Pragmatic Case Studies in Psychotherapy, http://pcsp.nationalregister.org/
Volume 21, Module 1, Article 2, pp. 69-82, 01-26-25 [copyright by author]

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

Insights from a Dual Case Study of Regulation Focused Psychotherapy for Children (RFP-C) with Externalizing Behaviors: The Cases of "Jack" and "Oliver"

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ABSTRACT

This dual case study involving "Jack" and "Oliver" provides critical insights into the efficacy and therapeutic processes of Regulation Focused Psychotherapy for Children (RFP-C), a manualized psychodynamic approach designed to address emotion regulation difficulties in school-age children. The study demonstrates both the strengths and limitations inherent in case study research within child therapy. Strengths include the extensive use of diverse measures and a thorough examination of the complexities involved in child therapy. Nevertheless, limitations arise from challenges in generalizing findings and the intricacies of the methodology. This commentary addresses these aspects, highlighting how case studies can enrich and complement randomized controlled trial results by offering a nuanced understanding of psychotherapy processes and outcomes. Such insights are essential for enhancing clinical practice. Future research should improve methodological rigor and investigate key psychotherapy variables, especially the dynamics of building and maintaining therapeutic alliances with children and parents. Additionally, rigorous qualitative analysis of interviews with children, parents, and therapists could offer valuable insights into the complexities of therapeutic interventions.

Key words: commentary; case study; child therapy; process & outcome research; mixed methods research; clinical case study

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The dual case study of "Jack" and "Oliver" (Brooks et al., 2025) offers a detailed analysis of the process and outcomes of Regulation Focused Psychotherapy for Children (RFP-C) in treating externalizing behavior problems. RFP-C is a manualized psychodynamic therapy designed to tackle emotion regulation issues over a ten-week period, consisting of 16 sessions with the child and four with the child's parents (Hoffman et al., 2016). This commentary explores the factors—relating to the child, parent, therapist, and treatment—that influence the

success of RFP-C, based on two cases from a randomized controlled trial (RCT) of RFP-C (Prout, Rice, et al., 2022). This commentary begins by highlighting the importance of systematic case study research in youth psychotherapy. It then summarizes the dual case study, evaluating the strengths and limitations of the methodology employed. Finally, the commentary provides clinical reflections and discusses the implications of the findings presented.

CASE STUDIES IN PSYCHOTHERAPY RESEARCH

Ever since the earliest psychoanalytic case study published by Freud (1905), the detailed analysis of single cases has been instrumental in developing and articulating evidence-based clinical theories. However, early reports were criticized for not meeting the rigorous standards of evidence required by the modern medical-scientific community (McLeod, 2013; Midgley, 2006). In response to these criticisms, researchers have started applying systematic research methods to empirical case studies (McLeod, 2013; Cirasola et al, 2022; 2024). This approach is facilitated by using session recording and developing empirical tools to assess various dimensions of patient functioning and therapeutic processes.

In the field of child therapy, our understanding is still developing, especially when compared to adult therapy. As such, empirical case studies are particularly valuable in this context. They offer an in-depth exploration of the complex interactions between a child's developmental stage, psycho-social capacities, and therapeutic interventions. This detailed examination is crucial for tailoring therapeutic approaches to meet the unique needs of each child, which can significantly improve treatment outcomes. However, it is crucial that these studies are conducted systematically and rigorously to maximize their contributions to the field.

Case studies typically involve an in-depth analysis of a single case, but they can also include multiple case studies, where two or more cases are analyzed within the same empirical study (Halfon et al., 2017). This approach allows researchers to compare different therapeutic processes, outcomes, and contextual factors, offering a broader perspective on the effectiveness and adaptability of interventions. Examining two cases simultaneously allows researchers to gain deeper insights into therapeutic success. However, dual case studies also present certain challenges. Balancing the depth of analysis for each case while ensuring meaningful comparisons can be difficult. To conduct a dual case study systematically, it is crucial that the cases share similar baseline characteristics or involve the same therapist. If the cases are too dissimilar, comparisons may be unfair or misleading. Additionally, focusing on multiple cases can sometimes dilute attention from individual case details, potentially leading to less in-depth exploration of each case's unique aspects (McLeod, 2013; Lingiardi et al., 2010).

