Pragmatic Case Studies in Psychotherapy, http://pcsp.nationalregister.org/
Volume 21, Module 1, Article 1, pp.1-68, 01-26-25 [copyright by authors]

Editor's Note: For the interested reader, an outline of the structure of the case study of "Jack" and of "Oliver" is shown in Appendix 1.

Regulation Focused Psychotherapy for Children (RFP-C) with Externalizing Behaviors: Comparing the Successful Case of "Jack," and the Unsuccessful Case of "Oliver"

CARLY BROOKS,[a] TATIANNA KUFFERATH-LIN,[b] TRACY A. PROUT,[b,h] MARIAGRAZIA DI GIUSEPPE,[c] JORDAN BATE,[d] KATIE AAFJES-VAN DOORN,[e] LEON HOFFMAN,[f] & TIMOTHY RICE [g]

[a] Independent Practice, New York, NY

[b] IMPACT Psychological Services, Beacon, NY

[c] University of Rome Tor Vergata

[d] Ferkauf Graduate School of Psychology, Yeshiva University, Bronx, NY

[e] NYU Shanghai, Shanghai, China

[f] New York Psychoanalytic Society and Institute, New York, NY

[g] Icahn School of Medicine at Mount Sinai, New York, NY

[h] Correspondence regarding this article should be sent to: Tracy A. Prout, IMPACT Psychological Services, 1183 North Avenue, Beacon, NY 12508
Email: tracyprout@impact-psych.com

ABSTRACT

Regulation Focused Psychotherapy for Children (RFP-C) is a manualized, time-limited, psychodynamic approach for children who experience challenges with emotion regulation and demonstrate externalizing behavior problems (Hoffman et al., 2016). In research settings, it takes place over ten weeks and includes 16 sessions with the child and four with the child's parents. This protocol can be extended or modified in regular clinical practice.

The current study utilized a dual case study method to analyze pretreatment and post-treatment measures and compare psychotherapy outcomes and process in RFP-C between a successful and an unsuccessful case. Data examined included (a) quantitative outcome measures; (b) case conceptualizations and clinical vignettes drawn from review of session videos; (c) post-treatment interviews with parent, child, and therapist; and (d) psychotherapy process codings of child and parent sessions. These data were employed to (a) identify

differential psychotherapy processes; (b) assess parental defense mechanisms; (c) assess parental attachment classifications; and (d) evaluate therapist countertransference ratings.

Results indicated that many variables contributed to successful versus unsuccessful treatment outcomes, including but not limited to (a) the child's spontaneity; (b) the child's active participation and emotional expression throughout treatment; (c) themes of child play; (d) the therapist's countertransference; (e) the child and parental defense mechanisms; and (f) the parental attachment styles. Taken together, findings from this study contribute to the literature on therapeutic outcomes for children and families and highlight some of the essential characteristics of successful psychotherapy process. Limitations of the study and directions for future research are also discussed.

Keywords: oppositional defiant disorder; Regulation-Focused Psychotherapy for Children (RFP-C); externalizing disorders; psychotherapy outcome; emotion regulation; case study; clinical case study

---

1. CASE CONTEXT AND METHOD

Throughout our time as child psychotherapists, parents have visited our offices with a similar refrain: "I love my child, but right now, I don't really like him/her/them." Often, these weary and worried parents are raising children whom researchers and clinicians term "irritable" children. Such children have strong negative emotions, are easily hurt or reactive, and frequently engage in disruptive or externalizing behaviors such as arguing, fighting, and breaking rules (Brotman et al., 2017). It is one of the most common reasons for referral for psychiatric evaluation and care (Peterson et al., 1996). Many "irritable" children are diagnosed with oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD), or disruptive mood dysregulation disorder (DMDD; Leibenluft, 2011). They are often labeled as "difficult" kids and teachers and other professionals may feel intimidated, frightened, or overwhelmed by their needs (Mishne, 1996; Shachner & Farber, 1997).

When children are referred to a psychotherapist for concerns related to disruptive behavior, treatment typically focuses on behavioral interventions, such as parent-child interaction training (PCIT; Brinkmeyer & Eyberg, 2003) or parent management training (PMT; Forgatch & Patterson, 2010). While these interventions are effective for some families, research indicates that a diversity of approaches is needed. Some studies have found high attrition rates for certain populations who are enrolled in behavioral treatments due to high family stress, high symptom severity, limited resources, and differential attributions about where the "problem" resides – whether in parenting methods or within the child (Baden & Howe, 1992; Bickett et al., 1996; Lanier et al., 2011; Granero et al., 2015; Prout et al., 2015).

Regulation-Focused Psychotherapy for Children (Hoffman et al., 2016), or RFP-C, is a manualized, short-term, psychodynamic psychotherapy (STPP) for children with emotion dysregulation and externalizing behaviors. The guiding principles in RFP-C are that *it is easier to get mad than to feel sad* and *all behavior has meaning*. In other words, children display externalizing behaviors as a defense against vulnerable feelings. In RFP-C, the clinician utilizes play within the therapeutic relationship to address the child's implicit emotion regulation strategies (e.g., defenses) by highlighting the connection between the child's vulnerable feelings and their avoidant, disruptive behaviors. By repeatedly addressing defenses within the context of a warm and empathic therapeutic relationship, the clinician helps the child increase their ability to tolerate painful feelings, thus lessening the child's need to resort to disruptive behaviors to regulate painful feelings (Hoffman, 2007; 2015; Prout et al., 2019a).

Outcomes in RFP-C have been tested in three studies. A small pilot study demonstrated significant reductions in externalizing symptoms with continued gains at three-month follow up (Prout et al., 2019b). Additionally, this study demonstrated the cost effectiveness of the treatment with training costing $3,333 per clinician as compared with behavioral parent training interventions which average $73,000 in training costs per clinician (Blueprints for Healthy Development, 2024). This was followed by a randomized controlled trial (RCT) demonstrating the effectiveness of RFP-C in treating children diagnosed with oppositional defiant disorder (Prout, Rice et al., 2022). In the RCT, there was evidence of high treatment attendance (98.5% of sessions attended) and completion (91.8%) rates (Prout, Rice et al., 2022). This is compared with child/adolescent cognitive behavioral therapy where the rates of pre-treatment discontinuation and premature termination during treatment are 18.5% and 28.8%, respectively (Fernandez et al., 2015), including among children and adolescents with externalizing behaviors (Chacko et al., 2016). Finally, a fully online delivery of RFP-C during the COVID-19 pandemic demonstrated significant decreases in parent-reported symptoms of ODD (d = 2.05) (Storey et al., 2023).

The following paper is a dual case-study describing the treatment of two children who received a course of RFP-C as part of their participation in the initial RCT of RFP-C. One child (Jack) experienced a significant reduction in symptoms, while the other child (Oliver) remained unchanged. Our aim is to highlight some of the child, parent, therapist, and treatment factors that may contribute to success with this modality, and in the treatment of externalizing behaviors more broadly. The children and parents described in this paper gave their informed assent and consent for their stories and data to be utilized for research and training in a de-identified manner. Efforts have been taken to preserve the clinical dynamics of these cases, while altering or disguising details that may identify the families being discussed.

Both therapists were woman-identified trainees in a clinical psychology doctoral program. They participated in eight hours of RFP-C training provided by the authors of the RFP-

C manual (Hoffman et al., 2016), which included theoretical background and clinical application of RFP-C. While treating their clients, the therapists attended weekly group supervision where they showed recorded videos of therapy sessions to facilitate case review and feedback. The supervisor was an experienced psychodynamic therapist and developer of the treatment approach. Both children and their parents gave their assent and informed consent for sessions to be recorded for training and research.

2. THE CLIENTS

The participants, Jack (age 8)[1] and Oliver (age 9), were referred to the RFP-C RCT due to concerns about oppositional and aggressive behavior. Both families were from a middle socioeconomic status composed of married, highly educated, professional, biological parents.

3. GUIDING CONCEPTION WITH RESEARCH SUPPORT

The RFP-C Model of Therapy

The aim of Regulation-Focused Psychotherapy for Children (RFP-C) is to decrease irritable, oppositional, and aggressive behavior by helping the child to develop a greater tolerance for difficult feelings. There is significant evidence that children with disruptive behavior disorders have underdeveloped capacities for emotion regulation (Cavanagh et al., 2017; Drabick & Gadow, 2012). Children with externalizing disorders including those with ODD and DMDD frequently display chronic irritability that are associated with mood and anxiety symptoms in later childhood and adolescence (Stringaris & Goodman, 2009; Gadow & Drabick, 2012; Vidal-Ribas & Stringaris, 2021). Increasing emotion regulation and affect tolerance should therefore be a central goal in treating children with irritable presentations.

Explicit emotion regulation is defined by processes that require conscious effort for initiation and require some level of monitoring during implementation (Gyurak et al., 2012; Braunstein et al., 2017). Furthermore, explicit emotion regulation is purposeful and effortful, and is associated with some level of insight and awareness. It is not realistic for an individual to be able to engage in explicit regulation at all times; therefore, the use of efficient implicit emotion regulation processes is critical for well-being. Unlike explicit emotion regulation, implicit emotion regulation occurs automatically, and sometimes spontaneously, without prompting, insight or awareness (Gyurak et al., 2012, Braunstein et al., 2017). Many children with externalizing behaviors struggle with problematic implicit (e.g., maladaptive defense mechanisms, such as denial or projection) and/or explicit emotion regulation (e.g., consciously

[1] To protect patient confidentiality, pseudonyms are used in this manuscript and details of case material have been changed or omitted to ensure anonymity.

employed coping strategies, such as deliberate verbal or even physical attacks against rule-makers such as parents and teachers).

Commonly utilized treatments for chronically irritable and oppositional children focus on modifying behavior directly (Brotman et al., 2017). While increasing emotion regulation is a central goal in both psychodynamic and cognitive behavioral treatments, many cognitive behavioral approaches emphasize strategies that employ the explicit emotion regulation system, such as distraction or reappraisal (Palmieri et al., 2022; Braunstein et al., 2017). Many irritable and oppositional children with underdeveloped emotion regulation capacities, may begin treatment unable to engage in this kind of effortful, controlled emotion regulation strategy (e.g., such as being instructed to, "think what would happen if you cursed at or try to attack your teacher"). There is therefore a distinct need to incorporate a focus on affect into treatments for irritable and oppositional children and to help strengthen the child's implicit emotion regulation capacities. A greater capacity for implicit emotion regulation forms the foundation for the development of more controlled emotion regulation techniques (Silvers, 2020).

The psychodynamic concept of defense mechanisms represents an observable and measurable manifestation of implicit emotion regulation. Defense mechanisms are described as automatic psychological processes that protect an individual from experiencing anxiety, danger, or stressors (Rice & Hoffman, 2014). Defense mechanisms and implicit emotion regulation have several similarities: both are processes that are intended to protect against anxiety and other unpleasant emotions, both operate on a largely unconscious level, both mechanisms originate in infancy and are developed across the lifespan and, when used successfully, both mechanisms require cognitive flexibility and the capacity for affect tolerance (Rice & Hoffman, 2014). Taken together, implicit regulation processes are similar to the psychodynamic concept of defense mechanisms against unpleasant emotions. The parallels between implicit emotion regulation and defenses mechanisms are especially salient when working with children who are chronically irritable and oppositional. Rather than confronting and experiencing unpleasant emotions, it is common for children with irritable and oppositional symptoms to defend against unpleasant emotions, resulting in severe emotion dysregulation (Hoffman & Rice, 2014; Hoffman et al., 2016; Prout et al., 2018; Prout et al., 2019a).

Addressing children's maladaptive defense mechanisms in psychotherapy can help foster more adaptive implicit emotion regulation. By examining defense mechanisms and supporting children's ability to manage environmental and interpersonal stressors, children can improve their capacity for self-regulation and increase adaptive implicit emotion regulation (Prout et al., 2019a). It is particularly important to address implicit emotion regulation for irritable and oppositional children, as increased affect tolerance and adaptive skills can increase resilience and

decrease aggressive or out-of-control responses to stressful events (Di Giuseppe et al., 2021; Prout et al., 2019a).

In RFP-C, the clinician works with the child and parents to understand together how the child's externalizing behaviors are used to defend against, or cope with, unpleasant emotions (Hoffman et al., 2016). Addressing defenses is seen as "a form of joining with the child and empathically noticing the ways the child is trying to take care of himself or herself and his or her feelings, even if those methods are not adaptive in the long run" (Prout et al., 2020, p. 50). Play and interactions between the therapist and child provide the primary means of observing and addressing defenses in the session (Hoffman et al., 2016; Hoffman et al., 2023).

RFP-C also emphasizes parental support, given that there is significant evidence that a parent's own difficulties with emotion regulation can exacerbate behavioral symptoms (Morelen et al., 2016; Crespo et al., 2017). Parent sessions in RFP-C focus on creating a supportive and reflective environment in which the therapist guides the parent toward greater understanding of the meaning behind the child's behavior. In particular, the clinician utilizes illustrations from the family's life and material from the child's individual sessions to empathically join with the parent, highlight the emotional experience that might underlie the child's disruptive behavior, and consider ways of responding to the child that will better meet the child's emotional needs (Hoffman & Prout, 2020; Kufferath-Lin et al., 2021). For more information about this, the Center for Regulation Focused Psychotherapy offers an instructional video for parents.

The Duration and Three Phases of RFP-C

RFP-C takes place over 8 weeks and involves a total of 16 child sessions and 4 parent sessions. These take place over three phases, as described below.

Phase One. The first phase of RFP-C consists of an introductory meeting with parents, two initial sessions with the child, and a parent "feedback" meeting to present an initial formulation of the child's difficulties from an RFP-C framework. The primary tool used for conceptualization is the "Triangle of Conflict." Inspired by the work of Leigh McCullough and David Malan (Malan, 1979; McCullough et al., 2003), the Triangle of Conflict illustrates the hidden feelings that underlie a child's disruptive or oppositional behavior (see Figure 1).

The clinician works with the parents to understand that, although the child's disruptive behaviors seem unexpected and unreasonable, they are a self-protective response to manage the anxiety created by strong feelings that are unbearable or shameful for the child. Parents are presented with the idea that "disruptive behavior has meaning" – it is a way of managing anxiety by pushing painful feelings out of awareness. The clinician encourages the parent to understand and reflect on the child's emotional experience, rather than simply seek to control or modify the child's behavior (Hoffman & Prout, 2020; Kufferath-Lin et al., 2021). The goals of this first

phase of treatment are to formulate an initial understanding of the child and develop a strong alliance with both the child and their caregivers (Hoffman et al., 2016).

Phase 2. In the second phase of RFP-C, the clinician meets with the child two times per week over the course of five weeks. The sessions are child-led where the child is encouraged to play, talk, and interact with the materials in the room as they feel comfortable while helping the child to maintain limits for safety. The primary intervention in this stage is to repetitively address and pay close attention to the child's defenses against painful feelings (Hoffman et al., 2016). These defenses may manifest as disruptive behavior similar to that for which the child was referred, as well as more subtle manifestations of avoidance, such as changes in subject or tone of voice, shifts or incongruence in affect, abrupt changes in play, or distorted and unrealistic thoughts (Perry & Henry, 2004). Through observing these defenses, the clinician communicates understanding of the painful feelings that the child is avoiding and why these feelings cannot be tolerated (Hoffman et al., 2016). The clinician closely monitors the therapy process. Comments and interventions are meant to be "experience-near", reflecting only what the clinician is observing in the moment (e.g., "*You lost the game, and now you decided you want to play something different. I wonder if there was something difficult about losing." "I said there were five more minutes left, and then you threw the ball at me. Maybe you're telling me how bad it feels to say goodbye."*) The child is encouraged to join the clinician in noticing these defensive strategies in order to decrease avoidance and increase tolerance of painful feelings. By addressing the child's defenses, the clinician provides consistent and gradual exposure to the child's painful, but hidden feelings, strengthening the child's capacities for emotion regulation (Prout et al., 2015).

An empathic and attuned therapeutic relationship is central to this process, and the clinician's attention to transference and countertransference provides depth to the work (Hoffman et al., 2016). By addressing repetitive patterns of affect avoidance between the clinician and the child, the clinician uses the transference to increase generalization of emotional learning to other contexts, such as at school and home (Hoffman et al., 2023; Hoffman et al., 2016). The clinician's attention to the countertransference during this phase allows for deeper empathy for both the child and parents, as countertransference feelings lend understanding of the emotional experience of parents and teachers when working with the child and additionally provide insight into negative feelings toward the self that the child is placing on the clinician (Hayes et al., 2018; Winnicott, 1949). Parent sessions during this phase focus on continuing to provide support, deepening understanding of the child's painful, but hidden feelings, and encouraging parents to communicate their understanding to the child by moving away from punitive practices and toward relationally attuned limit-setting (Hoffman & Prout, 2020;

Kufferath-Lin et al 2021). Care is taken to regulate the parents' own unbearable feelings that arise in response to the child's challenging behavior (Hoffman et al., 2016).

Phase 3. In the final phase of RFP-C focuses on termination. This occurs over two weeks of twice-weekly sessions with the child. The goal is to use the painful feelings that inevitably arise with this stage of treatment as an opportunity to develop more effective ways of coping with difficult emotions. This is achieved through a continued empathic address of the child's mechanisms of avoidance. Parents in a final parent session are encouraged to implement new ways of responding to their child with the understanding that "disruptive behavior has meaning" and the clinician provides support in thinking about how to handle future instances of disruptive behavior (Hoffman et al., 2016).

An overview of the treatment protocol is presented in Figure 2.

Variations in Outcome

Although RFP-C was found to be effective overall in the studies described above, it was not effective for every child. As with all child psychotherapies, RFP-C has variable outcomes. Research has highlighted the quality of the therapeutic relationship, therapist behaviors, and parent involvement as each having a significant effect on the outcome of a child's treatment (Katzmann et al., 2019; Karver et al., 2006; Karver et al., 2005). Evaluating a treatment through the use of systematic case studies can highlight context-specific factors that contribute to the effectiveness of a treatment and can assist in closing the gap between research and practice (Datillio et al., 2010; Fishman, et al., 2017). In addition, case studies provide the opportunity to utilize multiple methods (qualitative and quantitative) to provide more specific data beyond the whole-group outcome data emphasized in clinical trials (Fishman, 2023).

The present study compares a "successful" case (Jack) in which there was significant symptomatic improvement, to an "unsuccessful case" (Oliver) in which the client remained unchanged symptomatically. A dual-case study method can thus highlight the various factors that may contribute to the effectiveness of RFP-C, and child psychotherapy more generally, in addressing chronic irritability and disruptive behavior in children.

