

Why Is It Easier to Get Mad Than It Is to Feel Sad? Pilot Study of Regulation-Focused Psychotherapy for Children

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Objective: This article reports results of a pilot study of three participants receiving regulation-focused psychotherapy for children (RFP-C), a manualized, short-term, psychodynamic treatment for children with oppositional defiant disorder and other externalizing problems. RFP-C targets implicit emotion regulation while using an intensive, psychodynamic, play therapy approach to decrease the child's need for disruptive behaviors.

Methods: Three children with oppositional defiant disorder participated in a trial of RFP-C. Externalizing symptoms were assessed with the Oppositional Defiant Disorder Rating Scale, and emotion regulation was assessed with the Emotion Regulation Checklist.

Results: All three children improved in accordance with expectations. Participants exhibited clinically significant and reliable change, as assessed by the primary symptom measure, and demonstrated improved capacity for emotional regulation.

Conclusions: Results suggest that RFP-C has the potential to produce significant improvements in emotion regulation capacity and in symptoms of oppositional defiant disorder. This pilot study provides initial support for RFP-C as an efficacious and cost-effective intervention, with high treatment compliance rates, and lays the groundwork for a randomized controlled trial of the intervention.

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Externalizing behaviors are common in a wide range of child mental health problems. Oppositional defiant disorder is the leading reason for referral to youth mental health services, with a lifetime prevalence of 10.2% (1). The *DSM-5* (2) describes the disorder as a recurrent pattern of developmentally inappropriate levels of negativistic, defiant, disobedient, and hostile behavior toward authority figures. Children with disruptive behavior disorders, such as oppositional defiant disorder, are more likely to have impaired academic progress, early substance use problems, and higher rates of adult incarceration (3, 4). A significant proportion of children with acute externalizing behaviors have poor longitudinal outcomes in terms of psychopathology and functional ability (1). The disorder also is a strong predictor of generalized anxiety disorder, panic, and depression in adulthood (5). Although a diagnosis of oppositional defiant disorder increases a child's risk for poorer outcomes across the lifespan, the disorder is highly variable in its presentation and developmental trajectory.

CURRENT TREATMENT APPROACHES

Psychosocial treatments are the preferred first-line treatment for disruptive behavior problems (6). Current

evidence-based approaches for elementary school-age children with oppositional defiant disorder include behavioral parent training (7–9), family skills training approaches (10, 11), and the collaborative and proactive solutions intervention (12). There are two components to all behavioral parent

HIGHLIGHTS

- Oppositional defiant disorder is the leading reason for referral to youth mental health services.
- Cost-effective treatments that foster treatment completion and address the implicit emotion regulation deficits of the disorder are needed.
- Regulation-focused psychotherapy for children (RFP-C) is a manualized, psychodynamic treatment for children that reduces symptoms of oppositional defiant disorder and activates more adaptive forms of implicit emotion regulation.
- This pilot study provides preliminary support for the efficacy of RFP-C and lays the groundwork for a larger-scale randomized controlled trial of the intervention.

training approaches: working to improve the parent-child relationship and providing parents with more effective behavior management strategies, such as positive attending, contingent attention, reinforcement, and the use of time-out procedures (13). These interventions help parents define and monitor their child's behavior, improve their parenting practices, and apply consistent and effective discipline to encourage prosocial behaviors. Family skills training builds on traditional behavioral interventions by offering children and parents their own skills groups and providing structured opportunities for the family to practice together (11). Collaborative and proactive solutions is a cognitive-behavioral model that emphasizes helping adults and children to develop skills to collaboratively resolve issues of disagreement (14).

