NEGATIVE EMOTION EXPRESSION AND EMOTION REGULATION IN REGULATION FOCUSED PSYCHOTHERAPY FOR CHILDREN (RFP-C) WITH EXTERNALIZING AND COMORBID INTERNALIZING/EXTERNALIZING PROBLEMS

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Duru Eğrilmez
122639004

Assoc. Prof. Dr. Sibel Halfon
Istanbul Bilgi Üniversitesi _________________

Assist. Prof. Dr. Pelinsu Bulut Özer
Istanbul Bilgi Üniversitesi _________________

Assist. Prof. Dr. Nur İnci Namlı
İstanbul Doğuş Üniversitesi _________________

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Name Surname: Duru Eğrilmez

Signature:

ABSTRACT

Emotion regulation refers to how children utilize various strategies to manage the intensity and duration of their emotions, as well as the way they process emotional experiences. Difficulties in emotion regulation have been linked to the development of externalizing problems in children leading to growing emphasis on therapeutic approaches that address these regulatory difficulties. Regulation Focused Psychotherapy for Children (RFP-C) is a time-limited psychodynamic treatment model developed for children aged 5 to 12 who exhibit externalizing problems. In RFP-C, externalizing behaviors are conceptualized as maladaptive defenses against unbearable emotions such as sadness, shame or guilt, resulting from impairments in implicit emotion regulation capacity. By systematically interpreting children's defenses, the therapist aims to help the child increase emotional tolerance and find adaptive ways to express these unbearable feelings. While limited research has demonstrated the effectiveness of RFP-C in reducing externalizing symptoms and improving emotion regulation, there remains a lack of empirical studies investigating how affective processes evolve throughout therapy. The present study aimed to examine how children's emotion regulation and negative emotion expression change over the course of RFP-C, using the Children's Play Therapy Instrument. It was hypothesized that anger expression would decrease while sadness expression and emotion regulation would increase over the course of therapy. The study was conducted as part of a Randomized Controlled Trial (RCT) at Istanbul Bilgi University. The sample consisted of 34 school-aged children with externalizing and comorbid internalizing/externalizing problems. Three therapy sessions per child were coded for affect regulation and affect expression using the CPTI. Repeated measures ANOVAs revealed a significant increase in anger expression across sessions, while sadness expression and affect regulation remained stable. These findings suggest that increased anger expression may reflect a shift from defensive acting out to symbolic processing of aggression through play. The stability of sadness expression highlights the need for more sensitive tools to detect subtle emotional changes, while the absence of change in emotion regulation may reflect the non-linear nature of therapeutic progress

and highlight the need for more frequent session-level assessments and fine-grained analytic methods to detect subtle changes over time.

Keywords: Emotion Rregulation; Negative Emotion Expression; Externalizing Problems; Child Psychotherapy; Process Research

ÖZ

Duygu düzenleme, çocukların duygularının yoğunluğunu ve süresini yönetmek ve duygusal deneyimlerini işlemleme biçimlerini kontrol etmek için kullandıkları çeşitli stratejiler anlamına gelir. Duygu düzenlenlemedeki zorluklar, çocuklarda dışavurumcu problemlerin gelişimiyle ilişkilendirilmiş ve duygu düzenleme güçlüklerini hedef alan terapi yaklaşımınlarına artan bir vurguya yol açmıştır. Çocuklar için Düzenleme Odaklı Psikoterapi (RFP-C), 5 ila 12 yaş arasındaki dışavurucumcu davranışlar sergileyen çocuklar için geliştirilmiş, süre sınırlı bir psikodinamik tedavi modelidir. RFP-C'de dışavurumcu davranışlar, örtük duygu düzenleme kapasitesindeki yetersizlikler nedenliyle üzüntü, utanç, suçluluk gibi dayanılmaz duygulara karşı geliştirilen uyumsuz savunmalar olarak kavramsallaştırılır. Terapist, çocuğun savunmalarını sistematik biçimde yorumlayarak çocuğun katlanmakta zorlandığı duygulara karşı toleransını artırmayı ve bu duyguları daha uyumlu yollarla ifade etmesini sağlamayı amaçlar. RFP-C'nin dışavurumcu semptomları azaltma ve duygu düzenleme becerilerini geliştirmedeki etkinliğini gösteren sınırlı sayıda araştırma olsa da, terapi sürecindeki duygusal süreçlerin değişimini inceleyen ampirik çalışmalar halen yetersizdir. Bu çalışma, Çocuk Oyun Terapisi Aracı (CPTI) kullanılarak çocukların oyun içerisindeki duygu düzenleme ve olumsuz duygu ifadesi (üzüntü ve öfke) düzeylerinin RFP-C boyunca nasıl değiştiğini incelemeyi amaçlamıştır. Öfke ifadesinin azalacağı, üzüntü ifadesinin ve duygu düzenlemenin ise artacağı hipotez olarak öne sürülmüştür. Çalışma, İstanbul Bilgi Üniversitesi'nde yürütülen bir Randomize Kontrollü Çalışma'nın (RKÇ) parçası olarak gerçekleştirilmiştir. Örneklem, dışavurumcu ve eş tanılı (içedönük/dışavurumcu) sorunlara sahip 6-12 yaş aralığında 34 okul çağı çocuğundan oluşmaktadır. Her çocuğun üç terapi seansındaki (başlangıç, orta ve son) duygu düzenleme, öfke ifadesi ve üzüntü ifadesi CPTI kullanılarak kodlanmıştır. Zaman içerisindeki değişimi incelemek için yinelenen ölçümler varyans analizi (ANOVA) uygulanmıştır. Sonuçlar, terapi sürecinde öfke ifadesinde anlamlı bir artış olduğunu, ancak üzüntü ifadesi ve duygu düzenleme düzeylerinin sabit kaldığını göstermiştir. Bu bulgular, artan öfke ifadesinin, savunmacı dışavurumdan oyunda öfkenin simgesel olarak işlenmesine doğru bir geçişi yansıtıyor

olabileceğini düşündürmektedir. Üzüntü ifadesinde değişim olmaması, daha örtük duygusal değişimleri tespit edebilecek duyarlı ölçüm araçlarına ihtiyaç olduğunu düşündürürken, duygu düzenleme becerisindeki sabitlik terapötik ilerlemenin doğrusal olmayan doğasına işaret etmekte ve zaman içindeki küçük değişimleri yakalayabilmek için süreç içerisinde daha çok terapi seansının kodlanıp değerlendirilmesi ile ayrıntılı analiz yöntemlerine olan ihtiyacı ortaya koymaktadır.

Anahtar Kelimeler: Duygu Regülasyonu; Olumsuz Duygu İfade Etme; Dışa Yönelim Problemleri; Çocuk Terapisi; Süreç Araştırması

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To my mother, for all the vitality, and for making the world feel full of wonder

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INTRODUCTION

Emotion regulation refers to how children utilize various strategies to manage the intensity and duration of their emotions, as well as the way they process emotional experiences (Hoffman et al., 2023). Expanding research underscores the trans-diagnostic significance of addressing emotion regulation skills (Fernandez et al., 2016) and its critical role in both the development and persistence of externalizing behaviors (Cavanagh et al., 2017; Compas et al., 2017; Mitchison et al., 2019). Moreover, a growing body of literature highlights that extreme negative emotionality is associated with externalizing behaviors (e.g., Clark et al., 1994; Lengua et al., 1998). While anger and irritability have been associated with externalizing disorders (Eisenberg et al., 2001), research has also indicated that sadness and fear can be present in children with externalizing disorders (Eisenberg et al., 2005; Lemery et al., 2002).

Many therapeutic treatment models have been developed to assist school-aged children who struggle to understand, express and regulate their dysphoric emotions (Hoffman et al., 2023). Regulation Focused Psychotherapy for Children (RFP-C) is one of the time limited psychodynamic treatment models specifically designed for children between the ages of 5 and 12 with externalizing symptoms (Hoffman et al., 2016). According to Hoffman et al. (2023), children who struggle to consciously experience and verbalize their distressing emotions due to impairment in their emotion regulation capacity (Ramsden & Hubbard, 2002) are more likely to exhibit externalizing behaviors. They exhibit aggressive behaviors as a defense mechanism for protecting themselves from unbearable emotions such as sadness, anxiety and fear. In other words, in RFP-C literature these externalizing symptoms serve as a form of emotion regulation, helping them cope with painful feelings they struggle to regulate effectively (Rice, Hoffman, 2014). In RFP-C, through systematic interpretation of the child's defenses the goal is decreasing the child's need to act out when confronting unbearable distressing emotions and increasing their ability to regulate these previously avoided emotions (Prout et al., 2021).

While play therapies have demonstrated positive outcomes in improving children's emotional and behavioral functioning, most studies have primarily focused on overall symptom reduction rather than exploring how affective processes in play evolve throughout the therapy (Bratton et al., 2005). The high prevalence of externalizing behaviors and their significant impact on child development have been well documented, but research on focusing on these problems within psychodynamic child psychotherapy literature is limited. Research by Halfon and colleagues has provided initial insights into changes in emotion regulation and affect expression during psychodynamic child therapy. For instance, Halfon and Bulut (2017) found that improvements in emotion regulation followed a nonlinear trajectory in the therapy process and the treatment adherence significantly influenced these changes. In another study, Halfon et al. (2019a) demonstrated that the expression of negative emotions in therapy predicted improvement in children's emotion regulation.

Despite these contributions, there is a notable absence of studies in the literature examining how children's negative emotion expression and emotion regulation evolves throughout the course of RFP-C. To address this gap, this study aims to track changes in children's expression of negative emotions, specifically sadness and anger, and emotion regulation across three time points of the RFP-C treatment, using the Children Play Therapy Instrument (CPTI; Kernberg et al., 1998). The following sections will review the relationship between externalizing symptoms and emotion regulation difficulties, as well as the role of negative emotion expression in externalizing behaviors. Empirical literature on emotion expression and emotion regulation in child psychotherapy will also be reviewed. Finally, the theoretical foundations and key therapeutic mechanisms of RFP-C were introduced, and the existing empirical literature on RFP-C will be summarized.

