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

Reflections on Methods, Therapeutic Alliance, and Possibilities for Psychotherapy Integration in the RFP-C Cases of "Jack" and "Oliver"

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ABSTRACT

The commentaries by Cirasola (2025) and Kigin and Hembree-Kigin (2025) on the comparison case study of a successful and unsuccessful treatment of Regulation-Focused Psychotherapy for Children (RFP-C; Brooks et al., 2025) explore ways to extend the depth and breadth of child psychotherapy research; highlight the importance of therapeutic alliance research; and offer alternative perspectives on the treatment of externalizing behaviors. Cirasola (2025) notes concepts regarding the importance of case selection in comparative case studies, the crucial role of interviewers when obtaining interview data, and offers suggestions about ways to enhance analysis of qualitative data. Kigin and Hembree-Kigin (2025) approach the case studies from a behavioral perspective, using Parent Child Interaction Therapy (PCIT) as a framework for reconceptualizing the clinical material and emphasizing the importance of parents as agents of change in child psychotherapy outcomes. In our response we aim to, in essence, converse with these colleagues who have generously taken the time to read the original comparative case study and have shared their expertise with us.

Key words: Regulation-Focused Psychotherapy for Children (RFP-C); children; externalizing behaviors; oppositional defiant disorder; case study; clinical case study

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INTRODUCTION

Before undertaking a response, we want to offer genuine thanks to Cirasola (2025) and Kigin and Hembree-Kigin (2025) for their thoughtful commentaries on our dual case study of Jack and Oliver. Their detailed analyses highlight critical aspects of our research and offer valuable perspectives on the methodology, clinical implications, and future directions for Regulation Focused Psychotherapy for Children (RFP-C). We deeply appreciate the authors' recognition of the study's contributions, particularly in advancing nuanced process research within child psychotherapy. While our perspective is largely psychodynamic—and informed by child development and neuroscience research—we, like the authors of the commentaries, have a deep and abiding commitment to supporting children and families who struggle with disruptive behavior problems and seeking to alleviate these problems in a way that heals the family system. The psychological science of child psychotherapy is still in its infancy. While significant progress has been made in understanding child development and how to ameliorate distress, there is still a great deal to learn about the complex cognitive, emotional, and social processes that occur during childhood and how to study our methods for improving the lives of children and their parents. Dialogues like this one offer a unique and powerful opportunity to advance the science of helping children and families.

Our primary aims in responding to the two commentaries are to:

1. **Address the selection of the two cases in our study.** Cirasola (2025) and Kigin and Hembree-Kigin (2025) both raise important questions about case selection that were not adequately addressed in the original paper. Relatedly, Kigin and Hembree-Kigin (2025) highlight a significant confound in the multiple parent reporters used in Jack's case and we return to these important questions with acknowledgement of some of the challenges in clinical research and what is known about discrepancies in parent reports of children's distress and symptoms.
2. **Revisit the outcome data from the larger randomized controlled trial (RCT) of RFP-C.** Kigin and Hembree-Kigin (2025) reviewed the outcome data from the RCT (Prout et al., 2022). Given the relatively small sample size of that study, we discuss outcomes in the context of overall and individual level change and offer a comparison to a study of Parent Management Training—Oregon Model, which had comparable proportions of change on reliable change index scores.
3. **Discuss the methods used for qualitative data analysis.** Cirasola (2025) highlights the crucial role of interviewers when obtaining interview data and offers suggestions about ways to enhance analysis of qualitative data. These valuable insights are discussed and elaborated on.

4. **Consider the centrality of therapeutic alliance in child psychotherapy research and its central role in helping children address and master problematic feeling states.** There is a small, but growing, body of research on therapeutic alliance in child psychotherapy and Cirasola (2025) rightly points to this variable as one worthy of study. We briefly discuss the limitations of grant-funded child psychotherapy research and highlight a recently concluded, but not yet published, study of therapeutic alliance in RFP-C.
5. **Offer support for an integrative psychotherapy approach.** Finally, we build on the detailed case conceptualizations offered by Kigin and Hembree-Kigin (2025) to advance integrative and eclectic ways of thinking about how we help improve outcomes for children with disruptive behavioral problems.

One point that we have chosen not to address in-depth is the cost of implementation of PCIT and RFP-C. We did re-examine the figures cited in our original paper, drawn from the Blueprints for Healthy Youth Development website (https://www.blueprintsprograms.org/) on PCIT and our own cost estimations for training and implementation of RFP-C. Although the figures remain the same, we understand that there are many ways to "slice the pie" and do not see the utility of debating these numbers. We agree with Kigin and Hembree-Kigin that providing affordable, accessible treatment is crucial for several reasons. Early intervention can prevent the development of more severe distress later in life. Training more professionals in child-specific mental health treatments and making these treatments easily accessible ensures a broader reach, helping to meet the widespread need. Providing affordable, accessible mental health services ensures that all children, regardless of socio-economic status or geographic location, have the opportunity to receive care. This is crucial for reducing health disparities and promoting equity in health care access. We share their commitment to training, dissemination, and implementation of treatments that are cost effective and accessible for a wide range of families and providers.