The aforementioned treatment approaches have demonstrated efficacy with modest effect sizes across multiple studies. However, child psychotherapy interventions are limited by the elevated attrition rates among vulnerable populations, because of factors such as low socioeconomic status, ethnic minority status, parental functioning, maternal stress, low parental motivation, and child symptom severity (15–18). Poor treatment compliance and outcome also are attributable to the fact that parent-focused models of treatment contradict parents' beliefs that the cause of the problem resides within the child (19–21). Effectiveness of these programs is dependent on parental engagement in the treatment (22), and because of the considerable time commitment required by such programs, participation may not be feasible for parents facing high levels of stress (16). Nearly one-third of treated children do not benefit from traditional behavioral interventions (17, 18), and positive effects have been shown to decline posttreatment among disadvantaged families (23). Finally, parent training modalities are relatively expensive psychotherapy interventions that, as a result, are not always widely available in community care settings (24).

It has also been argued that none of the cognitive and behavioral interventions described above adequately address implicit emotion regulation (25–27). Previous research has demonstrated the importance of addressing the affective and emotion regulation components of oppositional defiant disorder (28–31). In contrast to the *DSM-5* criteria for the disorder, which focus on a set of behaviors, it appears that oppositional defiant disorder is best conceptualized as a disorder of emotion regulation rather than simply a disorder of behavioral dysregulation (26, 29, 30, 32). Negative emotionality, coupled with deficits in self-regulation, have been identified as primary precursors to behavioral difficulties

TABLE 1. Participant characteristics, pilot study of regulation-focused psychotherapy for children (RFP-C) with oppositional defiant disorder (ODD)

Participant characteristic	Child 1	Child 2	Child 3
Age (years)	9	5	8
Race-ethnicity	Black/non-white Hispanic	Black	White
Medication	No	No	No
Diagnosis ^a	ODD, dysthymia	ODD	ODD, enuresis
Estimated FSIQ ^b	83	95	91
Prior therapy	Yes	No	Yes
School type	Public	Public	Public
Family income	0–19,999	20,000–39,999	120,000–139,999
Caregiver 1 education	College	Some college	Graduate degree
Caregiver 2 education	N/A	GED	GED

^a Diagnosis of ODD, as assessed via the Kiddie-Schedule for Affective Disorders and Schizophrenia-Present/Lifetime and the Child Behavior Checklist.

^b FSIQ=Full-scale intelligence quotient (IQ); average IQ score in the population is 100, with a standard deviation of 15.

such as those evident in oppositional defiant disorder (33). Given these findings, there is a need for treatments that are cost-effective, encourage treatment compliance, and address the core implicit emotion regulation deficits that are evident in the disorder.

REGULATION-FOCUSED PSYCHOTHERAPY FOR CHILDREN (RFP-C)

Regulation-focused psychotherapy for children (RFP-C) (34) is a manualized, time-limited, psychodynamic treatment for children with externalizing behaviors that aims to activate more adaptive forms of implicit emotion regulation. The RFP-C treatment approach, along with many clinical examples, are described in the manual and several associated publications (25, 26, 34–37). The intervention consists of 16 individual play therapy sessions with the child and four parent meetings, delivered over the course of 10 weeks. RFP-C conceptualizes disruptive symptoms as maladaptive attempts to regulate emotions. When certain emotions are too difficult for children to consciously experience or verbalize, they involuntarily rely on aggressive, disruptive behaviors to hide from these painful emotions and remove them from their awareness (26, 35). In essence, for these children, it is easier to get mad (e.g., act out) than it is to feel sadness, guilt, loss, or shame. Disruptive behaviors divert both the child's and the caregivers' attention away from the underlying and painful affect. These psychological processes are similar to impaired implicit emotion regulation capacities (26, 38). The term *emotion regulation* suggests internal adjustments and compromises that are made in the service of emotional homeostasis; this concept contrasts with behavioral approaches that emphasize emotional restraint (27).

Although there is a long history of psychodynamic psychotherapy being used in the treatment of disruptive behavior problems (34, 35, 39–42), RFP-C is the first attempt to systematize the process of addressing children's defense mechanisms against unpleasant emotions. Throughout the course of the play therapy sessions, the clinician notices and

TABLE 2. Change in ODD-RS scores for three children receiving 10 weeks of RFP-C^a

Child	Intake	Completed	Difference	$E \Delta^b$	Cohen's d^c	RCI ^c	Classification
1	8	4	-4	-.5	.79	-1.97	Recovered
2	19	14	-5	.5	.98	-2.46	Improved
3	13	9	-4	-.5	.79	-1.97	Improved
Mean	13.33	9	-4.33	-.17	.85		

^a ODD-RS, Oppositional Defiant Disorder Rating Scale. Scores range from 0 to 24, with higher scores indicating greater symptom severity. RFP-C, regulation-focused psychotherapy for children.

