

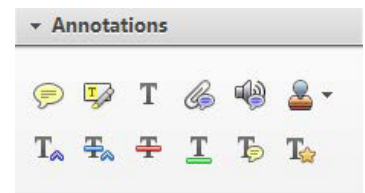
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# An Examination of Parent Sessions in Regulation-Focused Psychotherapy for Children

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Collateral work with parents is a widely adopted practice within child psychotherapy. Therapeutic process within these parent sessions has not been empirically studied or defined, despite a sizable process-outcome literature in both child and adult individual therapy. This link between research and practice is particularly important among manualized, child-focused treatments, where the proposed therapeutic action and clinical approach to parent work is defined according to distinct theoretical principles. To address this gap in the child treatment literature, the present study used the Psychotherapy Process Q Set to examine the in-session processes of parent sessions from 16 treatments of regulation-focused psychotherapy for children (RFP-C). RFP-C is a manualized, psychodynamic treatment for children with disruptive behaviors that consists of 16 child sessions and four collateral parent sessions. The parent-session process ratings were compared to existing adult therapy prototypes and the RFP-C child session prototype. Results indicated that observer-coded psychotherapy process in RFP-C parent sessions was most similar to a cognitive-behavioral therapy prototype and moderately correlated with both a supportive-expressive psychodynamic psychotherapy and a reflective functioning prototype. Observer-coded parent session process was distinct from the RFP-C child prototype. Limitations and directions for future research and clinical practice are discussed. The findings of this study indicate the need to intentionally examine process in parent sessions, both within RFP-C and across modalities, as these sessions have their own unique mechanisms of therapeutic action that ultimately may be additive with regard to child outcomes.

## Clinical Impact Statement

**Question:** What aspects of psychotherapy process characterize parent sessions in regulation-focused psychotherapy for children (RFP-C)? **Findings:** RFP-C parent sessions are characterized by supportive and collaborative discussions between therapist and parent that focus on helping the parent to make meaning of their child's disruptive behavior. **Meaning:** The findings of this study extend process research beyond the traditional therapist-parent dyad, laying the foundation for empirical examination of parent work both within RFP-C and across modalities, including process-outcome research, determination of common factors in parent work, and the use of clinical data to inform and shape manualized treatments. **Next Steps:** Future studies may compare process in parent work across child-focused treatments, potentially developing tools specifically for this purpose, which then can be related to child outcomes to determine the effective clinical ingredients of collateral work with parents.

**Keywords:** psychotherapy process, parents, mentalization, reflective functioning, child psychotherapy

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and writing – review & editing. Katie Aafjes-van Doorn served as lead for funding acquisition and served in a supporting role for writing – original draft and writing – review & editing. Tracy A. Prout served in a supporting role for methodology, writing – original draft, and writing – review & editing. Tatianna Kufferath-Lin, Katie Aafjes-van Doorn, and Tracy A. Prout contributed to conceptualization equally. Tatianna Kufferath-Lin and Katie Aafjes-van Doorn contributed to formal analysis equally. Tatianna Kufferath-Lin and Katie Aafjes-van Doorn contributed to methodology equally. Katie Aafjes-van Doorn and Tracy A. Prout contributed to supervision equally.

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There has been significant effort in the past 3 decades to empirically identify the specific processes that take place within individual psychotherapy treatments for adults and how these relate to outcome. One of the most commonly used tools within this field of research is the Psychotherapy Process Q Set (PQS; Jones, 2000), a pan-theoretical observer-rating system used to identify and distinguish specific components of psychotherapy process across modalities. Research using the PQS has revealed that different treatment modalities can be reliably distinguished (Jones & Pulos, 1993), that specific processes contribute to psychotherapy outcome (Ablon et al., 2006), and that therapeutic dyads create their own unique processes and interaction structures that contribute to therapeutic change (Jones & Ablon, 2005). The development of the PQS has inspired similar PQS tools for examining the therapy process in child therapy (CPQ; Schneider & Jones, 2004) and adolescent therapy (Bamberg et al., 2007).

Interestingly, although different types of treatment can be reliably distinguished, there is also clear evidence that despite claiming adherence to a specific treatment approach, practitioners often “borrow” techniques from other approaches (Ablon & Jones, 1998, 1999, 2002; Jones & Pulos, 1993). Researchers have created PQS prototypes that describe ideal treatments in different theoretical modalities (Ablon & Jones, 1998; Leichsenring et al., 2016), to assess the adherence (or divergence) of actual treatment sessions to theoretical ideals. Using the same PQS approach, an ideal “reflective functioning” prototype has been developed (Goodman, 2013). According to this prototype, sessions focused on reflective functioning are characterized by a focus on the patient’s feelings, the therapy relationship, and exploring and comparing the therapist and patient’s mental states (e.g., thoughts, perceptions, desires, beliefs). Such interventions are used to improve the patient’s capacity to interpret both their own and others’ behavior as meaningful, motivated by these aforementioned mental states. Reflective functioning has been hypothesized as an implicit process common to many different treatments (Goodman, 2013).

Studies using the CPQ (Schneider & Jones, 2004) have revealed parallel findings to adult process studies using the PQS. As with adult therapy, different treatment modalities can be reliably distinguished (Schneider et al., 2009), with specific therapeutic actions and interaction structures between therapist and child being linked to outcome (Halfon et al., 2020). Prototypes similar to those created by the PQS have been used to describe ideal treatment in several modalities (Goodman et al., 2015; Schneider et al., 2009), including mentalization-based treatment (Goodman et al., 2016). Reflective functioning, as with adult therapy, has been found to be a common process factor in both psychodynamic and cognitive-behavioral treatments (Goodman et al., 2016), and a focus on reflective functioning has been found to increase emotion regulation and use of symbolic play in child treatment (Halfon & Bulut, 2019). However, even when treatments adhere theoretically to the same modality, therapeutic process is unique to each dyad, with both therapist and child contributing to unique patterns of interaction that shift over the course of treatment (Goodman, 2015; Goodman & Athey-Lloyd, 2011). There is evidence that there is a dynamic relationship between process variables, therapeutic alliance, and symptoms, such that changes in any of

these variables can lead to effects on the others (Goodman et al., 2017).