CASE SELECTION

Both Cirasola (2025) and Kigin and Hembree-Kigin (2025) raise questions about how the two cases in the comparative case study were selected. Cirasola (2025) wrote that it would be helpful to have "additional details on how these cases were selected from the larger RCT sample" (p. 73) particularly whether these cases were representative of the broader sample. Kigin and Hembree-Kigin (2025) also asked for more details about the process of case selection. They raise the possibility that Jack and Oliver represented the most extreme outcomes in the RCT subject pool and also question whether these cases were selected in such a way that they would confirm the study's hypotheses.

In terms of the process of selecting the cases, the comparative case study of "Jack" and "Oliver" was undertaken within the context of a larger RCT of RFP-C. In the original RCT (Prout et al., 2022), all cases were assessed for clinically significant change utilizing reliable change index (RCI) scores (Jacobson & Truax, 1992), which were calculated for all treatment completers. The RCI is the difference between the post-treatment (Time 2) and the pretreatment (Time 1) scores on the primarily outcome measure, the Oppositional Defiant Disorder Rating Scale (ODDRS; Hommersen et al., 2006) (T2 –T1), divided by the standard error of their difference (Sdiff). Based on Jacobson and Truax's formula, which is widely used in psychotherapy outcome research to examine individual-level change, an RCI value of ±1.96 or greater indicates that there is a statistically significant reliable change from pre- to post-treatment. A statistically and clinically significant change is present when the RCI value is ±1.96 and the post-treatment score is below the clinical threshold. On average, 79.4% of children who received a full RFP-C treatment experienced statistically reductions in ODD symptoms, and of those, 26.5% were clinically significant. (For more on this, see Table 1.)

Given the racial/ethnic, socioeconomic, and chronological age (5-12) diversity of our sample in the RCT, we first sought to identify two clients from similar backgrounds from the Recovered and Unchanged groups. We calculated RCI scores for each of the resulting six participants (3 recovered and 3 unchanged) and reviewed qualitative data for each. The final two cases to be compared were chosen because (a) they had full data available and did not present any circumstances that made them particularly unique; and (b) they were also similar in age. For example, one available case was excluded because the parents did not complete the outtake interview; another was excluded due to the presence of co-morbid moderate autism spectrum disorder.

Jack and Oliver appear to be representative of the overall sample. In the larger RCT, the mean ODDRS score for all children who received treatment was 18.65 (SD = 3.50, Median = 19)) at baseline. Jack and Oliver's intake scores of 24 and 19, respectively, were both above the mean score for all children in the study. The mean ODDRS score at post treatment was 11.56 (SD = 5.24, Median = 12). Comparatively, Jack and Oliver's post-treatment scores of 6 and 17, respectively, differed from the mean by approximately one standard deviation. Given the purpose of this comparative case study—to examine psychotherapy process in a successful and an unsuccessful case of RFP-C—it is expected that these two cases would differ from the average scores for the overall sample.

Regarding Kigin and Hembree-Kigin's question about whether Jack and Oliver represent the most extreme outcomes in the RCT, Jack was one of five children who scored in the highest range on the ODDRS (total score of 23 or 25). All of these children were in the recovered or improved range at the end of treatment. Among children whose RCI scores indicated that their

symptoms were unchanged at the end of treatment, all except one were rated at 19 or 20 on the ODDRS at intake, similarly to Oliver; one child scored a 14. Given the relatively small sample size of the RCT it was not feasible to do smaller group-level statistical analyses to identify children in the recovered and unchanged groups who were most representative of those groups. However, future studies with larger sample sizes would benefit from these types of analyses to be conducted to allow for the most representative participants to be identified for case study research.

Kigin and Hembree-Kigin's (2025) question about whether these cases were selected in such a way that they would confirm the study's hypotheses is somewhat perplexing. The aims of the case study were to better understand the effects and process of RFP-C in two cases drawn from a larger RCT of RFP-C. Two cases were presented in order to help identify (a) those psychotherapy processes; (b) those child, parent, and therapist factors; and (c) those other key variables that may contribute to variable outcomes in RFP-C. We did not identify any clearly defined hypotheses and the findings do not appear to wholly support a priori hypotheses that might have been generated based on what the larger child psychotherapy literature has found. Although the therapist variables and most client factors aligned with what might be expected, there were distinct differences in what we found regarding parent factors in child psychotherapy. For example, it was surprising that Jack's father in his successful case demonstrated an avoidant attachment style and relied on slightly less adaptive defense mechanisms. Conversely, Oliver's mother in his unsuccessful case demonstrated a secure attachment style, highly adaptive defenses, and was committed to treatment.

POTENTIAL RATER CONFOUNDS

Kigin and Hembree-Kigin (2025) highlight a significant confound in the data relating to Jack's case. Unfortunately, we obtained intake data from Jack's mother and all subsequent ratings, including post-treatment ratings, were completed by Jack's father. While the use of multiple parent informants in our case study certainly reflects the realities of clinical practice in which we "use what we have", we agree that it would have been ideal to have one rater provide symptom reports for all children in our study. However, our close review of the data suggested that the change observed between Jack's mother's ratings prior to treatment and Jack's father's ratings after treatment were reflective of actual change. As we stated in the original paper, "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" (p. 42).