2. LITERATURE REVIEW

2.1. Emotion Regulation Challenges in Children with Externalizing Behaviors

Children's problems are classified into two categories, such as internalizing and externalizing behaviors (PDM Task Force 2006; Achenbach & Edelbrock 1978). Internalizing problems refer to the difficult emotions that the child feels within, while externalizing behaviors are when the child acts out these emotions or his/her conflicts through behaviors instead of verbalizing them (Hoffman et al., 2016). This distinction highlights that children who have internalizing disorders tend to overcontrol their behavior, which leads to depression, fear, and anxiety. On the other hand, children who have externalizing disorders have difficulty controlling their behavior, including aggression, which results in conduct disorders and attention deficit/hyperactivity disorders (Vaillancourt & Boylan, 2015). In conclusion, children with internalizing and externalizing disorders are often characterized by their inability to regulate negative emotions (see Eisenberg, Spinrad, & Eggum, 2010 for a review). Building on this, extensive research indicates that impairments in emotion regulation are a fundamental component of psychological challenges in children with internalizing and externalizing disorders (Brenning et al., 2021; Cavanagh et al., 2017). Furthermore, several studies emphasize the critical role of emotion regulation in both the emergence and persistence of externalizing problems (Cavanagh et al., 2017; Compas et al., 2017; Halligan et al., 2013; Mitchison et al., 2019; Mullin et al., 2007).

In particular, externalizing behaviors are among the most common mental health challenges faced by children and their families. These behaviors are the most frequent reason for seeking help from specialty clinics (Loeber et al., 2000) because they impact children's academic success, social relationships, and adaptive functioning (Leadbetter & Ames, 2016). These children believe that their difficulties stem from their environment. Because they have difficulty using adaptive coping mechanisms, their insight into their actions is limited. It is important to understand this lack of insight not merely as a cognitive weakness, but as a maladaptive coping mechanism. They also struggle with

recognizing their own emotion dysregulation. Because of the lack of insight, it is very difficult for them to consciously reflect on and respond to questions about their emotional world (Prout et al., 2021). These dysfunctional coping strategies may arise from deficits in child's emotion regulation capacity. Consequently, they rely on primitive defense mechanisms like denial and projection. From an early age, children with externalizing problems tend to overly sensitive to negative emotions and become easily frustrated. In this context, aggression serve as a defensive reaction to avoid unbearable emotions, rather than a simple attack on a perceived enemy (Hoffman et al., 2016). In order to comprehensively understand the roots of these challenges, it is important to explore how emotion regulation develops during early childhood and how this process is influenced by parent-child relationships.

2.1.1. Normal Development of Emotion Regulation

Before exploring the development of emotion regulation, it is important to address the discussions in the literature regarding the differences between affect and emotion. According to Panksepp and Pincus (2004), affect refers to the subjective experience of emotions, whereas emotion is understood as a broader concept that encompasses various components. On the other hand, Gross (2014) describes affect as an umbrella term covering stress reactions, mood states, and emotions. Hoffman et al., (2016) concluded that the differentiation between the affect and emotion remains ambiguous, and therefore, the terms are frequently considered interchangeable. In line with this perspective, the present study will use these terms interchangeably too.

Emotion regulation commonly defined as an individual's ability to manage, change, and control the intensity and length of emotions (Eisenberg et al., 2010) and begins to develop during the early stages of infancy (Kopp & Neufeld, 2003). The research on emotion regulation literature is divided into two main categories: implicit and explicit emotion regulation processes (Gyurak, et al., 2011). Explicit emotion regulation involves the conscious coping mechanisms of the individual to think about how to express and manage their emotions (Etkin et al., 2015). Implicit emotion regulation involves processes that modify emotional responses, such as their intensity and duration, without requiring

conscious control or deliberate effort (Koole & Rothermund, 2011, p. 390). These unconscious processes frequently result in corresponding shifts in the behavioral markers of emotional reactions (Braunstein et al., 2017). As children grow, they learn how to regulate their intense emotions through their early relations with their families. The parent's ability to regulate both their own and their child's emotion is essential, as healthy regulating strategies of the parents can significantly foster their child's regulatory development (Rice et al., 2021). Regarding this, the infant-caregiver relationship provides a critical framework for children's emotional development, particularly through the attachment patterns formed during infancy. According to the existing literature, children with a secure attachment style demonstrate a higher capacity for understanding both their own and others' emotions and thoughts -conceptualized as mentalization-, and for effectively regulating their emotions (e.g., Stern, 1985; Beebe & Lachmann, 1994; Fonagy et al., 2002). Conversely, children who have experienced trauma or abuse, resulting in insecure attachment, often struggle to express their own emotions and to understand those of others (Cicchetti & Barnett, 1991; Maughan & Cicchetti, 2002). Therefore, early childhood trauma affects the development of emotion regulation (Kim & Cicchetti, 2010). Given these challenges, understanding these dynamics underscores the importance of examining early parent-infant relationship in depth to gain insights into how emotion regulation capacities evolve during infancy.

Infants depend on their caregivers to regulate their emotions and gradually internalize the caregiver's soothing strategies (Eisenberg et al., 2010). Thus, it is essential for caregivers to recognize and make sense of their infant's emotions encountered in daily life (Fonagy et al., 2002). Infants convey their developing positive emotions, such as joy and excitement, and negative emotions, such as fear and anger to their caregiver, enabling the caregiver to help regulate these emotional states (Schore & Schore, 2014). When caregivers are sensitive to the infants' emotional cues and can read and mirror these emotions effectively, they begin to understand and make sense of their internal states (Beebe et al., 2012). Therefore, encouraging the children to express their emotions and engage in mentalization supports the development of the child's emotion regulation capacity (Schore, 2001; Sroufe & Sroufe, 1995). On the other hand, if the caregiver responds insufficiently or excessively to the child's negative states it can hinder the

child's emotion regulation capacity (Kim et al., 2014). For instance, caregivers with a history of trauma may freeze in response to their child's negative emotions, escalating the child's aggression and leading to aggressive behaviors such as biting or hitting. Others may respond punitively to their children's negative emotional states. Such reactions limit children's opportunities to experience sensitive and regulatory interactions, hindering their ability to develop emotion regulation skills (Tronick et al., 1978). Ultimately, both positive and negative interactions between child and the caregiver play a crucial role in shaping child's self-regulation skills and influencing the development of implicit emotion regulation capacity (Campos et al., 2011).

2.1.2. Negative Emotionality in Children with Externalizing Behaviors

For healthy development, the ability of children to verbalize and discuss their negative emotions plays a crucial role (Lagattuta, 2014). According to the American Psychiatric Association (2013), certain forms of psychopathology are characterized by high levels of negative emotionality. There is a large body of literature indicating that extreme negative emotionality is associated with both internalizing and externalizing behaviors (e.g., Clark et al., 1994; Lengua et al., 1998). The following paragraph will explore the role of negative emotionality in children with externalizing behaviors.

Katan (1961) highlights the essential role of verbalization in managing impulsive behaviors among children with externalizing problems. She emphasizes that language functions as a mediator between innate impulses and a child's capacity for emotion regulation. According to her, children who act out their emotions rather than expressing them verbally are likely to develop patterns that make them prone to acting out in adulthood. In line with this view, children who struggle to consciously experience and verbalize their distressing emotions are more likely to exhibit externalizing behaviors (Hoffman et al., 2023). Furthermore, children who have externalizing problems cannot express their emotions in an adaptive way due to impairments in their emotion regulation capacity (Ramsden & Hubbard, 2002). This difficulty may lead to the development of various symptoms (e.g., Kranzler et al., 2016). To be more specific, dysphoric affects such as fear, anxiety, and depression are associated with internalizing problems, while

anger and irritability are linked to externalizing problems (Eisenberg et al., 2001). Although anger and irritability are the primary underlying emotions behind children's externalizing behaviors, the negative reactions they receive in response to their behaviors such as bullying, lying or defiant actions further increase their frustration and anger (Eisenberg et al., 2005). On the other hand, sadness and fear have also been found to be present in externalizing disorders (Eisenberg et al., 2005; Lemery et al., 2002). According to Asher et al. (1990), one of the reasons that children with externalizing problems may experience anxiety and sadness is their tendency to be rejected frequently by peers that can lead to social isolation. Moreover, Eisenberg et al. (2005) indicated that the negative responses from family and adults resulting from children's behavioral problems may increase their anxiety, depression and fear. Due to the difficulties they experience in social interactions, children with externalizing behaviors also struggle to sustain daily activities and academic tasks. The challenges they encounter in their daily social and academic lives are likely to increase their anxiety and even depressive symptoms.

2.1.3. Emotion Regulation and Negative Emotion Expression in Child Psychotherapy

According to Winnicot (1971), play is a fundamental aspect of childhood. It facilitates children's cognitive, emotional and social development (Isenberg & Quisenberry, 1988). In child psychotherapy, play serves as a medium to help children express their emotions, regulate affects and navigate inner conflicts (Chethik, 2003). Through play, children enact their inner worlds, attributing thoughts, intentions and emotions to imagined characters. It helps them to develop their capacity to experience different parts of the self (Fonagy & Target, 1997). Children can explore both their positive and negative emotions in the safe realm of play, which provides a secure and structured environment. Through play, children may have a chance to enhance their positive emotions while diminishing negative ones (Halfon et al., 2016).

Building on the idea that play facilitates emotion expression, the concept of emotion expression in psychotherapy has been defined as the extent to which a patient deeply experiences and expresses their feelings throughout therapy (Greenberg & Pascual-

Leone, 2006). Psychodynamic treatment models for children (Kernberg & Chazan, 1991) highlight the importance of experiencing and verbalizing emotions, particularly negative affect which is closely related to the patient's symptoms. Empirical research supports this association: expression of negative emotions and/or aggression in children's disorganized play was found to predict externalizing symptoms (Von Klitzing et al., 2000). Furthermore, children with externalizing problems tend to exhibit higher levels of negative affects, specifically aggression, during play (Dunn & Hughes, 2001; Halfon et al., 2016) and show poor affect regulation capacity (Halfon & Bulut, 2017). Children diagnosed with conduct disorder and attention deficit hyperactivity disorder often express more negative affects, including hostility and anger, and demonstrate reduced capacity to regulate and organize their emotions in their play (Butcher & Niec, 2005).