Psychotherapy process research is invaluable in determining the effective ingredients of psychotherapy, yet there are notable gaps within this literature that remain to be examined. In particular, within the realm of child psychotherapy, significant effort is put forth to conduct collateral sessions with people in the child’s life, such as parents and teachers. Parent work is an essential component of many child psychotherapy treatments (Forgatch & Patterson, 2010; Midgley et al., 2017).<sup>1</sup>

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Although rapport-building and a supportive presence are universally emphasized in parent work (Kernberg et al., 2012; Siqueland & Diamond, 1998), cognitive-behavioral, mentalization-based, and psychodynamic treatments can take very distinct approaches to work with parents, at least in theory. Mentalization-based dynamic treatments tend to focus on parental reflective functioning and understanding the child’s inner world (Midgley et al., 2017; Slade, 2008). Psychodynamic work with parents may also emphasize parental reflective functioning (Hoffman & Prout, 2020); however, there is also an emphasis on tolerating the parent’s strong emotions surrounding their children, navigating developmental conflicts (such as autonomy and closeness), and linking the parent’s past and present (Novick & Novick, 2013). Cognitive-behavioral treatments tend to focus on exploring the parent’s potentially distorted thoughts and beliefs about parenting and teaching the parent skills for responding to and managing behavior (Forgatch & Patterson, 2010; Siqueland & Diamond, 1998). However, given the findings that therapists’ interventions do not always reflect their theoretical orientations, it is unclear whether therapists are actually behaving in a way that is theoretically expected when working with parents. Although much is written about collateral parent work, therapeutic process in these sessions has yet to be empirically examined.

The examination of psychotherapy process within parent work is especially important when studying manualized interventions, which delineate very clear guidelines for the principles and methods used to guide the treatment. Regulation-focused psychotherapy for children (RFP-C; Hoffman et al., 2016) is a manualized short-term psychodynamic treatment specifically designed for children (ages 5–12) with externalizing behaviors. RFP-C is a 20-session treatment, and includes 16 individual sessions with the child and four meetings with the child’s parent(s). Therapists use a play-centered and child-led approach, building the child’s capacity for emotion regulation by addressing disruptive behaviors, which are conceptualized as defenses against painful feelings (Hoffman et al., 2016). A study by Prout, Goodman, et al. (2018) used the CPQ to create an ideal process prototype of RFP-C child sessions. This prototype was associated with established prototypes of child psychodynamic psychotherapy and child-centered play therapy but had no relationship with a cognitive behavior therapy prototype. The RFP-C child session prototype was also associated with reflective functioning. However, the relationship between process in child and parent sessions of RFP-C has yet to be examined.

<sup>1</sup> We are using the term “parents” to refer to the child’s caregivers, regardless of biological linkage.

In RFP-C, the four parent sessions are used to inform parents about what their child is exploring in therapy. They also provide opportunities for the parent to develop a deeper understanding of their child's behavior and the situations that evoke negative emotions in their child and thus bring on his or her disruptive behaviors. In other words, RFP-C parent sessions aim to help parents understand that all behavior has meaning. Throughout the parent sessions, the therapist is instructed to embody a reflective stance toward both the child and the parent. Using examples both from the child's individual sessions and examples of life at home or school provided by the parent, the therapist wonders aloud about what the child might have been feeling when the incident occurred and how the child might have responded to these feelings (i.e., the possibility that the child acted disruptively to avoid the unpleasant feelings; [Figure 1](#)). For example, the therapist might share that the child ran out of the room when discussing the reason for treatment, which prompts a discussion about the child's possible difficulty tolerating feelings of shame or vulnerability.

Through the repeated activation of the parent's mentalizing system, the therapist attempts to move the parent away from certainty about the child's intentions and toward a sense of curiosity about the motivations and feelings that underlie the child's behavior. In maintaining an empathic and curious stance toward both the parent and child, the therapist provides an opportunity for "implicit reappraisal" of both the meaning of the child's disruptive behavior and the parent's reaction to it ([Hoffman & Prout, 2020](#); [Hoffman et al., 2016](#)).

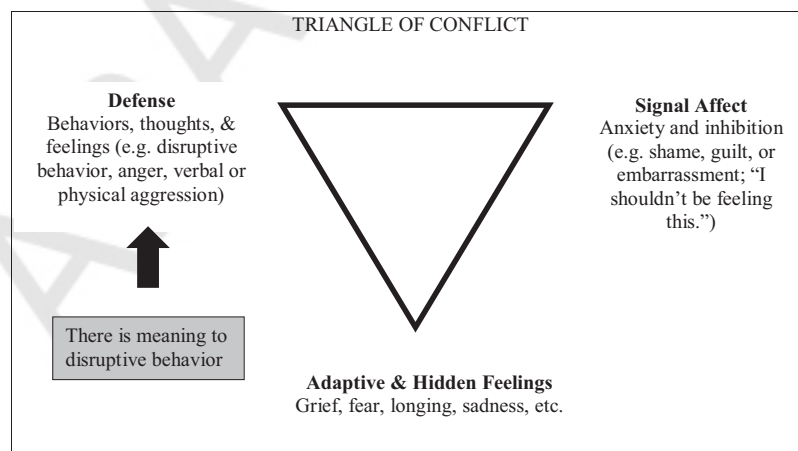
In contrast to specific parenting programs that seek to enhance mentalization skills for the purposes of enhancing the parent-child relationship ([Sadler et al., 2013](#); [Sleed et al.,](#)

[2013](#)), in RFP-C parent sessions, the focus on parental reflective functioning is aimed at supporting the child's emotion regulation capacities. One way therapists might do this is by helping the parent recognize and communicate to the child that disruptive behavior is meaningful and arises from avoidance of difficult feelings ([Hoffman et al., 2016](#)). For example, a father shares that his son had refused to take a shower the night before, leading to a big argument. Upon further discussion, the father recounts that earlier in the day, he had received a message from his son's teacher, indicating that a classmate had made fun of his son's skin condition. The therapist wonders aloud if these two incidents might be related, and the father recognizes that his son's refusal may have been related to worry or shame about his skin, rather than stubbornness. This leads him to approach future discussion of his son's hygiene with greater sensitivity and collaboration. Ideally, ongoing contact with parents in RFP-C is meant to activate and enhance a skillset in parents that will allow them to create a home environment for the child that encourages and builds upon the constructive emotional self-regulatory capacities that the child begins to develop in therapy.