4. ASSESSMENT OF THE CHILD'S PRESENTING PROBLEMS & HISTORY

Jack

Jack could become verbally and physically aggressive when frustrated, although his parents reported that this happened primarily at home. Jack also presented as sad and "low energy" and had made remarks about wanting to hurt himself and others. Jack's mother reported that he followed her around the home wherever she went, became very upset when she needed to

leave the house, and checked in frequently when they were apart. She reported that Jack worried about perceived threats, particularly the potential for a violent military attack, which he spoke about often at home.

His presenting problems dated back to when he was in preschool, when his teacher noticed that he was demonstrating aggressive behavior and was biting other children. In addition to his aggressive behavior, was sensitive to smell and tactile sensations. He had received occupational therapy and speech therapy in preschool and was diagnosed with sensory processing disorder. Jack and his family had completed several courses of cognitive behavioral therapy, within minimal results, prior to enrolling in the RCT. He was not taking any psychotropic medication at the time of this therapy and did not report any history of psychiatric medication use. Jack's parents reported a family history of anxiety and depression.

Oliver

At the initial interview, Oliver's parents reported that he had been "acting out" and demonstrating disruptive and aggressive behavior at home and at school. Oliver's teachers reported that he frequently shouted out "rude comments" to other students and authority figures, refused to comply with rules, and provoked his peers when he became angry. Oliver's mother reported that Oliver was very emotional and sensitive, and "would get set off quickly" if he did not get his way, especially at home with his sibling. Oliver's father reported that there had been numerous incidents in school where Oliver was verbally and physically aggressive toward peers and authority figures.

Oliver's presenting problems dated back to age two. Two emotionally significant events occurred during this time—the birth of a sibling and the sudden death of a pet. Oliver's problems in school began in the second grade after several close extended family members moved out of state. He had been to therapy "on and off" throughout the years without significant success. There was no reported history of psychiatric medication for Oliver in the past or during this course of psychotherapy. Oliver's parents reported that his difficult behavior had made it challenging to find a consistent childcare provider. Oliver's parents denied any family mental health history.

Quantitative Assessment

As mentioned above, Jack and Oliver were subjects drawn from a randomized control study (Prout, Rice, Chung, et al., 2022). In that study, a variety of relevant, standardized quantitative measures were administered to assess initial status and change over the course of therapy to all the study subjects, including Jack and Oliver. These measures are described below, and the results on these measures are provided in Table 1. Note that six of the seven measures

are based on parent self-report. The seventh measure, the Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA), is based on the child's self-report.

The Oppositional Defiant Disorder Rating Scale (ODD-RS; O'Laughlin et al., 2010)

The ODD-RS is a standard eight-item questionnaire that is used to screen for ODD. Caregivers are asked to rate each ODD symptom on a 4-point scale, ranging from 0 (not at all) to 3 (very much), yielding an overall total score for symptom severity. The ODD-RS has demonstrated high internal consistency (α = .92) and interrater reliability between caregivers (*r* =.70; Hommerson et al., 2006).

Each family participating in the RCT completed this questionnaire on a weekly basis. On the ODD-RS, Jack's mother marked "very much" for every item, resulting in the highest possible score (Score = 24). Oliver's mother reported a high score at intake, and endorsed that Oliver often lost his temper, argued with adults, defied rules, and was touchy or easily annoyed by others (Score = 17). Both children scored well-above the clinical cutoff of eight, indicating clinically significant ODD symptoms.

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001)

The CBCL is a caregiver questionnaire for measuring emotional and behavioral problems. Caregivers are asked to think of their child's behavior in the past six months and rate whether items are 0 (Not True), 1 (Somewhat True) or 2 (Very True).

The CBCL is one of the most widely used measures for assessing emotional and maladaptive behaviors including internalizing behavior (such as depression and anxiety) and externalizing behaviors (such as aggression and disruptive behaviors) (Halfon et al., 2017). Reliability and validity among diverse populations has been established (Rescorla et al., 2007). The CBCL has demonstrated internal consistency for the Externalizing Problems subscale (α = .94), the Oppositional Defiant subscale (α =.86), and the Aggressive Behavior subscale (α =.94) (Achenbach & Rescorla, 2001).

On the CBCL, both Jack (T-Score=78) and Oliver's (T-Score = 75) overall externalizing problems were in the clinical range, with clinically elevated oppositional defiant problems and conduct problems. Jack's mother also reported clinically elevated affective problems and anxiety problems on the CBCL.

The Eyberg Child Behavior Inventory (ECBI; Rich & Eyberg, 2001)

The ECBI is a widely used caregiver report instrument used to assess problem behavior among children 2-16 years old with disruptive behavior disorders (Rich & Eyberg, 2001). The ECBI contains 36 items that are rated on an Intensity Scale and a Problem Scale. On the Intensity Scale, caregivers use a scale ranging from 1 (Never) to 7 (Always), to assess the frequency and

severity of a child's disruptive behavior. On the Problem Scale, caregivers circle yes or no to indicate whether they consider the behaviors to be problematic for themselves. A caregiver report of more than 15 problematic behaviors (T = 60) indicates clinically significant disruptive behavior.

The ECBI has shown internal consistency and stability across scales (α =.98), as well as convergent and discriminant validity with psychopathology rating scales and behavioral observation measures (Robinson et al., 1980; Rich & Eyberg, 2001).

At initial assessment, each child's mother reported clinically elevated behavioral concerns on the ECBI (Jack T-Score = 65; Oliver T-Score = 67), which caused clinically significant problems in the home and/or at school (Jack T-Score = 71; Oliver T-Score = 71).

The Emotion Regulation Checklist (ERC; Reis et al., 2016)

The ERC is a 24-item caregiver report questionnaire that examines the emotion regulation of children by means of two scales: Emotion Regulation and Emotional Lability/Negativity. The Emotion Regulation subscale assesses the child's expression of emotions, empathy, and emotional self-awareness, and is related to social skills. The Emotional Lability/Negativity subscale assesses lack of flexibility, anger dysregulation, and mood lability, and is related to behavioral problems (Reis et al., 2016). The items on the ERC are rated on a 5-point scale, from 1 (Never) to 5 (Always). Higher scores on the Emotion Regulation subscale and lower scores on the Lability/Negativity subscale indicate greater ability to modulate emotions. The ERC has demonstrated strong internal consistency for the Emotion Regulation subscale (α =.83) and the Lability/Negativity subscale (α =.96) (Shields & Cicchetti, 1997).

On the ERC, both mothers reported that their children always tantrum easily, exhibit a wide range of mood swings, and respond angrily to limit-setting by adults. Oliver and Jack's emotion regulation scores were comparable (Jack = 23; Oliver = 21). However, Jack scored higher than Oliver on emotional lability and negativity (Oliver = 39, Jack = 47).

The Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA; Gullone & Taffe, 2011)

The ERQ-CA is a 10-item self-report measure that assesses two emotion regulation strategies: Cognitive Reappraisal and Expressive Suppression. Items are rated on a 7-point scale, ranging from 1 (Strongly Disagree) to 7 (Strongly Agree) (Gullone & Taffe, 2011). Cognitive reappraisal is considered an adaptive emotional response, while expressive suppression is considered a maladaptive emotional response. Higher scores on the cognitive reappraisal subscale and lower scores on the expressive suppression subscale indicate greater ability to manage and respond to emotional experiences. The ERQ has demonstrated high internal

consistency for both the 6-item cognitive reappraisal scale (α =.79) and the 4-item expressive suppression scale (α =.73) (Gross & John, 2003).

On the ERQ-CA, both Jack and Oliver reported similar maladaptive Expression Suppression strategies (Jack = 9; Oliver = 12). Jack reported significantly lower adaptive Cognitive Reappraisal strategies as compared to Oliver's self-report (Jack = 6; Oliver = 37).

The Inventory of Callous-Unemotional Traits Parent (ICU; Ezpeleta et al., 2013)

The ICU is a caregiver measure that includes 24 items coded on a 4-point scale, ranging from 0 (Not At All True) to 3 (Definitely True). The items are divided into three categories: Callousness, Uncaring, and Unemotional. The ICU is a pertinent measure for this study, as Callous-Unemotional traits have been found to contribute distinctly and significantly to disruptive behavior (Ezpeleta et al., 2013).

On the ICU, Jack and Oliver's uncaring (Jack = 15; Oliver = 16) and callousness (Jack = 11; Oliver = 9) scores were comparable and demonstrated that their parents perceived them as lacking empathy and having shallow emotions.

The Parenting Stress Index – Fourth Edition – Short Form (PSI-4-SF; Abidin, 2012)

The PSI-4-SF is a 36-item form that measures parents' levels of distress in the parent-child relationship. Caregivers are required to read statements and rate their responses on a 5-point scale ranging from Strongly Agree to Strongly Disagree. Responses to questions on the PSI-4-SF are classified into 3 domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form a Total Stress scale. The PSI-4-SF has demonstrated excellent internal consistency for the PD (α =.90) and Total Stress (.95) domains, and good internal consistency for the P-DCI (α =.89) and DC (α =.88) domains (Abidin, 2012).

On the PSI, Jack and Oliver's parent scores were comparable: Parent Total Stress (Jack = 82; Oliver = 80); Parent-Child Dysfunctional Interaction (Jack = 80; Oliver = 78); Difficult Child (Jack = 98; Oliver = 99). However, Jack's mother endorsed higher Parental Distress when compared to Oliver's mother (Jack = 76; Oliver = 46).

5. CASE FORMULATION AND TREATMENT PLAN

Within the framework of RFP-C, Jack and Oliver's aggressive and irritable behaviors were conceptualized as being the result of underdeveloped emotion regulation capacities. Disruptive behaviors were understood as maladaptive strategies for pushing vulnerable feelings out of awareness. Clinicians using an RFP-C framework can utilize the Triangle of Conflict to develop an initial formulation of the child's difficulties.

Jack

An initial case formulation for Jack using the Triangle of Conflict is presented in Figure 3. Jack's presenting problems included verbal and physical aggression. In addition, Jack's worries about military attacks seemed to be a displaced way of symbolizing his feelings of victimization and threat from others. Jack's history of sensory processing disorder and mood lability likely also made the world an overwhelming and overstimulating place at times, heightening a sense of danger and threat. The therapist's initial formulation was that Jack's aggressive and disruptive behaviors were a means of avoiding feelings of vulnerability, sensory overwhelm, and anxiety.

Given Jack's presentation, his therapist planned to closely monitor his behavior and affect in session, looking for signs that Jack was defending against painful feelings. In a similar fashion to his presentation at home, Jack might become overwhelmed and make aggressive statements toward himself or others. He might also talk about military forces and his fears of attack. The therapist anticipated that the therapist and the therapy room (with its many toys) would be likely to overstimulate or overwhelm Jack at certain points, and that he might become dysregulated or disruptive in response. These potential in-session defenses were marked as opportunities for intervention.

Oliver

Figure 4 provides a graphic depiction of Oliver's case conceptualization. Based on Oliver's parents' description of his presenting problems—including rude comments to peers and authority figures, bullying other children, and arguing when denied his own way—Oliver utilized defenses that are characteristic of many children with challenging behavior, including denial, acting out, and identification with the aggressor (Di Giuseppe et al., 2021). The clinician understands and conceptualizes this behavior as a means of avoiding painful feelings that are too anxiety-provoking to tolerate or express.

Events in Oliver's developmental history that preceded the onset and contributed to the maintenance of disruptive behavior provide some indication as to what these painful feelings might be. Given the numerous losses and transitions that preceded the onset of Oliver's disruptive behavior, his study therapist hypothesized that feelings such as loss, jealousy, or uncertainty might be difficult for him. Inadvertently, Oliver's disruptive behavior seemed to continue to provoke further experiences of loss and uncertainty, as he endured the continuous comings and goings of therapists and nannies who had difficulty managing his behavior.

Having this formulation in mind, Oliver's therapist planned to look for in-session indicators that he was experiencing these difficult feelings and mark these as opportunities for intervention. These could include behaviors similar to those observed in school and at home—for

example, making rude comments, becoming aggressive, or arguing with the therapist. However, these behaviors could also be more subtle: comments about or responses to other children in the waiting room, difficulty with the end of session, or defensive attempts to hold the therapist at a distance (e.g., silence in the room, not involving the therapist in the play).

Parent Work

Pre-treatment measures revealed that both Jack and Oliver's parents perceived them as lacking empathy and having shallow emotions. In addition, both mothers indicated that they found their child difficult to parent and were under a significant amount of stress more generally. In both cases, the therapist suspected that parents were attempting to manage their own unbearable feelings, and thus had less resources available for understanding or reflecting on their children's feelings.

A goal of parent work within both treatments was therefore to provide emotional support for parents in order to create a therapeutic environment where Jack and Oliver's emotions could be reflected upon. In addition, clinicians would provide psychoeducation using the Triangle of Conflict to highlight the link between disruptive behaviors and difficult feelings, with the goal of helping parents to view their children and their behavior differently and thus respond in a more empathic and emotionally-attuned way.

6. COURSE OF TREATMENT

The Case of Jack

During initial sessions, Jack had trouble entering the therapy room and engaging with the therapist. More specifically, Jack spent time in the hallway before reluctantly entering the therapy room. As expected, given the reports of Jack's sensory sensitivities, the therapist and therapy room were initially quite overstimulating for Jack. The therapist remained patient and calm, conveying her understanding that Jack's avoidance of the therapy room might be an expression of fear by remaining patient and warm.

At the beginning of treatment, Jack decided that he wanted to play with Legos; however, he expressed that he wanted the therapist to open the Lego box and appeared afraid of what might be inside. Again, Jack seemed to be holding the therapist at a distance, communicating his avoidance of nuclear bomb "inside." Throughout treatment, Jack played with Legos and created intricate war scenes where he pretended to fire missiles, plant bombs, and shoot the therapist. Each time Jack heard something outside (i.e., airplane, sirens from car), he ran to the window to see what it was. During the second session the therapist and Jack looked out the window and engaged in conversation about the sirens and airplane outside. Jack appeared to be very fixated on noises from outside and expressed that these noises were planes that might be heading toward New York City from a foreign military. It was apparent that Jack was experiencing severe

anxiety related to anticipated terrorist attacks. Jack was interested in talking about bombs and missiles and was responsive to the therapist's questions and comments about this topic.

> Jack*: Another airplane* [points to the window].
>
> Therapist*: What?*
>
> Jack*: Another airplane.*
>
> Therapist*: Another one? Woah. We must be close to an airport or something. What do you think?*
>
> Jack: [No response - points to the airplane silently.]
>
> Therapist*: Oh, woah.*
>
> Jack*: That was the one that was back there.*
>
> Therapist*: Yeah. So, we can watch them get closer.*
>
> Jack*: And there's another one over there* [points to the window].
>
> Therapist*: Yeah, there is.*
>
> Jack*: And it's getting bigger so it's coming towards us.*
>
> Therapist*: Yeah.*
>
> Jack*: And if it has no wings that means it's a missile coming towards us from North Korea.*
>
> Therapist*: It does? Oh, that's kind of a scary thought.*
>
> Jack*: I bet almost every kid in our class knows about it.*
>
> Therapist*: Every kid in your class knows about it?*
>
> Jack*: Almost.*
>
> Therapist*: Oh. Are they thinking about it a lot?*
>
> Jack*: I think about it a lot.*
>
> Therapist*: You do?*
>
> Jack*: And me and my friend Joe made a joke. Technically we're just waiting to be…have a nuclear bomb bomb us.*

Jack's active and imaginative play made it possible for the therapist to comment on behavior and highlight potential defenses throughout treatment. At times, as in the dialogue above, the therapist was able to join with Jack in communicating about frightening feelings directly. In RFP-C, the therapist's ability to address difficult feelings and support the client through them conveys to the child that the difficult feelings do not have to be avoided through disruptive behavior.

At other times, Jack responded to the therapist in a manner similar to how he responded outside of treatment. During Session 6 the therapist attempted to clarify or restate Jack's communication; however, her comments and questions were met with hostility and aggression – a pervasive communication pattern throughout Jack's sessions that mirrored the aggressive statements and behaviors he made toward adults and peers.

> Therapist*: When you hear noises do you usually think that it might be something dangerous?*
>
> Jack*: Yes.*
>
> Therapist*: Yea? What does that feel like? That must feel scary.*
>
> Jack*: It's very scary.*
>
> Therapist*: It is scary?*
>
> Jack*: It isn't very scary.*
>
> Therapist*: Oh, it isn't very scary.*
>
> Jack*: I'm gonna tase you for that* [pretends to use Taser gun leg].
>
> Therapist*: Ouch. When we do tasing we're just gonna pretend to touch the other person, ok, like this* [demonstrates tasing without touching child's body]. *Ok?*
>
> Jack: [No response - silently points gun at therapist head.]
>
> Therapist*: The gun is pointing at me (pause) I don't know what's gonna happen. I have so many thoughts in my head. Am I gonna be okay?*
>
> Jack: [No response - silently makes gun bigger.]
>
> Therapist*: I wonder if I'm…*
>
> Jack*: Pew* [shoots therapist].
>
> Therapist*:* [falls to the ground] *You got me. And now I'm dead. What happens now?*
>
> Jack*: Pew, pew, pew, pew , pew* [shoots therapist].
>
> Therapist*: Oh, every time I get up I get shot again.*
>
> Jack*: Mmm-hm.*
>
> Therapist*: I can't feel safe at all.*
>
> Jack*: Mmm-hm* [pause] *I'm making a gun…steering wheel…*
>
> Therapist*: You're making a second gun.*
>
> Jack*: I'm making another gun.*
>
> Therapist*: Ok…*

Jack*: And it's gonna be used to shoot you.*

Therapist*: And it's gonna be used for shooting me?*

Jack*: Mmm-hm.*

Therapist*: Oh boy.*

Jack*: Cause I like shooting you.*

Therapist*: You like shooting me?*

Jack*: Mmm-hm. Cause you're an easy target.*

In this dialogue, Jack's attempts to "shoot" the therapist are understood as a self-protective response to her mention of dangerous and scary feelings. Jack identifies with the aggressor and attempts to be powerful in the face of his anxieties. In response, the therapist takes on Jack's disavowed feelings of vulnerability by becoming the "easy target" that "can't feel safe at all."

Play sequences where Jack assigned the therapist as a target and pretended to harm her were common throughout treatment. During Session 12 Jack was quick to include the therapist in his make-believe play, however he demonstrated aggression toward the therapist through verbal communication and play and created numerous battle sequences where he lived, and the therapist died. These play sequences allowed for the therapist to comment on and to convey an understanding of Jack's need to protect himself, his use of aggression, and the general feelings of chaos and overwhelm in his environment.

Jack*: Your side is trying to stop my side from launching this missile* [pretends to launch missile].

Therapist*: Your guys are gonna launch the missile?*

Jack*: Mmm-hm and it's going straight towards where all of your guys live* [pretends to land missile].

Therapist*: Oh.*

Jack*: If they have another missile, they send it* [pretends to destroy therapist's village].

