	Mean Pile Number
Most characteristic PDT prototype		
9 ^a	Therapist works with young person to try to make sense of experience	4.00
18 ^a	Therapist conveys a sense of nonjudgmental acceptance	3.80
75	Therapist pays attention to young person's feelings about breaks, interruptions or endings in therapy	3.80
37	Therapist remains thoughtful when faced with young person's strong affect or impulses	3.70
46 ^b	Therapist communicates with young person in a clear, coherent style	3.70
96	Therapist attends to the young person's current emotional states	3.70
36	Therapist openly reflects on "mistakes", misunderstandings, or misattunements that have taken place in the relationship with the young person	3.60
97 ^b	Therapist encourages reflection on internal states and affects	3.60
60	Therapist draws attention to young person's characteristic ways of dealing with emotion	3.50
62	Therapist identifies a recurrent pattern in young person's behavior or conduct	3.50
92	Young person's feelings or perceptions are linked to situations or behavior of the past	3.50
Least characteristic PDT prototype		
21	Therapist self-discloses	-3.10
17	Therapist actively structures the session	-2.10
89 ^c	Therapist makes definite statements about what is going on in the young person's mind	-1.80
66	Therapist is directly reassuring	-1.80
27	Therapist offers explicit advice and guidance	-1.50
5 ^d	Young person has difficulty understanding therapist's comments	-1.30
15 ^d	Young person does not initiate or elaborate topics	-1.00
83	Young person is demanding	-0.80
53 ^c	Young person discusses experiences as if distant from his or her feelings	-0.80
67 ^c	Young person finds it difficult to concentrate or maintain attention during the session	-0.50

^aA most characteristic APQ item for all four prototypes. ^bA most characteristic APQ item for three of four prototypes. ^cA least characteristic APQ item for three of four prototypes. ^dA least characteristic APQ item for all four prototypes.

Table 4*Most and Least Characteristic APQ Items for the MBT Session Prototype*

APQ Number	APQ Item	Mean Pile Number
Most characteristic MBT prototype		
9 ^a	Therapist works with young person to try to make sense of experience	4.00
46 ^b	Therapist communicates with young person in a clear, coherent style	4.00
18 ^a	Therapist conveys a sense of nonjudgmental acceptance	3.90
31	Therapist asks for more information or elaboration	3.90
36	Therapist openly reflects on “mistakes”, misunderstandings, or misattunements that have taken place in the relationship with the young person	3.90
96	Therapist attends to the young person’s current emotional states	3.90
97 ^b	Therapist encourages reflection on internal states and affects	3.90
37	Therapist remains thoughtful when faced with young person’s strong affect or impulses	3.80
75	Therapist pays attention to young person’s feelings about breaks, interruptions or endings in therapy	3.70
86	Therapist encourages reflection on the thoughts, feelings and behavior of significant others	3.70
Least characteristic MBT prototype		
89 ^c	Therapist makes definite statements about what is going on in the young person’s mind	-2.50
58	Young person resists therapist’s attempts to explore thoughts, reactions, or motivations related to problems	-1.90
5 ^d	Young person has difficulty understanding therapist’s comments	-1.90
67 ^c	Young person finds it difficult to concentrate or maintain attention during the session	-1.60
15 ^d	Young person does not initiate or elaborate topics	-1.50
53 ^c	Young person discusses experiences as if distant from his or her feelings	-1.40
12	Silences occur during the session	-1.30
34	Young person blames others or external forces for difficulties	-1.20
51 ^c	Young person attributes own characteristics or feelings to therapist	-1.10
16	Young person fears being punished or threatened	-1.00
14 ^c	Young person does not feel understood by therapist	-1.00

^aA most characteristic APQ item for all four prototypes. ^bA most characteristic APQ item for three of four prototypes. ^cA least characteristic APQ item for three of four prototypes. ^dA least characteristic APQ item for all four prototypes.

Table 5*Most and Least Characteristic APQ Items for the CBT Session Prototype*

APQ Number	APQ Item	Mean Pile Number
Most characteristic CBT prototype		
9 ^a	Therapist works with young person to try to make sense of experience	4.00
39	Therapist encourages young person to reflect on symptoms	4.00
46 ^b	Therapist communicates with young person in a clear, coherent style	4.00
57	Therapist explains rationale behind technique or approach to treatment	4.00
4	Young person's treatment goals are discussed	3.90
68	Therapist encourages young person to discuss assumptions and ideas underlying experience	3.90
32	Young person achieves a new understanding	3.80
33	Therapist adopts a psychoeducational stance	3.80
18 ^a	Therapist conveys a sense of nonjudgmental acceptance	3.70
49	There is discussion of specific activities or tasks for the young person to attempt outside of session	3.70
56	Material from a prior session is discussed	3.70
Least characteristic CBT prototype		
14 ^c	Young person does not feel understood by therapist	-2.50
5 ^d	Young person has difficulty understanding therapist's comments	-2.50
15 ^d	Young person does not initiate or elaborate topics	-2.30
67 ^c	Young person finds it difficult to concentrate or maintain attention during the session	-1.80
51 ^c	Young person attributes own characteristics or feelings to therapist	-1.80
44	Young person feels wary or suspicious of the therapist	-1.80
87	Young person is controlling of the interaction with therapist	-1.70
16	Young person fears being punished or threatened	-1.50
58	Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems	-1.40
53 ^c	Young person discusses experiences as if distant from his or her feelings	-1.10

^aA most characteristic APQ item for all four prototypes. ^bA most characteristic APQ item for three of four prototypes. ^cA least characteristic APQ item for three of four prototypes. ^dA least characteristic APQ item for all four prototypes.

Table 6*Most and Least Characteristic APQ Items for the IPT Session Prototype*

APQ Number	APQ Item	Mean Pile Number
Most characteristic IPT prototype		
4	Young person's treatment goals are discussed	4.00
31	Therapist asks for more information or elaboration	4.00
57	Therapist explains rationale behind technique or approach to treatment	4.00
85	Therapist encourages young person to try new ways of behaving with others	4.00
9 ^a	Therapist works with young person to try to make sense of experience	3.89
18 ^a	Therapist conveys a sense of nonjudgmental acceptance	3.89
63	Young person discusses and explores current interpersonal relationships	3.89
69	Therapist encourages the exploration of the potential impact of young person's behavior on others	3.89
97 ^b	Therapist encourages reflection on internal states and affects	3.89
6	Young person describes emotional qualities of the interactions with significant others	3.78
49	There is discussion of specific activities or tasks for the young person to attempt outside of session	3.78
86	Therapist encourages reflection on the thoughts, feelings and behavior of significant others	3.78
Least characteristic IPT prototype		
89 ^c	Therapist makes definite statements about what is going on in the young person's mind	-3.89
90	Young person's dreams or fantasies are discussed	-3.44
14 ^c	Young person does not feel understood by therapist	-2.22
5 ^d	Young person has difficulty understanding therapist's comments	-2.00
87	Young person is controlling of the interaction with therapist	-1.89
44	Young person feels wary or suspicious of the therapist	-1.67
42	Young person rejects therapist's comments and observations	-1.56
51 ^c	Young person attributes own characteristics or feelings to therapist	-1.44
79	Young person's experience of his or her body is discussed	-1.11
21	Therapist self-discloses	-1.11
15 ^d	Young person does not initiate or elaborate topics	-1.11
12	Silences occur during the session	-1.11

^aA most characteristic APQ item for all four prototypes. ^bA most characteristic APQ item for three of four prototypes. ^cA least characteristic APQ item for three of four prototypes. ^dA least characteristic APQ item for all four prototypes.