The aims of the present study were threefold. First, we wanted to determine which aspects of psychotherapy process were most and least characteristic of parent-sessions of RFP-C. Second, we wanted to compare the therapy process of parent sessions to the therapy process in child sessions of RFP-C, as measured by the CPQ. We examined parent and child sessions of RFP-C separately to determine whether parent sessions represented a qualitatively distinct aspect of RFP-C in terms of process, to make the argument for studying parent work more broadly and intentionally across child-focused treatments. If collateral work with parents can enhance the effectiveness of

**Figure 1**

*Interventions Used in Regulation-Focused Psychotherapy for Children Parent Sessions (Adapted From [Malan \(1979\)](#) and [McCullough and Colleagues \(2003\)](#))*



*Note.* When discussing disruptive behavior, the regulation-focused psychotherapy for children therapist helps parents think about what prompted the disruptive behavior. In addition, they discuss the following:

- *What* is the feeling that is being avoided (feared feeling)?
- *How* is it being avoided (defense)?
- *Why* is that feeling being avoided (anxiety)?



child treatments, as is widely argued (Kernberg et al., 2012; Novick & Novick, 2013), then delineating process as we attempt to do in this study can provide researchers and clinicians with insight into the psychotherapeutic processes at work with parents. In addition, it is important to begin to empirically define what is happening in these sessions with descriptive tools such as the PQS, so that clinical researchers can then determine the “effective ingredients” of collateral work with parents. In other words, once we know what the therapeutic processes at work with parents are, we can then determine which processes contribute most to child outcomes, both within specific modalities, such as RFP-C, and across treatments.

Finally, we wanted to determine the extent to which the RFP-C parent session process is correlated with existing adult therapy prototypes, including cognitive-behavioral, psychoanalytic, supportive-expressive, and reflective functioning. There is a rich history of comparative process research between modalities of individual adult and child treatments (Ablon & Jones, 1998; Goodman et al., 2016), yet there are no comparable research findings for parent work in different modalities, despite the widespread practice of working closely with parents in child treatments. Within these treatments, clinicians of different orientations claim to operate on theoretically distinct principles, leading to distinct clinical approaches with parents (Prout, Chacko, et al., 2018). Descriptive studies such as this one lay a foundation for empirically examining these claims and for determining whether there might be transtheoretical “common factors” in therapist behaviors or interventions with parents that contribute to child outcomes. Such findings can help to integrate research and practice by contributing valuable clinical data from actual sessions with parents, which can be used to adapt existing treatment manuals and to inform future treatments involving parents.

Given the integrative nature of RFP-C, we hypothesized that RFP-C parent sessions would be associated with psychodynamic, reflective functioning, as well as the cognitive-behavioral adult prototypes. Specifically, the parent session’s focus on the child’s defense mechanisms and the focus on the child’s affect within discussions between the therapist and parent would suggest that observer-coded process ratings of RFP-C parent-sessions might show positive correlations to adult psychodynamic prototypes. Furthermore, given the explicit aim of the parent sessions to enhance parental reflective functioning and help parents understand that disruptive behavior has meaning, as well as research suggesting that reflective functioning is a common factor in both child and adult psychotherapy (Goodman, 2013; Goodman et al., 2016), we expected that process ratings would also reveal a positive correlation with the adult reflective functioning prototype. Finally, the psychoeducational aspect and limited number of the sessions results in a more structured and direct approach which informed the hypothesis that psychotherapy process in these parent sessions would be associated with the cognitive-behavioral prototype. In this way, we expected parent sessions to differ from RFP-C child sessions, which at least in theory, have no association with a child cognitive-behavioral prototype (Prout, Goodman, et al., 2018).

## Method

### Participants

Participants in this study comprised a subsample of 16 RFP-C treatments from an ongoing randomized controlled trial (RCT) of RFP-C. In the ongoing RCT of RFP-C (Prout, 2020), children and parents were assigned to either a 10-week waitlist control condition (during which they received a weekly phone call by a research assistant for 10 weeks before beginning treatment) or the experimental condition (in which they began treatment within two weeks of intake). Children were aged 5 to 12 years (range: 5–11,  $M = 7.7$   $SD = 2.3$ ), and child and their participating parent(s) were all fluent in English. All children met *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria for oppositional defiant disorder (ODD). In 18% of the 16 cases ( $N = 3$ ), both parents participated in the sessions. In two cases, both parents participated together, and in one case, parents “split” their attendance, such that each parent attended one or more sessions separately.<sup>2</sup> In this subsample, all families in which both parents participated were composed of a married mother and father. In 56% of cases ( $N = 9$ ), mothers participated alone, and in 25% of cases ( $N = 4$ ), fathers participated alone. All caregivers were the biological parents of the participating child, apart from one caregiver who was an adoptive mother since the child’s birth.

### Treatment

RFP-C is a 20-session treatment for children with oppositional defiant disorder and other externalizing problems. Treatment consists of sixteen 45-min individual child sessions, as well as four 45-min parent sessions (two at the beginning, one midway, and one pretermination). Within the RFP-C child sessions there is a large focus on affect, attempting to understand the child’s inner world and subjective experience and communicating this inner experience to the child in a developmentally appropriate way (Prout et al., 2015; Rice & Hoffman, 2014). Externalizing behaviors are conceptualized as defense mechanisms which help the child avoid difficult feelings, such as shame, anger, guilt, or fear. Therapists interpret these defenses against painful affects to build the child’s capacities for implicit emotional self-regulation (Hoffman, 2007, 2014, 2015; Hoffman et al., 2016; Rice & Hoffman, 2014).