Therapist*: That was a lot of missiles hitting. Were there any civilians there?*
Jack*: Many!*

Therapist*: Many?*

Jack*: And thousands of soldiers. The missiles killed a lot of you guys.*

Therapist*: They killed a lot of my guys and a lot of civilians?*

Jack*: Mmm-hm.*

Therapist*: Wow, that must be so sad.*

Jack*: P.S. you're all dead.*

Therapist*: Wow. Today's battle is really destructive.*

Jack's conflicted feelings about the therapy space extended throughout treatment. While his play clearly revealed that he utilized the space as a place to process his feelings and communicate his inner world, he also showed strong impulses to avoid treatment by frequently stating that he did not like coming to therapy and that he wanted to leave. These statements increased in frequency in response to termination and were understood as a further expression of Jack's desire to protect himself when facing the loss of the therapist.

During the last session, Jack reported that he was sick and did not want to enter the therapy room. After negotiating with his father, Jack decided that he would stay for the session provided he could sit outside of the therapy room**.** During this session, Jack explicitly stated his anxieties and aspects of his life that were difficult for him for the first time since beginning treatment. Jack shared that he had challenges with interacting with peers in school, difficulty separating from his mother, and an intense fear of going to the hospital. This session provided insight into Jack's life and underscored to the therapist that in earlier sessions he had been playing out his fears, rather than speaking about them. These late-in-treatment disclosures represented a newfound comfort with these thoughts and feelings.

Therapist*: So, it sounds like you have a lot to worry about. There are a lot of things that worry you.*

Jack*: Yeah.*

Therapist*: A lot of things that worry you.*

Jack*: Mmm-hm. How many more minutes?*

Therapist*: Six. How do you think we can help you with that?*

Jack*: Eh, I always worry.*

Therapist*: Does that feel good?*

Jack*: No.* [pause] *That's why once I figure out how to make gunpowder. I'm gonna make a handgun and then make a little [inaudible] so I'll be safe. And then I'm gonna make bullets and I know how they're made, they have gunpowder at the end of them.*

Therapist*: So you can use it on anyone if they try to hurt you?*

Jack*: Mmm-hm.* [pause] *Also that's*[pause] *why my cousins…that's why I'm a general of an army and my cousin is in charge of me and he's in charge of the army and the people.*

Therapist*: So that you can learn how to protect yourself?*

Jack*: I know how to protect myself. I just don't do it in school.*

Therapist*: It sounds like…*

Jack*: Cause if I go to school - if I act that way in school, I go to the hospital.*

Therapist*: Yeah. Yeah.*

Jack*: The hospital for mentally ill people.*

Therapist*: Yeah. That's right.*

Jack*: And I don't want to go there. And I once almost went there.*

Therapist*: You almost once went there?*

Jack*: Mhm.*

Therapist*: What happened that time?*

Jack*: I was at camp. I got mad at somebody. And I threatened to kill myself. I was choking myself. There you go. How many more minutes?*

Work with Jack's father, who primarily attended the parent sessions, took place in four sessions over the course of the treatment. Jack's father began his meetings with the therapist by describing intense scenes of behavioral dysregulation that often ended with Jack's father physically restraining him until he was able to calm down. Jack's parents attempted to manage this behavior by developing a point system which provided very clear rules for earning certain rewards (e.g., screen time) in exchange for good behavior. There was clear and present anxiety about the possibility of Jack needing to be hospitalized at some point in the future because of the intensity of his behavior.

Jack's therapist shared with the father instances of Jack's play each session which highlighted the anxiety and sensory challenges that often seemed to underlie his son's aggression. As a result, Jack's father began to reflect on ways that he and his wife might change the home environment to reduce anxiety and overstimulation more generally (e.g., not watching the news in front of Jack). Nevertheless, Jack's father continued to identify the cause of Jack's behavior as "not getting what he wants" and continued to deal with misbehavior at home using behavioral methods, such as drawing up a contract for the child to sign that said he would not hit others.

During the last parent session, Jack's father and the therapist reviewed the course of the treatment. They reflected together on a session where Jack hesitated to enter the therapy room and where Jack's father and the therapist had used different approaches. Jack's father had threatened to take away Jack's "points" if he didn't go into the therapy room, which in turn made Jack more resistant. Jack's therapist had said to Jack, "It's hard to go in the therapy room and

talk about difficult things." In response, Jack began to speak about difficult topics that he had not yet disclosed. Jack's father reflected that sometimes the point systems and other methods he had been using had felt "shaming and attacking" for Jack, and that perhaps using a different approach of addressing feelings could be a tool and skill to continue to develop and help instill in Jack.

The Case of Oliver

From the beginning of treatment Oliver's play lacked spontaneity and excitement, and he presented with a flat affect. Oliver engaged in socially appropriate play and repeatedly chose to play board games (i.e., Sorry and Checkers) throughout treatment, making it challenging to create opportunity for rich and imaginative play. Oliver's lack of verbal engagement, particularly at the beginning of treatment, made it difficult for the therapist to facilitate conversation and engage in meaningful play sequences. During Session 2 the therapist attempted to engage Oliver in conversation while he was building a Lego motorcycle, and he was not responsive.

Therapist*: It's going to be a colorful motorcycle.*

Oliver: [No response – continues building.]

Therapist*: Oh wow. You're stacking those pieces on there.*

Oliver: [No response - continues building.]

Therapist*: Oh, that's a new piece.*

Oliver: [No response - continues building.]

Therapist*: What part of the motorcycle is that?*

Oliver*: Steering wheel.*

Therapist*: Oh, the steering wheel. So it has a steering wheel, and some wheels, what else?*

Oliver:[No response - continues building.]

Therapist*: Adding more parts to the motorcycle. More parts?*

Oliver: [No response - continues building.]

Therapist*: What part of the motorcycle are you putting on now?*

Oliver*: The seat.*

Therapist*: The seat?*

Oliver*: Mhm.*

Therapist*: Ok. So you've got the steering wheel and the seat.*

Oliver: No response- continues building.

Therapist*: Wow, maybe he's ready to go.*

Oliver: [No response - pushes motorcycle to move.]

Therapist*: He's moving, but he fell down!*

Oliver: [No response - pushes motorcycle to move.]

Interactions similar to this one were present throughout treatment. Reflecting on the therapist's initial formulation, Oliver's awareness of the short-term nature of the treatment may have evoked pre-emptive feelings of loss, resulting in his need to push the therapist away. However, it seemed difficult for the therapist to be aware of this dynamic in the room. Instead, the therapist seems to be "holding" anxiety for both herself and Oliver, responding to his silence by continually attempting to find a way to connect. It is easy to imagine that this anxiety and uncertainty also pervaded the responses of other adults interacting with Oliver.

Nevertheless, it appeared that Oliver began to warm up to the therapist and became increasingly comfortable communicating with her over time. Toward the middle of treatment, during Session 6, Oliver was kneeling on the ground to open the toy cabinet and he saw the camera in the corner of the room, which was used to record sessions as part of the research trial. After seeing the camera, Oliver remained crouched on the ground with his body hidden behind the toy cabinet door. The therapist tried to interpret Oliver's body language and behavior and elicit his feelings about the camera.

Therapist*: I wonder why you're sitting all the way over there behind the door?*

Oliver: [No response - silently points to the camera.]

Therapist*: Oh, the camera?*

Oliver: [No response – silently nods.]

Therapist*: Hmm. What's with the camera. Remember I told you that the camera is just on so that I can remember everything that we do in here.*

Oliver*: Mhm.*

Therapist*: Seems like you still want to sit away from the ca…sit behind the door.*

Oliver: [No response – continues playing checkers.]

Therapist*: What do you think the camera is for?*

Oliver: [No response – continues playing checkers.]

[no talking for 1 minute– continues playing checkers]

Therapist*: Hmm I wonder if that's a checkmate. Not sure.*

[no talking for 1 minute – continues playing checkers]

Therapist*: You're really thinking about which one you should move.*

Therapist*: Hm. I wonder if it's easier to play checkers than to talk when the camera is there.*

Oliver: [No response - continues playing checkers.]

In this interaction, Oliver was reluctant to respond to the therapist's inquiries about the camera. Throughout the next few sessions, the therapist made many attempts to help Oliver understand his feelings about the camera. Oliver appeared inhibited throughout the next few sessions and remained silent or said "I don't know" when asked questions related to the camera. During Session 7, when the therapist commented, "Seems like maybe it [the camera] bothers you a little bit," Oliver replied, "No," immediately. It is unclear why Oliver was so disturbed by the camera; however, one can imagine that the camera might evoke feelings of being in trouble, or being watched, monitored, or "spied upon." The presence of a camera can also heighten feelings of insecurity. As the therapy has progressed, the therapist began to understand Oliver's silence as a self-protective mechanism. However, she had difficulty knowing what to do with Oliver's silence and stonewalling of her interpretations. Oliver seemed unable to approach even subtle hints at the difficult emotions being evoked by the camera (e.g., that the camera "bothered" him).

Understanding this, the therapist then took an indirect approach to communicating her understanding of Oliver's anxiety. During Session 10 the therapist selected a new game to play and laid it out for Oliver to see upon entering the room. When Oliver arrived, he was eager to play a new game and appeared more behaviorally engaged than in previous sessions. Through this action, the therapist communicated to Oliver that she understood it was too difficult for him to talk about things, and he responded by becoming more engaged.

After this session, Oliver was able to choose and participate in a more diverse array of activities within the session; however, the therapist continued to struggle to engage in rich and meaningful conversation with Oliver as treatment progressed. During Session 12 Oliver selected an arts and crafts game that he seemed eager to complete. The therapist tried to ask Oliver questions about the game and Oliver continued to respond in very few words.

Therapist*: Which one are you thinking?*

Oliver*: I'll finish this one.*

Therapist*: You want to finish that one?*

Oliver: [No response - continues opening box.]

Therapist*: Do you remember which one you had?*

Oliver*: Yeah. This one.*

Therapist*: I don't remember the one I was doing.*

Oliver*: You were doing that one (points).*

Therapist*: Oh, that one. How did your weekend go?*

Oliver*: Good.*

Therapist*: Did your [sibling] have [their] birthday party?*

Oliver*: Yeah.*

Therapist*: How was that?*

Oliver*: What?*

Therapist*: How was it?*

Oliver*: Good.*

Therapist*: Oh and it was Father's Day too, right?*

Oliver: [No response – continues playing.]

Therapist*: How was that?*

Oliver*: Good.*

[Continue to sit silently for several minutes.]

It appears that Oliver's minimal conversational engagement evoked anxiety in the therapist. As a result, the therapist continuously felt pressure to try to bring in "outside" material and had difficulty remaining experience near. While she expressed curiosity about Oliver's experience, Oliver's self-protective distancing made it difficult for her to remain centered on the case formulation and the use of RFP-C interventions. Rather than being a meaningful expression of his difficulty opening himself to a person who would soon leave his life, Oliver's silence was experienced as a behavior that needed to be modified.

During the last few sessions, Oliver began doing magic tricks for the therapist which created a shared experience between the patient and therapist and made for a more collaborative therapeutic relationship. During Session 16**,** the therapist let Oliver know that there were only a few minutes left of the session. Oliver ignored the therapists' comment and continued showing his magic trick. Similar to Oliver's behavior throughout treatment, he did not express emotions related to ending treatment and presented with a flat affect when told that there were only a few minutes left of the last session. Again, Oliver's silence and distancing can be understood as a self-protective response – one that Oliver needed to tightly hold onto within this short-term treatment.

Oliver*: And now for, for the paperclip one.*

Therapist*: So, we have about five more minutes.*

Oliver*: This one's also very similar. It doesn't have, it doesn't have any secret. It's just really about how you fold them.*

Therapist*: Ok.*

Oliver*: You go like...you fold it like in eight, like this – like you make sure that this paper clip goes here and that this paper clip holds this together.*

Therapist*: Seems like it's a bit hard to hear that we have five more minutes left.*

Oliver*:* [continues to show the trick] *Now that we pull. Oh..*

Therapist*: Instead it's easier to keep showing me the trick.*

Oliver*:* [continues to show the trick] *Now when we pull, like this, they join together.*

Therapist*: Oh, does that one have a mathematical explanation too?*

Oliver*: No, it's not from the same book.*

Therapist*: Oh, ok.*

[Oliver continues to show another magic trick.]

Work with Oliver's parents, which took place over four sessions throughout the treatment, centered on highlighting the meaning behind Oliver's disruptive behavior and supporting difficult parental feelings. From the beginning, Oliver's parents had many painful and difficult stories to share about Oliver's misbehavior. In particular, Oliver's mother shared her "heartbreak" that Oliver and his sibling did not get along. She also shared concerns over his tendency to hit children and adults alike and to call them names. The therapist introduced the Triangle of Conflict to the parents, who were readily able to identify possible feelings of insecurity, fear, and loss that might contribute to Oliver's behaviors. However, Oliver's parents described a general focus on behavior modification in response to tantrums and aggression, noting that, as a consequence for misbehavior, they often made Oliver recite reasons why he should not have done what he did.

In subsequent sessions, Oliver's mother continued to share instances of disruptive behavior, which were met with the same consequence – reciting reasons why the behavior was wrong. In response to these stories, the therapist continued to use the Triangle of Conflict to help Oliver's parents identify the feelings underlying Oliver's behavior. The therapist also explored other factors that might be contributing to Oliver's behavior, including a sensitive temperament and sensory sensitivities. Although they recognized the many contributors to Oliver's behavior, his parents continued to share concern, exhaustion, and disappointment about their family situation. The therapist responded empathically to these feelings; however, for the most part, the

ways in which Oliver's parents' own feelings might have contributed to their continued focus on behavior modification and logical reasoning was left unexplored. Ultimately, by the end of treatment, Oliver's parents reported having a broadened understanding of and ability to reflect on the "why" behind Oliver's behavior; however, they continued to be concerned about discipline and Oliver's ability to "adapt" to his environment.

7. THERAPY MONITORING AND USE OF FEEDBACK

Both Jack and Oliver's parents filled out the Oppositional Defiant Disorder Rating Scale (ODD-RS; Hommersen et al., 2006) on a weekly basis throughout treatment. This allowed the clinician to see how symptoms progressed throughout treatment and allowed for a weekly point of feedback between clinicians and parents about Jack and Oliver's and functioning at home. Overall, Jack's score on this measure decreased significantly from the highest possible score to below the clinical threshold for ODD; in contrast, Oliver's score at pre and post-treatment remained the same.

The therapists also participated in a weekly small group supervision meeting that was 90 minutes in length. During this weekly supervision meeting, the therapists played video clips of their sessions for the week and received feedback from an experienced psychodynamic therapist and one of the developers of the treatment approach. This allowed for the therapists to receive guidance, to have a further opportunity to reflect on and examine in-session defenses, and process countertransference feelings.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

The current study compares two RFP-C cases, one successful (Jack) and another unsuccessful (Oliver), with the aim of identifying possible client, parent, therapist, and therapy process variables that might explain differential treatment outcomes for children with irritability and disruptive behavior.

Child Factors

As shown in Table 1, Jack's scores on standardized measures significantly decreased on the ODD-RS, CBCL, ERC Lability Scale, ERQ-CA Reappraisal Scale, and ICU Parent-Report Callousness Scale from pretreatment to post-treatment. These significant improvement in scores indicate a successful treatment course, with both Jack and his father perceiving significant gains as a result of participating in RFP-C. As also shown in Table 1, in terms of the quantitative data, many of Oliver's scores were comparable from pretreatment to post-treatment, and no significant changes were noted. Thus, Oliver and his caregivers did not experience notable improvements in

problem behaviors after participating in RFP-C, and the course of treatment was considered unsuccessful.

Most child psychotherapy research relies primarily on quantitative outcomes such as these, provided by self or parent report. However, qualitative data as well as data on psychotherapy process helps to illuminate key factors that contributed to the variable outcomes of these two cases, selected from a larger randomized controlled trial of RFP-C.

The Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2009) was used to describe the psychotherapy process in the larger RCT sample overall, and for each participant individually. The CPQ is a 100-item child psychotherapy process measure adapted from the Psychotherapy Process Q-Set (PQS; Jones, 1985, 2000). The CPQ is a systematic quantitative coding system that assesses the processes of therapeutic change within a video-recorded child psychotherapy session (Schneider, 2004; Schneider & Jones, 2004). Independent raters watch a videotaped psychotherapy session and sort 100 statements into nine categories, ranging from least characteristic (Pile 1) to most characteristic (Pile 9) of the observed child psychotherapy session.

The CPQ statements fall into one of three categories:

1) description of the child's attitudes, emotions, behaviors or experiences, e.g*., Child expresses negative feelings (criticism, hostility) toward therapist (vs. expresses approval or admiration);*
2) description of the therapist's behaviors and attitudes, e.g., *Therapist points out child's use of defenses;* and
3) description of the style of the dyad's interaction or the atmosphere of the session, e.g., *Therapist tolerates child's strong affect or impulses* (Schneider, 2004).

To increase reliability, the CPQ includes a coding manual that provides clear definitions and examples of each item and instructions for how to classify each statement (Schneider & Jones, 2004). Interrater reliability among trained coders has consistently reached .70 or higher (Ramires et al., 2017) and its discriminant validity has also been demonstrated (Goodman et al., 2016; Schneider et al., 2009). Furthermore, a recent study examined 60 child sessions that were coded by a team of 10 raters using the CPQ. Process ratings for each of the 100 items on the CPQ were averaged by two raters across five different teams. Interrater reliability across teams reached .76 (Prout, Goodman et al., 2022).

Table 2 lists the ten most and least characteristic items in Jack and Oliver's therapy sessions. Both Jack and Oliver's sessions were notable for avoidance of feelings. One of Jack's

most characteristic items was "58. Child is distant from his or her feelings"; and one of Oliver's most characteristic items was 40. "Child communicates without affect."

Oliver and Jack both frequently made attempts to push their therapists away. However, Jack was able to express negative feelings, such as hostility and aggression, toward his therapist (see item 1 for Jack in Table 2). Thus, Jack's communication, while overtly negative at times, provided opportunities for the therapist to clarify his communications and speak about affectively laden events such as the end of the session or termination of the treatment. In contrast, Oliver did not express many feelings toward the therapist at all (see item 40 for Oliver in Table 2. Thus, Jack's communication, while overtly negative at times, provided opportunities for the therapist to clarify his communications and speak about affectively laden events such as the end of the session or termination of the treatment.

Another major difference between Jack and Oliver's process is in the description of their play. One of Jack's most characteristic process items is "71. Child engages in make-believe play," which allowed him to convey his feelings indirectly. In contrast, one of Oliver's most characteristic items is "95. Child's play lacks spontaneity," reflecting that he was afraid or unable to express his feelings indirectly.

As a result, while both Jack and Oliver's therapists were described as developmentally attuned, Oliver's therapist felt pressure to encourage Oliver to speak and engage more in the treatment, reflected in item "3. Therapist's remarks are aimed at encouraging child's speech."