Whether including one or more cases, well-designed empirical case studies should use standardized measures, clear criteria for evaluating outcomes, and robust data collection

methods. Integrating both qualitative and quantitative methodologies, along with perspectives from clients, therapists, and observers, enhances the evaluation of psychotherapy processes and outcomes (Lingiardi et al., 2010; McLeod, 2013). When approached rigorously, case study research provides a rich, nuanced understanding of therapeutic dynamics that larger-scale studies might overlook. This approach ensures that findings are not just descriptive but also offer meaningful insights into the mechanisms of change within psychotherapy. By providing detailed insights into therapeutic processes and outcomes, case studies allow researchers and clinicians to see how interventions are applied in real-world contexts.

Despite their strengths, case studies have inherent limitations. Their findings often lack generalizability to broader populations due to their focus on individual cases. Additionally, these studies may be influenced by researcher bias, where the therapist's or researcher's subjective interpretations affect the conclusions. To address these limitations, case studies should be complemented by larger-scale research to validate and extend their findings. They should be considered as part of a broader research continuum that incorporates both qualitative and quantitative methodologies. Moreover, accumulating a variety of case studies is essential for advancing the overall knowledge base. This integrated approach can enhance our understanding of psychotherapeutic processes and outcomes, particularly in child therapy, where tailored and evidence-based interventions are still evolving and needed (Midgley, 2006).

SUMMARY OF THE CASE STUDY OF OLIVER AND JACK

This commentary focuses on a dual case study that aimed to identify the factors related to the child, parent, therapist, and treatment that influence the success of RFP-C in addressing externalizing behaviors (Brooks et al., 2025). I will first summarize the results of the two cases, then discuss the strengths and limitations of the study, and finally explore the implications of the findings.

The Case of Jack

At the start of treatment, Jack displayed verbal and physical aggression at home, along with sadness, low energy, and excessive anxiety about perceived threats. He had high scores on the Oppositional Defiant Disorder Scale (ODD-RS; O'Laughlin et al., 2010), thoughts of self-harm, and sensory sensitivities, with behavioral issues dating back to preschool. At the beginning of RFP-C, Jack struggled to engage with the therapist due to his sensory sensitivities and his play often reflected severe anxiety about potential terrorist attacks. Despite these challenges, Jack's play during RFP-C sessions provided a foundation for addressing his anxieties and emotions. Over time, he began to openly discuss fears related to school, separation from his mother, and hospitals. By the end of therapy, Jack's Oppositional Defiant Disorder symptoms had improved significantly, falling below the clinical threshold. Analysis with the Child Psychotherapy Q-Set

(CPQ, Schneider, & Jones, 2004; 2009) showed increased imaginative play and expression of negative feelings, which facilitated therapeutic progress. Jack's active participation and ability to articulate his experiences were key to these positive outcomes.

During the course of treatment, Jack's therapist experienced high levels of positive countertransference, reflecting a strong therapeutic alliance and connection with Jack. Despite occasional frustration, the therapist remained engaged and noted that Jack's imaginative play and rigid routines provided valuable insights into his internal fears, guiding the sessions effectively. Regarding parental factors, during the RFP-C process, Jack's father shifted from a behavioral approach to a more reflective one, being more aware of Jack's emotional needs. This shift enhanced understanding and communication, and post-treatment, Jack's father reported a deeper connection with his son and valued the therapist's insights. Although Jack's father demonstrated an avoidant attachment style, he used adaptive defenses such as humor and self-assertion, with defense scores in the non-clinical range.

Overall, the diverse data used in this case study suggest that the success of Jack's treatment may have been influenced by a combination of factors, including a strong therapeutic relationship, Jack's ability to express his fears through play, positive countertransference, and his father's growing understanding of Jack's behavior.