Given the established link between externalizing problems and emotion regulation difficulties, several studies have explored how emotion expression and emotion regulation manifest in child psychotherapy. Since children with externalizing problems have difficulties regulating their negative emotions, they also struggle with organizing symbolic play. These children have difficulty expressing their negative emotions verbally and organizing them coherently within the play context. As a result, they become overwhelmed by these emotions, preventing them from achieving the adaptive distance necessary to organize symbolic play effectively (Fonagy et al., 2002). However, research also suggests that that children who express their negative emotions during play, are better at processing their traumas. According to researchers, the reason behind this is that play helps children find more adaptive ways to cope with their negative emotions by providing a space for them to identify and integrate those emotions. This adaptive process depends on the extent to which these emotions can be expressed by the child during play (Gaensbauer & Siegel, 1995).

In Türkiye, Halfon et al. (2016) examined affective changes in children receiving psychodynamic play therapy. The study included 20 children aged 4 to10 presenting with internalizing and externalizing problems. The authors analyzed 289 play segments across 120 sessions. Their findings showed that children with externalizing problems exhibited higher levels of anger in early sessions compared to children with internalizing problems.

However, no significant change was found in anger expression over time. In a subsequent study, Halfon and Bulut (2017) examined the relationship between adherence to mentalization principles and improvements in symbolic play and emotion regulation. The study followed 48 children with behavioral problems and analyzed 329 therapy sessions to track changes over the psychodynamic therapy process. Results indicated nonlinear trajectory of change: while symbolic play initially increased before stabilizing, affect regulation first declined and then improved later in treatment. They also found that higher adherence to mentalization principles was linked to greater improvements in affect regulation, whereas children in low-adherence treatments showed no significant change. These findings highlight the important role of therapist's attunement and reflective functioning in fostering children's emotions through symbolic play. Moreover, the study emphasized the therapeutic importance of play as a medium for emotional processing. According to the findings, mentalization based interventions can increase emotion regulation capacities in children with behavioral problems. In another study, Halfon et al. (2019a) investigated the relationship between in-session negative affect expression and treatment outcomes. Their findings showed that negative emotion expression during treatment focusing on mentalization interventions significantly predicted improvements in children's emotion regulation and overall positive outcome. Thanks to this study, it was understood that the expression of negative emotions such as sadness, fear and anxiety in a therapeutic environment where the therapist seeks to understand and attune to the child's emotions was linked to improvements in the child's emotion regulation capacity.

2.2. Regulation Focused Psychotherapy for Children (RFP-C)

Regulation Focused Psychotherapy for Children (RFP-C) is a structured, time limited psychotherapeutic approach specifically developed for children aged 5-12 who experience emotion regulation difficulties and exhibit disruptive behaviors (Prout et al., 2019). According to Prout et al. (2018), RFP-C shares foundational principles with other psychodynamic psychotherapy approaches and child centered play therapy. In contrast, RFP-C is a short-term approach uniquely designed to address the cluster of symptoms associated with disruptive behaviors and to explore the underlying meaning of children's

actions (Prout et al., 2018). The model aims to promote more adaptive forms of implicit emotion regulation and foster resilience by addressing the child's maladaptive defense mechanisms. By improving implicit emotion regulation capacities, children often become better at expressing their painful emotions verbally and reducing the need to act out aggressively (Prout et al., 2019). The theoretical framework of RFP-C, which bridges psychodynamic psychotherapy with affective neuroscience (Rice & Hoffman, 2014), will be discussed in the next section, followed by an exploration of its key therapeutic interventions.

2.2.1. Theoretical Framework of RFP-C

To understand the theoretical framework of RFP-C, it is important to explore the main foundational works that influence this model. The original work of Berta Bornstein (1945) which played an essential role in developing the technique of addressing defenses against painful emotions in children, forms the foundation of contemporary approaches, including RFP-C. Moreover, the affect-oriented approach developed for working with children with conduct disorder (Kernberg & Chazan, 1991) has influenced RFP-C, particularly regarding the conceptualization of aggressive behavior. In their overview, Kernberg and Chazan define aggressive behavior as "often an unconscious effort to ward off the awareness of feelings of being disregarded and devalued (p. 29)." According to them, children with disruptive behaviors have developmental deficits. Thus, the goal of their therapy model is enhancing children's capacity to manage emotions verbally rather than acting them out through actions. Both treatment models have contributed to the RFP-C by providing perspectives on understanding aggressive behaviors and offering systematic techniques, especially defense interpretation, to help children in managing their painful emotions.

RFP-C model highlights an important theoretical connection between affective neuroscience and the psychodynamic model by emphasizing the compatibility of implicit emotion regulation with defense mechanisms. In other words, contemporary neurocognitive concept of emotion regulation aligns with the concept of unconscious automatic defense mechanisms. The main similarities between implicit emotion

regulation and defense mechanisms are that both operate primarily on an unconscious level and serve to protect individuals from anxiety caused by unpleasant emotions. They begin to develop in infancy and continue to evolve throughout the lifespan (Rice & Hoffman, 2014). From Cramer's (2006) point of view, defense mechanisms are unconscious strategies that individuals rely on to manage overwhelming anxiety or distressing emotions. As Rice and Hoffman (2014) suggest, these processes resemble the emotion regulating functions of neural networks in the brain which develop and evolve through normative developmental processes. As children grow, their ways of handling emotions become more complex. For instance, the defense mechanism of denial is dominant in early childhood, followed by projection in elementary school, and identification becoming more prominent in adolescence (Cramer, 2006). The use of mature defenses, such us humor and sublimation, is more adaptive while the use of immature defenses, such as denial and projective identification leads to psychological problems in children (Porcerelli et al., 2016). More specifically, children with externalizing behaviors rely on immature defense mechanisms due to impairments in their implicit emotion regulation (Cramer, 2014).

In line with this, RFP-C model conceptualizes externalizing behaviors as manifestations of maladaptive implicit emotion regulation or defenses that the child uses to hide or block out painful emotions from their consciousness. As suggested by Rice and Hoffman (2014), children with externalizing and comorbid problems may display aggressive affect as a way to shield themselves from the emotional dysregulation caused by experiencing dysphoric emotions such as sadness, anxiety and fear. These children are unable to regulate these emotions due to lack of higher order cognitive processes, which involve the use of more mature defense mechanisms. Their only way of dealing with sadness is avoidance or denial (Hoffman et al., 2016). Expanding on this perspective, Cole and Zahn-Waxler (1992) proposed that the expression of anger and aggression may serve as a defense to conceal underlying sadness or other dysphoric emotions. In this way, disruptive behaviors redirect the attention of both the child and the caregiver from the underlying unbearable emotions (Hoffman et al., 2016). In this respect, the primary goal of the RFP-C is to decrease the child's need to act out when encountering painful emotions while increasing their ability to tolerate, process and verbalize previously

avoided feelings (Prout et al., 2021). The specific interventions that are used to increase implicit emotion regulation will be discussed in following section.

2.2.2. Key Therapeutic Mechanisms in RFP-C

The history of RFP-C is based on children play therapy (Axline, 1947) and defense interpretation (Bornstein, 1945; Hoffman, 2007; McCullough et al., 2003). RFP-C integrates these historical techniques with contemporary findings that emphasize the essential role of implicit emotion regulation (Etkin et al., 2015). In this integrative therapeutic model, the main focus is one aspect of psychodynamic therapy: addressing children's defenses or implicit emotion regulatory mechanisms that help them to manage their unbearable emotions. In this regard, RFP-C is a first manualized technique that systematizes how therapists can address defenses while working with children exhibiting disruptive behaviors (Prout et al., 2015).

RFP-C is a play therapy approach that creates a communicative space through unstructured play. In RFP-C, the main aim is not enhancing children's play developmentally or adaptively, in contrast it fosters aggressive and regressive themes in play for the benefit of the therapeutic process (Prout et al., 2020). From the perspective of RFP-C, there is a meaning behind all behaviors. In line with this perspective, repetitive and disruptive themes in children's play also have meanings. The primary focus is on verbal and nonverbal disruptions that occur in the child's play and communication flow (Prout et al., 2020). Disruptions are understood as efforts to avoid unpleasant and distressing emotions (Prout et al., 2015). In RFP-C, three therapeutic processes are useful. First, the therapist pays attention to the topics that cause disruption, in the play or discussion. Second, the therapist tries to understand the hidden emotion that leads to the disruption. Third, the therapist assesses the nature of the play or the topic, when the disruption happens. As time goes by, the therapist begins to understand why the avoided affect is so overwhelming for the child. It is important to note that sharing these observations with the child and addressing the defenses takes time. The primary goal of the therapist in the early phase of the treatment is to build a therapeutic alliance. At the beginning of the therapeutic process, it is crucial for the therapist to avoid interfering the

child's denial or labeling the underlying sad affect that the child denies, as this could lead the child become more defensive or defensively aggressive (Hoffman et al., 2016).