^b Values indicate how far the difference score for each case is (positive or negative) from the expected difference of 4.5 points.

^c Computed with the same weighted SD as was used for the computation of the reliable change index (RCI) described above. This value of d was consistent with the expected effect size of $d = .879$ (4.5 expected difference) used for the power analysis.

gently identifies the child's defensive behaviors and verbalizations when they occur. This iterative and gradual exposure to avoided, and largely unconscious, feelings improves the child's implicit emotion regulation abilities (25, 35, 43), thereby enabling the child to function better in his or her environment. RFP-C also includes parent meetings that encourage caregivers to develop an understanding of the meaning of the child's behavior.

The purpose of this study was to evaluate changes in oppositional and defiant symptoms and emotion regulation among children participating in RFP-C. Three cases were selected for inclusion to obtain initial data in preparation for a larger randomized controlled trial, now underway. We hypothesized that participants' symptoms of oppositional defiant disorder would decrease, and emotion regulation would increase, after treatment and at the three- and six-month follow-ups.

METHODS

Participants

Three children and their caregivers participated in this pilot study. Nine parents took part in the initial phone screening, and six were invited for an in-person intake interview along with their children. Participants who were excluded at each stage of screening received referrals for treatment elsewhere. All participants were assessed for parental and child trauma history as part of the intake process. While there were no reports of acute traumatic events (e.g., natural disasters or abuse) and none of the participants met diagnostic criteria for posttraumatic stress disorder, all families reported one or more stressful life events (e.g., divorce, death of grandparents, financial stressors). In accordance with the RFP-C model, which emphasizes attending to painful affect, stressors reported for each child and family were taken into account by the treating clinician. A summary of demographic and other characteristics of participants can be seen in Table 1.

Procedures

The study protocol was reviewed and approved by the Albert Einstein College of Medicine Institutional Review Board.

Parents and/or caregivers responded to postings in the community and online by calling the intake coordinator. Those who met the phone screening criteria ($N=6$) attended an in-person intake where caregivers provided informed consent and children provided assent for participation. Three families, who completed the full intake process and met inclusion criteria, were enrolled.

Inclusion criteria for the children were ages 5–12 years, met *DSM-5* criteria for oppositional defiant disorder, fluent in English, and able to attend treatment twice a week for 10 weeks. Children with comorbid disorders were included. Exclusion criteria were the

presence of psychosis or suicidal or homicidal risk, current enrollment in another therapy program, anticipation of major medication changes during the trial, and intellectual disability. The RFP-C treatment manual (34) was used by the study therapists (3rd- and 4th-year students in a psychology doctoral program) to deliver the intervention. All therapy sessions were video recorded, and the recordings were reviewed in weekly supervision meetings.

Measures

At intake, parents completed the Kiddie-Schedule for Affective Disorders and Schizophrenia–Present/Lifetime (K-SADS-PL) (44), a psychiatric diagnostic interview for school-age children. Clinical presentation was confirmed with subscales of the Child Behavior Checklist (CBCL) (45), which was completed by parents before and after treatment. Children's intellectual functioning was assessed at intake with the Wechsler Abbreviated Scale of Intelligence (two-subtest form), and parents' English fluency was assessed with the Word Reading subtest of the Wechsler Individual Achievement Test–III.

Symptoms were assessed with the Oppositional Defiant Disorder Rating Scale (ODD-RS) (46). Respondents rate the eight symptoms of the disorder using a 4-point response scale ranging from 0 (not at all) to 3 (very much). The ODD-RS has good internal consistency ($\alpha=0.92$) and moderate interrater reliability between caregivers ($r=0.70$). Parents completed the ODD-RS at intake, weekly throughout the treatment, at the conclusion of treatment, and at follow-ups.