In thinking about Kigin and Hembree-Kigin's suggestion "the case of Jack should have been excluded from the selection pool" (p. 86), we went back to the qualitative data obtained

from Jack's father and include some of his comments here. Some of these data were not included in the original article, and we commend Kigin and Hembree-Kigin for calling attention to the need to cite them. For example, at the start of 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 were attempting 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 anxiety about the possibility of Jack needing to be hospitalized at some point in the future because of the intensity of his behavior.

In response to the question, "What changes do you continue to experience because of what you learned in therapy? What do you feel contributes to maintaining those changes?" Jack's father responded, "The changes are exponential. [We] are on a different path." In response to the question, "What was/was not helpful or useful about therapy? For your child?" Jack's father paused and then replied, "I think the interaction with an adult that is really trying to get more insight into his behavior and trying to direct him towards something better or an alternative." Finally, the interviewer also asked, "On a scale of 1-10 with 10 meaning therapy has been very helpful for your child, and 1 meaning it has not at all been helpful, how would you rate your experience in therapy?" Jack's father stated, "Definitely positive. Maybe around a 7."

These responses suggest that the potential confound of Jack's father providing lower ratings than his mother was likely minimal. His comments in the interview suggest that he experienced dramatic change—described as "exponential"—in Jack's symptoms of disruptive behavior. Though we cannot be certain that Jack's father would have rated Jack's symptoms on the ODDRS and the CBCL as high as his mother did at intake, it seems probable that the declines on these measures—below the clinical cutoff on the ODDRS and the ODD subscale of the CBCL—were representative of improvements experienced by both parents. Given these facts we decided to proceed with the case comparison despite the pre and post measures being completed by two parents.

RFP-C OUTCOME DATA

Although examining the efficacy of RFP-C was not an aim of our comparative case study, we welcome the opportunity to discuss results of the RCT. Kigin and Hembree-Kigin rightly state that in the initial RCT of RFP-C, when comparing active treatment to waitlist participants, the results indicated significant intervention effects on the primary outcome measure, the ODDRS; however, as they note, there were no significant effects found on the secondary outcome measures—the CBCL oppositional defiant problems subscale and parent and child-reported emotion regulation. As stated in the original outcome study, the CBCL oppositional defiant problems subscale contains five items meant to reflect primary diagnostic

criteria for ODD. As compared to the items on the ODDRS, which includes all diagnostic criteria for ODD, the CBCL subscale does not include items that pertain to key symptoms of ODD including children annoying others deliberately, blaming others for misbehavior, and behaviors that indicate vindictiveness.

It is also worth noting that the CBCL scores for the treatment group decreased by approximately eight points and were, on average, just one point above the clinical cutoff. As stated in the RCT paper, we identified limitations in measuring implicit emotion regulation with currently available measures, which address explicit emotion regulation. In our case study of Jack and Oliver, we noted the differentiation of these two types of emotional regulation. *Explicit* emotional regulation involves consciously employed coping strategies, such as deliberate verbal or even physical attacks against rule-makers such as parents and teachers. In contrast, *implicit* emotional regulation occurs automatically, and sometimes spontaneously, without prompting, insight or awareness, and can include maladaptive defense mechanisms, such as denial or projection (Gyurak et al., 2012, Braunstein et al., 2017).

In fact, improvements in implicit emotion regulation may be more effective and durable than changes in explicit emotion regulation (Braunstein et al., 2017; Koole & Rothermund, 2011). Our hypothesis is that there is a similarity between the psychological construct of defense mechanisms and the neuroscience hypothesis of implicit emotion regulation (Rice and Hoffman, 2014). Empirical work needs to be done to verify that hypothesis, including the idea that developing more mature/adaptive defense mechanisms in response to painful emotions is equivalent to improving implicit emotion regulation. Thus, our interpretation of the lack of findings related to explicit emotion regulation emphasized the low internal consistency for both emotion regulation measures and our belief that children's implicit emotion regulatory abilities cannot be measured by existing measures of explicit emotion regulation.

Given the small size of treatment and waitlist groups in the RCT we also examined overall outcomes for all treatment completers. Thus, children in the waitlist group received treatment after a 10-week waiting period and the data for these children were combined with that of the original treatment group and change was examined using paired-samples *t*-tests ($N = 24$). In this analysis—notably a sample nearly twice the size of the comparison groups used in the intent-to-treat analyses—significant declines were found on the ODDRS, the CBCL oppositional defiant problems subscale, the CBCL externalizing problems subscale, and parent-rated lability/negativity.

In addition to these analyses, we also examined whether improvements in child behavior was clinically significant at the individual level, using the previously described RCI scores calculated using the ODDRS, our primary outcome measure. Based on the Jacobson-Truax method (1991), children were classified as recovered, improved, unchanged, or deteriorated. The

percentages of children in each category for RFP-C are presented in Table 1. To further contextualize these outcomes, we present a comparison of RCI outcome data from the RCT of RFP-C and outcome data from a study of Parent Management Training—Oregon Model for children with externalizing behaviors by Thijssen and colleagues (2017).