A study conducted by Prout, Goodman, and colleagues (2022) examined aspects of psychotherapy processes that were most characteristic of child sessions in RFP-C. The study highlighted the importance of both therapist and child contributions to psychotherapy process. Specifically, the study found that therapist attunement, responsiveness, and nonjudgmental stance helped children feel understood and safe, which yielded more favorable treatment outcomes (Prout, Rice et al., 2022). Furthermore, the study highlighted the child's level of engagement and participation in therapy as an important factor that contributes to successful treatment outcome (Prout, Rice et al., 2022).

The findings of the current comparative case study reveal that Jack and Oliver's varying abilities to engage in play and express feelings toward the therapist directly impacted their experiences in RFP-C. Furthermore, Jack and Oliver's differing levels of comfort with the camera in the room, used to record the psychotherapy session, likely influenced their therapy experiences. Although the use of recordings in therapy sessions is widespread, there is little research regarding patient's reactions toward the use of audio or video recording in psychotherapy sessions. According to Alpert (1996), many individuals presume that recording therapy sessions results in increased anxiety for both therapists and patients. A university-based

study examining patient's comfort with recording psychotherapy sessions found that individuals with interpersonal sensitivity and paranoid ideation were less comfortable with audio or video recording (Briggie et al., 2016).

After seeing the camera in session, Oliver told his mother that he was not going to speak. Evidently, Oliver experienced anxiety related to the camera which impacted his willingness to communicate with the therapist and fully engage in treatment. Furthermore, at intake Oliver's parents endorsed that Oliver has consistently experienced interpersonal challenges throughout his life. In line with the findings of Briggie and colleagues (2016), it is likely that Oliver's interpersonal sensitivity and paranoid ideation caused him to have an aversive reaction to the camera in the room and negatively impacted treatment outcomes. Though Oliver became more comfortable and conversational over time, there were many sessions when Oliver said few words and engaged solely in structured play, making it challenging for the therapist to highlight his emotions and defense mechanisms to help him understand his inner experience. Tying Oliver's behavior back to the therapist's initial formulation, Oliver's silence in the presence of the camera can be seen as a defense in itself; a way of protecting himself against feelings of vulnerability. However, since this reaction to the camera was situated within the larger context of Oliver remaining largely unresponsive to the therapist during treatment, the therapist seemed to have trouble responding to Oliver's avoidance of the camera effectively.

Unlike Oliver, Jack did not experience anxiety related to the camera in the room and was verbally and behaviorally engaged throughout treatment. During Jack's post-treatment interview, he reported that he became "less shy" and better able to speak to his therapist as a result of therapy. Jack's anxiety and feelings of anger and frustration manifested in playing out war scenes during therapy. Jack's action-packed play made it possible for the therapist to make meaningful comments and therapeutic interpretations to help Jack gain better insight into challenging emotions, including anxiety and anger.

There is ample adult psychotherapy research highlighting that the client's active involvement in the therapeutic process is a crucial factor for successful psychotherapy outcome (Bohart & Tallman, 2010). This finding carries over into psychotherapy with youth; parental and child willingness to participate in treatment both have a significant effect on psychotherapy outcomes (Karver et al., 2006). Children and parents who willingly participate and collaborate with the therapist are more likely to achieve successful treatment outcomes when compared to clients who are less participatory and/or defensive throughout the course of treatment.

Jack's ability to engage in imaginative play, and willingness to let the therapist be part of his play, helped the therapist better understand him and feel more connected to him, thereby helping him achieve positive therapeutic outcomes. Overall, when compared to Oliver's

experience as a more inhibited client, Jack's high level of activity, creativity, and willingness to engage in the therapeutic process despite at times negative feelings yielded more successful treatment outcomes.

Post-treatment interviews provide further insight into Jack and Oliver's experiences of RFP-C treatment. When asked why he was attending therapy, Jack replied, "Because I have sensory processing disorder, I think. Because I am different. Because I am an outcast." When asked the same question, Oliver demonstrated less insight into his challenges and explained that he did not know and was only attending because his mother told him to. During the post-treatment child interview, both Jack and Oliver were asked to share about a conversation they remembered from therapy. Jack recalled many details and expressed anxiety related to this moment in therapy. Jack stated, "I remember one about (long pause) something that will get me arrested." Jack said he told the therapist about an army that he was part of. Jack explained that the government would not like the army because they would be scared that it would become "too powerful and overwhelm them." While recalling this conversation, Jack said, "If you want to know about it, to make sure it's not a bad thing, you could ask [therapist's name]." He continued to assure the interviewer that "it wasn't a bad thing" and said "so don't tell the police, because I will get arrested and sent to the hospital. I will probably be killed by a shot. A shot will go in with poison and murder me." In contrast, Oliver shared that his therapist explained to him that everyone has feelings, which had a positive impact on him and made him feel good to know that he is not alone.

When asked about their feelings when first attending therapy, Jack reported that he was "shy" and Oliver reported that he was "scared." Oliver began to warm up initially; however, after seeing the camera in session he told his mother "I'm just not gonna say anything. I'm not gonna talk at all because of the camera."

During the post-treatment child interview, Jack described therapy saying, "One word to describe it is hell. The other is the worst thing on earth. The other is for disorganized kids who are an outcast and who are different." When asked what he liked about therapy, Jack reported that it was "kinda fun," but he was glad when it ended because it "took up too much time." Jack also reported that his patience improved as a result of participating in therapy.

Oliver reported, "I had the opportunity to speak to my therapist about incidents, but I didn't want to because I wanted to keep them to myself." While Oliver was reluctant to share personal information, especially after seeing the camera in the room, he reported that he liked playing games during therapy and thought it was "fun." When asked how he would describe therapy to a friend, Oliver said "I would say that therapy is when a psychologist [I don't know what to say…] talks about your feelings with you."

Interestingly, although Jack engaged in the therapy process more than Oliver, and had more successful treatment outcomes, he did not appear to enjoy the experience as much as Oliver.

A study conducted by Carlberg and colleagues (2009) revealed that a child's ability to articulate important personal experiences and problem areas, and demonstrate positive expectations of the therapy process prior to treatment, resulted in positive overall post-treatment experiences. Thus, it is likely that Jack's awareness of why he was in therapy and willingness to discuss his problematic behaviors and feelings (despite some anxiety about doing so) allowed him to benefit more from therapy when compared to Oliver, who demonstrated less insight into the reasons for his participation.

Parent Factors

In addition to considering child factors that impacted treatment outcomes (i.e., differing levels of anxiety, and capacity and willingness to engage in symbolic play), it is also important to consider parent factors that impacted treatment outcomes. Shirk and Karver (2003) emphasize that parent willingness to participate in treatment is moderately related to treatment outcomes. If parents are actively engaged in treatment, it is likely that they will gain a better understanding of their child's behavior and acquire skills to help increase desired behaviors and decrease undesired behaviors. This, in turn, creates an environment that is well suited to support positive therapeutic outcomes (Karver et al., 2006).

In post-treatment interviews, both parents reported a change in the way they perceived and now understood their children's externalizing behaviors. Jack's father was able to articulate that RFP-C had a direct impact on his understanding of his son. Jack's father reported that the therapist's insight offered him "another perspective on what he [Jack] might be going through or how to approach him." Similarly, Jack's father reported that he gained a "steady progression of further understanding" and feels "more connected with the child's feelings" after participating in RFP-C. During the post-treatment parent interview, the therapist recalled that she told Jack's father that psychodynamic therapy was less skills-based than CBT, and Jack's father replied, "If you can learn to see the behaviors differently, then that's a skill in and of itself."

Oliver's mother reported that she learned that Oliver's defiant behavior is often a result of anxiety and nervousness. Oliver's mother reported that Oliver appears "calmer at home"; however, she explained "I don't know if it's the result of therapy." When discussing the benefits of the treatment, Oliver's mother replied, "I can't pinpoint what exactly it was, but it does seem to have had a positive effect." When asked how helpful therapy was to their child on a scale of 1-10, Jack's father reported 7 and Oliver's mother reported 8, indicating that both parents felt RFP-C was beneficial to their children overall.

The above-mentioned Psychotherapy Process Q-Set (POS; Jones, 1985, 2000) was used to examine the therapeutic process within parent sessions of RFP-C. As mentioned, the PQS is a pan-theoretical instrument used to identify how specific components of the psychotherapy process impact therapeutic change. In RFP-C, the PQS is utilized to examine the psychotherapy processes within four video-recorded psychoeducational parent sessions. Independent raters watch a videotaped psychoeducational parent session and sort 100 statements into nine categories, ranging from least characteristic (Pile 1) to most characteristic (Pile 9). The instructions facilitate a forced normal distribution by specifying the number of items required in each of the nine categories. The statements describe the therapist behaviors, patient behaviors, and therapist-patient interactions. Each statement is worded in neutral and descriptive language in order to decrease the amount of inference required by the rater. The PQS has demonstrated high reliability and validity across a variety of treatment samples and therapeutic modalities, with inter-rater reliability ranging from .83 to .89 per rater pair, and single-item reliability ranging between .50 and .95 across samples (Ablon, Levy, & Smith-Hansen, 2011). The most and least characteristic items from Jack and Oliver's parent sessions are presented below in Table 3.

A study conducted by Kufferath-Lin and colleagues (2021) examined psychotherapy processes of the parent component of RFP-C and closely examined the most and least characteristic aspects of psychotherapy process in RFP-C parent sessions. Process ratings for all items on the PQS were average across five raters. This PQS demonstrated high reliability, and interrater reliability across all sessions was .93 (Kufferath-Lin et al., 2021). Kufferath-Lin and colleagues (2021) found that discussion of the parent's current life situation and interpersonal relationships were two of the most characteristic items of RFP-C process in parent sessions.

Similarly, two of the most characteristic items of Jack and Oliver's RFP-C parent sessions were discussion of the parent's current life situation and interpersonal relationships (items 63 and 69). These two main foci highlight parents' emphasis on discussing their child and current challenges related to their child's behavior. Both Jack's and Oliver's parents brought up significant issues and material in session, demonstrating their engagement in the process. These findings support the notion that RFP-C parent sessions are characterized by collaboration between the therapist and parents, with the goal of helping parents better understand the meaning behind their child's challenging behaviors. By helping parents recognize that disruptive behavior is meaningful and stems from avoidance of difficult feelings, parents are able to approach children in a sensitive manner, help them better understand their own emotions, and create an environment that enhances emotional self-regulatory capacities (Kufferath-Lin et al., 2021).

One salient quality of Jack's father's parent sessions was that the therapist frequently asked for more information and offered suggestions and interpretations for the meaning of

others' behavior. The therapist explained Jack's oppositional and defiant behavior as a manifestation of anxiety about being bombed, which achieved a main goal of RFP-C parent sessions by helping Jack's father understand that disruptive behavior has meaning (Hoffman et al., 2016). More specifically, Jack's father reported that the therapist's insight helped him understand Jack's experience from a different perspective, helped him feel more connected to Jack, and resulted in improved parent-child communication.

Interestingly, although Oliver's treatment outcome was unsuccessful, his mother's commitment to the work of therapy and explicit discussion of goals for treatment were two of her most characteristic PQS items (items 73 and 4, respectively). In terms of the therapist-focused items, it was highly uncharacteristic for either therapist to be condescending, tactless, or aloof, which created a supportive and non-competitive therapeutic environment (see, for example, item 45 for Jack's parent and item 6 for Oliver's parent). Of particular note, the therapist working with Oliver's mother was empathic and attuned to her feelings. In both cases, the therapist explained the rationale behind RFP-C and communicated with the parent in a clear and coherent style, which represents the therapist's attempt to build a strong therapeutic alliance and contributes to a positive parent-therapist interaction (Price & Jones, 1998).

During the post-treatment parent interview, the therapist recalled a salient moment where Jack's father verbalized the purpose of RFP-C in a clear and concise manner, which demonstrated his understanding of this intervention. It is likely that the therapist's supportive stance, curiosity, and tendency to ask for more information to better understand Jack's father served as a helpful model for how Jack's father can interact with Jack. Parent sessions can be utilized to model reflective functioning, and help parents increase their ability to adopt a curious and non-defensive approach to understanding the meaning of their child's behavior (Hoffman et al, 2016). It is apparent that Jack's father increased his reflective functioning capacities throughout treatment, thereby allowing him to interpret Jack's behaviors as products of internal emotional states (Fonagy et al., 1991), likely contributing to the successful treatment outcome.

During the post-treatment parent interview with Oliver's mother, she articulated that Oliver appeared calmer. However, she was not able to identify the impact of RFP-C on Oliver's current behavior, and she stated that she was not sure if his change in behavior was a result of engaging in therapy. When compared to Jack's father's ability to identify specific skills he learned, and ways that therapy directly benefited Jack and the parent-child relationship, it appeared that Oliver's mother may not have understood the treatment approach and intended purposes of RFP-C as well as Jack's father.

Parental Defenses

Parental defense mechanisms are also important to examine when considering factors that contribute to different treatment outcomes. A parent's characteristic defense mechanisms can influence the way they cope with their child's distress (Cramer & Kelly, 2010; Senberg et al., 2023); children often internalize these characteristic ways of handling emotions, whether adaptive or maladaptive. A study of parental defense mechanisms using data from parents in the RFP-C randomized controlled trial found that parents in the study used affiliation, humor, suppression, and devaluation of others' image more frequently than community controls (Di Giuseppe et al., 2020). Moreover, a parent's characteristic defenses can influence their ability to utilize treatment strategies outside parent sessions. For example, a parent who uses affiliation may be more likely to adopt the therapist's reflective stance, whereas a parent who typically uses denial or devaluation may be less likely to do so (Di Giuseppe et al., 2020).

Parental defense mechanisms in the current study were coded with the Defense Mechanism Rating Scale Q-Sort (DMRS-Q; Di Giuseppe et al., 2014) using videos of parent sessions from the treatment phase. The DMRS-Q is an observer-rated, computerized, method for assessing defense mechanisms (Di Giuseppe & Perry, 2021). The DMRS-Q is a modification of the original Defense Mechanism Rating Scale (DMRS; Perry, 1990), which is the closest method to a criterion for identifying defenses. The DMRS-Q assesses 30 individual defenses based on the seven hierarchical levels of defenses, ranging from immature defenses to mature defenses: action, major image-distortion/borderline, disavowal, minor image-distortion/narcissistic, neurotic, obsessional, and high adaptive defenses (Di Giuseppe & Perry, 2021). The DMRS-Q is comprised of 150 statements and takes 30 minutes to complete.

The computerized DMRS-Q was created to address the limitations of the DMRS, which relied on transcripts of sessions, and provides clinicians and researchers with a reliable and valid measure for detecting defense mechanisms. Raters are provided with a DMRS-Q tutorial, where rating processes are explained in greater detail. Once ratings are complete, the software automatically provides the Defensive Profile Narrative (DPN), which is a qualitative description of the participant's defensive profile. The software also provides quantitative scores of 30 individual defenses, 7 defense levels, and Overall Defensive Functioning (ODF) (Di Giuseppe & Perry, 2021).

A case study comparing results from the DMRS and the DMRS-Q reveals that the two scales similarly measure defense mechanisms, indicating well-established validity and reliability of the DMRS-Q (Di Giuseppe et al., 2014). These results have been confirmed in a recent validation study (Békés et al., 2021), which also demonstrated that both trained and untrained raters were able to assess defenses with moderate to excellent reliability on the DMRS-Q,

although untrained coders showed slightly lover reliability than rater who have receive the DMRS-Q training.

Tables 4 and 5 represent the most characteristic defenses present in Jack and Oliver's parent sessions. Jack's father and Oliver's mother both utilized humor, which allows for the expression of unpleasant feelings in an adaptive way. Humor is not a one-dimensional construct; Martin and colleagues (2003) highlighted different types of humor—self-enhancing and self-defeating—and their variable outcomes. The DMRS-Q humor construct focuses on the self-enhancing type which tends to relieve the tension in a way that allows everyone to share in it, rather than being at one person's expense, as in derisive or cutting remarks (e.g., self-defeating humor, which would likely be coded as devaluation in the DMRS-Q).

Jack's father also utilized several higher-order defenses, including self-assertion, and affiliation. High-adaptive defenses are advantageous when navigating adverse experiences, while lower-adaptive defenses may be problematic and lead to avoidance of important thoughts and feelings (Békés et al., 2023; Fiorentino et al., 2024; Porcerelli et al., 2016). Notably, use of humor and affiliation have been shown to be common among parents of children with oppositional defiant disorder (Di Giuseppe et al., 2020). Furthermore, it is likely that parents who are able to rely on more adaptive defenses may be better able to help their children understand, and cope with, their own painful emotions (Porcerelli et al., 2016).

Results of the DMRS-Q indicate that Jack's father had an ODF of 5.76 (possible range 1-7), which was in the non-clinical/adaptive range. In addition to higher level, adaptive defenses, Jack's father also demonstrated use of neurotic defense mechanisms, such as repression. Repression involves excluding disturbing mental content from awareness (Prunas et al., 2019). Jack's father demonstrated repression by offering vague and non-descriptive explanations for topics that might have been unpleasant or emotionally loaded. Research demonstrates that repression is linked to an avoidant attachment style (Prunas et al., 2019). Jack's father's use of the minor image-distortion defense of devaluation of self-image may have, in some ways, served his child and provided an entry point for the therapist. When parents volunteer comments about their own shortcomings as parents it communicates an openness to identifying ways they might adapt or modify their responses to a disruptive child.

In her meeting with the therapist, Oliver's mother demonstrated the use of many high-adaptative defense mechanisms, including humor, affiliation, self-observation, and self-assertion. Oliver's mother's Overall Defensive Functioning (6.12, possible range 1-7) was in the non-clinical/adaptive range and was slightly higher than Jack's father's ODF.

Oliver's mother's most salient defense mechanisms were self-observation and humor, higher-level defenses which have been shown to be prevalent in adulthood (Diehl et al., 2014).

Self-observation serves an important function in allowing parents to adapt to the demands of an external reality (in this case, parenting a child with disruptive behaviors) while also maintaining an accurate view of themselves as parents. This defense is a precursor to seeking growth and adaptation in the face of stress. Parent work in RFP-C, in fact, relies on parents' ability to activate this defense in order to conceptualize the child's distress and their own responses, using the Triangle of Conflict. Although it did not lead to a favorable treatment outcome, it is likely that these abilities assisted Oliver's mother in developing a more nuanced perspective on Oliver's emotional and behavioral needs.

