Despite the pervasiveness of problematic externalizing behaviors in children (disruptive and aggressive), there are very few well-established, evidenced-based individual psychotherapeutic approaches for children with chronic irritability and externalizing behaviors. Helping parents manage the behavioral disturbance is currently the predominant therapeutic path to helping these children (Eyberg et al. 2008; Steiner & Remsing 2007). Division 53 of the American Psychological Association considers Individual Parent Management Training as the only well-established treatment for these children. In addition, the most recent practice parameter from the American Academy of Child and Adolescent Psychiatry states that “current recommendations regarding the use of modalities such as individual therapy are based on clinical wisdom and consensus rather than extensive empirical evidence” (Steiner & Remsing 2007, page 136). It is noteworthy that both the Division 53 and American Academy of Child and Adolescent Psychiatry treatment recommendations have not been updated since 2007 and 2008.

Case studies, series of cases, and other descriptions of individual, dynamically oriented clinical work with disruptive children are common. This psychodynamic clinical history includes, among innumerable others, Bornstein (1945, 1949), Fonagy and Target (1994a, 1994b), Hoffman (1989, 2007, 2013a, 2013b, 2015), Karush (2006), and Yanof (1996a, 1996b, 2005). It is important to stress that despite the large clinical literature, to our knowledge, dynamically oriented works have not been systematically empirically evaluated with a level of methodological rigor to permit this approach’s classification as an evidenced-based treatment for children with disruptive disorders or with externalizing behaviors, who in fact are difficult to treat (Eresund 2007 and Midgley & Kennedy 2011). As a result, there has been an increasing use of psychotropic medications especially because of the difficulties these children pose for themselves and those who care for them (Olfson et al. 2012). Palmer et al. (2013) argue that behavioral problems are more resistant to a classical, insight-oriented psychodynamic approach, while CBT has real limitations in the treatment of severe disorders in comparison to psychotropic medications.

In addition to the dearth of empirically validated or empirically supported psychotherapies (other than parent management training and limited success
with variations of cognitive behavioral techniques) for children with disruptive disorders, there is a substantial amount of literature documenting the large dropout rates in child psychotherapy (Kazdin et al. 1997, Kennedy & Midgley, 2007). There are practical and emotional barriers that lead parents to discontinue their children’s therapy prematurely. Thus, any systematic individual psychotherapy for children has to include supportive work with parents and/or guardians.

**A systematic dynamic approach consistent with RDoC**

Given this state of affairs, it seems timely to provide clinicians with a systematic individual psychotherapy as an alternative to Parent Management Training (PMT), Cognitive Behavioral Therapy (CBT), and psychotropic medication for children who exhibit disruptive behavior problems.

This psychotherapy manual was developed for use by mental health professionals who work with children who have externalizing behaviors. The treatment approach may be used as a primary or as an adjunctive treatment with children who meet criteria for a variety of DSM-5 diagnoses including Oppositional Defiant Disorder (ODD), Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit/Hyperactivity Disorder (ADHD), and Conduct Disorder (CD) when an ability to empathically relate to another person remains (i.e., those children without callous-unemotional [CU] traits). Additionally, children with disorders classically conceptualized as internalizing often manifest with co-occurring oppositional and defiant symptoms, which may render them malleable to this approach. This includes Obsessive Compulsive Disorder (OCD) and Tourette’s Disorder (TD), where a rich clinical history dating back to Margaret Mahler and beyond describes efforts to address “affect-motor outbursts” (Mahler 1944, 1949) that in the current literature are described through the phenomenon of “rage attacks” (Budman et al. 2003). Indeed, increased attention to the disruptive emotional components of these (Stewart 2012) and other disorders is currently in vogue as we have previously described (Chapter 1).