In the second phase of the treatment, the therapist begins to address the child's maladaptive defenses by empathically joining the child and recognizing the unconscious automatic strategies that the child uses to take care of him/herself (Prout et al., 2020). The therapist's interpretations should be developmentally appropriate for the child and conveyed in a respectful manner. Because RFP-C is an experience near treatment model, the therapist's comments are based on interactions occurring in the here and now between the child and the therapist. The clinician helps the child to identify the avoidance strategies in order to understand his/her own emotions better (Hoffman et al., 2023). The clinician focuses on interpreting the child's defenses instead of interpreting the emotion underlying them. In this way, the therapist avoids speeding up the process and prevents the child from feeling exposed or humiliated (Prout et al., 2019). Through the gradual and consistent examination of the defenses that protect the child from internal anxiety, the goal is to create a safe environment where the child feels less overwhelmed when experiencing these painful affects. Sharing a safe relationship with the therapist helps the child experience and express distressing emotions. In this supportive relationship, children are repeatedly exposed to these emotional triggers during sessions, a process known as "working through", and through this gradual exposure, the intensity of these emotions decreases for the child. It is crucial to note that this process is iterative and therapist's interpretations are guided by the child's emotional readiness. For example, if the child has difficulty leaving the room at the end of the session and becomes angry, the first step is addressing the overt emotion: aggression. The therapist might say "When I said the time is over, you got angry with me." The next step involves adding the painful experience to the sentence: "You do not want to leave because you don't want to see another child come into this room, so you get angry." The final step will be addressing the painful emotion behind the child's aggression: "When I said the time is over, you felt sad." (Hoffman et al., 2016, p. 74). Step by step, if the child is prepared enough to the next step, the therapist can deepen the interpretation with more specific comments. The consistent interpretation of the children's defenses helps the children gaining insight into their painful emotions and the unconscious behaviors they use to protect themselves from

these emotions (Hoffman et al., 2023). With this developing awareness in the supportive environment, the child’s tolerance for painful feelings increases, resulting in a decrease in the use of maladaptive defense mechanisms. Some children begin to elaborate on their emotions and fantasies verbally throughout the process, while others can only start to discuss their painful emotions openly (Hoffman et al., 2016). In RFP-C, these therapeutic interventions help the children feel less overwhelmed by painful emotions and gain better control over their emotions. The improved capacity of the implicit emotion regulation increases the child’s self-control and leads to more adaptive social interactions.

2.3. Empirical Studies of RFP-C

As explained in previous chapters, RFP-C is a structured, time-limited therapy model developed for children experiencing emotion regulation difficulties and exhibiting disruptive behaviors (Prout et al., 2019). The main therapeutic mechanism of RFP-C involves addressing the child’s defenses underlying painful emotions and increasing their implicit emotion regulation capacity throughout the therapy process. Several studies investigated both the outcomes of RFP-C in reducing externalizing symptoms and the therapeutic processes that facilitate change. However, there is a gap in the literature regarding the specific changes in emotion regulation capacity and negative affect expression in children's play throughout the RFP-C. Consequently, this study aims to address this gap by examining the changes in emotion regulation and emotion expression across different time points in therapy, using the CPTI. More specifically, the study focuses on changes in expression of sadness and anger, as well as emotion regulation capacity within the RFP-C. Before presenting the current study in detail, the empirical literature of RFP-C will be reviewed. First, outcome studies examining the effectiveness of RFP-C will be summarized. Then, process research investigating the mechanism of change in RFP-C will be examined.

2.3.1. Outcome Studies

The first pilot study assessing the effects of RFP-C was conducted by Prout et al. (2019) which aimed to examine whether RFP-C leads to reduction in children's ODD symptoms and improvement in their implicit emotion regulation capacity. The study included three children aged 5,8 and 9, all diagnosed with ODD. Children's ODD symptoms and emotion regulation capacities were assessed at baseline and post-treatment. Findings indicated a significant decrease in ODD symptoms of three children, along with clinically significant improvements in their emotion regulation capacities. According to the researchers, this study serves as a groundwork for subsequent RCTs investigating the effectiveness of RFP-C in larger clinical samples.

Building on these preliminary findings, Prout et al. (2021) conducted the first randomized controlled trial (RCT) to further assess the effectiveness of RFP-C in reducing ODD symptoms and improving explicit emotion regulation capacity. This study involved 43 school-aged children (5-12) diagnosed with ODD. They were randomly assigned to either RFP-C (N= 21) or a waiting list control group (N= 22). Children's ODD symptoms and explicit emotion regulation capacities were assessed at the baseline and at the end of treatment, and waitlist period. Results indicated a clinically significant reduction in children's ODD symptoms at the end of 10-week treatment. However, no significant changes were found in children's explicit emotion regulation capacities. According to the authors, this finding may be due to the nature of RFP-C, which primarily targets implicit emotion regulation through defense interpretation rather than explicit emotion regulation strategies. Unlike cognitive behavioral therapies that focus on trying to gain skills to manage emotions, RFP-C emphasizes modifying unconscious affective processes. Thus, the authors suggest that behavioral therapies incorporating directive techniques may be more effective in improving explicit emotion regulation (Lieneman et al., 2019; Nelson-Gray et al., 2006). Moreover, they note that children's implicit emotion regulation abilities cannot be measured by the Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) and Emotion Regulation Questionnaire for Children and Adoloscents (ERQ-CA; Gullone & Taffe, 2012), emphasizing the need for e measure specifically designed to assess implicit emotion regulation (Braunstein et al., 2017).

Expanding on the evaluation of RFP-C efficacy, Storey et al. (2022) conducted a pilot study to evaluate the feasibility and effectiveness of implementing RFP-C within a school-based mental health program. Due to pandemic conditions, The RFP-C sessions conducted online, making this the first study to assess the effectiveness of RFP-C delivered remotely. The study included seven male children aged 7 to 9 years, recruited from six NYC elementary schools. They exhibited externalizing symptoms such as ODD and ADHD. The primary aim of this study to examine whether RFP-C leads to reduction in ODD symptoms and improvement in attentional difficulties, particularly in an online setting. Children's ODD symptoms and attentional difficulties were assessed before and after treatment. According to the parent reports, children's ODD symptoms significantly decreased, and slight improvements in secondary attentional problems were observed. Moreover, parents reported that their children's behaviors were positively change following treatment. The findings support the feasibility and effectiveness of remotely delivered RFP-C and encourage further research on the efficacy of online psychodynamic treatment models. The findings also highlighted the importance of collaboration between schools and mental health programs.

2.3.2. Process Studies

The first study to investigate the therapeutic process of RFP-C was conducted by Prout et al. (2018). In this study, three expert clinicians utilized the Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2006) to create an ideal RFP-C prototype, which can be used in future studies to assess adherence in RFP-C. They also compared the RFP-C prototypes with other established child psychotherapy prototypes. According to the findings, RFP-C was significantly correlated with the prototypes of psychodynamic child psychotherapy and child-centered psychotherapy. Moreover, reflective functioning was also linked to the RFP-C prototype. Nevertheless, no relationship was found between RFP-C and cognitive behavioral therapy prototype.

Prout et al. (2021) explored the psychotherapy process in RFP-C using 60 child sessions with 20 children diagnosed with ODD. The Child Psychotherapy Q-Set was used to compare RFP-C with the prototypes of psychodynamic psychotherapy, cognitive

behavioral therapy, child-centered play therapy and reflective functioning. They also aimed to identify the most and the least common aspects of RFP-C sessions. Results showed that RFP-C shares common characteristics with multiple psychotherapy prototypes and common factors played a more significant role than expected. Furthermore, adherence to the psychodynamic therapy (PDT) prototype predicted a greater decrease in children's symptoms. Moreover, when working with children who have comorbid attention difficulties, therapists showed greater adherence to the cognitive behavioral therapy (CBT) prototype. They also found that adherence to the RFP-C model increased across sessions but overall adherence to the RFP-C prototype was lower than anticipated.

In their study, Kufferath- Lin et al. (2021) investigated the therapeutic process in RFP-C parent sessions. They used the Psychotherapy Process Q-Set (PQS; Jones, 2000), to analyze 49 parent sessions and compared the findings with established adult psychotherapy prototypes. The researchers found that RFP-C parent sessions were most closely associated with cognitive behavioral therapy (CBT). According to them, this similarity may be due to the structured and directive nature of parent sessions. To be more specific, while defense interpretation is the main therapeutic technique in child sessions, parent sessions emphasize therapeutic alliance and psychoeducation. This highlights a clear distinction between the therapeutic processes of child and parent sessions process prototypes in RFP-C. They also found moderate correlation between RFP-C parent sessions with both reflective functioning and supportive-expressive psychodynamic psychotherapy prototypes. However, they did not find any significant correlation with the psychoanalytic therapy prototype.

2.4. Current Study

A growing body of literature indicates that play-based therapies lead to significant improvement in children's emotional and behavioral difficulties. However, many studies primarily focus on positive outcome without exploring the specific connections between play processes and therapeutic methods (Bratton et al., 2005). Within the field of psychodynamic child psychotherapy, research on children with externalizing behaviors is

limited, despite the high prevalence of these behaviors and their adverse impact on development. Early evidence supports positive outcomes of psychodynamic psychotherapy for children with externalizing problems. However, the specific mechanism that facilitate therapeutic change remain unclear (Midgley et al., 2017). RFP-C was specifically developed for children with behavioral problems, emphasizing the role of emotion regulation in treatment (Hoffman et al., 2016). There is a notable gap in RFP-C literature regarding in-session therapeutic processes and how affective change unfolds throughout treatment. To address this gap, the present study aims to examine emotion regulation and negative affect expression (sadness and anger) in children's play within the context of Regulation-Focused Child Therapy (RFP-C). Using the Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998), this study will systematically assess changes in emotion expression and emotion regulation over the course of treatment. In line with the RFP-C framework, aggression is conceptualized as a defensive reaction against painful emotions such as sadness. Through systematic interpretation of defenses, the therapy aims to increase children's tolerance for experiencing these unbearable emotions, allowing them to gradually express underlying painful feelings such as sadness more openly. Thus, it was hypothesized that anger expression will significantly decrease throughout the RFP-C process, while sadness expression and emotion regulation will show a significant increase during therapy.