Parent sessions in RFP-C are aimed to be psychodynamic in that therapists focus on clarifying their child’s defense mechanisms and their role in the child’s disruptive behavior (Hoffman et al., 2016). The RFP-C therapist conceptualizes the child’s disruptive behavior in light of the Triangle of Conflict (see Figure 1, adapted from Malan, 1979; McCullough et al., 2003) and reflects on what feelings are being avoided by the child, how they are being avoided (the defense/externalizing behavior), and why the child feels the need to avoid this feeling. A more detailed description of the treatment approach and its theoretical basis is provided in the manual (Hoffman et al., 2016) and associated publications (Hoffman, 2014; Prout et al., 2015, 2019; Prout, Goodman, et al., 2018).

<sup>2</sup> In cases where both parents were present, an overall PQS score was designated for the parents together.

## Therapists

Therapists ( $N = 12$ ) were graduate students in a clinical psychology doctoral program. Twelve therapists worked with one family, whereas three therapists worked with two families. All therapists conducted both the parent collateral sessions and the individual child sessions with their respective families. Therapists ranged from second to fourth-year students, reflecting 1 to 3 years of formal clinical experience.

## Measures

### Psychotherapy Process Q Set

The PQS (Jones, 2000) is a pan-theoretical observer-rating system used to identify and distinguish specific components of psychotherapy process across modalities. The PQS consists of 100 items which contain statements describing aspects of the therapist's behavior and attitudes, the client's behavior and attitudes, and the interaction between therapist and client. Items are sorted into nine categories in an ipsative forced-choice procedure that allows the rater to determine which processes are most and least characteristic of the psychotherapy session. The PQS has been found to reliably distinguish treatment types and has been widely used to study psychotherapy process, with interrater reliability across items ranging from 0.83 to 0.89 (Ablon et al., 2011).

The PQS is a tool used to delineate psychotherapy process within individual, adult psychotherapy; thus, the use of the PQS for the examination of parent sessions in this study was a novel application and had inherent limitations (see Discussion). To preserve the integrity of the tool, no changes were made to the items; however, raters were instructed to refer to the parent when items mentioned the "patient" (e.g., "Therapist points out the *parent's* defensive maneuvers"; "The *parent* expresses negative feelings toward the therapist"). No items were removed or added.

### PQS Process Prototypes

Expert raters in various modalities have created PQS prototypes which reflect the distribution of PQS items based on their theoretical conceptions of an ideal psychotherapy session in that modality. Adult psychotherapy process prototypes have been developed for a wide variety of treatments, including treatment focused on reflective functioning (RF; Goodman, 2013), psychoanalytic (PA) and cognitive-behavioral therapy (CBT; Ablon & Jones, 1998), and supportive-expressive therapy (SET; Leichsenring et al., 2016).

## Procedure

This post hoc study on a subsample of the RCT data was approved by the Albert Einstein College of Medicine Institutional Review Board (#2016–6595). The four parent sessions (as well as all child sessions) were video-recorded as part of the RCT procedures, and both therapists and parents consented for these videos to be used in future research studies.

Owing to technical recording errors, not all parent sessions were recorded. Of the 64 total sessions conducted, 49 recorded parent sessions ( $M = 3.06$  sessions per treatment) were available for this post hoc analysis. All parent sessions were transcribed verbatim by the first author, using the standards outlined by Mergenthaler and

Stinson (1992). All identifying information was removed. All sessions were coded by a team of five research assistants using the PQS (Jones, 2000). Raters received 12 hr of training on the PQS by an expert coder (Professor Porcerelli). During this training, research assistants practiced coding using therapy transcripts from both cognitive-behavioral and psychoanalytic adult therapy provided by the expert coder. Discrepant ratings were discussed, and another practice transcript was provided until each rater achieved interrater reliability of 0.80 in relation to expert codes. Research assistants coded each RFP-C parent session independently and met weekly for a period of 25 weeks to discuss discrepant items. Due to the ipsative nature of the PQS, no changes to scores were made after the discussion (as changing one item would require changes to all other items); rather, discussions were used to inform future codings. Process ratings for each of the 100 items on the PQS were averaged across the five raters to yield an overall item score for every session in the sample. Interrater reliability across all sessions was  $\alpha = .93$ .

Ratings of RFP-C parent sessions were compared to previously published adult psychotherapy process prototypes for RF (Goodman, 2013), PA, CBT (Ablon & Jones, 1998), and SET (Leichsenring et al., 2016).

## Data Analyses

Using Q-sort methodology, the 10 most characteristic and 10 least characteristic process items were identified. Pearson correlations were used to measure adherence of process in RFP-C parent sessions to prototypes of ideal therapeutic process in adult therapies of RF, PA, CBT, and SET. G\*Power sensitivity analysis (Feld & Erdfelder, 1992) for the correlations indicated that based on an alpha of .05, two-tailed tests, power of .80, and sample size of 49 sessions, a medium effect size ( $p$ ) of .38 or larger could be identified. For the correlations per treatment ( $N = 16$ ), an effect size of .6 or larger could be identified. For each of the 16 treatments, the composite Q-ratings for each PQS item (an average of the rating for each item across all available sessions for that treatment) were transformed to  $z$  scores and correlated with that item's factor score from the RF, PA, CBT, and SET prototypes. Pearson correlations for each treatment were transformed to  $z$  scores using Fisher  $r$  to  $Z$  transformations. These  $z$ -scores represent the degree to which each parent session was correlated with each prototype. Correlations across all participants were averaged to determine a mean level of adherence ( $z$  score  $M$ ) to that prototype for the entire sample. A Venn diagram was created to compare most and least characteristic items across prototypes.

## Results

### Demographics

In this sample of 16 cases, 63% were boys ( $N = 10$ ) and 37% were girls ( $N = 6$ ). The mean age of the children was 7.7 years ( $SD = 2.3$ ), ranging from 5 to 11 years. The ODD rating scale (O'Laughlin et al., 2010) was used as a measure of ODD symptom severity; the mean score was 17.2 ( $SD = 4.5$ ), ranging from 12 to 24, with a score of 8 or above denoting a score in the clinical range. Parents' age ranged from 35 to 62 years. Of the 16 participating cases, most parents (43%) identified as White ( $N = 7$ ), as



Black (12%,  $N = 2$ ), or as Hispanic or Latino (25%;  $N = 4$ ). In cases where both parents participated, demographic data was collected for the parent identified as the primary caregiver. Approximately half of the 16 participating parents were married (56%;  $N = 9$ ). Families reported a wide range in terms of income. See **Table 1** for detailed demographic information.