From the perspective of the NIMH Research Domain Criteria (RDoC; Insel 2014), children with externalizing behaviors exhibit deficits primarily in two domains: Negative Valence Systems (i.e., systems for aversive motivation) (NIMH 2014a) and Systems for Social Processes (NIMH 2014b). They manifest problematic behaviors in the construct of “Frustrative nonreward,” which is manifested by physical and relational aggression. In the domain Systems for Social Processes, children manifest problematic behaviors as a result of difficulties with their perception and understanding of themselves; they do not manifest a developmentally appropriate perception of their competences, skills, abilities, beliefs, intentions, desires, and/or emotional states. As we have noted previously (Rice & Hoffman 2014), we propose that the modern neurocognitive concept of implicit emotional regulation (ER) is equivalent to unconscious automatic defense mechanisms. Therefore, we have chosen the term “Regulation-Focused Psychotherapy” instead of “Defense-Focused” for our therapeutic intervention.
because the term, “regulation,” is more descriptive and theory-neutral than the term, “defense.” And, in fact, as described in the RDoC domains noted above, a key feature in children with externalizing behaviors involves an inability to regulate their affective responses to negative stimuli.

The goal of defining a systematic and operationalized individual approach for children with externalizing behaviors and their parents is to allow for reliable implementation by a wide variety of clinicians. This manual will also aid in empirical evaluation of RFP-C’s impact on children, in particular their main area of deficit, implicit affect regulation. With this approach, the clinician observes the child’s disruptive symptoms and conceptualizes them as a way of avoiding an awareness of painful emotions. Over time, the clinician identifies and addresses in the psychotherapy session this pattern of avoidance of painful emotions. Over time, the clinician works with the child to identify the protective, yet maladaptive, coping devices and helps the child become able, in time, to discuss the painful emotions themselves. This process of gradual exposure to painful emotions thus shares similarity with Exposure with Response Prevention (ERP) treatment strategies. This gradual process allows for the development of more effective mastery, control, and modulation of disturbing emotions. Over time, developmental delays in the implicit emotion regulatory system can be resolved (see Chapter 4).

Working with parents

In working with the child’s parents, the clinician first empathizes with the difficulty parents experience in parenting a child with poor affect regulation. The clinician tries to communicate that their children’s disruptive behavior has meaning (e.g., there is a reason for the disruptive behavior) and helps parents identify situations that provoke negative emotions and trigger disruptions for the child. Over time, the clinician discusses methods that parents may employ in order to set behavioral limits while appreciating the child’s difficulties complying with such limits.

Roots of RFP-C

Regulation-Focused Psychotherapy for Children with Externalizing Behaviors (RFP-C) owes a debt to the original work of Berta Bornstein (1945) and Paulina Kernberg (Kernberg & Chazan 1991) with children and adolescents, as well as other authors of dynamic treatment models such as Barbara Milrod and colleagues (2007). Another important source of ideas comes from Leigh McCullough and colleagues (2003) and their conception of affect phobia in adults. Affect phobia refers to a phobia about feelings (an internal phobia in contrast to an external phobia). In their manual (page 38), these authors discuss the Triangle of Conflict derived from Malan (1979); the three poles of the triangle are as follows:

1 Feeling (the feared feeling). What is the activating feeling that is being avoided?
Anxiety (inhibitory affects). Why is that feeling being avoided? What is the excessive inhibitory affect?

Defense (a phobic avoidance reaction). How is the adaptive feeling being avoided?

**An experience-near approach**

The avoidance of thoughts, feelings, and behaviors can be conceptualized to be similar to avoidance of external phobic situations. Similar to the response-prevention component of ERP, the child is prevented from engaging in avoidance mechanisms, or established “responses.” The clinician achieves this through recognizing and commenting on the avoidance (defense) and thus disempowering their function. The emphasis remains on observed behaviors and emotions within the clinical encounter; naming of inferred instinctual drives and intellectualized “deep” interpretations are avoided. It is important to stress that RFP-C is an “experience-near” treatment whereby the clinician mainly speaks with the child about the “in-the-moment” interaction between child and clinician and minimizes discussion of what he/she heard from the parents and/or school. This technique allows the clinician to help the child observe and discuss the inevitable repetitions in the sessions of the maladaptive problematic externalizing behaviors. In addition, since this technique does not require the clinician to infer the children’s motivations that are not observable, it is a technique that allows for ease of replicability and facilitates RFP-C’s capability for empiric studies of treatment efficacy.