The Case of Oliver

Oliver began treatment due to concerns about his disruptive and aggressive behavior at home and school. He scored high on the Oppositional Defiant Disorder Scale (ODD-RS; O'Laughlin et al., 2010) and was described by his mother as emotionally sensitive and quick-tempered, particularly towards his sibling. His father noted verbal and physical aggression towards peers and authority figures. Oliver's issues began around age two, following the birth of a sibling and the death of a pet, and worsened in the second grade amid family relocations. At the beginning of RFP-C, Oliver showed a flat affect and struggled to engage in therapy. He was only able to participate in structured board games, with minimal, if any, engagement in imaginative play. His minimal verbal responses to the therapist's questions and comments made it difficult for the therapist to connect with him. Additionally, he showed discomfort with being recorded but resisted discussions about the camera in the room. As therapy progressed, Oliver began engaging more through non-verbal activities like magic tricks, though his verbal communication remained limited.

Despite some improvement in the therapeutic relationship, his flat affect persisted, even when discussing the end of therapy. His Oppositional Defiant Disorder symptoms remained stable throughout treatment, and Child Psychotherapy Q-Set (CPQ) analysis indicated avoidance of emotions on Oliver's part, alongside a lack of spontaneous play. The therapist experienced significant negative countertransference, including feelings of inadequacy, disengagement, and

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frustration. These emotions, combined with Oliver's difficulty in engaging, most likely affected their ability to build a strong therapeutic alliance.

Regarding parental factors, Oliver's parents initially focused on behavior modification but gradually recognized the emotional aspects of his behavior. By the end of treatment, they gained some insight into these underlying causes but remained concerned about Oliver's adaptability and behaviors. Oliver's mother displayed a secure attachment style and employed adaptive coping strategies, such as humor and self-assertion, which likely supported her parenting. Despite this supportive environment, the therapy did not achieve the desired outcomes for Oliver, suggesting that other factors might have influenced its effectiveness.

Overall, Oliver's case revealed challenges in both the therapeutic process and outcomes. His lack of engagement and minimal responses during sessions, combined with the therapist's negative countertransference, likely hindered the effectiveness of the therapy and influenced the outcome.

CASE STUDY METHODOLOGY

The dual case study discussed in this commentary (Brooks et al., 2025) utilizes a variety of measures to evaluate therapeutic processes and outcomes from an RCT. I commend the authors for including two cases in their study. Furthermore, they selected cases from the same RCT and used the same treatment manual for both, ensuring methodological consistency for valid comparisons. However, additional details on how these cases were selected from the larger RCT sample would have been beneficial. For instance, knowing whether these cases were representative of the broader sample and providing more information on how similar the two cases were at baseline would enhance the study's validity.

A notable strength of this study is its use of diverse and comprehensive measures. These include: (1) several quantitative outcome measures; (2) case conceptualizations and clinical vignettes based on session videos; (3) post-treatment interviews with the parent, child, and therapist; and (4) psychotherapy process coding tools applied to the sessions. Specifically, to assess outcomes, seven standardized measures were employed. Six of these measures evaluated specific aspects of the child's emotional and behavioral issues—one completed by the child and the others by the parents. The seventh measure assessed parental distress. All measures were collected at both intake and the end of treatment.

In addition to the array of outcome measures, the study utilized several detailed therapy process assessment tools to examine aspects of the therapy sessions, parental defenses, and attachment styles, as well as the therapist's countertransference. Specifically, the Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2009) was used to evaluate therapy processes in both child and parent sessions. This tool assesses patient behaviors, therapist actions, and session

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dynamics. To understand the therapist's perspective, the Therapist Response Form (TRF; Zittel et al., 2005) was employed to assess countertransference, offering insights into the therapist's emotional responses and interactions with the child. For the parent sessions, two additional measures were utilized: (a) the Defense Mechanism Rating Scale Q-Sort (DMRS-Q; Di Giuseppe et al., 2014), which evaluates parental defense mechanisms; and (b) the Patient Attachment Coding System (PACS; Talia et al., 2014; 2017), which analyzes parental attachment styles based on verbalizations during sessions. These measures highlight the significant impact of parental defenses and attachment styles on child outcomes. Additionally, qualitative insights were gathered through interviews with the child, parents, and therapist at the end of therapy.