### Overall Process Ratings

For each of the 49 sessions, the rating (1–9) for each of the 100 PQS items was averaged across all five raters, yielding a composite score for each item per session. These composite item scores were then averaged across all 49 sessions to obtain an overall mean rating for each PQS item for the sample as a whole. The 10 most and 10 least characteristic process items in this sample of RFP-C parent sessions are listed below in **Tables 2** and **3**. Examples of highly characteristic items included a focus on the parent's current life situation (PQS 69) and interpersonal relationships (presumably with the child; PQS 63). Highly uncharacteristic items included the therapist acting distant, condescending, or aloof (PQS 51, 9).

**Table 1**

*Participant Demographic Data ( $N = 16$ )*

Child gender	Frequency	Percent (%)
Male	10	62.5
Female	6	37.5
Child ethnicity		
White/Caucasian	9	56.3
Black	2	12.5
Hispanic/Latino	4	25.0
Multiracial	1	6.3
Parent ethnicity		
White	7	43.8
Black	2	12.5
Hispanic/Latino	4	25.0
Jewish	1	6.3
American/Northern European	1	6.3
No response	1	6.3
Child age		
5	4	25.0
6	3	18.8
7	1	6.3
8	1	6.3
9	2	12.5
10	3	18.8
11	2	12.5
Marital status of parent		
Married	9	56.3
Divorced or separated	2	12.5
Living with partner	2	12.5
Never married	2	12.5
Data missing/unavailable	1	6.3
Family income		
20–39,999	1	6.3
40–59,999	5	31.3
60–99,999	0	0
100–119,999	1	6.3
120–139,999	4	25.0
140,000–1,000,000	5	31.3

*Note.* When both parents participated in the parent sessions, demographic data are provided for the parent who was identified as the primary caregiver.

These items were then compared with the most and least characteristic items from the RF, PA, CBT, and SET prototypes.<sup>3</sup>

Another way to consider psychotherapy process in the parent sessions is to relate the most and least characteristic items to the three overarching categories of the PQS—therapist contributions, patient or “parent” contributions, and cocreated qualities of the therapeutic interaction. This is reflected in the “category” column of **Tables 2** and **3**.

### Adherence to Prototypes

For each treatment, composite Q-sort ratings of all 100 PQS items across all available sessions for that treatment were transformed to  $z$ -scores and correlated with prototypes of ideal therapeutic process in RF, PA, CBT, and SET modalities for each treatment. These correlations were transformed to  $z$  scores using the Fisher  $r$  to  $Z$  transformation, and averaged across all participants to determine a mean level of adherence to each prototype for the sample (**Table 4**). Observer-coded RFP-C parent session process was strongly correlated with the CBT process prototype ( $z$  score  $M = 0.88$ ,  $SD = 0.09$ ) and moderately correlated with both the SET process ( $Z$  score  $M = 0.62$ ,  $SD = 0.05$ ) and RF process prototypes ( $Z$  score  $M = 0.36$ ,  $SD = 0.04$ ). There was no relationship between observer-coded parent session process and the PA process prototype ( $z$  score  $M = -0.06$ ,  $SD = 0.03$ ).<sup>4</sup>

**Figure 2** illustrates the overlap of the RFP-C parent sessions with the respective PQS prototypes in a Venn. Of note, the number of characteristic items shared with each prototype does not share a direct relationship with the strength of adherence to that prototype. For example, while the SET process prototype and RFP-C parent sessions share seven out of 10 most characteristic items, RFP-C parent sessions only share four characteristic items with CBT. However, process in the parent sessions adhered more strongly overall to ideal CBT process than ideal SET process. This indicates that “middle items”—those that are somewhat characteristic or uncharacteristic of the session, or are neutral, as rated by the PQS—also play a part in determining a session's adherence to a particular prototype.

### Discussion

The purpose of this study was to more closely examine psychotherapy process in the parent component of RFP-C, a manualized, short-term, psychodynamic treatment for children between the ages of 5 and 12 with disruptive behaviors (Hoffman et al., 2016). This study was intended to clarify the most and least characteristics aspects of psychotherapy process in RFP-C parent sessions

<sup>3</sup> Given the wide range in terms of age and symptom severity within the sample, we undertook further analyses to determine if these variables might lead to differences in results with regard to process. First, the sample was divided into two groups: participants with children 5–8 years old and participants with children aged 9 to 11 years. The sample was also divided into a more symptomatic and less symptomatic group based on a median ODD-RS score of 16.5. Analyses to determine most and least characteristic items were re-run with each of these groups; minor differences in process findings based on these post-hoc analyses are noted in **Table 3**.

<sup>4</sup> No significant differences were found in the pattern or strength of adherence to the various prototypes when the sample was divided based on age or symptom severity.

Fn3

T4

Fn4

F2

**Table 2**

*Most Characteristic Psychotherapy Process Q Set Items for Regulation-Focused Psychotherapy for Children Parent Sessions (N = 49)*

Category	Psychotherapy Process Q Set number	Psychotherapy Process Q Set item	Mean rating number
Parent characteristics	88	Parent brings up significant issues and material.	8.15
Therapist characteristics	46 <sup>a,b,c</sup>	Therapist communicates with parent in a clear, coherent style.	7.90
	45 <sup>c,d</sup>	Therapist adopts a supportive stance.	7.87
	31 <sup>c,d</sup>	Therapist asks for more information or elaboration.	7.73
	6 <sup>a,b,c</sup>	Therapist is sensitive to the parent's feelings, attuned to the parent, empathic.	7.70
	18 <sup>b,c</sup>	Therapist conveys a sense of nonjudgmental acceptance.	7.68
Co-created elements	43	Therapist suggests the meaning of other's behavior.	7.63
	69 <sup>a,c,d</sup>	Parent's current or recent life situation is emphasized in discussion.	8.49
	63 <sup>c</sup>	Parent's interpersonal relationships are a major theme.	8.43
	23 <sup>d</sup>	Dialogue has a specific focus.	8.01

*Note.* CBT = cognitive behavioral therapy; RF = reflective functioning; PA = psychoanalytic; SET = supportive-expressive therapy.