Additionally, this style of engagement in emotion and behaviors also allows for a synchrony of language with the implicit ER system in which these children have deficits (Rice & Hoffman 2014). It is the premise of RFP-C that these children’s reliance on avoidant and externalizing behaviors result from developmental delays in implicit emotion regulation (ER) capacities. Children remain unable to tolerate dysphoric affects through dissipation of the painful or intolerable aspect of the emotion, and they thus avoid it. Their disruption occurs not only as a manifestation of autonomic arousal wrought by the undigestable/unregulatable emotion, but also as a self-reinforcing tactic to influence the environment away from the painful content. By addressing the externalizing behaviors as methods of avoidance, the RFP-C clinician does not allow this diversion tactic to continue endlessly.

**Implicit emotion regulation dysfunction**

To develop this concept further, an underdeveloped implicit ER system results in heightened prolonged limbic, hormonal, and autonomic nervous system arousal when these children are challenged with strong and painful emotions. These biochemical changes promote impulsive action and, when coupled with the cognitive
distortions and errors in judgment afforded by their denials and projections, they cause major and multiple problems in these children’s lives. RFP-C removes roadblocks to normative development by safely exposing children in the sessions to their feared affects and thereby promoting the maturation of ER processes. When introducing the process of therapy to parents with children who are experiencing maladaptive externalizing behaviors, the clinician should be mindful of these principles as a way to explain the nature of the child’s symptoms as well as the nature of the treatment.

Some children may require more specialized interventions than those described in this manual. These include children with clinically significant disturbances in their capacities to relate to other people and children with significant problems in their sense of reality. They will thus be excluded as “good candidates” for RFP-C, unless it is clear to the clinician that the child’s problems with relatedness and sense of reality are manifestations of a maladaptive coping strategy (as opposed to a psychotic or autistic spectrum disorder).

**A short-term approach**

RFP-C is a short-term, 16-session approach to irritable and disruptive children who frequently have tantrums. The psychotherapy has been designed to target the specific functional deficits in these children, that is, deficits in their implicit emotion regulation capabilities. RFP-C’s foundation, within the RDoC approach, can be hypothesized to target circuit-level processes between prefrontal, limbic, and sympathetic/parasympathetic systems. Affective neuroscience has shown that persistently irritable children have deficits within this emotion regulation system (Deveney 2013), and that targeted interventions may correct aberrant neural signatures in children with externalizing symptoms (Woltering 2011). For example, Bebko et al. (2014) found that “reduced left ventrolateral prefrontal cortex activity to win may reflect reward insensitivity in youth with disruptive behavior disorders” (p.71).

The first step is to systematically implement RFP-C and determine whether it is clinically effective via the application of systematic empirical clinical rating scales and other measures (e.g., The Affective Reactivity Index [ARI; Stringaris et al. 2012]). Because of its hypothesized theoretical basis within the brain-based ER system, attempts at correlating results of RFP-C with biomarkers may be later considered.

Some of the children who will be treated with RFP-C will have symptoms consistent with ODD, especially those who experience a great deal of irritability (Stringaris and Goodman 2009). Based on existing literature on the neuroscience of externalizing behaviors, we hypothesize that a central mechanism leading to the disruptive behavior in these children is a result of the utilization of a variety of psychological mechanisms (defense mechanisms), explicit and implicit, to avoid the experience of painful emotions.
Central features of RFP-C

There are three central features of RFP-C:

1. By following the child’s play and verbalization, the problematic symptoms that lead to disruption at home and/or at school will inevitably be repeated with the clinician.

   The clinician, thus, has the opportunity to observe directly the child’s maladaptive behavior and the trigger to the child’s maladaptive behavior (for example, in a situation, when the clinician says, “No” to a child’s attempts to hit the clinician).

2. The child’s difficulties regulating his/her emotions may become manifest at such moments.

3. From the beginning of psychotherapeutic work in RFP-C, the clinician addresses the sequence of events with the child as they occur and are experienced in the session, with the goal of helping find more adaptive emotion regulation mechanisms, such as avoiding explosions when faced with a “No,” even if he/she feels angry and hurt.

   A child can automatically, without conscious deliberation, utilize the mechanism of avoidance of painful emotions. At other times, a child can consciously avoid addressing a painful topic, such as parents’ divorce by saying: “Let’s not talk about that anymore; let’s go back to our chess game.”