Parental Attachment Style

Parental attachment style has been linked to numerous outcomes with children including maltreatment and failure to thrive (Jones & Cassidy, 2014; Lo et al., 2019). The Patient Attachment Coding System (PACS; Talia et al., 2014; 2017) was used to classify Jack's father's Oliver's mother's attachment styles. The PACS classifies an individuals' attachment style based on in-session verbalizations (Talia et al., 2017). To determine attachment patterns, therapy sessions were recorded, transcribed, and then coded line by line. Coders used 27 specific attachment markers that are each correlated with one of three main attachment scales: Proximity Seeking, which measures the patient's ability to seek emotional closeness; Exploring, which measures the patient's capacity to demonstrate reflective functioning; and Resistance, which measures the patient's tendency to distance themselves from others. The coder counted the number of times each attachment marker appeared in the session transcript and then classified the patient in one of three attachment categories: Balance (secure), Avoidant (dismissing), and Resistant (preoccupied) (Talia et al., 2014; 2017).

Jack's father exhibited an avoidant attachment style. It is common for avoidantly attached individuals to deactivate emotion regulation strategies, downplay emotional experiences, deny attachment-related needs, and avoid support from others (Mikulincer & Shaver, 2003). Therefore, it is possible that Jack's father downplayed Jack's emotional and behavioral challenges throughout his life, and especially at the end of treatment, which could have contributed to more successful treatment outcomes for Jack. Since the behavior of caregivers is often a child's first example of social interaction and norms, it is likely that Jack's father's avoidant attachment style informed the way Jack learned to communicate interpersonally. It is possible that Jack therefore had more to gain from a therapeutic space where feelings could be expressed openly, as opposed to Oliver, whose parent was perhaps more capable of providing this kind of space.

Unlike Jack's father, Oliver's mother demonstrated a secure attachment style. A secure attachment is characterized by consistency, comfort, safety, and understanding. A secure

attachment is linked to a caregiver's ability to meet the physical and emotional needs of their child, which allows the child to develop reliable expectations, a sense of security, and a willingness to explore the world more comfortably, knowing that their caregiver will be present and responsive during a time of need (Bowlby, 1977,1988).

Therapist Factors

It is also critical to consider the influence of therapist factors in treatment. Post-treatment interviews provided information about both therapists' feelings toward Jack, Oliver, and the therapy. Jack's therapist reported that Jack had a "very active imagination" and that "his play led the sessions." The therapist commented that she felt bored in sessions occasionally and viewed herself as a "secondary in the room." The therapist reported that she realized that Jack's routine and rigid play of creating war scenes was actually a strength of his, as he was playing out his internal fears rather than having to speak about them.

Oliver's therapist reported that the beginning of treatment was "very slow", and although Oliver became more comfortable, talkative, and engaged over the time, he never got to the point where he felt completely comfortable in session. The therapist highlighted that his quiet disposition made her feel anxious and uncertain about how to approach treatment. Furthermore, Oliver's therapist reported feeling like she was "interchangeable" and like any therapist could take her place. Both therapists reported that they could have benefitted from working with Jack and Oliver for a longer period of time, as they believed both patients' underlying anxiety could have been addressed more directly if time allowed.

Therapist Countertransference

The Therapist Response Form (TRF; Zittel et al., 2005) was used as a measure of therapist countertransference. The TRF is a 79-item, self-report questionnaire that measures a wide range of the participating clinician's thoughts, feelings, and behaviors toward their patients. The statements are written in simple language so that clinicians can use the tool without bias. Therapists rate each item on a five-point Likert scale, ranging from 1 (Not True) to 5 (Very True).

The TRF measures countertransference along eight dimensions derived by factor analysis: (1) overwhelmed/disorganized, e.g., "I feel resentful working with him/her"; (2) helpless/inadequate, e.g., "I feel I am failing to help him/her"; (3) positive e.g. "I look forward to sessions with him/her"; (4) special/overinvolved, e.g., "I disclose my feelings with him/her more than with other patients"; (5) sexualized, e.g., "I find myself being flirtatious with him/her"; (6) disengaged, e.g., "I feel bored in sessions with him/her"; (7) parental/protective, e.g., "I feel like I want to protect him/her"; and (8) criticized/mistreated, e.g., "I feel unappreciated by him/her". The TRF has demonstrated good internal consistency (Betan et al., 2005). The following

Cronbach's alpha values were obtained for the eight factors: overwhelmed/disorganized (.79), helpless/inadequate (.87), positive (.84), special/overinvolved (.75), sexualized (.80), disengaged (.78), parental/protective (.80), and criticized/mistreated (.84).

The means, standard deviation, range, and alphas for each of the eight countertransference dimensions are presented in Table 6. As shown, Jack's therapist endorsed high scores on the Positive/Satisfying domain of countertransference. These endorsements on the TRF align with the therapist's comments in the post-treatment therapist interview data. In contrast, Oliver's therapist endorsed high scores on Helpless/Inadequate, Disengaged, and Criticized/Mistreated domains of countertransference.

Jack's Therapist

Jack's therapist 's high scores on the Positive/Satisfying domain of countertransference indicate experiencing a positive working alliance and close connection with the patient (Betan & Westen, 2009). While Jack's therapist felt sad and overwhelmed by Jack's needs and experienced occasional boredom and annoyance with him throughout treatment, she felt very nurturant toward him in general. Jack's therapist reported that she found it exciting to work with Jack, liked him very much, and looked forward to their sessions together. Jack's therapist did not feel confused or disengaged in sessions at all during treatment and endorsed that she felt like she understood Jack and his inner world well. As indicated by the TRF, Jack's therapist felt like she had a strong therapeutic relationship with Jack and was able to help him throughout treatment. Thus, Jack's therapist CT behavior likely had a positive impact on the therapeutic relationship and created a more enjoyable and successful therapeutic process.

Oliver's Therapist

The TRF demonstrated that Oliver's therapist experienced challenges when working with Oliver in RFP-C. When compared to the overall sample and Jack's therapist's report, Oliver's therapist endorsed high scores on Helpless/Inadequate, Disengaged, and Criticized/Mistreated domains of countertransference. The Helpless/Inadequate subscale depicts feeling overwhelmed, anxious, and worrying about not being good enough; the Disengaged subscale represents feeling bored, disengaged, and irritated; and the Criticized/Mistreated subscale represents feeling underappreciated, dismissed, or experiencing an urge to "walk on eggshells" around the patient (Betan & Westen, 2009).

A study by Dose and colleagues (2022) found that among children with a primary diagnosis of ODD or conduct disorder, the strength of the therapist-patient alliance at the beginning of treatment predicted symptomatic improvement by the end of therapy. This may be because of the ways in which a poor working alliance can impact the client and therapist's feelings, and thus the therapeutic process. According to Hayes & Gelso (2001), the therapist's

countertransference (CT) has the capacity to negatively influence the working alliance between the therapist and the client. Specifically, the therapist's attitude toward a client can influence important process variables including the client's willingness to engage in treatment and the depth of the therapeutic relationship (Colli & Ferri, 2015).

Oliver's therapist reported that she felt bored, confused, and frustrated in sessions with Oliver (i.e., Disengaged). Throughout treatment, the therapist tried to intervene by making various comments, interpretations, and asking questions. However, Oliver's tendency to limit his verbalizations and play structured board games, rather than engage in make believe play, made it increasingly challenging for the therapist to adhere to the RFP-C protocol. As a result of sitting alongside Oliver and watching him play or being met with resistance when trying to narrate or join the play, the therapist did not feel fully engaged with Oliver and thought that Oliver might do better with another therapist or a different type of treatment (i.e., Criticized/Mistreated).

Oliver's rigid and routine play, and lack of spontaneity or imaginative play, resulted in the therapist feeling like she was "interchangeable" and did not matter so much in the therapy room. Due to challenges with communicating and engaging in play with Oliver throughout treatment, the therapist reported that she felt less successful helping Oliver than other patients and expressed worries about feeling like she was not helping him (i.e., Helpless/Inadequate).

According to Hayes & Gelso (2001), therapists are more likely to act on negative CT if they have difficulty managing their own anxiety regarding the therapeutic relationship. Anxiety and negative countertransference are common experiences for therapists working with children with disruptive behavior problems (Hoffman, 2015). Acting on one's own countertransference is less likely to occur when a therapist has strong conceptualization skills and can employ appropriate interventions to target the patient's symptoms (Hayes & Gelso, 2001). Thus, it is likely that Oliver's therapist's confusion about how to successfully engage him in treatment, while following the RFP-C protocol, led to feelings of anxiety, thereby increasing CT behavior. According to Colli and Ferri (2015), CT can manifest in the therapist withdrawing from the client and creating a relationship that is characterized by under-involvement.

Taken together, the therapist's feelings toward Oliver likely impacted the working alliance and made for a challenging therapeutic environment. It is also possible that Oliver's own sense of helplessness and disengagement led to a parallel process in which the therapist experienced similar feelings about the treatment, and this may have contributed, in part, to the unsuccessful treatment outcome.

Implications of this Comparative Case Study

In summary, a dual case study method was utilized in this project to compare the effects and process of two RFP-C cases, one (Jack) with a positive treatment outcome and one (Oliver)

where the child's symptomatic functioning remained the same. A simplified summary of the quantitative and qualitative study results can be found in Table 7, including 11 items of data. Specifically, the project examined:

- Quantitative outcome data (items 1-6 in Table 7).
- Psychotherapy process coding, using the Child Psychotherapy Q-Set (CPQ) for child sessions and the Psychotherapy Process Q-Set (POS) for parent sessions (items 7 and 8);
- Parental defense mechanism data from the Defense Mechanisms Rating Scale Q-Sort (DMRS-Q; item 9
- Countertransference measures from the Therapist Response Form (TRF, item 10)
- Parent attachment style measures from the PACS = Patient Attachment Coding System (PACS, item 11); and
- qualitative interviews with the child, parent, and therapist at the end of treatment.

We believe the findings of this study yield important contributions to the literature on therapeutic outcomes for children and families by identifying some of the essential characteristics of successful psychotherapy process in these two contrasting-outcome cases who presented with the same problem and who received the same, manualized treatment. In particular, items 1-6 in Table 7 document Jack and Oliver's contrasting response to treatment. Items 7 and 10 reflect that when a child is willing to engage and collaborate with the therapist, it helps the therapist understand the child and feel more connected to them, which contributes to a strong therapeutic alliance.

Child Anxiety and Level of Awareness About Engaging in Therapy

This case study comparison indicates the importance of considering how a child's level of anxiety in the therapy room impacts treatment. As reflected in Oliver's case, high levels of anxiety about participating in therapy (e.g., his great concern over the camera) can result in limited speech and highly structured play (see item 7 in Table 7). Lack of speech, spontaneity, and imaginative play directly impacts the therapist's ability to intervene, and, in the case of RFP-C, makes it challenging to highlight a patient's emotions and defense mechanisms. Due to uncertainty about how to successfully intervene, highly anxious children might be less likely to understand their experience compared to their less anxious peers.

In addition, based on Jack's and Oliver's post-treatment interviews, this study highlighted the relationship between a child's level of awareness about engaging in therapy (high for Jack and low for Oliver) and successful therapeutic outcomes (positive for Jack and negative for Oliver).

Due to the time limited nature of the manualized RFP-C treatment, each patient's course of treatment included only 16 child therapy sessions and four parent sessions. As evidenced by Jack and Oliver's variable abilities to open up to the therapist and become increasingly comfortable over time, a longer course of treatment may have yielded a greater therapeutic outcome for Oliver. Given Jack's enthusiasm for the work of therapy and his capacity for imaginative play, little was required to draw him into the therapeutic relationship. In contrast, Oliver was a reluctant participant, often silent and withdrawn, and this was paralleled in the therapist's countertransference, with a sense of confusion and frustration as she tried to reach him.

Early assessment of a child's willingness or ability to engage in therapy may be helpful in adapting therapeutic interventions like RFP-C for children like Oliver to foster greater participation in the therapeutic relationship. Most research in this area has focused on motivational interviewing (MI) techniques with parents seeking Parent-Child Interaction Training (PCIT; N'zi et al., 2017; Webb et al., 2017) and with adolescents receiving treatment for conduct problems (Clair-Michaud et al., 2016; Gallagher et al., 2010). Some researchers have cautioned against using MI with elementary aged children (Strait et al., 2012) because MI requires cognitive processes such as self-appraisal, planning, and theory of mind that are not well-developed at this stage of childhood. However, perhaps a helpful adjunctive technique with children like Oliver could be a modified version of MI, more in line with Collaborative/Therapeutic Assessment (Finn et al., 2012; Tharinger et al., 2009). In this approach to child assessment, clients are encouraged and invited as full partners in the assessment process itself to explore how their test scores and patterns reflect who they are in their daily lives and how they can learn to cope with the challenges in their lives. Thus, resistant clients like Oliver could be identified and actively engaged in the therapy process at the initial, assessment phase of therapy.

Parent Engagement

Parent engagement (item 8 in Table 7) in both cases was high relative to broadly documented challenges of engaging parents in treatment for disruptive behaviors (Martinez et al., 2017). This participation level—with both children's parents attending all required parent sessions—may be due to the framework of RFP-C which includes psychoeducation that begins in the first parent session; detailed discussion of the causes and meaning of disruptive behavior; and a collaborative approach to achieving the goals of therapy. Notably, these components have been shown to predict parental involvement in treatment for child disruptive behavior (Martinez et al., 2014). Moreover, Jack and Oliver's parents were not distinctive for RFP-C clients. In the larger randomized controlled study involving RFP-C therapy, from which Jack and Oliver's case studies are drawn, 91.8% of participants completed the treatment protocol. Additionally, as

mentioned above, the larger RCT sample demonstrated high compliance rates among treatment completers with 98.5% of scheduled sessions attended by children and/or their parents (Prout, Rice, et al., 2022).

As also mentioned above, a distinctive strength of RFP-C is its high percentage rate of treatment engagement for both parents and children in the 90's. This is as compared with high dropout rates in the most popular alternative to treating disruptive behaviors, that is, behavioral parent training (BPT) approaches which emphasize work with parents more so than with the child. Specifically, Chacko et al. (2016) found that "at least 25% of those identified as appropriate for BPT not enrolling in such programs. An additional 26% begin, but drop out before completing treatment, ... with a combined dropout rate of at least 51 %" (p. 204).

Parent Defense Mechanisms and Attachment Style

We collected standardized quantitative measures on Jack and Oliver's caregivers – Jack's father and Oliver's mother. The results on these measures, together with the post-treatment interviewers with these caregivers, did not show any differences that could account for the differential outcome results in Jack's and Oliver's treatments.

Limitations to This Case Study Comparison

There are several limitations to this study. First, since this study largely utilized qualitative and observer-rated data, it is important to consider how researcher bias might impact the results (University of Southern California Guides, n.d.). In this regard, it should be noted that even though the researchers are developers and promoters of RFP-C, they did not have a bias towards positively seeing the impact of RFP-C since the case of Oliver was chosen specifically because of his failure to profit from RFP-C treatment. Also, the use of standardized, quantitative measures provided a less potentially biased balance to the use of the researchers' observations per se. In addition, the results for Jack and Oliver are strengthened by their consistency with the results from the larger, randomized control study of RFP-C (Prout, Rice, et al., 2022).

A second limitation was in the caregiver ratings of Jack. In the cases participating the RFP-C study, like Jack and Oliver, parents were required to complete measures at intake, before treatment began, and when treatment had ended. Oliver's mother completed all measures at intake and outtake, which made it simple to compare his mother's pretreatment and post-treatment ratings on various measures.

On the other hand, Jack's mother completed all pretreatment measures and spoke with the therapist on the phone prior to beginning treatment. The therapist reported that she thought she would be meeting with Jack's mother, as his mother had facilitated all previous communication; however, on the day of the first session Jack's father showed up alone. Jack's father consistently

attended treatment alone, as Jack's mother was ill and remained at home. Due to the fact that Jack's mother completed all pretreatment measures and Jack's father completed all post-treatment measures, it is unclear whether the change in ratings from pretreatment and post-treatment is a valid representation of his improvement. Jack's post-treatment measures had significantly decreased across the board, and it is possible that his mother and father perceived Jack's behavior differently, with Jack's mother indicating more severe behavior at baseline than Jack's father, which could have drastically impacted treatment outcome measures. Thus, to eliminate confounding variables, it would have been helpful for the same parent to complete all pretreatment and post-treatment measures. However, despite this possible limitation, there is evidence that parent ratings tend to have moderate agreement and mother's ratings tend to be consistently higher than father's (Schroeder et al., 2010). Moreover, all the other data in the study—such as Jack self-ratings and his post-treatment interview, the process of the therapy as reflected in the videotapes, Jack's therapist's reaction to Jack, and the qualitative content of Jack's father's post-treatment interview—confirm the results of Jack's father's post-treatment caregiver ratings.

Future Research

While this study examined parental defense mechanisms, it would be useful to study child defense mechanisms and their impact on the psychotherapy process in RFP-C. Given the growing evidence for the salience of defenses as a mechanism of change in psychotherapy with adults (Babl et al., 2019), there is a need for more research on the role of defenses in child therapy.

More comparative RFP-C case studies like those of Jack and Oliver will help strengthen the knowledge we gained from comparing these two boys. In addition, we could expand our knowledge by including case studies where participation in psychotherapy exacerbated symptoms and resulted in harmful outcomes.

The design of future RFP-C studies could be enhanced in a number of ways. First, formal measures of treatment fidelity could be included. Second, there could be a comparison of the RFP-C treatment group with an active treatment comparison group (unlike the waitlist control in the 2022 RCT by Prout, Rice, and colleagues from which the cases of Jack and Oliver were obtained). Third, independent-observer-coded measures of symptoms together with teacher measures of classroom behavior could be added, in addition to self-report measures from parents and child clients.

Clearly, the comparison of any two contrasting-outcome cases is limited by the unique aspects of any particular case. However, the knowledge yield of the comparison of Jack's and Oliver's case studies argues for conducting many more such case comparisons to investigate how

this knowledge can be strengthened and expanded by such case comparisons drawn from group studies.

Finally, comparisons of successful cases like Jack's and unsuccessful cases like Oliver's reveal variables and patterns that can be researched in group studies. One example that particularly stands out in Jack and Oliver's cases is the role of client engagement, and how it seems central in the capacity of RPT-C as currently practiced to produce positive outcomes.

For Further Reading

For more information on Regulation Focused Psychotherapy for Children, resources such as an animated video and a booklet for parents, a provider directory, and other tools are available at www.centerforrfp.org.

REFERENCES

Abidin, R. (2012). Parenting Stress Index: Fourth Edition. Lutz. PAR.

Ablon, J. S., Levy, R. A., & Smith-Hansen, L. (2011). The contributions of the psychotherapy process Q-set to psychotherapy research. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *14*(1), 14–48. https://doi.org/10.4081/ripppo.2011.46

Achenbach, T., & Rescorla, L. (2001). Manual for the ASEBA school-age forms & profiles. In. Burlington, VT: University of Vermont Research Center for Children, Youth & Families.

Alpert, M. (1996). Videotaping psychotherapy. *Journal of Psychotherapy Practice and Research, 5,* 93-105.