Emotion regulation capacities were assessed with the Emotion Regulation Checklist (ERC) (47), a 24-item parent report questionnaire that assesses children's emotion regulation capacities. Reliability coefficients are high for the overall scale (0.89) and for the two subscales (lability/negativity=0.96, regulation=0.83).

A research assistant, who was not one of the staff providing the intervention, interviewed parents after the treatment concluded. Interview prompts were adapted from those described in an earlier study of children's expectations and experiences of psychodynamic psychotherapy (48).

Data Analysis

Power analysis. A power analysis was conducted targeting change in scores on the ODD-RS as the focal outcome measure. For this study, the average effect size for symptom change from a recent meta-analysis of externalizing disorders was used ($d=0.879$) (49). An estimated mean for children with a diagnosis of oppositional defiant disorder on the ODD-RS was 14.94 ($SD=5.30$), compared with children without a diagnosis, whose mean was 7.83 ($SD=4.97$) (46). Using an effect size of $d=0.879$, we expected a mean reduction of 4.5 points on the ODD-RS after treatment.

Cutoff scores for inclusion. A cutoff score of 8 on the ODD-RS was chosen, corresponding to standard norms (44) and endorsement of four or more of the symptoms on the scale being characteristic of the child's current behavior. This criterion is consistent with *DSM-5* criteria for a diagnosis of oppositional defiant disorder.

Reliable change index (RCI). Clinically significant and reliable change was assessed by creating classifications of "recovered," "improved," "unchanged," or "deteriorated" based on the cutoff score and an index of measurement error, the reliable change index (RCI) (50). The RCI determines, for each case, whether posttreatment change was significant, over and above measurement error. The RCI is the difference between the posttreatment and pretreatment scores divided by the standard error of their difference. RCI scores of 1.96 or greater indicate that there is a statistically and clinically significant reliable change from pre- to posttreatment. Given the small sample size of this study, we used the weighted average of the standard deviations reported for groups with and without a diagnosis to calculate the standard error (44).

RESULTS

Treatment Compliance

All three families in this study completed treatment and maintained attendance throughout the treatment protocol. Specifically, of 60 possible sessions (16 child sessions plus four parent meetings across three cases), only one child session was missed.

Outcomes

After 10 weeks of treatment with RFP-C, all three children showed improvements in accordance with expectations and the a priori power analysis. An overview of the RFP-C protocol is available in the online supplement. Detailed data for change in ODD-RS scores and emotion regulation (ERC) can be seen in Tables 2 and 3, respectively. Figure 1 presents changes in ODD-RS scores for each participant throughout RFP-C treatment and at the three- and six-month follow-ups. One participant was lost to follow-up at the six-month time

TABLE 3. Change in emotion regulation of three children receiving 10 weeks of RFP-C^a

Child	Scale	Intake	Completed	Difference	Cohen's d	RCI
1	Emotion Regulation	19	21	2	.42	2.00
1	Lability and Negativity	31	31	0	.00	0
2	Emotion Regulation	21	24	3	.64	3.00
2	Lability and Negativity	33	30	-3	.64	-7.32
3	Emotion Regulation	26	31	5	1.06	5.00
3	Lability and Negativity	34	26	-8	1.70	-19.51

^a As measured with the Emotion Regulation Checklist. Subscale scores range from 8 to 32, with higher scores indicating greater emotion regulation. Lability and Negativity subscale scores range from 15 to 60, with higher scores indicating greater dysregulation. RFP-C, regulation-focused psychotherapy for children; RCI, reliable change index.

point. Improvements in oppositional and defiant symptoms appear to have been maintained at follow-up for the sample overall (see Table 4).