3. METHOD

3.1. Randomized Control Trial (RCT)

3.1.1. RCT Introduction

The current study, which investigated the changes in children's emotion regulation capacities and expression of sadness and anger throughout the Regulation Focused Psychotherapy for Children (RFP-C) process was conducted as a part of Randomized Controlled Trial (RCT) at Istanbul Bilgi University. The RCT was structured as a parallel-group study, focusing on evaluating the effectiveness of Regulation Focused Treatment for Children (RFP-C) in comparison to Parenting and Child Social Skills Group Intervention (PSSG). The current study includes participants who were randomly assigned to RFP-C treatment group in the RCT study. First, the RCT design will be presented, followed by a detailed explanation of the selection criteria. Comprehensive details regarding the RCT study can be found in the clinical study protocol in Appendix B (Protocol No: NCT06060353).

3.1.2. RCT Sample

Client selection for the study began in September 2023. The therapy sessions were conducted between October 2023 and November 2024. Participants in the study were chosen from families who applied to Istanbul Bilgi University Psychological Counseling Center. The comprehensive overview of the client acceptance process can be found in the Consolidated Standards for Reporting Trials (CONSORT) Flow Diagram which is available in Appendix C.

The inclusion criteria for the RCT were as follows: (a) the child exhibiting clinical levels of externalizing and comorbid internalizing/externalizing problems as measured by the Strengths and Difficulties Questionnaire (SDQ) – Parent Version (SDQ-P; Goodman, 2001; Guvenir et al., 2008), and (b) children aged between 6 and 12 years, and (c)

parent(s) able to participate four parent meetings. The exclusion criteria are as follows: (a) children who have primary diagnosis of psychosis and/or eating disorders as diagnosed through Turkish adaptation of the Schedule for Affective Disorders and Schizophrenia for School Aged Children (6-18) (K-SADS-PL DSM-5; Kaufman et al., 2016; Gökler et al, 2004), (b) children who have risk for suicide and or/ violence as measured by KSADS-PL, (c) children who are currently enrolled in another psychosocial treatment and/or require medication changes during the treatments, (d) children who have intellectual disability or major developmental delay as measured by K-SADS-PL & Turkish Adaptation of Wechsler Abbreviated Scale of Intelligence- WASI (WISC-IV; Wechsler 2012; Öktem et al., 2013) (e) parents exhibiting acute psychosis as assessed by Turkis adaptation of Structured Clinical Interview for DSM-5 Disorders Clinical Version (SCID-5-CV; First et al., 2017; Elbir et al., 2019), (f) families with a history of domestic violence as measured by K-SADS-PL (g) parents who are at risk of harming themselves or others as measured by SCID (g) cognitive impairments in the child and the parent(s) assessed using the Matrix Reasoning and Vocabulary subtests from the Turkish adaptation of WISC- IV (Wechsler Intelligence Scale for Children- Fourth Edition) for children and the WAIS-IV (Wechsler Adult Intelligence Scale- Fourth Edition) for parents. In this study, intelligence scores were calculated by averaging the Matrix Reasoning and Vocabulary subtest scores from the WASI. The average score was 9.63 (*SD* = 2.64) for children, 8.32 (*SD*= 2.44) for mothers, and 8.48 (*SD* = 2.28) for father.

A total of 311 individuals were screened for eligibility. Of these, 133 were invited to participate in clinical interviews. Following the application of exclusion citeria, 53 participants were excluded. Thus, 80 participants met the inclusion criteria and were randomly assigned to either RFP-C intervention group or the PSSG control group. Specifically, 40 clients (50%) assigned to the RFP-C intervention group, while 40 clients (50%) were assigned to the PSSG control group.

3.1.2.1. Regulation Focused Psychotherapy for Children (RFP-C)

RFP-C is a manualized, time limited, psychodynamic treatment designed for children aged 5-12 with externalizing behaviors. The standard protocol consists of 16 child

sessions and 4 parent sessions over a 10-week period, typically with two child sessions per week. However, in the context of the RCT, the protocol was adapted to include only one child session per week, extending the duration of treatment accordingly. As a result, the 20-session intervention was delivered over the course of 16 weeks.

The therapy protocol comprises three main phases. The first phase begins with an initial meeting with the parents to gather developmental history of the child and to understand main difficulties that the child and parents have. Subsequently, two initial sessions are conducted with the child, followed by a feedback session with the parents. During this feedback session, the therapist introduces “triangle of conflict”, a conceptual framework used to help parents understand how their children’s disruptive behaviors may serve as defenses against distressing emotions such as sadness, shame or fear. The primary aim of this phase is to build a therapeutic alliance with the family and to provide psychoeducation that supports a more reflective understanding of the emotional meanings underlying the child’s behaviors. The second phase covers sessions 3 through 11. In this phase, the therapist focuses on identifying disruptions in the child’s play or verbal expression that indicate defensive functioning. The therapist observes the child’s defensive behaviors and tries to understand which emotions are being avoided, how the child is avoiding them, and why those emotions feel intolerable. The therapist’s comments remain experience-near, limited to observations within the session and do not involve interpretations related to past experiences. This here-and-now approach in which the therapist systematically interprets the child’s defenses, helps the child gradually become more aware of the painful feelings behind their aggressive behaviors, enhances tolerance for painful emotions, and reduces reliance on maladaptive defense mechanisms. The third phase includes sessions 12 through 16. The main focus of this phase is separation in which offers the child an opportunity to process the difficult emotions associated with separation. In the last parent session, the therapist reviews the overall treatment process, highligts gains in the child’s emotion regulation capacity, and supports the caregivers in continuing to reinforce these regulatory capacities.

The overarching main aim of RFP-C is to activate more adaptive forms of implicit emotion regulation capacity by systematically addressing the child’s maladaptive defense

mechanisms. By improving implicit emotion regulation capacities, children often become better able to express their painful emotions verbally, reducing the need to act out aggressively. Moreover, the purpose of the parent sessions is to help parents understand that their children's disruptive behaviors have underlying meanings and to assist them in exploring the emotions that trigger these behaviors.

19 master's students in Clinical Psychology at Bilgi University completed eight hours of RFP-C training. The therapists' ages ranged from 24 to 31 years ($M = 26$). Their clinical experience varied between 0 and 2 years: 47.0% ($n = 9$) had less than one year of experience, while 52.6% (n = 10) had between 1 and 2 years. Nearly all therapists were female (94.7%). The RFP-C training was conducted by Dr. Tracy Prout. After completing the training, the therapists became RFP-C Practitioners and subsequently administered the RFP-C intervention. The sessions were conducted under the supervision of instructors Sibel Halfon and Can Büyükaşık from the Center for Regulation Focused Psychotherapy.

3.1.3. Ethical Approval

The randomized controlled trial titled "A Pragmatic Randomized Controlled Trial of Regulation-Focused Psychotherapy for Children with Externalizing and Comorbid Internalizing/Externalizing Problems (RFP-C)" received ethical approval (no: 2023-40224-120) from Istanbul Bilgi University Human Studies Ethics Board (see Appendix A). Written consent was collected from participating parents, while verbal consent was obtained from the children involved in the study.

3.1.4. RCT Data Collection

Demographic data were collected from clients prior to the beginning of treatment. Outcome measures were assessed at several time points: before treatment, at the midpoint of the treatment, at the end of the treatment, and during follow-up at the 6th month. All therapy sessions were recorded using both video and audio formats. Process measures were obtained at three time point: first session (T1), mid-treatment session (T2), and termination session (T3). If the session at the planned timepoint was unavailable due to

the child's absence, lack of play during the session or recording issues, the closest subsequent session was selected and coded instead.

3.2. Data Collection Tools for the Current Study

3.2.1. Data Collection Tools

This section outlines the instruments employed in the current study. Detailed information regarding all assessment tools used within the RCT is available in the clinical study protocol in Appendix B (Protocol No: NCT06060353).

3.2.2. Sociodemographic Information Forms

The demographic information form completed by parents in the RCT conducted by Halfon includes data regarding the child's sex, age, previous therapy history, as well as the family's socioeconomic background, educational level, and marital status.

3.3. Assessment and Process Measure

3.3.1. Children's Play Therapy Instrument (CPTI)

Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998) provides a comprehensive evaluation of affect, assessing both emotion regulation capacity and the various types of emotions expressed during play. In general, this tool is designed to evaluate children's play behaviors in psychotherapy from a psychodynamic approach. Following the observation of a child's therapy session, the session is categorized into several segments: *nonplay, interruption, preplay* and *play activity. Nonplay* segments include actions unrelated to play, while *interruption* covers times when the child is outside the therapy room. The *preplay* phase involves the child's preparations before engaging in play, and *play activity* includes the play the child initiates. Coders then focus on the longest play segment, analyzing it according to CPTI's framework for descriptive,

structural, and functional analysis. CPTI consists of multiple scales, each capturing distinct aspects of play. It assesses the type of play activity (e.g., gross motor play, pretend play, game play, art activity), the play script (e.g., the child's ability to initiate and sustain play) and the play environment (i.e., the spatial context in which play occurs). It examines affective components, including children's emotional expressions (e.g., anger, anxiety/fear, pleasure, sadness) and emotion regulation strategies employed by the child. Additionally, children's cognitive components can be assessed by coding their role representations in play, while their language use is evaluated through their play narratives. Their social level can be determined by their interaction with the therapist during play. Finally, their functional level (e.g., adaptive, conflicted, polarized, disorganized) can be analyzed by observing defense mechanisms they use in play.

In this study, the CPTI's "regulation and modulation of affect" item was used to assess the affect regulation, and the "affects expressed by the child while playing" item will be used to assess emotion expression. Regulation and modulation of affect examine a child's ability to express and manage emotions when faced with an anxiety- provoking situation in play, rated on a scale from 1 (very rigid), to 5 (very flexible). "Affects expressed by the child while playing" examine the array of emotions that the child expresses during play. Four emotions (e.g., anger, anxiety/fear, pleasure, sadness) are rated on a 1–5 Likert scale, where 5 indicates the emotion is highly characteristic and 1 means there is no evidence of the emotion being shown. In general, higher ratings are given when affect expression, emotion-related words and thematic content are combined in children's play. In this scale, the coder observes both verbal and nonverbal emotional expressions of the child during play. Thus, the child does not need to explicitly express emotions but also convey feelings through body language, facial expression and tone of voice. Anger is often reflected on the themes of conflict, destruction or harm. A child may engage in fighting scenarios, breaking toys, using aggressive words such as "I will kill you!". Anxiety/fear appears in themes involving school anxiety, doctor control, fear of punishment or general worry. In play, the child expresses his/her anxiety through actions of hiding, fleeing or signs of agitation. Sadness emerges in narrative of loneliness, illness, or physical pain. In the context of this study, the expressions of anger and sadness will be assessed. Detailed scoring guidelines for the assessment of emotion regulation, anger

expression and sadness expression can be found in Appendix D, which includes the relevant sections from the CPTI manual.