The data in Table 1 suggest that individual outcomes in the RFP-C study are on par with that of parent management training interventions. It is also notable that, in contrast to the PMTO study, none of the children in the RFP-C RCT deteriorated significantly. In addition to the Prout and colleagues (2022) RCT, two other studies of RFP-C have demonstrated positive outcomes. A small pilot study demonstrated positive outcomes (Prout et al., 2019) and a slightly larger study of online delivery of RFP-C during the pandemic produced significant symptom improvement (as measured by the ODDRS and the Vanderbilt Parent Rating Scale) with large effect sizes (Storey, Nimroody, Prout, Tice, & Hoffman, 2023). Recently, Sibel Halfon completed an RCT comparing outcomes in RFP-C to those of a Parenting and Child Social Skills Group, with 40 families in each active treatment group (S. Halfon, personal communication, October 8, 2024). We look forward to seeing future published results of this study.

QUALITATIVE INTERVIEW DATA

As a leader in qualitative research with youth, Cirasola's feedback about our interview data was welcome. She asked for more detail on the interview schedule, the individuals who conducted the interviews, and the methods used for analyzing the interview data. We agree that there were missed opportunities here for a more rigorous qualitative analysis that would have enhanced and complemented the quantitative data.

On the first point regarding the interview schedule, the answer is brief. Interviews were conducted once and only at the conclusion of therapy. The interviews we developed were loosely based on those originally developed by Gunnar Carlberg and colleagues (Carlberg et al., 2009). We applaud the work done within the IMPACT-My Experience (IMPACT-ME), which is a rich and multilayered qualitative study built within the groundbreaking Improving Mood With Psychoanalytic and Cognitive Behavioral Therapy [IMPACT] study conducted in part by staff at the Anna Freud Centre where Cirasola is affiliated. In the IMPACT-ME study, interviews were conducted with adolescents and parents at the start of treatment to explore expectations of treatment, at the end of treatment to better understand the experience of therapy, and one year after the end of treatment still examining the experience of therapy but with more focus on youth who withdrew from treatment prematurely, relapsed or continued to experience benefits of treatment (Midgley et al., 2014). Regarding the second point, interviews were conducted by research assistants employed by the study.

Cirasola's insights about qualitative data analysis rest on the shoulders of her many publications that have utilized case study and qualitative methodologies to examine youth psychotherapy outcomes and their experience of these treatments. We agree with her suggestion that Interpretative Phenomenological Analysis (IPA; Smith et al., 1999; Smith et al., 2021) or Thematic Analysis (TA; Braun & Clarke, 2006) of the interviews could have identified key themes and variations between the child, parent, and therapist. Thematic analysis has been used in qualitative psychotherapy research to assess treatment perceptions in regard to treatment outcome and process (Dittmann & Jensen, 2014; Thompson-Janes et al., 2016). For example, Thompson-Janes and colleagues (2016) utilized thematic analysis to elucidate parents' perceptions after attending a therapeutic group for parents of children with behavioral disorders. Similarly, Dittmann and Jensen (2014) used thematic analysis to assess how youth experience Trauma-Focused Cognitive Behavioral Therapy.

We have conducted a yet-unpublished study that uses thematic analysis to analyze 81 post-treatment interviews conducted with 27 children, their parents, and the respective therapists who took part in the RCT of RFP-C. Thematic analysis was used to examine these post-treatment interviews to identify emerging themes from the data and to analyze similarities and differences between the perspectives of the children, parents, and therapists. These data have been analyzed but not yet prepared for publication. At the time this comparative case study of Jack and Oliver was conducted, the related qualitative study of the interview data was still underway and findings were therefore not incorporated into the paper submitted to PCSP.

However, we look forward to continued conversation with Cirasola when that paper is published. We offer a brief preview here. Based on thematic analysis of transcripts of 81 interviews, seven overarching themes were identified. One theme consisted of "enjoyment and a safe place to play." For example, a child stated, "It was a good place to talk to someone about my feelings and not let them build up and turn into a big situation."). Another theme was "a strong therapeutic relationship." For example, a child stated "It's okay to share your feelings with [the therapist]; they won't get you in trouble if you share your feelings."

Another theme that emerged was "positive treatment outcomes." For example, one parent stated,

> I can just tell in how he [the child] is um, how he just carries himself, that he, when he gets upset now, he's just able to calm and center himself which he's never been able to do before, and even if something's starts to go in a bad direction, he can really turn it around. Which he would go off the deep end before.

Similarly, a child reported in his end-of-treatment interview,

> Um, yeah. I feel like I kind of 'cause like before it's like it would usually it would just come like as a reflex basically. It's like—I—if my sister's doing something annoying that annoys

> me I kind of just yell. Like, I just yell as a reflex. But, I think I kind of understand myself better now, and I can kind of like interpret why I'm mad and then think about is it even a good reason to be mad.