Parents' Experiences of RFP-C

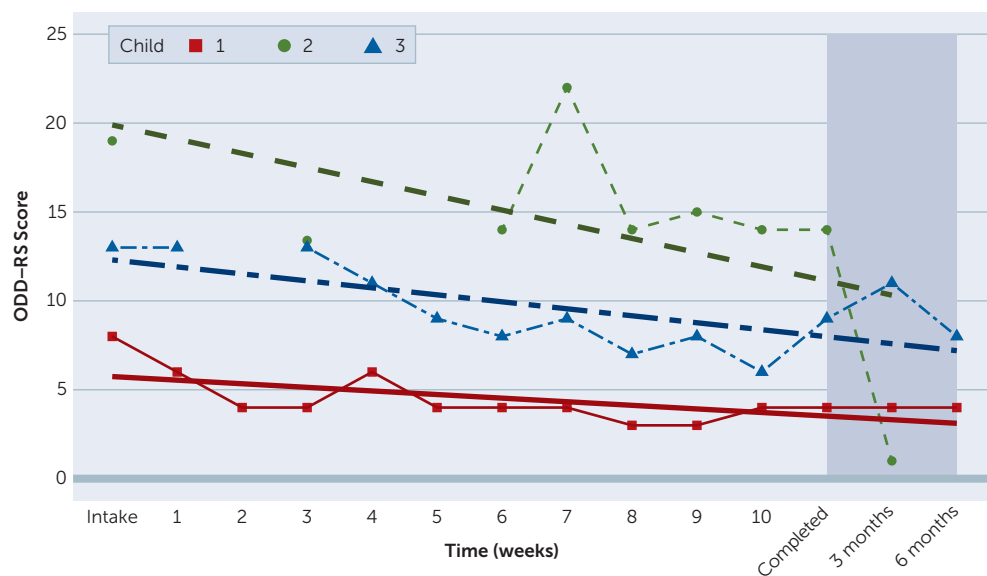
The responses parents gave in end-of-treatment interviews were uniformly positive about the experience of participating in RFP-C. To protect their identities, we have used all male pronouns to refer to the child participants. Parents described a sense of relief at receiving help for their children and being empowered to understand their children's oppositional behavior. One parent stated, "I think therapy was very helpful. I wish therapy could have been a little longer... It helped him so much. He looked at things differently. The time from February until now, he is a different kid." Another parent explained changes after RFP-C this way, "I can tell you the tantrums are not long and drawn out like they were. They are less frequent. He stopped wetting the bed. That is huge. I didn't expect to see change so quickly. I'm seeing the changes already. And I'm sorry I didn't start it sooner. I wish I would have." The only negative feedback was a repeated comment that parents wished the therapy had lasted longer than 20 sessions.

DISCUSSION

This study is the first empirical examination of RFP-C treatment response among children with oppositional defiant disorder. Our hypothesis that children would experience a decrease in symptoms after treatment was supported. One child began with relatively fewer symptoms and experienced enough improvement to be classified as recovered. The two other children, with higher levels of oppositional and defiant behavior at the start of treatment, experienced greater improvement and were classified as improved at the end of treatment. Two of the three participants were in the recovered range at the three-month follow up.

There was also support for the hypothesis that RFP-C would be associated with improvements in the children's abilities to manage difficult emotions. All three children demonstrated clinically significant improvements in emotion regulation. Two demonstrated significant decreases in lability and/or negativity, and one demonstrated no change in

FIGURE 1. Oppositional Defiant Disorder Rating Scale (ODD-RS) scores over the course of treatment for the three children^a



^a Each point represents an ODD-RS score. The center line for each child shows the trend over the course of the treatment. Possible scores range from 0 to 24, with higher scores indicating greater symptom severity.

ability or negativity. Finally, parents reported a positive experience in the exit interviews, suggesting the possible utility of RFP-C among families who have traditionally had difficulty in traditional behavioral treatment. This pilot study provides preliminary support for further investigation of RFP-C. A larger-scale randomized controlled trial is now under way.

Dropout rates from psychotherapy interventions appear to have improved during the last 20 years as more tailored approaches have emerged; however, premature termination from child psychotherapy persists, with about 1 of every 3.5 clients dropping out of cognitive-behavioral treatments (51) and even higher attrition rates among those with disruptive behavior problems (52). It is notable that all the families in this study completed treatment and maintained attendance throughout the treatment protocol. Additionally, the intervention was cost-effective to administer (\$3,333 per clinician) compared with behavioral parent training interventions (\$73,000 per trained clinician) (24). We anticipate that the average cost to deliver RFP-C can be reduced to approximately \$2,500 per clinician for future studies.