<sup>a</sup> One of the most characteristic RF prototype items. <sup>b</sup> One of the most characteristic PA prototype items. <sup>c</sup> One of the most characteristic SET prototype items. <sup>d</sup> One of the most characteristic CBT prototype items.

and examine how process in RFP-C parent sessions compared to existing adult psychotherapy prototypes. In empirically defining the process of parent work in this specific modality, our goal was to lay a foundation for broader empirical research into collateral parent sessions across treatments, including process-outcome research that might clarify which therapeutic interventions with parents contribute most to child outcomes.

### Process of RFP-C Parent Sessions

Many of the most characteristic items of RFP-C process, such as discussion of the parent's current life situation and interpersonal relationships, align with the parent sessions' focus on the child and their current problems. Many items that stood out as important (either because they were highly characteristic or highly uncharacteristic of process in the parent sessions) were not specific to any particular modality per se, but rather reflected an effort to build a strong therapeutic alliance (Price & Jones, 1998). For example, it was highly characteristic of these sessions for the therapist to be

supportive, empathic, and nonjudgmental, and highly uncharacteristic for the therapist to be condescending or aloof. In a study of adults undergoing brief psychodynamic psychotherapy, these aspects of process were all significantly associated with alliance ratings (Price & Jones, 1998). Process ratings characterized the parent-therapist relationship, at least in the current sample, as polite and collaborative, noting that parents did not verbalize negative feelings toward the therapist, and that therapy relationships lacked a competitive quality.

Overall process ratings also reflected distinctive aspects of RFP-C as an intervention. It was highly characteristic of these sessions for therapists to suggest the meaning of others' behavior. This indicates that therapists are indeed using sessions to help parents understand that "disruptive behavior has meaning" (Hoffman et al., 2016). However, although RFP-C therapists consistently pointed out the child's defenses, they were unlikely to explicitly point out the parents' use of defenses in the parent sessions. Thus, in contrast to the ego psychology-based psychody-

**Table 3**

*Least Characteristic Psychotherapy Process Q Set Items for Regulation-Focused Psychotherapy for Children Parent Sessions (N = 49)*

Category	PQS number	PQS item	Mean pile number
Parent characteristics	1	Parent verbalizes negative feelings toward therapist. <sup>a</sup>	2.83
Therapist characteristics	2	Therapist draws attention to parent's nonverbal behavior.	2.70
	36	Therapist points out parent's use of defensive maneuvers.	2.69
	77 <sup>b,c,d,e</sup>	Therapist is tactless.	2.37
	24 <sup>b,d,e</sup>	Therapist's own emotional conflicts intrude into the relationship.	2.36
	9 <sup>b,c,e</sup>	Therapist is distant, aloof.	1.80
Co-created elements	39 <sup>b,c,e</sup>	There is a competitive quality to the relationship.	2.52
	11	Sexual feelings and experiences are discussed.	1.67
	51 <sup>b,c,d,e</sup>	Therapist condescends to or patronizes the parent.	1.66
	19 <sup>b,e</sup>	There is an erotic quality to the therapy relationship.	1.07

*Note.* PQS = Psychotherapy Process Q Set; CBT = cognitive behavioral; RF = reflective functioning; PA = psychoanalytic; SET = supportive-expressive therapy.

<sup>a</sup> In children between the ages of 5 and 8 (vs. children ages 9–11), this item was replaced by PQS 64 "Love and romantic relationships are a topic of discussion." In more symptomatic children (with an oppositional defiant disorder rating scale score of 19 or above), this item was replaced by PQS 68 "Real and fantasized meanings of experience are actively differentiated." <sup>b</sup> One of the least characteristic CBT prototype items. <sup>c</sup> One of the least characteristic RF prototype items. <sup>d</sup> One of the least characteristic PA prototype items. <sup>e</sup> One of the least characteristic SET prototype items.

**Table 4**

*Average Adherence to Ideal Process Prototypes Across Treatments (N = 16)*

Prototype	<i>z score M</i>	<i>SD</i>
CBT	0.88	0.09
RF	0.36	0.04
PA	−0.06	0.03
SET	0.62	0.05

*Note.* CBT = cognitive behavioral; RF = reflective functioning; PA = psychoanalytic; SET = supportive-expressive therapy. *Z score M* reflects the average level of adherence to ideal process prototypes across all treatments. Pearson correlations between each treatment and CBT, RF, PA, and SET prototypes were converted to *z* scores using the Fisher *r* to *Z* transformation and averaged to find the *z score M*.

namic nature of the individual child sessions, where defense interpretation is central, the RFP-C therapist tends to take on a more supportive and unchallenging stance in the parent sessions. This may be particularly helpful to this parent population, as parents of children with disruptive behavior often conceptualize externalizing problems as residing within the child and having less to do with parental attitudes or practices (Webb et al., 2017; Williamson et al., 2016). In contrast, many existing interventions for disruptive behavior in children focus heavily on parents' attitudes and practices and their relationship to externalizing behaviors.

### Adherence to Ideal Process Prototypes

A comparison of RFP-C parent sessions with ideal psychotherapy process in adult cognitive-behavioral and psychoanalytic therapy, short-term psychodynamic supportive-expressive therapy, and a common factors reflective functioning prototype, indicated that RFP-C parent sessions were most strongly correlated with cognitive-behavioral process, and moderately correlated with both supportive-expressive process and reflective functioning process. In addition, there was almost no relationship with ideal psychoanalytic psychotherapy process. These results stand in contrast to Prout, Goodman, et al. (2018)'s study of ideal process in RFP-C child sessions, which found no overlap with a child CBT prototype.