As we reflect on these examples, we wonder if some are indicative of the above mentioned concept of implicit emotion regulation—the child or parent seem to describe situations that "just happen" rather than ones where there is conscious deliberation as one would see when explicit reappraisal is utilized (Koole & Rothermund, 2011). In fact, we have proposed that the concept of reappraisal should be broadened to include implicit reappraisal (Hoffman et al., 2023).

THERAPEUTIC ALLIANCE

Cirasola astutely emphasized the value of assessing therapeutic alliance in RFP-C. Her work in this area is a significant benefit to child and adolescent psychotherapists (Cirasola, Fonagy et al., 2024; Cirasola, Midgley et al., 2024). We agree wholeheartedly that the therapeutic alliance is the basic ingredient of all successful psychotherapies and broader health care interventions. Halfon and colleagues (in press) have written that the therapeutic alliance in psychodynamic child therapy fosters "a secure relational environment that enables the child to explore unconscious conflicts, express difficult emotional experiences, regulate affect, and construct new ways of relating to others."

Alliance with children and parents in RFP-C is discussed in the RFP-C treatment manual (Hoffman, Rice, & Prout, 2016). A primary goal of the initial child sessions is to establish a strong alliance between the therapist and child. In RFP-C, an alliance is fostered when the value of the real relationship between the child and the clinician is acknowledged and respected. This is done by bringing a warm and collaborative attitude to child sessions and limiting historical analytic concepts of anonymity, neutrality, and abstinence. The clinician's ability to chat comfortably with the child about everyday activities, play games, and interact spontaneously are important for the maintenance of a therapeutic alliance. This authentic and inviting stance is predicated on Anna Freud's work who stressed the importance of the child's ability to trust the therapist.

In the comparative case study of Jack and Oliver, we only explored the therapeutic alliance through the lens of therapist countertransference and the Child Psychotherapy Q-Sort. We highlighted that Jack's therapist had largely positive countertransference in her work with him, and that this likely contributed to a positive working alliance and close connection with the patient. In contrast, Oliver's therapist reported feeling helpless, inadequate, disengaged at times, and criticized. It seems likely that these variable experiences contributed in part to the development and maintenance of differing levels of therapeutic alliance in the two cases. The adult psychotherapy literature suggests that negative countertransference can manifest in the

therapist withdrawing from the client and creating a relationship that is characterized by under-involvement (Colli & Ferri, 2015).

On the Child Psychotherapy Q-Sort (CPQ) it was evident that Jack and Oliver both frequently attempted to reject the therapist or create emotional distance between themselves and the therapist. Jack expressed his negative feelings toward the therapist more directly and this created opportunities for the therapist to clarify his communications and speak about affectively laden events such as the end of the session or the termination of the treatment. In contrast, Oliver did not express many feelings toward the therapist at all, remaining neutral. In short, Jack was able to translate his distress into words whereas Oliver struggled to do this. This may have limited the therapist's ability to engage in and work through a necessary cycle of alliance-rupture-repair. However, these may have been clear withdrawal ruptures which could have been addressed more directly if the therapeutic alliance was a more central component of the treatment protocol.

Cirasola, Midgley and colleagues' (2024) psychotherapy process study of four adolescents, using the observer-based Rupture Resolution Rating System (3RS; Eubanks et al., 2015, 2019), provides valuable insights into the ubiquity of withdrawal type ruptures in psychotherapy with young people. In their study, most observed ruptures among depressed adolescents were classified as withdrawal type and included things like minimal responding or denial. They identify four categories of resolution of these ruptures. Category A involves demonstrating respect for the client's ideas and individuality, thus supporting a developmentally appropriate drive toward autonomy; Category B involves drawing attention to the rupture with gentle questioning or pauses; and Category D involves quick reestablishment of a collaborative relationship through changing topic, clarifying a misunderstanding, or providing rationale (Category D).

Category C, the most frequent method of rupture resolution, was identified as unique to psychodynamic psychotherapy and defined as "all exploratory efforts to delve into the ruptures and their underlying meaning, patterns, and/or wishes" (Cirasola, Midgely et al., 2024). These implicit and exploratory strategies are thought to help therapists to slow down the client's immediate emotional response and gently support the client's ability to regulate negative emotions. Their utility is, according to Cirasola and colleagues, dependent on the presence of a strong client-therapist alliance; the client's readiness to participate in the therapeutic process; and the therapist's ability to maintain a validating and collaborative approach. This first point—a strong working alliance as a foundation for later rupture-repair cycles—likely extends to work with children who present with externalizing symptoms and is supported by Dose and colleagues (2022) who found that the strength of the therapist-patient alliance at the beginning of treatment

predicted symptomatic improvement by the end of therapy among children with a primary diagnosis of ODD or conduct disorder.

In RFP-C we encourage the open expression of aggression towards the therapist, understanding it as reflective of a strong therapeutic alliance between the child and therapist—an alliance that can weather affective storms. It demonstrates a conviction of safety by the child with the therapist. As we quoted one child above, "It's okay to share your feelings with [the therapist]; they won't get you in trouble if you share your feelings." Our work has shown us that the open expression of aggression enables children to develop stronger emotion regulation systems by using their words instead of destructive actions. As Sigmund Freud quoted an English writer long ago, "the man who first flung a word of abuse at his enemy instead of a spear was the founder of civilization" (Breuer & Freud, 1956/1893, p. 12).