   RFP-C works through an integrative therapeutic approach that combines elements of behavioral therapy (limiting dangerous behavior in the therapy room) with those traditionally termed psychodynamic (allowing the child to lead the play and discussion in order to understand the meaning of the child’s symptoms and behavior). In RFP-C, it is useful to conceptualize:

   1. The child’s emotions that are avoided;
   2. How the emotion is being avoided; and
   3. Trying to understand why that emotion is being avoided in a maladaptive way.

   Malan’s (1979) “Triangle of Conflict” and its utilization by McCullough et al. (2003) in the treatment of adults has influenced the development of this manual. Parents may be provided with material that discusses the process of therapy (see Appendix A).

   In children with externalizing behaviors, one can observe their difficulties experiencing negative emotional responses (to a “No,” for example). Such a child may want to leave the playroom immediately upon hearing the word “No.” By so doing, the child masks the emotional-response-to-be-avoided by becoming angry at the clinician, wanting to leave him (a maladaptive response). The goals
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of RFP-C are to try to understand why that original emotion had to be avoided so dramatically and to help the child find more adaptive emotional regulation devices. When introducing the process of RFP-C to parents with children who are experiencing maladaptive oppositional symptoms, the clinician needs to bear in mind this “triangle of conflict” as a way to explain the nature of the child’s symptoms as well as the nature of the treatment.

The manualization of this approach permits hypothesis testing and empirical study of this approach for these children. In addition, utilization of this manual may one day enable the study of the impact of RFP-C on the neurobiology of these children through the examination of biomarkers and their responsivity to treatment. For example, these youth show increased limbic activation with frustrating stimuli (Deveney et al. 2013), and they are hypothesized to have commensurate deficits in the prefrontal regions which modulate limbic responsiveness. The explosion of interest in the ER concept (Gross 2013) and the increasing transition to a transdiagnostic, brain-based dimensional system (Insel et al. 2010) means not only that biomarkers may be increasingly developed when the time for evaluation presents, but that such efforts will be accessible to a wide range of academic clinicians and researchers.

Procedure of RFP-C

The procedure for RFP-C will encompass three steps:

Step 1: An introductory meeting/s with the parents, two initial sessions with the child, and a feedback meeting with the parents. Ongoing check-ins and meetings with parents are crucial in order to develop a therapeutic alliance with the parents as well as with the child. As described in the manual, the clinician needs to carefully listen to parents, empathize with their plight, and carefully explain the process, as well as help them understand the nature of the problems at home and school and help them develop more effective interactions with the child.

Step 2: Sessions 3–11 (the bulk of the treatment) consist of the clinician addressing how the child responds to situations that trigger unpleasant emotions in the sessions with the clinician. In the language of psychodynamics, the clinician will address the defenses the child utilizes to ward off painful emotions in the transference. By directly addressing the child’s maladaptive coping mechanisms that the child manifests explicitly and directly, the clinician does not have to guess what is on the child’s mind. These sessions will be conducted twice weekly. Throughout the treatment, the clinician will recommend to the parents that they meet regularly and contact him/her whenever they need to report some event. The clinician will meet with the parent briefly every week in order to maintain a therapeutic alliance with them, provide support, and discuss with them the ongoing progress of the child, helping them understand the child and helping them find ways to deal with the child’s externalizing behaviors. In the middle of the treatment (after about session 10), the clinician will meet with the parents in an in-depth way to review the progress and to prepare for the termination which will occur.
Step 3: Termination Step during sessions 12–16.
In Appendix B, we delineate adherence scales for these various steps in the treatment.

**Goals of RFP-C**

Finally, it is crucial to note that the focus of this treatment is not to promote cognitive (intellectual) change in the child (classical insight) (“Oh, now I understand”) but to promote implicit awareness in the child that

1. The emotional state being avoided by the child is not as overwhelming as he/she thinks it is and that it will not destroy him/her.
2. There are better ways to manage those emotions than to fight.
3. That the clinician will not be hurt by those feelings and those feelings will not destroy the clinician.

The clinician, by understanding that the behavior has meaning, is always implicitly communicating to the child that his/her externalizing behaviors have meaning as well as implicitly communicating a nonjudgmental attitude towards the child.

**Note**

1. For information, see http://effectivechildtherapy.com/content/disruptive-behavior-problems-odd-cd

**References**


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