The lack of relationship between RFP-C parent session process and PA process is not unexpected, given that many of the most characteristic aspects of psychoanalytic process (according to the Ablon and Jones (1998) prototype, e.g., discussing the parent's dreams or fantasies, or interpreting the parent's unconscious wishes) are likely to be avoided within these child-focused, psychoeducational sessions. The RFP-C therapist is keeping the focus of discussion on the child and their defenses.

At first glance, the strong correlation between RFP-C parent session process and cognitive-behavioral process seems surprising. However, previous studies of brief psychodynamic treatment approaches using the PQS have revealed similar levels of adherence to the CBT prototype. Ablon and Jones (1998) examined psychotherapy process in brief cognitive-behavioral and psychodynamic interventions and found that while CBT therapists adhered quite strictly to CBT techniques, psychodynamic treatments were characterized equally by cognitive-behavioral and psychoanalytic process (as measured by adherence to the CBT and

PA prototypes). Similarly, Ablon et al. (2006) found that a sample of brief psychodynamic treatments for panic disorder was most characterized by CBT process. As in the present study, Ablon et al. (2006) found that many of the most and least characteristic process items that these psychodynamic sessions shared in common with CBT process conveyed a focus on structure (e.g., dialogue has a specific focus, therapist asks for more information) and alliance-building (e.g., maintaining acceptance and empathy and avoiding aloofness or condescension). Ablon et al. (2006) hypothesized that the time-limited nature of treatment, as well as the difficulty the patients in their sample had putting their experience into words, may have contributed to the more active, structured approach of the therapists in their sample. Likewise, RFP-C is time-limited, with the parent component limited to four sessions. It is likely that process findings would be somewhat different in the context of a long-term collaborative relationship between the therapist and the parent. Parents participating in these sessions may also find it difficult to put their experience into words or reflect on their child's behavior, particularly given the strong feelings these behaviors evoke. Finally, given that parent sessions are ultimately meant to provide a foundation for successful work with the child, RFP-C therapists maintain a strong focus on building an alliance with the parent. All of these factors likely contribute to the predominance of CBT process in parent sessions.

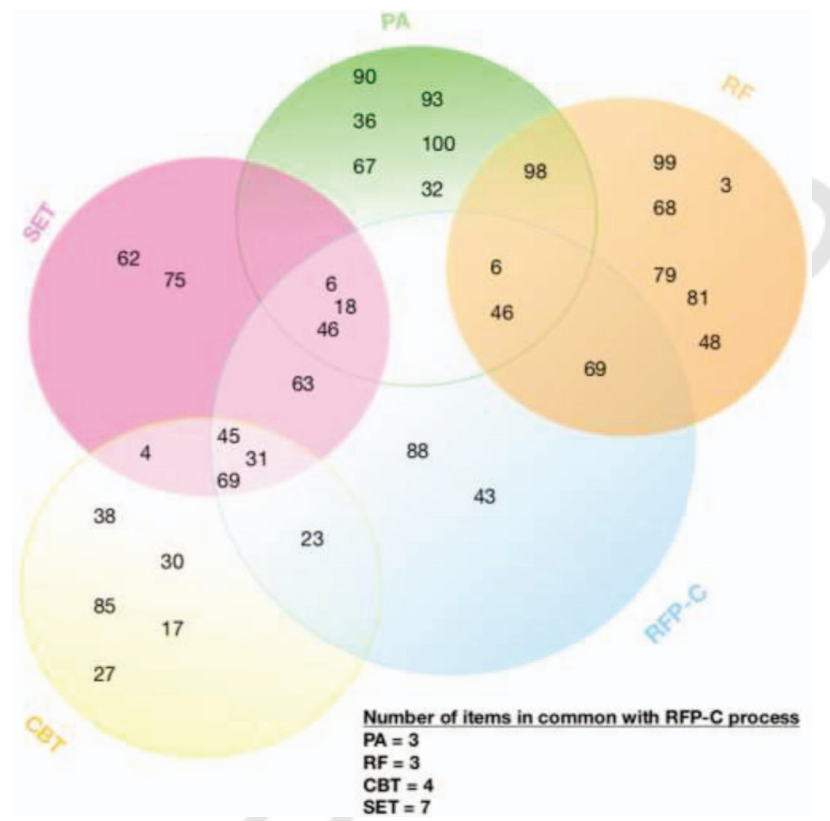
As expected, although observer-coded parent sessions showed no correlation with ideal PA process, there was a moderate correlation with the ideal process of SET. SET is a form of short-term psychodynamic psychotherapy. The main objectives of SET are to establish a strong working alliance and to enhance the patient's understanding of his or her difficulties, particularly through understanding patterns in their relationships with others (Leichsenring & Leibling, 2007). Thus, the moderate correlation between ideal SET process and RFP-C parent session process likely reflects similarities between these modalities in the focus and goals of treatment. Finally, the moderate correlation between RFP-C parent session process and ideal RF process is not only consistent with previous literature denoting RF as a common factor (Goodman, 2013) in psychotherapy, but is also consistent with the aim of RFP-C parent sessions as outlined in the RFP-C manual (Hoffman et al., 2016) to activate the parent's mentalizing system.

### Limitations

There are several limitations to this study. First, the study contained no measurement of the parent's own psychopathology or baseline reflective functioning abilities. It is possible that therapists tailored their interventions and manner of interaction with parents based on these factors and that there might subsequently be systematic differences in process between parents with high and low levels of psychopathology or reflective functioning (Cerosimo & Hilsenroth, 2020; Karlsson & Kermott, 2006). Second, although there were some therapists who worked with more than one parent in this sample, the small size of the sample prevented us from examining potential therapist effects on the process. Third, although we did not find any substantive differences in process when the sample was divided by age and ODD symptom severity, our small sample size limited potential age and symptom severity effects that might have lent more nuance to the data. Future RFP-C parent session process studies would benefit from a larger sample,

**Figure 2**

*Comparison of Most Characteristic Psychotherapy Process Q Set Items Between Observer-Coded Regulation-Focused Psychotherapy for Children Sessions and Ideal Prototypes*



*Note.* Regulation-focused psychotherapy for children = blue; reflective functioning = orange; psychoanalytic therapy = green; supportive-expressive psychodynamic therapy = pink; cognitive-behavioral therapy = yellow. Several items are duplicated in this figure in order to convey overlap between various modalities. RF = reflective functioning, PA = psychoanalytic, SET = supportive-expressive, CBT = cognitive-behavioral. See the online article for the color version of this figure.

where more detailed analyses can highlight differences among therapists, among children, and in parent sessions over time.