Babl, A., Holtforth, M. G., Perry, J. C., Schneider, N., Dommann, E., Heer, S., … Caspar, F. (2019). Comparison and change of defense mechanisms over the course of psychotherapy in patients with depression or anxiety disorder: Evidence from a randomized controlled trial. *Journal of Affective Disorders*, *252*, 212–220. https://doi.org/10.1016/j.jad.2019.04.021

Baden, A. D., & Howe, G. W. (1992). Mothers' attributions and expectancies regarding their conduct-disordered children. *Journal of Abnormal Child Psychology*, *20*(5), 467-485. https://doi.org/10.1007/BF00916810

Békés, V., Perry, J. C., Starrs, C. J., Prout, T. A., Conversano, C., Di Giuseppe, M. (2023). Defense mechanisms are associated with mental health symptoms across six countries. *Research in Psychotherapy: Psychopathology, Process and Outcome, 26*(3). https://doi.org/10.4081/ripppo.2023.729

Békés, V., Prout, T. A., Di Giuseppe, M., Wildes Ammar, L., Kui, T., Arsena, G., & Conversano, C. (2021). Initial validation of the Defense Mechanisms Rating Scales Q-sort: A comparison of trained and untrained raters. *Mediterranean Journal of Clinical Psychology, 9*(2). https://doi.org/10.13129/2282-1619/mjcp-3107

Betan, E., Hem, A., K, Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. *The American Journal of Psychiatry, 162*(5), 890-898. https://doi.org/10.1176/appi.ajp.162.5.890

Betan, E. J., & Westen, D. (2009). Countertransference and personality pathology: Development and clinical application of the Countertransference Questionnaire (pp. 179-198). In R.A. Levy and J.S. Ablon, Eds. *Handbook of Evidence-Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice.* Humana Press.

Bickett, L. R., Milich, R., & Brown, R. T. (1996). Attributional styles of aggressive boys and their mothers. *Journal of Abnormal Child Psychology*, *24*, 457-472. https://doi.org/10.1007/BF01441568

Blueprints for Healthy Youth Development. https://www.blueprintsprograms.org/programs/198999999/generationpmto/ Accessed May 3, 2024.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), The heart and soul of change: Delivering what works in therapy (2nd ed., pp. 83–111). American Psychological Association. https://doi.org/10.1037/12075-003

Bowlby, J. (1977b). The making and breaking of affectional bonds: II. Some principles of psychotherapy. *The British Journal of Psychiatry*, *130*, 421-431. https://doi.org/10.1192/bjp.130.5.421

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.

Braunstein, L. M., Gross, J. J., & Ochsner, K. N. (2017). Explicit and implicit emotion regulation: a multi-level framework. *Social Cognitive and Affective Neuroscience*, *12*(10), 1545-1557. https://doi.org/10.1093/scan/nsx096

Briggie, A. M., Hilsenroth, M. J., Conway, F., Muran, C., & Jackson, J. M. (2016). Patient comfort with audio or video recording of their psychotherapy sessions: Relation to symptomatology, treatment refusal, duration and outcome. *Professional Psychology: Research and Practice, 47*(1), 66-76. https://doi.org/10.1037/a0040063

Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 204-223). Guilford Press.

Brotman, M. A., Kircanski, K., & Leibenluft, E. (2017). Irritability in children and adolescents. *Annual Review of Clinical Psychology*, *13*, 317-341. https://doi.org/10.1146/annurev-clinpsy-032816-044941

Carlberg, G., Thorén, A., Billström, S., & Odhammar, F. (2009). Children's expectations and experiences of psychodynamic child psychotherapy. *Journal of Child Psychotherapy,*

35(2), 175–193. https://doi.org/10.1080/00754170902996130

Cavanagh, M., Quinn, D., Duncan, D., Graham, T., & Balbuena, L. (2017). Oppositional defiant disorder is better conceptualized as a disorder of emotional regulation. J*ournal of Attention Disorders, 21*(5), 381-389. https://doi.org/10.1177/1087054713520221

Chacko, A., Jensen, S.A., Lowry, L.S., Cornwell, M., Chimklis, A., Chan, E., Lee, D., & Pulgarin, B. (2016). Engagement in behavioral parent training: Review of the literature and implications for practice. *Clinical Child and Family Psychology Review, 19,* 204-2015. https://doi.org/10.1007/s10567-016-0205-2

Clair-Michaud, M., Martin, R. A., Stein, L. A., Bassett, S., Lebeau, R., & Golembeske, C. (2016). The impact of motivational interviewing on delinquent behaviors in incarcerated adolescents. *Journal of Substance Abuse Treatment, 65*, 13-19.

Colli, A. & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry, 28*(1), 46-56. https://doi.org/10.1097/YCO.0000000000000119

Cramer, P., & Kelly, F. D. (2010). Attachment style and defense mechanisms in parents who abuse their children. *The Journal of Nervous and Mental Disease*, *198*(9), 619-627. https://doi.org/10.1097/NMD.0b013e3181ef3ee1

Crespo, L. M., Trentacosta, C. J., Aikins, D., & Wargo-Aikins, J. (2017). Maternal Emotion Regulation and Children's Behavior Problems: The Mediating Role of Child Emotion Regulation. *Journal of Child and Family Studies*, 26(10), 1-13. https://doi.org/10.1007/s10826-017-0791-8

Dattilio, F. M., Edwards, D. J., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training*, *47*(4), 427. https://doi.org/10.1037/a0021181

Diehl, M., Chui, H., Hay, E. L., Lumley, M. A., Grühn, D., & Labouvie-Vief, G. (2014). Change in coping and defense mechanisms across adulthood: Longitudinal findings in a European American sample. *Developmental Psychology, 50*(2), 634–648. https://doi.org/10.1037/a0033619

Di Giuseppe, M., & Perry, J. C. (2021). The hierarchy of defense mechanisms: Assessing defensive functioning with the Defense Mechanisms Rating Scales Q-Sort. *Frontiers in Psychology, 12*, 718440. https://doi.org/10.3389/fpsyg.2021.718440

Di Giuseppe, M., Perry, J. C., Petraglia, J., Janzen, J., & Lingiardi, V. (2014). Development of a q-sort version of the defense mechanism rating scales (DMRS-Q) for clinical use. *Journal of Clinical Psychology*, *70*(5), 452–465. https://doi.org/10.1002/jclp.22089

Di Giuseppe, M., Prout, T. A., Ammar, L., Kui, T., & Conversano, C. (2021). Assessing children's defense mechanisms with the Defense Mechanisms Rating Scales Q-sort for

Children. *Research in Psychotherapy: Psychopathology, Process and Outcome, 24*, 320-327. https://doi.org/10.4081/ripppo.2021.590

Di Giuseppe, M., Prout, T. A., Fabiani, M., & Kui, T. (2020). Defensive profile of parents of children with externalizing problems receiving Regulation-Focused Psychotherapy for Children (RFP-C): A pilot study. *Mediterranean Journal of Clinical Psychology*, *8*(2).

Dose, C., Thöne, A., Del Giudice, T., Görtz-Dorten, A., Faber, M., Benesch, C., Hautmann, C., Lindenschmidt, T., & Döpfner, M. (2022). Child-therapist and parent-therapist alliances and outcome in the treatment of children with oppositional defiant/conduct disorder. *Psychotherapy Research, 33*(4), 468-481. https://doi.org/10.1080/10503307.2022.2138791

Drabick, D., & Gadow, K. (2012). Deconstructing oppositional defiant disorder: clinic-based evidence for an anger/irritability phenotype. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(4), 384-393. https://doi.org/10.1016/j.jaac.2012.01.010

Ezpeleta, L., Osa, N., Penelo, E., Granero, R., & Domenech, J. (2013). Inventory of callous-unemotional traits in a community sample of preschoolers. *Journal of Child & Adolescent Psychology, 42*(1), 91-105. https://doi.org/10.1080/15374416.2012.734221

Fernandez, E., Salem, D., Swift, J. K., & Ramtahal, N. (2015). Meta-analysis of dropout from cognitive behavioral therapy: Magnitude, timing, and moderators. *Journal of Consulting and Clinical Psychology*, *83*(6), 1108-1122. https://doi.org/10.1037/ccp0000044

Finn, S. E., Fischer, C. T., & Handler, L. (2012). *Collaborative/therapeutic assessment: A casebook and guide.* John Wiley & Sons.

Fishman, D. B. (2023). The "cases within trials" (CWT) method: An example of a mixed methods research design. In H. Cooper, M. N. Coutanche, L. M. McMullen, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology: Research designs: Quantitative, qualitative, neuropsychological, and biological* (2nd ed., pp. 257–283). American Psychological Association. https://doi.org/10.1037/0000319-013

Fishman, D.B. (2017). The pragmatic case study in psychotherapy: A mixed methods approach informed by psychology's striving for methodological quality. *Clinical Social Work Journal, 45,* 238-252. https://doi.org/10.1007/s10615-016-0612-3

Fiorentino, F., Lo Buglio, G., Morelli, M., Chirumbolo, A., Di Giuseppe, M., Lingiardi, V., Tanzilli, A. (2024). Defensive functioning in individuals with depressive disorders: A systematic review and meta-analysis. *Journal of Affective Disorders, 357*, 42-50. https://doi.org/10.1016/j.jad.2024.04.091

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal, 12*(3), 201–218. https://doi.org/10.1002/1097-035

Forgatch, M. S., & Patterson, G. R. (2010). Parent Management Training—Oregon Model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 159-177). Guilford Press.

Gadow, K. D., & Drabick, D. A. (2012). Anger and irritability symptoms among youth with ODD: Cross-informant versus source-exclusive syndromes. *Journal of Abnormal Child Psychology*, *40*(7), 1073-1085. https://doi.org/10.1007/s10802-012-9637-4

Gallagher, R., Kurtz, S., & Blackwell, S. C. (2010). Engaging adolescents with disruptive behavior disorders in therapeutic change. In D. Castro-Blanco & M. S. Karver (Eds.), *Elusive alliance: Treatment engagement strategies with high-risk adolescents* (pp. 139–158). American Psychological Association. https://doi.org/10.1037/12139-005

Goodman, G., Midgley, N., & Schneider, C. (2016). Expert clinicians' prototypes of an ideal child treatment in psychodynamic and cognitive-behavioral therapy: Is mentalization seen as a common process factor? *Psychotherapy Research, 26*(5), 590-601. https://doi.org/10.1080/10503307.2015.1049672

Granero, R., Louwaars, L., & Ezpeleta, L. (2015). Socioeconomic status and oppositional defiant disorder in preschoolers: parenting practices and executive functioning as mediating variables. *Frontiers in Psychology*, *6*, 155312. https://doi.org/10.3389/fpsyg.2015.01412

Gullone, E., & Taffe, J. (2011). The emotion regulation questionnaire for children and adolescents (ERQ–CA): A psychometric evaluation. *Psychological Assessment*, *24*(2), 409–417. https://doi.org/10.1037/a0025777

Gyurak, A., Gross, J. J., & Etkin, A. (2012). Explicit and implicit emotion regulation: A dual-process framework. *Cognition and Emotion, 25*(3), 400-412. https://dx.doi.org/10.1080%2F02699931.2010.544160

Halfon, S., Bekar, O., & Gurleyen, B. (2017). An empirical analysis of mental state talk and affect regulation in two single-cases of psychodynamic child therapy. *Journal of Psychotherapy, 54*(2), 207-219. https://doi.org/10.1037/pst0000113

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy, 55*(4), 496–507. https://doi.org/10.1037/pst0000189

Hayes, J. A., & Gelso, C. J. (2001). Clinical implications of research on countertransference: Science informing practice. *Psychotherapy in Practice, 57*(8), 1041-1051. https://doi.org/10.1002/jclp.1072

Hoffman, L. (2007). Do children get better when we interpret their defenses against painful feelings? *The Psychoanalytic Study of the Child*, *62*(1), 291-313. https://doi.org/10.1080/00797308.2007.11800793

Hoffman, L. (2015). Mentalization, emotion regulation, and countertransference. *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(3), 258–271. https://doi.org/10.1080/15289168.2015.1064258

Hoffman, L., Prout, T. A., Rice, T., & Bernstein, M. (2023). Addressing emotion regulation with children: Play, verbalization of feelings, and reappraisal. *Journal of Infant, Child, and Adolescent Psychotherapy, 22*(1), 1-13. https://doi.org/10.1080/15289168.2023.2165874

Hoffman, L. & Prout, T. A. (2020) Helping parents spare the rod: Addressing their unbearable emotions. *The Psychoanalytic Study of the Child, 73*(1), 46-61, https://doi.org/10.1080/00797308.2020.1690867

Hoffman, L., Rice, T. R., & Prout, T. A. (2016). *Manual of regulation- focused psychotherapy for children (RFP-C) with externalizing behaviors: A psychodynamic approach*. Routledge.

Hommersen, P., Murray, C., Ohan, J. L., & Johnston, C. (2006). Oppositional defiant disorder rating scale: preliminary evidence of reliability and validity. *Journal of Emotional and Behavioral Disorders*, *14*(2), 118-125. https://doi.org/10.1177/10634266060140020201

Jones, E.E. (1985). Manual for the Psychotherapy Process Q-Set. University of California at Berkeley, unpublished.

Jones, E. E. (2000). *Therapeutic action: A guide to psychoanalytic therapy*. Jason Aronson.

Jones, J. D., & Cassidy, J. (2014). Parental attachment style: Examination of links with parent secure base provision and adolescent secure base use. *Attachment & Human Development, 16*(5), 437-461. https://doi.org/10.1080/14616734.2014.921718

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*(1), 35–52. https://doi.org/10.1007/s11020-005-1964-4

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, *26*(1), 50–65. https://doi.org/0.1016/j.cpr.2005.09.001

Katzmann, J., Goertz-Dorten, A., Hautmann, C., & Doepfner, M. (2019). Social skills training and play group intervention for children with oppositional-defiant disorders/conduct disorder: Mediating mechanisms in a head-to-head comparison. *Psychotherapy Research, 29*(6), 784-798. https://doi.org/10.1080/10503307.2018.1425559

Kimonis, E. R., Fanti, K. A., & Singh, J. P. (2014). Establishing cut-off scores for the parent-reported inventory of callous-unemotional traits. *Archives of Forensic Psychology*, *1*(1), 27-48.

Kufferath-Lin, T., Aafjes-van Doorn, K., Prout, T. A., & Hoffman, L. (2021). An examination of parent sessions in regulation focused psychotherapy for children. *Psychotherapy, 58*(1), 109-120. https://doi.org/10.1037/pst0000314

Lanier, P., Kohl, P. L., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of parent–child interaction therapy. *Journal of Child and Family Studies*, *23*(2), 449-460. https://doi.org/10.1007/s10826-012-9708-8

Leibenluft, E. (2011). Severe mood dysregulation, irritability, and the diagnostic boundaries of bipolar disorder in youths. *American Journal of Psychiatry*, *168*(2), 129-142.

Lo, C. K., Chan, K. L., & Ip, P. (2019). Insecure adult attachment and child maltreatment: A meta-analysis. *Trauma, Violence, & Abuse, 20*(5), 706-719. https://doi.org/10.1177/1524838017730579

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics*. Butterworth Heinemann.

Martin, R. A., Puhlik-Doris, P., Larsen, G., Gray, J., & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of Research in Personality, 37*(1), 48-75. https://doi.org/10.1016/S0092-6566(02)00534-2

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C.L. (2003). *Treating affect phobia: a manual for short-term dynamic psychotherapy.* Guilford Press.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. *Advances in Experimental Social Psychology, 35*, 53–152. https://doi.org/10.1016/S0065-2601(03)01002-5

Mishne, J. M. (1996). Therapeutic challenges in clinical work with adolescents. *Clinical Social Work Journal*, *24*, 137-152.

Morelen, D., Shaffer, A., & Suveg, C. (2016). Maternal emotion regulation: Links to emotion parenting and child emotion regulation. *Journal of Family Issues*, *37*(13), 1891-1916. https://doi.org/10.1177/0192513X14546720

N'zi, A. M., Lucash, R. E., Clionsky, L. N., & Eyber, S. M. (2017). Enhancing parent–child interaction therapy with motivational interviewing techniques. *Cognitive and Behavioral Practice, 24*(2), 131-141. https://doi.org/10.1016/j.cbpra.2016.03.002

O'Laughlin, E. M., Hackenberg, J. L., & Riccardi, M. M. (2010). Clinical usefulness of the Oppositional Defiant Disorder Rating Scale (ODDRS). *Journal of Emotional and Behavioral Disorders*, *18*(4), 247–255. https://doi.org/10.1177/1063426609349734

Palmieri, A., Fernandez, K. C., Cariolato, Y., Kleinbub, J. R., Salvatore, S., & Gross, J. J. (2022). Emotion regulation in psychodynamic and cognitive-behavioural therapy: An integrative perspective. *Clinical Neuropsychiatry*, *19*(2), 103-113. https://doi.org/10.36131/cnfioritieditore20220204

Perry, J. C. (1990). *Defense mechanism rating scales (5th ed.).* Harvard School of Medicine: The Cambridge Hospital.

Perry, J. C., & Henry, M. (2004). Studying defense mechanisms in psychotherapy using the Defense Mechanism Rating Scales. *Defense Mechanisms: Theoretical, Research and Clinical Perspectives*, *136*(1), 165-186.