The methodological approach employed in this study offers several strengths along with areas for improvement. The use of diverse and validated measures provides a thorough evaluation of child behavior and therapeutic interactions. The inclusion of various tools—such as quantitative outcome assessments, detailed therapy process evaluations, and qualitative insights—ensures a comprehensive understanding of therapeutic dynamics. Specifically, the Child Psychotherapy Q-Set enabled a nuanced analysis of therapeutic processes. These detailed and complex measures significantly enriched the study, offering valuable insights into how different factors influence treatment outcomes.

However, some aspects of the methodology could benefit from improved clarity. For instance, there is limited information about the rater(s) for the observer-rated measures. To enhance the study's rigor, it would be helpful to include details on who conducted the ratings, whether they were blinded to the case outcomes, and if the same rater was used for all measures. Addressing these aspects would provide a more comprehensive understanding of the research methods.

Moreover, the report provided little detail on the interview schedule, the individuals who conducted the interviews, and the methods used for analyzing the interview data. As someone passionate about qualitative research, I believe there were opportunities to better demonstrate how rigorous qualitative analysis could enhance and complement the quantitative data. For example, using Interpretative Phenomenological Analysis (IPA; Smith, Jarman, & Osborn, 1999; Larkin, Flowers, & Smith, 2021) could have provided deeper insights into the therapy experiences of both the therapist and the child. IPA focuses on understanding how individuals make sense of their experiences, capturing the subjective meaning and emotional significance from each perspective. This approach would complement observer-rated results by offering a nuanced view of the therapy process. Alternatively, Thematic Analysis (TA) (Braun & Clarke, 2006) of the interviews could have identified key themes and variations between the child, parent, and therapist. TA systematically analyzes qualitative data to uncover patterns and themes,

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providing a comprehensive understanding of different perspectives and experiences in therapy. Depending on the specific goals and questions of the interviews, tailored qualitative analysis could have further enriched the findings from this dual case study by delving more deeply into the rich data available. Similarly, while I appreciated the inclusion of case vignettes, I found myself questioning the criteria used for their selection.

Finally, while it is challenging to cover every aspect of the therapy process, given RFP-C's focus on the therapeutic relationship, a more detailed examination of how therapists manage and monitor the therapeutic alliance would be valuable. Understanding how to handle and resolve therapeutic ruptures could significantly enhance our grasp of therapy processes and outcomes. Although my strong personal interest in this topic might influence my perspective, it is crucial to acknowledge that research consistently supports the importance of the therapeutic alliance. Studies demonstrate its critical role in predicting successful outcomes in child and adolescent psychotherapy (Karver et al., 2018; Bose et al., 2022; Cirasola & Midgley, 2022).

Overall, the study is well-executed and offers valuable insights. Some additional detail on methodological aspects, such as the criteria for selecting cases and video clips, the raters involved, and the qualitative methods for analyzing interview data, could further enhance the clarity and transparency of the research. Yet, it is important to acknowledge that there are various approaches to ensuring rigor in research, each with its own considerations. Balancing these approaches with practical constraints is a key aspect of conducting a thorough and systematic case study. While there is always potential for further refinement, the current study does a commendable job of navigating these complexities and provides meaningful insights within its scope. Hence, despite some limitations—common to all research, particularly in the complex field of psychotherapy with its numerous variables—this dual case study offers a detailed and insightful analysis of both cases. It makes a significant contribution to the field of child therapy, which still lacks the depth of process research found in adult therapy. The level of detail provided is exceptional, and few studies in this domain match its depth (Halfon et al., 2017).

CLINICAL AND RESEARCH IMPLICATIONS AND CONSIDERATIONS

The detailed analysis and examination of various factors in this dual case study underscore the complexity of child therapy and the multitude of interrelated variables involved, including child factors, therapist factors, parental factors, and the dynamic interactions among them.

Factors Related to the Child, Therapist, and Therapeutic Relationship

This case study illustrates how each child brings unique challenges to the therapeutic setting, influencing both the process and outcomes of therapy. For example, Oliver's case illustrates how a child's difficulty engaging and high anxiety about participating in therapy can impact the therapeutic relationship. Specifically, his limited understanding of the reason for his referral and his preoccupation with the camera and other sources of discomfort resulted in restricted verbal communication and overly structured play. Oliver's withdrawal from therapy—demonstrated by his minimal responses, lack of spontaneity, and absence of imaginative play—hampered the therapist's ability to intervene effectively. These behaviors can be seen as 'ruptures' in the therapeutic alliance.