In this study, six master's level research assistants participated in a 7-hour coding training session led by Selin Kitiş in August 2024 and September 2024. Selin Kitiş had previously trained by Sibel Halfon, who was trained by Saralea Chazan. During the training, assistant rated five training sessions until their inter-rater reliability reached an intraclass correlation (ICC) of 0.70. Following the training, pair of coders independently began coding the child sessions from the study. Three time points in the therapy process were selected for coding: the beginning phase of the treatment (Session 2), the middle phase of the treatment (Session 11), and the final session (Session 19). Interrater reliability was continuously monitored, and any session with a Cronbach's alpha below .70 was re-coded by the same pair to ensure consistency. Inter-rater reliability among coders was found to be good to excellent, with $M = .86$, $SD = 0.08$, and scores ranging from .71 to 1.00. In the current study, inter-rater reliability among coders had a mean of .89 ($SD = 0.08$), with scores ranging from .71 to 1.00.

4. RESULTS

4.1. Sample Characteristics

The current study included 40 clients who participated in the RFP-C intervention. One participant discontinued treatment after the first session. The participants who had missing data on the process measures at any time point (pretreatment, mid-treatment and post-treatment) were excluded from the analyses. Consequently, five participants were removed from the final dataset. The final sample consisted of 34 participants. Table 4.1 provides a summary of the demographic characteristics of the participants.

Table 4.1. Demographic Characteristics of the Children

Baseline Characteristics	*M (SD)*	*N (%)*
Age	8.26 (1.67)	34
Sex		
Male		26 (76.5%)
Female		8 (23.5%)
Clinical Characteristics – SDQ[a]		
Externalizing		9 (26.5%)
Comorbid		25 (73.5%)

Note: *SDQ = Strengths and Difficulties Questionnaire. Sex was dummy coded as "1" = female, "2" = male.*

[a] *Cutoff criteria for SDQ internalizing scores: Scores between 0-3 are considered nonclinical, while scores of 4 or above fall into the borderline or clinical range*

4.2. Data Analysis

A series of repeated measures ANOVA were conducted to test the hypotheses regarding change over time in emotion regulation, sadness expression and anger expression. All statistical analyses were performed using SPSS Version 28. Each dependent variable was

analyzed separately across time points (T1: beginning session, T2: mid-treatment session, T3: termination session).

Prior to the main analyses, preliminary tests were conducted to examine whether age and gender were significantly associated with the outcome variables. Multivariate Analyses of Variance (MANOVAs) revealed no statistically significant effects of age or gender. Therefore, no covariates were included in the repeated measures ANOVA models.

4.3. Results

Descriptive statistics of the study variables across the three time points (T1: beginning session, T2: mid-treatment session and T3: termination session) are presented in Table 4.2. These variables include affect regulation, and the child's expression of anger and sadness during play. These variables were coded based on video-recorded psychotherapy sessions using the CPTI.

Table 4.2. Descriptive Statistics for Affect Regulation, Anger Expression and Sadness Throughout the Therapy

Variables	*N*	*M*	*SD*	*Min*	*Max*	*Skewness*	*Kurtosis*
Beginning Sessions (T1)							
Affect Regulation	34	3.01	0.89	1.00	4.50	-0.22	-0.70
Anger Expression	34	2.26	1.34	1.00	5.00	0.60	-0.85
Sadness Expression	34	1.57	0.73	1.00	3.50	1.47	1.54
Midpoint Sessions (T2)							
Affect Regulation	34	3.00	0.81	1.00	4.50	-0.37	-0.14
Anger Expression	34	2.93	1.34	1.00	5.00	0.09	-1.17
Sadness Expression	34	1.53	0.67	1.00	3.50	1.23	0.95
Termination Sessions (T3)							
Affect Regulation	34	3.16	0.60	2.00	4.00	-0.34	-0.61
Anger Expression	34	2.75	1.35	1.00	5.00	0.39	-1.11
Sadness Expression	34	1.93	0.93	1.00	4.00	0.71	-0.48

Note: *T1 = Timepoint 1; T2 = Timepoint 2; T3 = Timepoint 3*

Skewness and kurtosis values indicated that affect regulation scores were approximately normally distributed across time points. Although anger and sadness expression variables showed positive skewness and moderate kurtosis at several time points, particularly at baseline and midpoint, their values remained within the acceptable range (-2 to +2) for statistical analyses (George & Mallery, 2010). Thus, no data transformation was needed.

Preliminary analyses were conducted to assess the effects of age and gender across the three time points (T1: beginning, T2: mid-treatment, T3: termination). The results indicated that neither age nor gender had a statistically significant effect on affect regulation, anger expression or sadness expression.

For affect regulation, the multivariate analysis showed Wilks' Lambda = .906, $F(2, 30) = 1.561$, $p = .227$ for age, and Wilks' Lambda = .839, $F(2, 30) = 2.882$, $p = .072$ for gender. For anger expression, the results were Wilks' Lambda = .922, $F(2, 30) = 1.260$, $p = .298$ for age, and Wilks' Lambda = .984, $F(2, 30) = .238$, $p = .789$ for gender. Finally, for sadness expression, Wilks' Lambda = .948, $F(2, 30) = .827$, $p = .447$ for age and Wilks' Lambda = .878, $F(2, 30) = 2.090$, $p = .141$ for gender.

4.3.1. Repeated Measures Analyses

A series of repeated measures ANOVAs were conducted to examine changes in affect regulation, anger expression and sadness expression across three time points. Table 4.3 provides a summary of the overall repeated measures ANOVA results for each variable.

Table 4.3. Summary of Repeated Measures ANOVA Examining the Impact of Time on Change in Affect Regulation, Anger Expression, and Sadness Expression (N = 34)

Measure				
	df	*F*	η^2	*p*
Affect Regulation	2,66	0.57	.017	.566
Anger Expression	2,66	3.52	.096	.035
Sadness Expression	1.62, 53.59	1.98	.078	.80

Note: *Degrees of freedom and p-values for sadness expression are based on Greenhouse-Geisser correction due to sphericity violation (Mauchly's W = .768, p = 015*)

Following the overall results, detailed findings for each outcome variable are presented below.

4.3.1.1. Affect Regulation

To examine whether affect regulation increased throughout therapy, a repeated measure ANOVA was applied to assess changes across three time points (T1: beginning session, T2: mid-treatment session and T3: termination session). Mauchly's test indicated that the assumption of sphericity was met, χ^2 (2) = 0.725, p = .696. The analysis revealed no significant effect of time, F (2, 66) = 0.574, p = .566, partial η^2 = .017.

4.3.1.2. Anger Expression

The hypothesis that children's anger expression would decrease over the course of therapy was tested using a repeated measures ANOVA. The analysis was conducted across three time points (T1: beginning session, T2: mid-treatment session and T3: termination session). According to Mauchly's test, the assumption of sphericity was not violated, W = .908, p = .213. Therefore, sphericity assumed values were used. The analysis revealed a statistically significant effect of time, F (2, 66) = 3.52, p = .035, partial η^2 = .096. Pairwise comparisons using Bonferroni correction revealed that the increase in anger expression from T1 to T2 was statistically significant, M = −0.66, SE = 0.25, p =

.034, 95% CI [−1.28, −0.04]. The differences between T1 and T3 ($M = -0.49$, $SE = 0.23$, $p = .127$) and between T2 and T3 ($M = 0.18$, $SE = 0.29$, $p = 1.000$) were not statistically significant.

4.3.1.3. Sadness Expression

The hypothesis that children's sadness expression would increase throughout the course of therapy was tested using a repeated measures ANOVA across three time point (T1: beginning session, T2: mid-treatment session and T3: termination session). Mauchly's test indicated that the assumption of sphericity had been violated for sadness expression, χ^2 (2) = 7.00, $p = .030$; therefore, degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .828$). The results revealed that the effect of time on sadness was not statistically significant, F (1.62, 53.59) = 2.80, p = .080, partial $\eta^2 = .078$.

5. DISCUSSION

RFP-C is a psychodynamic therapy model specifically designed to enhance implicit emotion regulation in children with externalizing symptoms (Prout et al., 2019). In RFP-C, the therapist systematically addresses the child's aggressive actions and defensive maneuvers used to avoid painful feelings, with the aim of helping the child feel less threatened by these emotions (Hoffman et al., 2016). One of the aims of RFP-C is to reduce the child's need to act out in response to painful feelings, while increasing their ability to tolerate, process and verbalize them (Prout et al., 2021). However, there is lack of research examining changes in emotion regulation capacity and negative emotion expression in children's play within the context of RFP-C. The current study aimed to address this gap by investigating changes in the expression of sadness and anger, and emotion regulation, during RFP-C.

It was hypothesized that emotion regulation would show a significant increase during therapy. However, the results did not support this hypothesis, as no significant change was observed over time. The second hypothesis was that anger expression would significantly decrease throughout the process. Instead, the analysis demonstrated a significant increase in anger expression across sessions. The third hypothesis was that sadness expression would show a significant increase during therapy. According to the analysis, the hypothesis was not supported, as no significant change was found in sadness expression across the sessions. In the following sections, each of these findings will be discussed in detail in relation to existing empirical literature.

5.1. Discussion of Current Findings

5.1.1. Emotion Regulation

One of the hypotheses of this study was that emotion regulation would statistically increase over the course of RFP-C. However, the results of repeated measures ANOVA

did not support the hypothesis. In other words, there was not any significant change in emotion regulation across treatment.