Porcerelli, J. H., Huth-Bocks, A., Huprich, S. K., & Richardson, L. (2016). Defense mechanisms of pregnant mothers predict attachment security, social-emotional competence, and behavior problems in their toddlers. *The American Journal of Psychiatry, 173*(2), 138-146. http://dx.doi.org/10.1176/appi.ajp.2015.15020173

Price, P. B., & Jones, E. E. (1998). Examining the alliance using the Psychotherapy Process Q-Set. *Psychotherapy*, *35*(3), 392–404. https://doi.org/10.1037/h0087654

Prout, T. A., Chacko, A., Spigelman, A., Aizin, S., Burger, M., Chowdhury, T., Ramakrishnan, A., Peralta, S., Vardanian, M. M., Rice, T. R., & Hoffman, L. (2018). Bridging the divide between psychodynamic and behavioral approaches for children with oppositional defiant disorder. *Journal of Infant, Child, and Adolescent Psychotherapy*, *17*(4), 364– 377. https://doi.org/10.1080/15289168.2018.1519755

Prout, T. A., Gaines, E., Gerber, L. E., Rice, T., & Hoffman, L. (2015). The development of an evidence-based treatment: Regulation-focused psychotherapy for children with externalising behaviours. *Journal of Child Psychotherapy, 41*(3), 255-271. https://doi.org/10.1080/0075417X.2015.1090695

Prout, T. A., Goodman, G., Chung, H., & Sherman, A. (2022). Psychotherapy process in regulation focused psychotherapy for children. *Journal of Psychotherapy Integration, 32*(4), 390. https://doi.org/10.1037/int0000275

Prout, T. A., Goodman, G., Hoffman, L., Rice, T., & Sherman, A. (2018). Expert clinicians' prototype of an ideal treatment in regulation focused psychotherapy for children (RFP-C). *Journal of Psychotherapy Integration*, *28*(4), 401–412. https://doi.org/10.1037/int0000102

Prout, T. A., Malone, A., Rice, T., & Hoffman, L. (2019a). Resilience, defenses, and implicit emotion regulation in psychodynamic child psychotherapy. *Journal of Contemporary Psychotherapy*, *49*(4), 235–244. https://doi.org/10.1007/s10879-019-09423-w

Prout, T. A., Rice, T., Murphy, S., Gaines, E., Aizin, S., Sessler, Ramchandani, T., Racine, E., Gorokhovsky, Y., & Hoffman, L. (2019b). Why is it easier to get mad than it is to feel sad? Pilot study of Regulation-Focused Psychotherapy for Children. *American Journal of Psychotherapy, 72*(1), 2-8. https://doi:10.1176/appi.psychotherapy.20180027

Prout, T.A., Rice, T., Chung, H., Gorokhovsky, Y., Murphy, S., & Hoffman, L. (2022). Randomized controlled trial of Regulation Focused Psychotherapy for Children: A

manualized psychodynamic treatment for externalizing behaviors. *Psychotherapy, 32*(5), 555-570. https://doi.org/10.1080/10503307.2021.1980626

Prunas, A., Di Pierro, R., Huemer, J., & Tagini, A. (2019). Defense mechanisms remembered parental caregiving, and adult attachment style. *Psychoanalytic Psychology, 36*(1), 64–72. https://doi.org/10.1037/pap0000158

Ramires, V. R. R., Godinho, L. B. R., & Goodman, G. (2017). The Therapeutic Process of a Child Diagnosed With Disruptive Mood Dysregulation Disorder. *Psychoanalytic Psychology*. https://doi.org/10.1037/pap0000134

Reis, A. H., Oliveira, S. E., Bandeira, D. R., Andrade, N. C., Abreu, N. & Sperb, T. M. (2016). Emotion regulation checklist (ERC): Preliminary studies of cross-cultural adaptation and validation for use in Brazil. *Trends in Psychology, 24*(1), 97-116. https://doi.org/10.9788/TP2016.1-07

Rice, T. R., & Hoffman, L. (2014). Defense mechanisms and implicit emotion regulation: A comparison of a psychodynamic construct with one from contemporary neuroscience. *Journal of the American Psychoanalytic Association*, *62*(4), 693–708. https://doi.org/10.1177/0003065114546746

Rich, B. A., & Eyberg, S. M. (2001). Accuracy of assessment: The discriminative and predictive power of the Eyberg Child Behavior Inventory. *Ambulatory Child Health, 7*, 249-257. https://doi.org/10.1046/j.1467-0658.2001.00141.x

Robinson, E. A., Eyberg, S. M., & Ross, W. A. (1980). The standardization of an inventory of child conduct problems behaviors. *Journal of Clinical Child Psychology, 9*(1), 22-28. https://doi.org/10.1080/15374418009532938

Schneider, C. (2004). The development and first trial application of the child psychotherapy Q-set. Retrieved from http://www.ipa.world/

Schneider, C., & Jones, E. (2009). *Child Psychotherapy Q-Set coding manual*. University of California, Berkeley.

Schneider, C., & Jones, E. E. (2004). *Child psychotherapy Q-Set coding manual*. Unpublished manuscript. University of California, Berkeley.

Schneider, C., Pruetzel-Thomas, A., & Midgley, N. (2009). Discovering new ways of seeing and speaking about psychotherapy process: The Child Psychotherapy Q-Set. In N. Midgley, J. Anderson, E. Grainger, T. Nesic-Vuckovic, & C. Urwin (Eds.), *Child psychotherapy and research: New approaches, emerging findings* (pp. 72-84). Routledge/Taylor & Francis Group.

Schroeder, J. F., Hood, M. H., & Hughes, H. M. (2010). Inter-parent agreement on the syndrome scales of the child behavior checklist (CBCL): Correspondence and discrepancies. *Journal of Child and Family Studies, 19*, 646-653. https://doi.org/10.1007/s10826-010-9352-0

Senberg, A., Schmucker, M., Oster, A., & Zumbach, J. (2023). Parental personality disorder and child maltreatment: a systematic review and meta-analysis. *Child Abuse & Neglect, 140*, 106148. https://doi.org/10.1016/j.chiabu.2023.106148

Shachner, S. E., & Farber, B. A. (1997). Effect of diagnosis on countertransferential responses to child psychotherapy patients. *Journal of Clinical Child Psychology*, *26*(4), 377-384. https://doi.org/10.1207/s15374424jccp2604_6

Shields, A., & Cicchetti, D. (1997). Emotion regulation among school-age children: The development and validation of a new criterion Q-sort scale. *Developmental Psychology, 33*(6), 906. https://doi.org/10.1037/0012-1649.33.6.906

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452–464. https://doi.org/10.1037/0022-006X.71.3.452

Slade, A. S. (2007). Reflecting parenting programs: Theory and development. *Psychoanalytic Inquiry, 26*(4), 640-657. https://doi.org/10.1080/07351690701310698

Silvers, J. A. (2020). Extinction learning and cognitive reappraisal: Windows into the neurodevelopment of emotion regulation. *Child Development Perspectives*, *14*(3), 178-184. https://doi.org/10.1111/cdep.12372

Storey, E., Nimroody, T., Prout, T. A., Rice, T., & Hoffman, L. (2023). Feasibility of a psychodynamic school-partnered mental health service: A pilot study. *Journal of Infant, Child, and Adolescent Psychotherapy*, *22*(1), 14-27. https://doi.org/10.1080/15289168.2023.2166330

Strait, G. G., McQuillin, S., Smith, B., & Englund, J. A. (2012). Using motivational interviewing with children and adolescents: a cognitive and neurodevelopmental perspective. *Advances in School Mental Health Promotion, 5*(4), 290-304. https://doi.org/10.1080/1754730X.2012.736789

Stringaris, A., & Goodman, R. (2009). Mood lability and psychopathology in youth. *Psychological Medicine*, *39*(8), 1237-1245. https://doi.org/10.1017/S0033291708004662

Talia, A., Daniel, S. I. F., Miller-Bottome, M., Brambilla, D., Miccoli, D., Safran, J. D., & Lingiardi, V. (2014). AAI predicts patients' in-session interpersonal behavior and discourse: A "move to the level of the relation" for attachment-informed psychotherapy research. *Attachment & Human Development*, *16*(2), 192-209. https://doi.org/10.1080/14616734.2013.859161

Talia, A., Miller-Bottome, M., & Daniel, S. I. F. (2017). Assessing attachment in psychotherapy: Validation of the Patient Attachment Coding System (PACS). *Clinical Psychology & Psychotherapy*, *24*(1), 149-161. https://doi.org/10.1002/cpp.1990

Tharinger, D. J., Finn, S. E., Gentry, L., Hamilton, A., Fowler, J., Matson, M., Krumholz, L., & Walkowiak, J. (2009). Therapeutic assessment with children: A pilot study of treatment

acceptability and outcome. *Journal of Personality Assessment, 91*(3), 238-244. https://doi.org/10.1080/00223890902794275

University of Southern California Research Guides. *Organizing your social sciences research paper: Writing a case study.* Retrieved from https://libguides.usc.edu/writingguide/assignments/casestudy

Vidal-Ribas, P., & Stringaris, A. (2021). How and why are irritability and depression linked?. *Child and Adolescent Psychiatric Clinics*, *30*(2), 401-414. https://doi.org/10.1016/j.chc.2020.10.009

Webb, H. J., Thomas, R., McGregor, L., Avdagic, E., & Zimmer-Gembeck, M. J. (2017). An evaluation of parent–child interaction therapy with and without motivational enhancement to reduce attrition. *Journal of Clinical Child & Adolescent Psychology, 46(*4), 537-550. https://doi.org/10.1080/15374416.2016.1247357

Winnicott, D. W. (1949). Hate in the countertransference. *The International Journal of Psychoanalysis, 30*, 69-75.

Zittel-Conklin, C., & Westen, D. (2005). Countertransference Questionnaire (CTQ) manual. Emory University.

Table 1. Outcomes and Reliable Change Indices

		Jack			Oliver		
Measure	Clinical Cutoff	Intake	Termination	RCI	Intake	Termination	RCI
ODD-RS	≥ 8	24	6	**-12.39***	19	17	-1.37
CBCL							
ODD	≥ 65	77	62	**-4.67***	80	77	-0.93
Externalizing	≥ 64	78	65	**-5.72**	75	74	-0.44
ECBI							
Intensity	≥ 60	65	61	-0.83	67	66	-0.20
Problem	≥ 60	71	64	-1.34	71	73	0.38
ERC							
Lability	n/a	47	36	**-7.46**	39	39	0.00
Regulation	n/a	23	24	0.60	21	24	1.80
ERQ-CA							
Reappraisal	n/a	6	20	**2.33**	37	30	-1.17
Suppression	n/a	9	12	0.63	12	18	1.27
ICU parent							
Uncaring	n/a	15	14	-0.44	16	13	-1.34
Callousness	n/a	11	6	**-2.23**	9	9	0.00
Unemotional	n/a	0	0	0.00	2	3	0.00
Total	≥ 24	28	26	-0.90	32	32	0.00
PSI							
PD	≥ 81	76	54	-1.51	46	72	1.79
P_CDI	≥ 81	70	76	0.41	78	72	-0.41
DC	≥ 81	98	94	-0.34	99	88	-0.93
Total	≥ 81	82	74	-0.79	80	84	0.39

Note 1. Bolded score = Reliable Change Index (RCI) indicates statistically significant change (≥ |1.96|) (Jacobson & Truax, 1991).
Note 2. Bolded score plus asterisk = Clinically Meaningful Change (significant RCI and movement from above clinical cutoff to below clinical cutoff (Jacobson & Truax, 1991).
Note 3. ODD-RS = Oppositional Defiant Disorder Rating Scale; CBCL = child Behavior Checklist, ECBI = Eyberg Child Behavior Inventory; ERC = Emotion Regulation Checklist; ERQ-CA = Emotion Regulation Questionnaire for Children and Adolescents; ICU = Inventory of Callous-Unemotional Traits – Parent Version; PSI = Parenting Stress Index – Fourth Edition – Short Form (PD = Parental Distress; P_CDI = Parent-Child Dysfunctional Interaction; DC = Difficult Child)
Note 4. Clinical cutoffs are not available for the ERC, ERQ-CA or subscale scores of the ICU.
Note 5. Determining a cutoff for the total ICU score is complex and varies widely for ages 7-12 , by client gender, and by reporter (e.g., mother or father). The cutoff score listed above is for all ages of boys as reported by mothers. Father-reported cutoff is 25. These cutoff scores are for identifying youth on trajectories of high stable co-occurring conduct problems and CU traits (Kimonis et al., 2014).

Table 2. Child Psychotherapy Process Q-Set for Child Sessions

Jack			Oliver		
Item #	**CPQ Item**	**Mean pile #**	**Item #**	**CPQ Item**	**Mean pile #**
Most Characteristic CPQ Items in RFP-C Sessions					
23	Therapy session has a specific focus or theme	8.5	29	The quality of the child's play is fluid, absorbed (vs. fragmented, sporadic)	8.67
1	Child expresses negative feelings (e.g., criticism, hostility) toward therapist (vs. expresses approval or admiration)	8	95	Child's play lacks spontaneity	8.17
71	Child engages in make-believe play	7.67	86	Therapist is confident, self-assured (vs. uncertain or unsure)	8.17
58	Child appears unwilling to examine thoughts, reactions, or motivations related to problems	7.67	40	Child communicates without affect	8.17
65	Therapist clarifies, restates, or rephrases child's communication	7.5	23	Therapy session has a specific focus or theme	8.17
52	Therapist makes explicit statements about the end of the hour, upcoming weekend, or holiday	7.5	93	Therapist is neutral	7.83
77	Therapist's interaction with child is sensitive to the child's level of development	7.33	42	Child ignores or rejects therapist's comments and observations	7.83
75	Interruptions, breaks in the treatment, or termination of therapy are discussed	7.33	6	Therapist is sensitive to the child's feelings	7.83
56	Child is distant from his or her feelings	7.17	3	Therapist's remarks are aimed at encouraging child's speech	7.83
42	Child ignores or rejects therapist's comments and observations	7.17	77	Therapist's interaction with child is sensitive to the child's level of development	7.67
Least Characteristic CPQ Items in RFP-C Sessions					
25	Child has difficulty leaving the session	1.17	13	Child is animated or excited	1.67
17	Therapist actively exerts control over the interaction (e.g., structuring, introducing new topics)	1.5	17	Therapist actively exerts control over the interaction (e.g., structuring, introducing new topics)	2
18	Therapist is judgmental and conveys lack of acceptance	1.83	49	Child conveys or expresses mixed or conflicted feelings about the therapist	2.33
9	Therapist is nonresponsive (vs. affectively engaged)	2.17	5	Child has difficulty understanding the therapist's comments	2.5
78	Child is compliant	2.33	78	Child is compliant	2.67
32	Child achieves a new understanding or insight	2.33	26	Child is socially misattuned or inappropriate	2.67
10	Child seeks greater intimacy with the therapist	2.33	10	Child seeks greater intimacy with the therapist	2.83
85	Child's aggression is directed toward self	2.5	72	Child is active	2.5
24	Therapist's emotional conflicts intrude into the relationship	2.5	32	Child achieves a new understanding or insight	3.17
61	Child feels shy and embarrassed (vs. un-self-conscious and assured)	2.83	30	Child's aspirations or ambitions are themes	3.17

Table 3. Psychotherapy Process Q-Set for Parent Sessions

Jack			Oliver		
Item #	**PQS Item**	**Mean pile #**	**Item #**	**PQS Item**	**Mean pile #**
Most Characteristic PQS Items in RFP-C Sessions					
69	Parent's current or recent life situation is emphasized in discussion	8.87	69	Parent's current or recent life situation is emphasized in discussion	8.1
63	Parent's interpersonal relationships are a major theme	8.53	57	Therapist explains rationale behind his or her technique or approach to treatment	8.05
88	Parent brings up significant issues and material	8.27	37	Therapist behaves in a teacher-like (didactic) manner	7.75
43	Therapist suggests the meaning of others' behavior	8.07	63	Parent's interpersonal relationships are a major theme	7.5
31	Therapist asks for more information or elaboration	8.07	73	The parent is committed to the work of therapy	7.5
23	Dialogue has a specific focus	8.07	23	Dialogue has a specific focus	7.5
45	Therapist adopts supportive stance	7.87	6	Therapist is sensitive to the parent's feelings, attuned to the parent; empathic	7.5
46	Therapist communicates with parent in a clear, coherent style	7.73	46	Therapist communicates with parent in a clear, coherent style	7.4
17	Therapist actively exerts control over the interaction (e.g., structuring, and/or introducing new topics	7.73	88	Parent brings up significant issues and material	7.35
57	Therapist explains rationale behind his or her technique or approach to treatment	7.6	4	The parent's treatment goals are discussed	7.3
Least Characteristic PQS Items in RFP-C Sessions					
19	There is an erotic quality to the therapy relationship	1	19	There is an erotic quality to the therapy relationship	1
11	Sexual feelings and experiences are discussed	1.13	11	Sexual feelings and experiences are discussed	1.55
51	Therapist condescends to or patronizes the patient	1.6	51	Therapist condescends to or patronizes the patient	1.95
9	Therapist is distant, aloof (vs. responsive and effectively involved)	1.87	1	Parent verbalizes negative feelings (e.g., criticism, hostility) toward therapist (vs. makes approving or admiring remarks)	2.05
64	Love or romantic relationships are a topic of discussion	2	9	Therapist is distant, aloof (vs. responsive and effectively involved)	2.15
24	Therapist's own emotional conflicts intrude into relationship	2.13	12	Silences occur during the hour	2.2
1	Parent verbalizes negative feelings (e.g., criticism, hostility) toward therapist (vs. makes approving or admiring remarks)	2.4	77	Therapist is tactless	2.35
39	There is a competitive quality to the relationship	2.4	64	Love or romantic relationships are a topic of discussion	2.45
77	Therapist is tactless	2.53	39	There is a competitive quality to the relationship	2.55
2	Therapist draws attention to patient's nonverbal behavior, e.g., body posture, gestures	2.6	15	Parent does not initiate topics; is passive	2.9

Table 4. Most Characteristic Defense Mechanisms for Jack's Father
Defensive Profile Narratives

Item#	Defense Level	Individual Defense	Statement
18	Level 7: High-Adaptive	Humor	The subject makes amusing or ironic comments about embarrassing situations to diffuse them.
19	Level 3: Disavowal	Rationalization	To avoid taking responsibility for one's actions or misdeeds, the subject makes excuses or points out others' contributions to the problem, thereby minimizing his or her own role.
26	Level 6: Obsessive	Intellectualization	The subject talks about his personal experiences by making general statements that appear accurate but somehow avoid revealing specific personal feelings and reactions.
31	Level 6: Obsessive	Isolation of Affects	In talking about a meaningful, emotionally charged experience, the subject talks in a detached way, as if he or she is not in touch with the feelings that should surround it.
55	Level 5: Neurotic	Reaction Formation	The subject is very compliant, agreeing to most everything the interviewer points out, when some disagreement and discussion would be expected.
107	Level 6: Obsessive	Isolation of Affects	The subject talks as if emotionally detached from whatever he says about himself or his experiences.
22	Level 7: High-Adaptive	Affiliation	Whenever the subject brings a personal problem to someone for help or advice, the subject is not expecting the other to take care of it, but rather to help come up with a solution which the subject will then implement.
29	Level 4: Minor Image-Distortion	Devaluation of Self-Image	The subject makes a lot of unwarranted negative, sarcastic, or biting statements about the self, but the individual can acknowledge some of their positive aspects, if these are pointed out.
39	Level 6: Obsessive	Isolation of Affects	The subject clearly describes the details of either positive or distressing or traumatic experiences but fails to show any attendant emotion in tone of voice, facial expression, or bodily expression.
50	Level 5: Neurotic	Repression	When discussing a topic that brings up negative, conflicting feelings, the subject prefers to keep things vague, reflected in very vague, general or inexact statements.