Alliance ruptures, which indicate tensions in the collaborative aspect of the therapeutic relationship or strains in the therapeutic bond, can represent a move away from or against the therapist or the therapy (Safran & Muran, 2000; Muran & Eubanks, 2020). Although ruptures are common in any relationship, including therapeutic ones, they can lead to poorer outcomes and higher dropout rates if not successfully addressed and repaired (Eubanks-Carter et al., 2018). It is challenging to pinpoint what might have helped resolve such ruptures. However, verbalizing and validating Oliver's potential feelings of discomfort in the therapeutic setting might have been beneficial. For instance, statements like, "I understand it might be difficult to talk to a stranger," "My questions might be hard for you to answer", and/or "Maybe there are things you don't feel like sharing with me quite yet" could have helped Oliver feel more at ease. These observations are speculative because the dual case study of Jack and Oliver lacks sufficient detail on the therapeutic alliance, including any potential ruptures and the therapist's efforts to address and resolve these issues.

Therapists' awareness of alliance ruptures and their strategies for resolution can significantly enhance treatment efficacy (Cirasola & Midgley, 2022; Cirasola et al, 2024; Muran, & Eubanks, 2020). Yet, the process of rupture repair in child therapy remains under-researched (Cirasola & Midgley, 2022), highlighting a critical area for future investigation. While substantial research on rupture and repair exists in adult therapy, with specific training for therapists (Muran, & Eubanks, 2020), this area is less developed in child therapy (Shirk & Karver, 2011; Cirasola & Midgley, 2022). Given the importance of the therapeutic relationship when working with young people, more research is needed to identify and repair ruptures in child therapy settings. Such research can inform clinical training and supervision, ensuring therapists receive the support needed to navigate challenging cases effectively. By understanding and addressing these issues, therapists can improve therapeutic outcomes and foster a supportive environment for children.

This dual case study also highlighted the importance and role of therapist countertransference. For example, Oliver's withdrawal could understandably have caused discomfort and negative feelings in the therapist. The therapist reported experiencing negative countertransference and feelings of inadequacy and frustration. Oliver's minimal engagement and flat affect may have triggered these emotions, creating challenges in establishing a strong therapeutic alliance. Negative countertransference can lead to misattunement and hinder the therapist's ability to respond effectively to the client's needs (Hayes et al., 2001). If not addressed, these feelings can become obstacles to therapeutic progress, impede the development of a strong alliance, and lead to less favorable outcomes (Muran & Eubanks, 2020), as seen in Oliver's case. This underscores the importance of providing therapists with reflective and supportive spaces when working with difficult-to-engage cases. Supervision can help therapists process and understand their countertransference reactions, preventing them from becoming overwhelmed (Ladany & Friedlander, 1995; Muran & Eubanks, 2020). Through ongoing self-reflection and awareness, therapists can also maintain a balanced perspective and adapt their approaches to better meet the needs of their clients.

Despite the difficulties in the therapeutic relationship and the lack of noticeable symptom improvement, it is especially noteworthy that Oliver shared in the post-therapy interview that he learned an important lesson: his therapist helped him understand that everyone has feelings. This realization had a positive impact on Oliver, helping him feel less alone. This suggests that he might have gained something from therapy and his relationship with the therapist that quantitative measures did not capture. This raises questions about what constitutes a good outcome when working with children. Some, like Oliver, may need more time to engage in therapy and feel comfortable expressing themselves, indicating that a slower process and lack of symptom reduction does not necessarily mean a poor outcome. This is an area for further research and understanding.