This result aligns with previous research. For instance, Prout et al. (2021) similarly did not find any significant improvement in children's emotion regulation capacity following RFP-C. In explaining this finding, the authors emphasized the limitations of using self-report tools (ERC and ERQ-CA) to capture changes in implicit emotion regulation, which is a core target of RFP-C. In contrast, our study used CPTI, an observational coding system used to assess emotion regulation within the context of play.

In contrast to these findings, a previous pilot study by Prout et al. (2019) reported improvements in children's emotion regulation capacity by using the same measurement tools (ERC). However, this study included only three participants and did not follow a randomized controlled design, in contrast to both the present study and Prout et al.'s (2021) later RCT.

In Türkiye, Halfon and Bulut (2017) found a nonlinear trajectory of change in emotion regulation. In their findings, emotion regulation declined during the early phase of treatment and began to improve in later stages. Additionally, in high-adherence treatments, emotion regulation increased towards to end of the therapy, whereas no change was observed in low-adherence cases. Similar to the present study, they used the CPTI to assess emotion regulation but coded six sessions for each participant, allowing for a more detailed sampling of the therapeutic process compared to the present study, which included three sessions for each participant. Moreover, the two studies differ in both the duration and therapeutic principles. In the present study, children received a short-term RFP-C intervention consisting of 16 sessions, whereas in Halfon and Bulut's (2017) study children underwent long-term psychodynamic psychotherapy based on mentalization principles, which included approximately 40 sessions. The two studies also differed in participant characteristics. In the present study, children were between 6 and 12 years old and the majority (72.5%) presented comorbid internalizing and externalizing problems. In contrast, Halfon and Bulut's (2017) sample consisted of younger children between 4 to 10 years old, who were primarily referred for behavioral difficulties.

In another study, Halfon et al. (2019a) found that emotion regulation improved when children expressed negative emotions, particularly in sessions marked by high therapist adherence to mentalization principles. In their study, they used CPTI to assess emotion regulation and they analyzed change through session-to-session coding across the entire treatment sessions. While the present study employed repeated measures ANOVA to assess the changes in emotion regulation between three sessions, Halfon et al. (2019a) used multilevel modeling and time-series panel analysis (TSPA) on 975 therapy sessions, allowing for examining session by session changes in emotion regulation throughout the therapy process. Additionally, therapist-adherence was not assessed in the current study. The two studies also have differences among therapeutic framework, therapy duration and participant characteristics. In the present study, children received a short-term RFP-C intervention consisting of 16 sessions, whereas in Halfon et al. (2017)'s study children underwent long-term psychodynamic psychotherapy based on mentalization principles, which included approximately 35 sessions. In terms of participant characteristics, Halfon et al. (2019a)'s sample included 40 children with a broader range of emotional and behavioral problems, whereas in the present study the majority (72.5%) of children presented with comorbid internalizing and externalizing problems.

5.1.2. Anger Expression

One of the hypotheses of this study was that anger expression would statistically decrease over the course of RFP-C. However, the results of repeated measures ANOVA did not support this hypothesis. Instead, anger expression significantly increased during the course of RFP-C.

Psychoanalytic theories highlight that play provides an important opportunity for children to manage overwhelming emotions. According to the mastery approach, children use play to symbolically express difficult emotions such as anger. Through pretend aggression, children can work through distressing experiences and find adaptive solutions to cope with real-life challenges (Erikson, 1963; Freud, 1965).

Drawing on similar principles to the mastery approach, RFP-C literature conceptualized aggression as a defensive reaction to avoid unbearable emotions in the child. The goal of the RFP-C is not to suppress the children's anger, but to help the child recognize, tolerate, and eventually verbalize the painful emotions underlying aggression. Within the therapeutic relationship, aggressive expressions are seen as important clues about the child's emotional world, and the therapist tries to understand the painful emotions hidden behind the aggression. In RFP-C, the emergence of aggressive themes and the expression of anger within the context of pretend play, rather than through direct physical attacks toward the therapist, is viewed as a sign of emotional development and therapeutic progress (Hoffman et al., 2016). In the RFP-C manual, the case of Betty, a six-year-old girl who have disruptive behaviors, provides an example of this progression. During the session, Betty expressed a desire to shoot the therapist but immediately clarified it was "in a pretend way." The therapist interpreted Betty's shift from real-world aggression to symbolic pretend attacks to the therapist as a sign of therapeutic progress, reflecting her growing ability to express anger symbolically through play. Another case described in the manual, Eli, a seven-year-old boy, similarly illustrates the shift of the aggression into symbolic play. During the termination phase of the therapy, Eli was able to express his anger about the ending through his drawings and pretend play including aggressive themes, rather than through physical aggression as he had exhibited at the beginning of the treatment process. In conclusion, an increase aggression in the play seen as a therapeutic improvement in the context of RFP-C. In conclusion, within the framework of RFP-C, channeling aggression into pretend play and expressing it symbolically is considered an important indicator of therapeutic progress.

Several studies in child psychotherapy literature have also emphasized the adaptive and therapeutic functions of aggression expressed during play. In an early study, Gaensbauer & Siegel (1995) emphasized the role of play in helping children process traumatic experiences by allowing them to express negative emotions such as anger and fear in a symbolic way. According to researchers, within the realm of play, children can find adaptive ways to cope their negative emotions in the context of an "as if" world. Fehr and Russ (2013) investigated the association between aggressive themes in pretend play and social-emotional functioning in preschool children. According to their results, oral

aggression in play was negatively associated with classroom physical aggression and positively associated with prosocial behaviors. These findings suggest that the expression of aggressive themes in play may be related to better social and emotional adjustment. They also noted that anger expression in play was associated with children's positive behaviors in the classroom environment, indicating that aggression in play was not a sign of actual aggressive behavior. In contrast to the present study, Fehr and Russ (2013) assessed emotion expression using The Affect in Play Scale (APS-P,Kaugars & Russ, 2009) by observing children's five-minute free play in a laboratory setting. Moreover, they evaluated children's behavioral adjustment through teacher reports. Differences in assessment methods, context, temporal scope may limit direct comparisons between the two studies.

Marcelo and Yates (2014) examined the relationship between preschooler's pretend play and behavioral adjustment within the context of children's exposure to stress. Their findings indicated that negative emotion expression during play was positively associated with greater coping flexibility. Moreover, the expression of negative emotions during play was linked to lower internalizing symptoms over time. These results highlight the importance of negative emotion expression in play as a factor contributing to the development of more adaptive coping mechanisms. It is also important to note that their sample primarily consisted of non-clinical preschoolers, a minority of children exhibited clinically significant internalizing and externalizing problems. In contrast, the present study involved a fully clinical sample of older children (6-12 years) with comorbid internalizing and externalizing difficulties. Moreover, they assessed children's emotion expression based on a single play session, whereas the present study observed temporal changes across three sessions. While the present study used CPTI to assess emotion expression in a therapeutic context, Marcelo and Yates employed the preschool version of The Affect in Play Scale (APS-P,Kaugars & Russ, 2009) in a laboratory setting. Differences in sample characteristics, clinical severity and assessment methods may limit direct comparisons between the two studies.

To our knowledge, only one prior study has systematically tracked changes in anger expression throughout the course of psychodynamic child psychotherapy using the CPTI.

In their study, Halfon et al. (2016) found that children with externalizing problems exhibited higher levels of anger in the early sessions. However, no significant change in anger expression was observed over the course of treatment. These results differs from the findings of the present study, which showed a significant increase in anger expression throughout the RFP-C process. Several methodological differences may help explain this discrepancy. While Halfon et. al.'s sample primarily consisted of children with behavioral problems, the present study included children with comorbid internalizing and externalizing problems. Moreover, their study examined a longer therapy process (an average of 40 sessions per child), whereas current study consisted of 16 sessions. They coded six sessions per child (two from each therapy phase: beginning, middle and end), while current study coded three sessions (Session 2, Session 11, Session 19). Their sample size was smaller (N = 20) compared to our study. While their participants were aged between 4 and 10, our sample ranged from 6 to 12 years. They assessed the process using Hierarchical Linear Modeling (HLM), which allowed them to account more detailed patterns of change across sessions. In contrast, the present study employed repeated measures ANOVA, which captures group-level differences but does not account for individual variation. As a result, individual differences in anger expression trajectories could not be detected in the present study. This methodological distinction may help explain the differences between two studies.

Another study by Halfon et al. (2019a) investigated the relationship between negative affect expression and emotion regulation capacities using the CPTI. According to their findings, while dysphoric affect expression (e.g., sadness, fear, anxiety) during therapy was positively associated with improvements in children's emotion regulation capacities in play, anger expression alone did not predict changes in emotion regulation. Unlike the present study, they did not examine changes in anger expression across the treatment process. Overall, their results suggested that the expression of dysphoric affects in play, particularly during session with high therapist adherence to mentalization principles, was associated with improvement in children's emotion regulation capacity.

In conclusion, the present study contributes to the literature by documenting a significant increase in anger expression throughout RFP-C. This finding was discussed in relation to mastery approach, which emphasize the adaptive function of anger expression in play.

5.1.3. Sadness Expression

One of the hypotheses of this study was that sadness expression would statistically increase over the course of RFP-C. However, the results of repeated measures ANOVA did not support this hypothesis. There were not any significant changes in sadness expression throughout the RFP-C process.