Table 4. Most Characteristic Defense Mechanisms for Jack's Father
Defensive Profile Narratives, continued

Item#	Defense Level	Individual Defense	Statement
53	Level 6: Obsessive	Intellectualization	There is a lifeless quality to most of the subject's descriptions of his feelings and reactions, because the subject tries to explain them intellectually rather than experience or express them. For example: 'My present predicament is an inevitable product of my parents' extreme expectations and other parental experiences when growing up'.
82	Level 4: Minor Image-Distortion	Devaluation of Others' Image	The subject devalues others' accomplishments or motives, to minimize their significance, but he or she quickly dismisses such topics rather than dwell on them.
90	Level 7: High-Adaptive	Self-Assertion	When the subject has a physical or emotional or practical problem, the subject takes steps to deal with his or her needs – possibly including initiating getting help – rather than ignore them or hope they will take care of themselves.
140	Level 6: Obsessive	Isolation of Affects	The subject describes events with good detail, but without mention of any attendant feelings, like a reporter describing the narrative of someone's life, but devoid of personal reactions.

Table 5. Most Characteristic Defense Mechanisms for Oliver's Mother

Defensive Profile Narrative

Item#	Defense Level	Individual Defense	Statement
9	Level 7: High-Adaptive	Self-Observation	When talking with someone about a personally charged topic, the subject displays an accurate view of him or herself and can see how he or she appears from the other person's point of view
22	Level 7: High-Adaptive	Affiliation	Whenever the subject brings a personal problem to someone for help or advice, the subject is not expecting the other to take care of it, but rather to help come up with a solution which the subject will then implement
32	Level 7: High-Adaptive	Self-Observation	When confronting emotionally important problems, the subject can reflect upon relevant personal experiences and explore emotional reactions. This allows the subject to adjust better to limitations and compromises, possibly leading to more fulfilling outcomes
77	Level 7: High-Adaptive	Self-Observation	When considering an emotionally important decision, the subject explores his or her own motives and limitations to arrive at a more fulfilling decision
119	Level 7: High-Adaptive	Humor	When confronted by a situation fraught with competitive, hostile, or jealous feelings, the subject reveals something about him or herself in a self-deprecatory, ironic, or amusing way to diffuse the tension
146	Level 7: High-Adaptive	Self-Assertion	When confronted with emotionally difficult situations, the subject expresses his or her thoughts, wishes, or feelings clearly and directly without inhibition or excess
18	Level 7: High-Adaptive	Humor	The subject makes amusing or ironic comments about embarrassing situations to diffuse them
40	Level 7: High-Adaptive	Humor	In confronting difficult situations which the subject cannot change, the subject uses humor about the situation to mitigate the negative feelings arising
51	Level 7: High-Adaptive	Humor	The subject diffuses a difficult situation with others by making a pertinent joke that centers on some important point that all can acknowledge without being at anyone's expense, thereby fostering cooperation
52	Level 5: Neurotic	Reaction Formation	When confronting a personal wish about which the subject may feel guilty, the subject does not acknowledge or express it, but substitutes an opposite attitude against the wish, for instance, a desire is supplanted by renunciation or anger at anything to do with the desire

Table 5. Most Characteristic Defense Mechanisms for Oliver's Mother
Defensive Profile Narrative, continued

Item #	Defense Level	Individual Defense	Statement
56	Level 4: Minor Image-Distortion		The subject is preoccupied with real or exaggerated faults in him or herself, although he or she can acknowledge some realistic positive aspects, if these are pointed out.
58	Level 7: High-Adaptive	Self-Observation	In interpersonal conflicts, the subject uses an understanding of his or her reactions to facilitate understanding others' points of view or subjective experiences. This may make the subject a better negotiator or collaborator.
66	Level 7: High-Adaptive	Affiliation	When confronted with emotional conflict or stressful situations, the subject describes confiding in someone. Emotionally meaningful sharing led to enhancement of coping skills, or direct assistance beyond what the subject would have done alone.
93	Level 7: High-Adaptive	Affiliation	When dealing with an emotionally difficult situation, the subject reports that talking to others helps the subject think through how best to handle the problem.

Table 6. Therapist Countertransference Self-Report

				Total Sample			
Factors	**# of Items**	***Jack***	***Oliver***	***M***	***SD***	**Range**	**α**
Parental/Protective	6	2.67	2.83	3.46	0.80	1.67 – 5.00	.86
Positive/Satisfying	8	2.50	2.00	3.19	0.77	1.75 – 4.50	.86
Helpless/Inadequate	9	1.22	3.11	2.28	.83	1.22 – 4.11	.90
Overwhelmed/Disorganized	9	1.67	1.56	1.92	.62	1.11 –3.67	.73
Special/Overinvolved	5	1.20	1.40	1.76	0.62	1.00 – 3.20	.67
Disengaged	4	1.25	2.50	1.98	0.68	1.00 – 4.00	.77
Criticized/Mistreated	18	1.28	1.61	1.69	.62	1.06 – 3.56	.93
Sexualized	3	1.00	1.00	1.10	.22	1.00 – 2.00	.40

Notes. Means, standard deviations, range, and alpha drawn from overall sample of 20 study therapists and 33 children; data obtained from therapist-reported responses on the Therapist Response Form (TRF; Zittel et al., 2005)

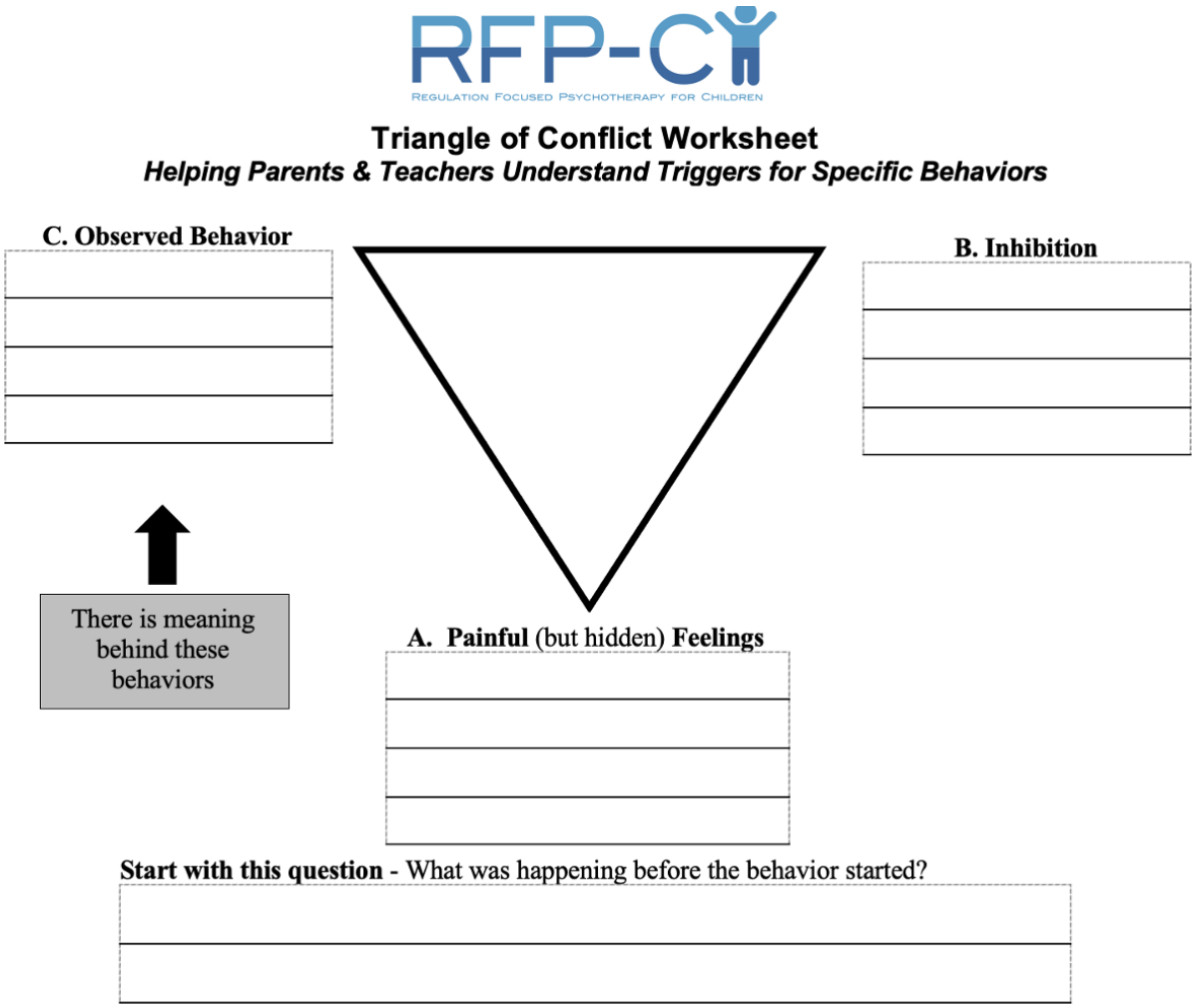
Table 7. Summary of Results for Oliver & Jack

Item	Measure	Jack	Oliver
1	ODDRS	***Clinically Significant Improvement***	*No change*
	CBCL ODD CBCL Externalizing	***Clinically Significant Improvement*** ***Clinically Significant Improvement***	*No change* *No change*
2	ECBI Intensity ECBI Problem	*No Change* *No Change*	*No change* *No change*
3	ERC Lability ERC Regulation	***Statistically Significant Improvement*** *No Change*	*No change* *No change*
4	ERQ-CA Reappraisal ERQ-CA Suppression	***Statistically Significant Improvement*** *No Change*	*No change* *No change*
5	ICU Parent - Uncaring ICU Parent - Callousness	*No Change* ***Statistically Significant Improvement***	*No change* *No change*
6	PSI PD P_CDI DC	*No change* *No change* *No change* *No change*	*No change* *No change* *No change* *No change*
7	CPQ	· Engaged in make-believe play · Expressed negative feelings toward therapist · Ignored therapist's commentary	· Play lacked spontaneity · Communicated without affect · Ignored therapist's commentary
8	PQS	· Parent brings up significant issues · Therapist asks for more information · Therapist suggest meaning of others' behavior	· Parent brings up significant issues Parent's treatment goals are discussed · Parent is committed to therapy
9	DMRS-Q	Jack's father demonstrated use of high-adaptive defense mechanisms (i.e., humor, affiliation), as well as repression and devaluation of self-image; slightly lower overall defensive functioning score	Oliver's mother demonstrated use of primarily high-adaptive defense mechanisms (i.e., self-observation, humor); slightly higher overall defensive functioning score
10	TRF	Jack's therapist felt excited to work with him, liked him very much, looked forward to sessions, did not feel confused or disengaged, and felt like she understood Jack	Oliver' therapist felt bored, confused, frustrated, worried that she was not helping, interchangeable and less successful in helping Oliver than when helping other patients
11	PACS	Jack's father exhibited an avoidant attachment style	Oliver's mother exhibited a secure attachment style

Note1. ODD-RS = Oppositional Defiant Disorder Rating Scale; CBCL = Child Behavior Checklist, ECBI = Eyberg Child Behavior Inventory; ERC = Emotion Regulation Checklist; ERQ-CA = Emotion Regulation Questionnaire for Children and Adolescents; ICU = Inventory of Callous-Unemotional Traits – Parent Version; PSI = Parenting Stress Index – Fourth Edition – Short Form (PD = Parental Distress; P_CDI = Parent-Child Dysfunctional Interaction; DC = Difficult Child); CPQ = Child Psychotherapy Q-Set; PQS = Psychotherapy Process Q-Set; DMRS-Q = Defense Mechanisms Rating Scale Q-Sort; TRF = Therapist Response Form; PACS = Patie CPQ = Child Psychotherapy Q-Set nt Attachment Coding System;

Note 2. Clinically Significant Improvement refers to an RCI ≥ |1.96| and an end-treatment score below the clinical threshold. Statistically Significant Improvement refers to an RCI ≥ |1.96| in which a clinical cutoff score is not available for the measure, or the score is not below the clinical threshold

Figure 1. RFP-C Triangle of Conflict



A. What **Painful** (but hidden) **Feelings** might have been provoked by this situation?
   a. Grief, fear, longing, sadness, dependency
   b. The emotions are difficult to tolerate but also understandable in context

B. What thoughts or experiences might have led to **Inhibition** around expressing these feelings?
   a. "I shouldn't be feeling this."
   b. There is an inner awareness that these painful emotions need to be vigorously avoided

C. What **Behaviors** did you observe?
   a. The behaviors we see are a result of the child's need to defensively ward off painful emotions
   b. There is meaning to this behavior.

Pragmatic Case Studies in Psychotherapy, http://pcsp.nationalregister.org/
Volume 21, Module 1, Article 1, pp.1-68, 01-26-25 [copyright by authors]

Figure 2. Regulation-Focused Psychotherapy for Children (RFP-C) Treatment Protocol

Session	Purpose
Parent/Caregiver Session 1	• Develop rapport with parent(s)/caregiver(s) • Review the chief complaint • Review developmental and psychiatric history • Introduce RFP-C principles including the RFP-C Triangle of Conflict • Emphasize family & child strengths
Child Sessions 1-2 *Early Phase*	• Establish rapport with child • Note topics that the child avoids • Use combination of structured and unstructured techniques to assess child's defenses against uncomfortable or painful affect
Parent/Caregiver Session 2	• Discuss basic case conceptualization with parent(s)/caregiver(s) • Emphasize the child's strengths • Revisit RFP-C triangle • Discuss meaning of behavior • Identify how to handle externalizing problems
Child Sessions 3-12 *Middle Phase*	• Maintain unstructured frame while insuring safety • Closely follow child's play and verbalizations • Observe/notice child's attempts to avoid painful emotions • Address how avoidance is experienced in the treatment
Parent/Caregiver Session 3	• Reintroduce RFP-C Triangle of Conflict • Provide information about child's progress • Help parents/caregivers activate their own scaffolding framework for helping the child cope with distressing emotions
Child Sessions 13-16 *Termination Phase*	• Utilize upcoming separation as a tool for working on feelings of loss or rejection • Discuss gains the child has made • Notice more adaptive ways of coping with distressing emotions
Parent/Caregiver Session 4	• Help parent(s)/caregiver(s) think about termination as a tool for the child to address difficult feelings • Summarize progress • Emphasize strengths • In non-research setting, leave open door for family to return to treatment if needed

Figure 3. RFP-C Triangle of Conflict for Jack

RFP-C
REGULATION FOCUSED PSYCHOTHERAPY FOR CHILDREN

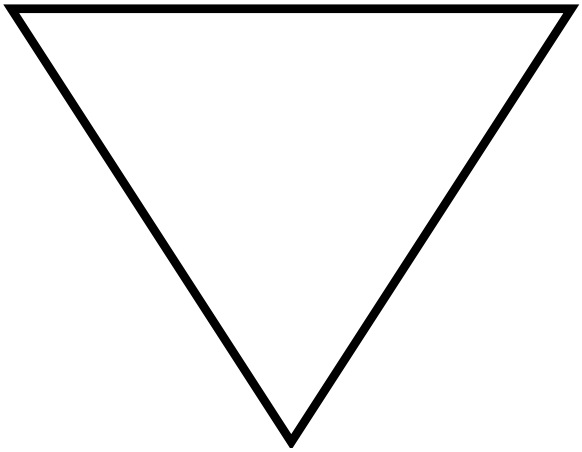
Triangle of Conflict Worksheet

Helping Parents & Teachers Understand Triggers for Specific Behaviors

C. Observed Behavior

Verbal & physical aggression

There is meaning behind these behaviors



B. Inhibition

"I can't be seen as weak, weakness leaves you in danger" ; "The world is too overwhelming and scary for me"

A. Painful (but hidden) **Feelings**

Vulnerability, fear of others' attacks, sense of the world as unpredictable and chaotic

Figure 4. RFP-C Triangle of Conflict for Oliver

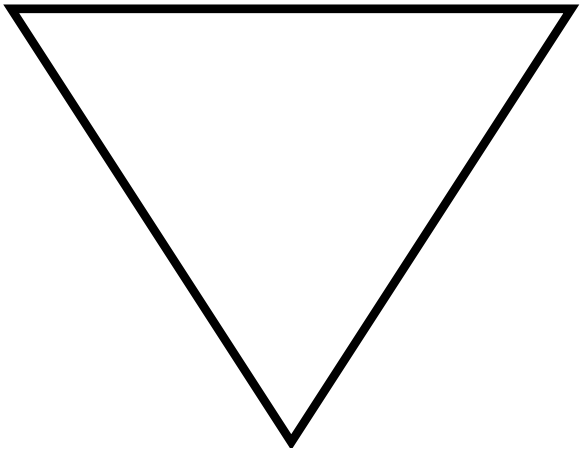
RFP-C
REGULATION FOCUSED PSYCHOTHERAPY FOR CHILDREN

Triangle of Conflict Worksheet

Helping Parents & Teachers Understand Triggers for Specific Behaviors

C. Observed Behavior

Bullying others, arguing, making insensitive comments about others



B. Inhibition

"If others come too close, I will lose them". ; "If someone looks too closely, I will get in trouble / be rejected"

There is meaning behind these behaviors

B. Painful (but hidden) **Feelings**

Fear of loss and/or rejection; jealousy of others

APPENDIX 1. OUTLINE OF THE CASE STUDIES OF "JACK" AND "OLIVER"

1. CASE CONTEXT AND METHOD

2. THE CLIENTS

3. GUIDING CONCEPTION WITH RESEARCH SUPPORT
   - ***The RFP-C Model of Therapy***
   - ***The Duration and Three Phases of RFP-C***
   - ***Phase One.***
   - ***Phase 2.***
   - ***Phase 3.***
   - ***Variations in Outcome***

4. ASSESSMENT OF THE CHILD'S PRESENTING PROBLEMS & HISTORY
   - ***Jack***
   - ***Oliver***
   - ***Quantitative Assessment***
     - The Oppositional Defiant Disorder Rating Scale (ODD-RS; O'Laughlin et al., 2010)
     - The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001)
     - The Eyberg Child Behavior Inventory (ECBI; Rich & Eyberg, 2001)
     - The Emotion Regulation Checklist (ERC; Reis et al., 2016)
     - The Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA; Gullone & Taffe, 2011)
     - The Inventory of Callous-Unemotional Traits Parent (ICU; Ezpeleta et al., 2013)
     - The Parenting Stress Index – Fourth Edition – Short Form (PSI-4-SF; Abidin, 2012)

5. CASE FORMULATION AND TREATMENT PLAN
   - ***Jack***
   - ***Oliver***
   - ***Parent Work***

6. COURSE OF TREATMENT
   - ***The Case of Jack***
   - ***The Case of Oliver***

7. THERAPY MONITORING AND USE OF FEEDBACK

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME
   - ***Child Factors***
   - ***Parent Factors***
   - ***Parental Defenses***
   - ***Parental Attachment Style***

Therapist Factors
Therapist Countertransference
Jack's Therapist
Oliver's Therapist
Implications of this Comparative Case Study
Child Anxiety and Level of Awareness About Engaging in Therapy
Parent Engagement
Parent Defense Mechanisms and Attachment Style
Limitations to This Case Study Comparison
Future Research
For Further Reading