TABLE 4. ODD-RS scores at intake and follow-up for three children in a 10-week pilot study of RFP-C^a

Time point	N	Mean	SD	Range
Intake	3	13.33	5.51	8–19
End of treatment	3	9.00	5.00	4–14
3-month follow-up	3	5.33	5.13	1–11
6-month follow-up	2	6.00	2.83	4–8

^a ODD-RS, Oppositional Defiant Disorder Rating Scale. Scores range from 0 to 24, with higher scores indicating greater symptom severity. RFP-C, regulation-focused psychotherapy for children.

This was an initial pilot study to evaluate the effectiveness of a manualized, psychodynamic intervention for children with oppositional defiant disorder. Our sample size was small, and there was no control group. A randomized controlled trial of RFP-C with a substantially larger sample size is currently under way and will add to our understanding of this treatment approach. Additionally, this study relied on parental reports of the child’s symptoms; however, parents appear to be valid reporters of children’s externalizing behaviors and social functioning (53). Future research should incorporate teacher and clinician reports of be-

havior. As with any pilot data, the sample size constrained our ability to evaluate for treatment moderator effects. Variables such as income and education, degree of callous-unemotional traits, and the role of adverse childhood experiences will be evaluated in future studies with sufficient sample sizes.

CONCLUSIONS

The high prevalence of oppositional defiant disorder and other disruptive behavior problems and the difficulties these disorders cause for children and their families suggest the importance of treatment protocols that can provide relief in a cost-effective manner. Given that oppositional defiant disorder presents an inordinate burden on health care expenditures (on par with asthma, epilepsy, or diabetes) (54) and the high rates of attrition in currently available psychotherapy approaches, there is a great need for innovative methods that can be delivered by professionals with a range of clinical experience and across a variety of settings. This pilot study provides initial support for RFP-C as a clinical intervention for children with oppositional defiant disorder. Findings suggest that RFP-C is associated with significant lessening of symptoms and improvements in emotion regulation capacities. Additionally, RFP-C can be delivered as a cost-effective, brief, psychotherapy intervention that appears to help families to maintain attendance and complete the treatment.

In classrooms and families, children are often identified because of oppositional behavior that creates problems for those around them. The profound difficulties these children have managing the unpleasant emotions that they experience as intolerable are less readily apparent. Although the presenting problem is the disruption or aggression the child

displays, contemporary, neuroscience-informed models suggest that these symptoms are signals of underlying impairments in emotion regulation. RFP-C works to remove roadblocks to managing difficult and unpleasant emotions, especially in children who have profound deficits in this area.

Explicit emotion regulation strategies, such as effortful distraction and cognitive reappraisal, are the primary targets of cognitive-behavioral interventions. In contrast, implicit regulatory strategies (much like defense mechanisms) are automatic, and thus outside of the child's awareness. Yet, these strategies negatively affect children's ability to cope with negative feelings and life stressors. In fact, a child's capacity for implicit emotion regulation may be more important for a child's emotional functioning than explicit skills to manage disruptive behavior (26, 35, 55). The procedures in RFP-C are designed specifically to engage children and families who have not done well in treatments emphasizing explicit skills. The clinician's focus on the child's in-session behaviors (e.g., remaining experience-near) and gradually increasing awareness of the meaning and the implicit purpose of disruptive behavior (e.g., protecting the child from painful affect), allows children to build implicit emotion regulation abilities in a safe, therapeutic environment. Parent meetings in RFP-C also empower parents to adjust their expectations and understanding of the child so that the home environment can better support these children as they begin to modify the quality, intensity, and duration of their emotional response. Close attention to children's difficulties with shame, guilt, sadness, and loss—as is the norm in RFP-C—may help facilitate greater and more lasting recovery from oppositional defiant disorder and other externalizing disorders.

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