The original RCT of RFP-C (Prout et al., 2022) looked at some client and therapist-level predictors of outcome using conditional multilevel modeling; however, measures of therapeutic alliance were not used in the RCT and alliance variables were, therefore, not included in these models. Of the variables included (e.g., patient gender, condition assignment, therapist year in graduate school, and number of hours of prior psychodynamic psychotherapy experience), none predicted end of treatment ODD symptoms. The benefit of the 3RS (Eubanks et al., 2015, 2019) system is that it allows for post-hoc analysis of psychotherapy recordings to identify a wide range of ruptures and resolution strategies. We would welcome researchers who want to use our dataset of therapy videos to apply the 3RS system, modified for use with children, to explore the unfolding therapeutic alliance in these child psychotherapy cases.

Similarly, we think there is great value in exploring other common factors in child psychotherapy within the context of RFP-C. It would be valuable to know more about the role of facilitative interpersonal skills (Anderson et al., 2016)—such as the therapist having a specific, persuasive theory of change and an ability to provide hope and positive expectations—in predicting outcomes in RFP-C. Additionally, the recently concluded RCT comparing RFP-C to a Parenting and Child Social Skills Group by Sibel Halfon that was mentioned above (S. Halfron, personal communication, October 8, 2024), includes the Therapeutic Alliance Scale for Children-revised (TASC-r; Creed & Kendall, 2005). This results on this scale will offer at least some preliminary information about the role of therapeutic alliance in RFP-C.

PSYCHOTHERAPY INTEGRATION & PATIENT CHOICE

In their commentary, Kigin and Hembree-Kigin (2025) provide a detailed course of treatment for the unsuccessful case of Oliver and a brief overview of how Jack's case may have been approached. Given our interest in psychotherapy integration and our familiarity with PCIT, we read these case conceptualizations with great interest. Although there is currently no

evidence-based model of integrative child psychotherapy, we recognize the benefits of considering interventions that can consider the duality of children's disruptive behaviors. We believe it is possible that these disruptive behaviors have both meaning and function and agree with Kigin and Hembree-Kigin that parents serve as essential agents of change in ameliorating children's distress. RFP-C and PCIT share a common, central goal of reducing oppositional and disruptive behavior in children. Both are relatively brief interventions and emphasize maintaining a strong therapeutic alliance with parents. As we have explored elsewhere (Prout et al., 2018), we wonder if there is potential for these treatments, despite their rather distinct theoretical differences, to be integrated to help children and their families.

There is a huge body of research supporting the efficacy of PCIT (Cooley et al., 2014; Thomas et al., 2017; Ward et al., 2016), particularly with children ages 2-7. As with most mental health interventions for children and families, PCIT suffers from high rates of attrition ranging from 18 - 35% in outpatient settings (Thomas & Zimmer-Gembeck, 2007) to 69% in larger, community-based studies (Lanier et al. 2011; Pearl et al., 2012)—even when motivation-enhanced PCIT is offered (Webb et al., 2017). These challenges maintaining families even in short-term psychotherapy for acute problems of childhood are not unique to PCIT; they are ubiquitous across all child psychotherapy paradigms.

While many clinicians and researchers have devoted decades of work in modifying clinical interventions, testing alternative formats and durations of available treatments, these challenges remain. Anecdotally, several families in the RCT of RFP-C had completed full courses of PCIT at nationally recognized centers prior to seeking RFP-C treatment and either reported minimal effect or a sense of being "blamed" for their children's distress. They expressed relief at the option to participate in a trial that focused more on the meaning of their children's behaviors. For these reasons, we suggest that offering a wider range of treatments to families may give them greater agency and enhance outcomes. One surprising but pragmatically very important finding of our RCT was the high level of treatment completion and attendance. We found that among the 34 families who began treatment, 29 participants attended all sessions. The treatment protocol allowed for up to two rescheduled sessions per family and missed sessions beyond that limit were not rescheduled, counting as missed sessions. Overall, treatment completers attended 98.5% of parent meetings and 98.3% of child sessions; this translates to 11 (of a possible 680) sessions missed.

Kigin and Hembree-Kigin identify likely causes of Oliver's disruptive behaviors as "chaotic…inconsistent and coercive parenting" and "increasing classroom behavioral and learning expectations." They describe that Jack's timid behavior (e.g., asking the therapist to open the Lego box for him and appearing afraid of what was inside) may have simply reflected a genuine request for help and uncertainty.

In contrast, we understood Jack's behavior in this moment as evidence of his distancing himself from the therapist and a communication that he had anxiety about looking inside not only the box, but also himself.