Jack's case also highlights the complexity and interplay of various factors in child therapy. Although there was an overall reduction in symptoms and a positive development in the therapeutic relationship, Jack maintained a distance from the therapist, particularly at the beginning of treatment. This distance suggested an initial reluctance to engage in self-reflection. Yet, he was able to bring his anxiety about potential terrorist attacks into therapy and responded well to the therapist's questions on these topics. The therapist's genuine interest in Jack's ideas, along with Jack's capacity for imaginative play and his awareness of the purpose of therapy (as his symptoms seemed ego-dystonic), allowed him to engage in therapy and build a strong relationship with his therapist.

During play, Jack displayed aggression toward the therapist, who received it non-defensively, demonstrating to Jack that such attacks were survivable. This communication,

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though sometimes negative, gave the therapist opportunities to clarify Jack's feelings and discuss emotionally charged topics, such as the end of sessions or treatment termination. Although Jack frequently expressed a desire to avoid therapy, especially as termination approached, these statements were seen as efforts to protect himself from losing the therapist and, therefore, a sign that a strong bond had been created between them. This bond was further highlighted in the post-therapy interviews, where Jack told the interviewer, "If you're unsure if something is dangerous, you could ask [therapist's name] to make sure it's not a bad thing." This comment reflects Jack's trust in the therapist as a reliable source of information and reassurance.

The positive therapeutic relationship was also evident in the therapist's countertransference. In Jack's case, the therapist experienced predominantly positive countertransference, characterized by strong feelings of empathy and a positive connection with Jack. This positive emotional engagement likely facilitated a strong therapeutic alliance, allowing the therapist to remain attuned to Jack's needs and adjust interventions accordingly. As a result, the therapy successfully helped Jack articulate and process his fears and anxieties, leading to significant improvements in his behavior.

Parental Factors

The cases of Jack and Oliver also provide an opportunity to explore the crucial role of parental involvement. In Jack's case, his father's shift from a predominantly behavioral approach to a more reflective and empathetic one may have significantly facilitated Jack's improvement. By focusing on understanding the emotional drivers behind Jack's behaviors rather than merely attempting to control them, Jack's father was able to provide more meaningful support. This transformation was aided by the therapist's guidance, which encouraged Jack's father to adopt a more compassionate and insightful perspective.

Parental attunement and the ability to understand behaviors in terms of underlying mental states, known as parental reflective capacity, are crucial for effective parenting**.** Parental reflective capacity is defined as a parent's ability to understand and interpret their own and their child's mental states, including thoughts, feelings, and intentions (Slade, 2005; Luyten, et al., 2017). Research indicates that this ability to empathize with and respond to a child's emotional needs can significantly enhance the child's emotional regulation and overall adjustment (Sharp & Fonagy, 2008; Rostad & Whitaker, 2018; Menashe-Grinberg et al., 2022).

However, it is important to note that Oliver's case illustrates that supportive parenting alone does not guarantee successful therapeutic outcomes. Despite Oliver's mother demonstrating a secure attachment style and employing adaptive defenses, these factors did not lead to a positive outcome for Oliver. This suggests that while supportive parenting is crucial, it must be accompanied by active therapeutic engagement and strategies tailored to the child's specific needs. Understanding these dynamics is vital for parents, who often feel guilty and may

blame themselves when their children struggle with mental health issues (Cooper & Redfern, 2015). It underscores the importance of a comprehensive therapeutic approach that includes, but is not limited to, parental involvement, highlighting that successful therapy is a multifaceted process involving collaboration between the child, therapist, and parents.

CONCLUSION

The dual case study of Jack and Oliver highlights the complex factors influencing the success of therapeutic interventions in child psychotherapy. Effective therapy goes beyond addressing the child's behavioral and emotional issues; it also requires building a strong therapeutic alliance, engaging with parents, and managing the therapist's emotional responses. These components are essential for achieving positive treatment outcomes. I commend the authors for their dedication, as empirical case studies are both time-consuming and complex. This study serves as an inspiration for clinicians and researchers, demonstrating how case study research can critically evaluate and enhance our practice. Such research is crucial for developing evidence-based therapies that cater to individual needs. Future studies should explore these dynamics more thoroughly, particularly focusing on variables like the therapeutic alliance, including its rupture and resolutions. Additionally, gathering insights from post-therapy interviews with therapists, children, and parents can provide valuable information on what facilitates or hinders the therapy process.

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