Fourth, the PQS is intended to code psychotherapy sessions containing patient–therapist dyads (Jones, 2000). Parents participating in this study were not themselves the designated focus of the intervention, and thus were technically not “patients.” Moreover, RFP-C parent sessions are not considered “therapy” sessions, but rather, psychoeducational, collateral sessions (Hoffman et al., 2016). Thus, by using the PQS for a novel purpose, we stretched its bounds in using the items to describe a therapeutic encounter beyond the patient–therapist dyad. We used the PQS because of the lack of measures suitable for coding collateral work specifically. It remains, however, that our results may be confounded because of the remote possibility that some PQS items would occur within an appropriate therapist–parent relationship (e.g., discussion of sexual feelings, dreams or fantasies are discussed). Nevertheless, RFP-C parent sessions, while not meant as therapy sessions for parents, use various aspects of psychotherapy process and can be argued to be “therapeutic” in the sense that these

parent-sessions help the parent understand the child’s behavior for the sake of the child’s emotional well-being (Hoffman et al., 2016; Kernberg et al., 2012). We believe that the vast majority of PQS items are applicable to parent work. However, future studies of this type of therapeutic encounter would benefit from the development of an adapted Q sort tool that contains items that are specifically tailored to work with parents (Clinical Implications).

Another limitation is that although there is a CPQ prototype to describe ideal process in RFP-C child sessions (Prout, Goodman, et al., 2018), there is no existing prototype for ideal process in RFP-C parent sessions developed as of yet. Therefore, it is important to note that the comparison in this study was between actual observer-coded parent sessions and “ideal” psychotherapy process in other adult therapy modalities.

### Clinical Implications and Future Directions

Although an ideal process prototype for RFP-C child sessions formulated with the CPQ found no overlap with CBT process



(Prout, Goodman, et al., 2018), parent sessions were characterized by CBT process. This finding suggests that regardless of the modality being employed with the child, work with parents may look quite different from work with children, especially when parents are participating in the treatment as collaborators and not as patients. It is important, therefore, to understand the specific elements of process being used in parent work and which of these elements contribute most to outcome. Examining the process of parent sessions is not only important in RFP-C, but also in other child therapy modalities that include parent work, such as parent-child interaction therapy (Brinkmeyer & Eyberg, 2003) or parent management training (Forgatch & Patterson, 2010).

All findings taken together, there are several potential lines of inquiry that could emerge from this study. First, our findings highlight the need for tools to specifically examine psychotherapy process with parents. One possibility is to continue to use the PQS, despite its limitations, to create “ideal” prototypes for parent sessions in different child-focused modalities, including RFP-C. These prototypes could then be used to facilitate comparisons across interventions, as well as compare “ideal” process with actual parent sessions. For example, once an ideal RFP-C parent session prototype is created, it could then be compared with the findings of the present study to determine whether observer-coded parent sessions diverge from what is theoretically proposed by experts in RFP-C. Another possibility is to create an adapted parent session process Q sort tool, similar to the CPQ (Schneider & Jones, 2004) or adolescent therapy (Bamberg et al., 2007), use this tool to formulate various “ideal” parent session prototypes for different modalities, and employ these prototypes to make comparisons of process across modalities (both in terms of “ideal” and observer-coded sessions). This Q sort tool could also be used to relate process and outcome.

Second, the finding that RFP-C parent sessions adhere most strongly to CBT process seems to support previous research in adult psychotherapy that therapists often “borrow” **form** modalities other than the one to which they ascribe theoretically (Ablon & Jones, 1998, 1999, 2002; Jones & Pulos, 1993). However, it is unclear whether this finding would be replicated with parent sessions in other child-focused treatments, such as mentalization based therapy for children (Midgley et al., 2017) or individual CBT treatments such as coping cat (Podell et al., 2010). Furthermore, it is unclear whether collateral parent sessions differ at all process-wise from interventions in which parents play a more active role, such as parent-child interaction therapy (Brinkmeyer & Eyberg, 2003) or mentalization-based family therapy (Asen & Fonagy, 2011). Finally, given the moderate relationship between RF process and RFP-C parent session process, it would be important to determine whether reflective functioning is a common factor that extends to parent work by examining whether aspects of RF process are present in other modalities.

Third, descriptive process research provides a basis for determining which specific therapy processes contribute to treatment outcomes. In the case of RFP-C, future studies can examine which aspects of process are most related to reductions in externalizing behaviors, and through what means (i.e., increasing parental reflective functioning, decreasing parenting stress, etc.). If descriptive studies of process with parents are completed in other modalities, we can then compare therapeutic action between different types of parent work. Are there transtheoretical interventions with

parents that are broadly effective, such as alliance-building in adult therapy (Price & Jones, 1998), and/or do different therapeutic interventions with parents have differential effects depending on the overall therapeutic approach (Ulvenes et al., 2012)? When the therapeutic modality is held constant, which interaction structures between parent and therapist contribute most to outcome, and does this vary based on parent characteristics (Halfon et al., 2020)? For example, one hypothesis might be that parents with low RF benefit from a more supportive, psychoeducational approach that adheres more to CBT process, whereas parents with higher RF at the start of treatment benefit from a mentalization-adherent approach.

Finally, this study offers an opportunity to continue to integrate research and practice by empirically evaluating the theoretical claims of treatment manuals, and adapting them accordingly based on feedback and data about what clinicians are actually doing in the field. With regard to RFP-C, findings from this study revealed that therapists’ interventions and clinical stance as rated by the PQS were quite similar to the ideal clinical stance detailed in the manual. However, it is still unclear whether these interventions contribute meaningfully to clinical outcomes. Future studies about which clinician interventions with parents contribute most to child outcomes can enhance the quality of manualized treatments and inform parent components of future child-focused interventions.

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