In preparing this response to the commentaries, we revisited the videos of this scene in Jack's therapy and noted that it was difficult to fully convey the body language and nonverbal communication evident in the videos that led to this conclusion. Carly Brooks, the first author of the case studies of Jack and Oliver, works from a primarily cognitive behavioral and DBT approach and her practice offers modified PCIT and parent management training. We think naming this perspective of the first author is important in terms of contextualizing our response. We suggest that there is room for multiple interpretations of Jack's behavior to co-exist. Our aim is to shift away from the siloed psychotherapy approaches that we believe have hampered our field's ability to modify and adapt treatment to meet the needs of clients more fully. The nature of RCT studies requires very well-defined and rigid treatments in order to identify whether the change seen is, in fact, due to the intervention as it was designed. However, clinical practice requires us to be nimble and flexible, remaining open to the possibility that other schools of thought have much to offer our clients. In the words of this journal's editor, "The pragmatic paradigm in psychology seeks to transcend psychology's dialectical culture wars by developing an integrative alternative" (Fishman, 1999, p. 33).

While it is possible that Jack was simply unsure about what was in the box, our review of the video indicated that this was also a striking moment that felt heavy with meaning. Brooks' review led her to ask, "Is it possible that Jack was uncertain about what is inside the box and having difficulty opening it, and at the same time, distancing himself from the therapist and communicating reluctance to reflect on his feelings?" The collective hope of our team – who each hold very different theoretical perspectives – is that there might be room for a multitude of understandings and interpretations. We ask, is it possible for a cognitive behavioral conceptualization and psychodynamic one to be true at the same time?

Similarly, we reviewed video of Oliver's brief responses to the therapist which Kigin and Hembree-Kigin suggested might have been a child engrossed in play rather than our interpretation that he was guarded and reluctant to engage. As with our interpretation of Jack's asking for help with the Lego box, it is difficult to fully convey the nonverbal communication viewed in the videos. In our review of Oliver's videos, we noted that he was pointedly making strong attempts to keep the therapist "at arm's length" and hardly responded to the therapist's attempt to engage him. Though there were a few moments in which Oliver may have been deeply engaged in play or distracted, the predominant sense in the videos is that he was avoiding any true connection with the therapist.

One of the key components of an RFP-C treatment is "to observe instances when the child tries to distance [themselves] from topics that provoke potentially painful emotional states" (Hoffman et al., 2016, p. 127). From our perspective, the centering of the child in RFP-C allows for a deep understanding of the child's inner world which can then be communicated and translated for the caregivers' benefit. The support for imaginative play also creates space for a broader range of communication that moves beyond language and observable phenomena.

Kigin and Hembree-Kigin suggest the possibility of excluding board games from the playroom if these games hinger imaginative play. In PCIT there is a hope that oppositional behaviors will be seen in vivo during the treatment sessions so that the behaviors can be targeted and modified in real time. Similarly, in RFP-C our hope is that a child's defenses will be evident in the treatment room so that they may be addressed. A typical RFP-C playroom has a wide array of toys and games and the child-led treatment affords children the opportunity to gravitate towards activities they enjoy. Frequently these activities also highlight children's most predominant defenses which provides a wonderful opportunity for the clinician to identify and interpret these defenses. We see a strong parallel between PCIT and RFP-C in this way—the "bread and butter" of the treatment is the opportunity to engage with the child's oppositional behaviors/defenses in a new way. With RFP-C, one of the new ways of engaging with the child's oppositional behavior is to communicate to the child that their problematic behavior masks unpleasant affects which are difficult to put into words

One point of correction we would like to make is regarding Kigin and Hembree-Kigin's statement that, "The theory behind RFP-C's potential efficacy is that children expressing oppositional behaviors have under-developed emotional regulation skills, and that by pointing out their emotions to them they will develop these skills" (p. 84). The primary intervention in RFP-C is not so much to address the underlying emotions but rather to identify how the child avoids awareness of unpleasant feelings and thoughts. This gentle approach is in line with the broader affect phobia literature and the concept of "compassionately melting defenses" (Affect Phobia Therapy, 2018; McCullough, 2003). Many parents, teachers, and therapists try to encourage children to "tell me in words how you feel." Unfortunately, this approach often increases the child's defensiveness. Instead, we think it is more valuable to say to the child something like, "I know it is very hard right now to tell me in words what is going on in your mind, like your feelings." We also suggest that an affect phobia approach offers an opportunity for synergy with behavioral modalities with a goal of compassionate and gradual exposure to uncomfortable and painful emotions. In RFP-C, this is achieved by addressing the ways in which the child avoids contact with these feelings through disruptive behaviors which defend against awareness of underlying emotions.

In their commentary, Kigin and Hembree-Kigin (2025) note that "Because Jack's anxiety plays a significant role in his sour affect, frustration, and aggression, he would be better served with an adaptation of PCIT designed for young children with anxiety called the Coaching Approach behavior and Leading by Modeling (CALM; Puliafico et al., 2020) program" (p. 98). This observation highlights for us an important distinction between Jack and Oliver. As we reviewed the case descriptions, we see a basic difference between the two boys. Oliver seems to have had primarily externalizing symptoms, whereas Jack had significant internalizing symptoms as well as sensory motor difficulties. Jack's symptoms are all signs of the irritable dimension of ODD which is correlated with depression and anxiety in the future (Burke et al., 2014; Stringaris & Goodman, 2009).

Perhaps as a result of these differences, there was a differential response to RFP-C. It is important to note that PCIT as described in the Kigin and Hembree-Kigin's (2025) commentary mainly focuses on the parents' responses to the child's affect, demeanor, and behavior. RFP-C primarily addresses these issues directly with the child and offers support to parents to help them reconceptualize their child's distress. Can a system be developed with an integration of these two perspectives?

One of the concerns clinicians and researchers have about psychotherapy integration is that something will be lost or "watered down" if delivery of a packaged treatment is modified with a wider range of interventions. For this reason, we appreciate Kigin and Hembree-Kigin's description of the CALM program, which offers a modified version of PCIT for young children. Additionally, we have learned about PCIT with an emotional development (ED) module (PCIT-ED; Lenze et al. 2011; Luby et al. 2008). This approach limits the traditional first phase of Child Directed Interaction (CDI) and the second phase of Parent Directed Interaction (PDI) to four sessions each and follows this with six sessions (a) to coach caregivers to recognize emotions in themselves and others; (b) to model Emotional Regulation (ER) strategies; and (c) to reinforce ER-related components of CDI and PDI (Lenze et al. 2011). PCIT, with its emphasis on ER, has focused primarily on explicit forms of acceptance and reappraisal. We see a bridge here between a psychodynamic approach, which emphasizes implicit reappraisal (Hoffman et al., 2023), and a more behavioral approach, which focuses on explicit reappraisal. This may be one path towards considering both the actual behavior (e.g., coercive cycles of reinforcement) between parents and children *and* the intrapsychic meaning of behavior that is obscured by disruptive behaviors.

One component of RFP-C we have continued to build is around the importance of working with parents. We agree with Kigin and Hembree-Kigin that parents are essential agents of change in the child's development. Although the manualized treatment prescribes only four parent meetings (along with regular check-ins), in actual clinical practice additional parent sessions are often added. We have also developed additional resources for parents on our

website. They include: (a) an animated video to help parents identify potential underlying feelings behind disruptive behaviors; and (b) a brief parent workbook to support parents in building their own insight and capacity for emotion regulation in the face of their child's disruptive behaviors. We see these resources and our desire to support parents as a point of connection between RFP-C and PCIT.

Perhaps each model—RFP-C and PCIT—is best suited to specific types of cases, such that assigning different cases to different models would increase overall success. We consider whether Jack benefitted from RFP-C because of his responsiveness to symbolic and expressive play; while Oliver, who was not so responsive, might have done better in PCIT. Because of the small samples available for child psychotherapy research, there have been very few trials that have examined patient's choice of psychotherapy interventions. One promising study that engaged youth (ages 7-15) and their caregivers in determining target problems and treatment techniques found that families who were offered such choices experienced lower decisional conflict and regret and more involvement in treatment when compared to those who were randomly assigned (Langer et al., 2022). There were no differences in outcomes across groups. We believe patient choice in clinical trial research is a significant, yet relatively unexplored, variable that should be more central in future child psychotherapy research.

CONCLUSIONS

We are grateful for the opportunity to engage in this dialogue with colleagues whose perspectives converge and diverge with ours. One of the best parts of clinical research and practice is learning from others and stretching our frame of reference in order to better serve children and families. Our field is young and benefits from collaboration, constructive communication, and curiosity about the ways in which we help.

There are so many opportunities ahead to develop greater understanding of what works for whom and why in psychotherapy with children and their families. We believe it would highly valuable to pursue the possibility of a hybrid model integrating RFP-C's emphasis on emotional regulation with PCIT's systemic parent-coaching approach. Such a model could offer a more comprehensive intervention for externalizing behaviors that leaves space both for the observable and the intrapsychic. We are also curious about whether increasing work with parents in RFP-C might lead to stronger outcomes. Certainly, the work of PCIT highlights the centrality of parents as agents of change.

We also appreciate Cirasola's input on considering both qualitative aspects of case study research and her privileging of the relational variables that are essential in this work. There is much to be learned about how children, their parents, and their therapists experience the process of psychotherapy and how these experiences may be predictive of outcomes. We are eager to

learn more about the role of the therapeutic alliance in Sibel Halfon's above-mentioned recent study of RFP-C. We also look forward to future opportunities to explore process variables, such as the use of facilitative interpersonal skills in RFP-C.

Overall, we have benefitted from this opportunity to reflect on our work and to consider the key ingredients in successful (and unsuccessful) child psychotherapy. We thank the commentators for taking the time to offer fresh perspectives to our work and to help us consider both our clinical and research data in new ways.

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Table 1

Percentages of reliable change based on parent-report of externalizing problems.

	Recovered	Improved	Unchanged	Deteriorated
RFP-C[1]	26.5	52.9	20.6	0
PMTO[2]	16.9	45.8	25.5	11.4

Note 1. Prout et al., (2022).

Note 2. Thijssen et al., (2017).

In the study of RFP-C, "Recovered" was defined as an RCI value of -1.96 *and* symptoms below the clinical threshold at post-treatment. "Improved" was defined as an RCI value of -1.96, but not symptoms below the threshold at post-treatment. Though not clearly defined in Thijssen and colleagues (2017), we expect that this widely accepted method of distinguishing between recovered and improved was used in their study as well.