As discussed in earlier chapters, the RFP-C literature conceptualize sadness as one of the unbearable emotions that children with externalizing difficulties tend to avoid. Due to their difficulties in accepting and regulating these emotions, they become overwhelmed, resulting aggressive outbursts. The goal of RFP-C is helping children to access, tolerate and work through these painful emotions by improving their emotion regulation capacity. At the beginning of the therapy, the child may deny his/her conflicts and underlying sadness behind them, attempting to maintain the grandiose self. The expression of sadness may occur in the later phases of treatment, as the therapist's systematic interpretation of the child's defenses gradually increases the child's capacity to tolerate and regulate painful emotions (Hoffman et al., 2016). However, this trajectory was not observed in the present study. According to the RFP-C manual, one possible explanation is that while some children may gradually begin to elaborate on their negative emotional experiences, others may not be ready to explicitly verbalize painful emotions. Many children may still struggle to verbalize overwhelming emotions directly, even as some begin to engage in more open discussions about their emotional states. The termination session of Alexander, an eight-year-old boy described in the RFP-C manual illustrates how children may demonstrate emotional progress without explicitly verbalize their painful feelings. In this session, although he did not express his sadness about the ending, he listened to the therapist's comments about the difficulty of separation without interrupting or denying. This shift was interpreted as an indicator of improvement in his emotion regulation capacity, as his defensive and aggressive attitude toward termination change throughout

the therapeutic process. Even though he could not verbalize his sadness, he was now able to tolerate and remain calm in the face of painful emotions evoked by the separation. Thus, a child's ability to tolerate painful emotions without acting on them can be seen as an important part of therapeutic change, even if the child does not express those feelings in words. To our knowledge, there is no research in the RFP-C literature specifically examined affective changes in RFP-C. Therefore, in the following section, the results will be discussed in relation to psychodynamic child psychotherapy literature that explores affective change processes, particularly the expression of sadness.

According to existing literature, there is no prior research in the psychodynamic child psychotherapy literature that systematically track changes in sadness expression throughout the course of treatment. Halfon et al. (2019a) conducted the first study to explore the impact of negative emotion expression on children's emotion regulation and treatment outcomes. Their findings indicated that dysphoric emotions- including sadness, fear and anxiety- was positively associated with improvements in children's emotion regulation, particularly in sessions with high therapist adherence. This study was the first study to demonstrate that mentalization-based interventions in child play therapy provide a space for children to process their negative emotions. A detailed comparison between this study and the present study was provided in the emotion regulation section.

In another single-case study focusing on change processes, Halfon et al. (2019b) explored how a child's play profile changed over time during psychodynamic child therapy. The case involves a nine-year-old girl who was referred for treatment due to behavioral difficulties. Affective changes -specifically fear, anxiety and pleasure- were examined using the CPTI across 24 sessions with in-depth qualitative analysis. In the early stages of treatment, the dominant theme in child's play was aggression and she primarily used polarized defenses. According to the authors, segment 15 marked a turning point in the therapeutic process, when the child was first able to express fear in play and link it to her unmet needs related to her parents. This moment was interpreted as the beginning of an integration process in which previously disconnected self-states – such as aggression and fear- were symbolically united in the play. Although sadness was not assessed in this study, the findings underscore the gradual nature of affective change in child

psychotherapy since the child bring her vulnerable feeling, fear, in the 15th session. Unlike the current study, Halfon et al. (2019b) focused on a single case of a child with behavioral problems. In their study, the child received 24 sessions of psychodynamic plat therapy, whereas children in present study received 16 sessions RFP-C. While the present study assessed change at three timepoints, Halfon et al. (2019b) conducted a session-by-session analysis using both quantitative and qualitative methods. While the present study directly examined changes in sadness expression, their focus was on fear and anger.

5.2. Clinical Implications

According to results, there was no significant change in children's emotion regulation capacity throughout the treatment process. This finding should be interpreted considering the non-linear dynamics of change in psychodynamic psychotherapy. As Chazan (2002) emphasized, when therapy is progressing effectively, children begin to bring their personal difficulties into the play. The intense emotions associated with these challenges can lead to dysregulation within the therapy process. For example, a study by Halfon and Bulut (2017) found that emotion regulation initially declined during the early phase of therapy and began to increase in later stage, suggesting that therapeutic progress may not always follow a linear pattern. Moreover, they did not find any significant change in children's affect regulation capacity with low-level adherence cases. In contrast to their methodology, which included a long-term psychodynamic therapy based on mentalization principles, the present study included 16 child sessions. It is possible that the short-term treatment and less frequent measurement was not sufficient to capture nonlinear trajectory of change. Additionally, therapist adherence to the treatment model was not assessed in the current study which would be an important mediating factor for emotion regulation. To analyze the temporal change in emotion regulation comprehensively, it may be important to conduct session by session analyses using more robust statistical techniques. In the current study, the majority of the sample consisted of children with comorbid internalizing and externalizing problems. These children can have more complex emotional difficulties and may require a long-term therapy process to improve their emotion regulation capacity. Future research can assess the emotion

regulation capacity separately for children with comorbid problems and externalizing symptoms. In the clinical context, it is important for the therapist that allow the child's dysregulation and to contain unbearable emotions as a "regulator", rather than judging or trying to correct the socially inappropriate behaviors.

The expression of anger statistically increased during the RFP-C process. Although this study focused on affective change rather than treatment outcomes, the findings are consistent with the mastery approach. According to Chazan (2002) children use play as a medium for expressing and working through their inner conflicts and negative emotions, which in turn facilitates emotion regulation. Given that children with externalizing and comorbid difficulties often exhibit anger and anxiety in play**,** the current finding support this conclusion. In the clinical setting, it is important for therapists to create a therapeutic environment in which children can safely redirect their anger into symbolic play and to contain the aggression, allowing emotional processing and regulation.

There was no significant change in sadness expression throughout the therapy process. One possible explanation is the restricted variance in the current data. Sadness scores were heavily clustered at lowest levels (1 and 1.5), indicating a floor effect that limits the ability to detect subtle changes over time. Sadness is typically a less overt emotion. In children with comorbid problems sadness expression may be more implicit and less behaviorally observable. As an indirect observational tool, CPTI may not be sensitive enough to capture children's nuanced changes in children's sadness expression. This highlights the need for more sensitive measurement methods such as physiological assessment or micro-analytic observations to more accurately detect changes in sadness expression over the course of treatment.

5.3. Limitations and Directions for Future Research

The current study had many strengths and limitations. One strength was that the data were derived from randomized control trial, which allowed for equal chances of treatment assignment and helped minimize potential confounding variables. Another strength was the use of an observation-based assessment tool, the Children's Play Therapy Instrument

(CPTI), which enabled coders to assess children's affective expressions and regulation in detail. However, the observational nature of the CPTI carries a risk of observer bias. Additionally, coders analyzed only the longest segment of each session, rather than the full session. It may have led to a limited representation of the child's emotional expression and regulation. In future research, coding entire sessions would be beneficial to better capture dynamic affective processes. It is also important to note that the CPTI coders were also RFP-C therapists involved in the study, and five were research assistants in the RCT. These overlapping roles may have made it difficult to maintain complete objectivity. To reduce potential bias, future research should consider employing independent raters who are blind to both the study and participants.

Altough the CPTI provides valuable insights into children's emotional expression during play, it relies solely on observational coding and can not fully capture the complexitity and fluidity of affective experiences. Recent research has emphasized the importance of supplementing observational methods with more physiological and automated approaches to measure affective change. For example, Halfon et al. (2020) adapted automatic facial and linguistic affect analysis modalities to assess affective dynamics in psychodynamic child psychotherapy. These tools were designed to capture emotional expressions through both facial movements and verbal content in play. This approach enable researchers to track emotional expressions more precisely and continuously throughout sessions, rather than relying on isolated segments. Integrating such tools alongside observer-rated methods could provide a more compherensive understanding of affective processes in therapy and improve the precision of affect measurement over time.

Another limitation was the small sample size, which restricts the generalizability of the findings. The sample primarily consisted of children with comorbid internalizing and externalizing problems. Future research should include larger sample size and assess children with comorbid and externalizing problems separately to better understand differences based on problem type. Moreover, the age range of the children was between 6 and 12 years which includes different developmental stages. Younger children usually express emotions more easily and anger expression often decreases as children get older and learn to regulate their emotions better (Liu et al., 2018). Future studies may benefit

from focusing on narrower age groups or investigating developmental differences in emotion expression and regulation more systematically.

In the current study, children received a short-term intervention consisting of 16 RFP-C sessions. The expression of negative emotions, especially more vulnerable affects like sadness, may require a longer-term. Future studies may examine these processes in longer-term psychodynamic child therapies.

Therapist adherence to the RFP-C model was not assesses in this study. However previous research has shown that adherence may influence on change in emotion regulation during treatment (Halfon and Bulut, 2017). In future research, it may be important to assess therapist adherence, as it could be a key factor influencing affective change throughout the treatment process.

Finally, repeated measure ANOVA is limited in capturing complex therapeutic processes. It was not possible to detect the therapist effect or individual differences between children. In future studies, more advanced statistical models such as HLM could be used to account for therapist effects, individual differences, session-level variability and to better handle missing data.

6. CONCLUSION

Current study aimed to analyze changes in emotion regulation and expression of anger and sadness throughout the course of RFP-C in a clinical sample of school-aged children. This study contributes to the limited literature on affective change in RFP-C by examining how children's expression of anger and sadness, as well as their emotion regulation capacities evolved over the course of RFP-C. The results indicated a significant increase in anger expression, while no significant changes were observed in sadness expression and emotion regulation.

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APPENDICES

Appendix A. Result of the Evaluation by the Ethics Committee

Ethics Board Approval is available in the printed version of this dissertation.

Appendix B. Clinical Trial Protocol

Active, not recruiting

Randomized Controlled Trial of Regulation-Focused Psychotherapy (RFP-C)

ClinicalTrials.gov ID NCT06060353

Sponsor Istanbul Bilgi University

Information provided by Sibel Halfon, Istanbul Bilgi University (Responsible Party)

Last Update Posted 2025-05-01

Researcher View Tab

Trial Contacts

Contacts	ICMJE
Contact information is displayed when a study is open for participants to join.	

Study Record Dates

First Submitted	ICMJE
2023-09-23	

First Posted	ICMJE
2023-09-29	

Last Update Posted
2025-05-01

Last Verified *
2025-04

Outcome Measures

Change History

See all versions of this study

Primary (Current) * ICMJE

(Submitted: 2023-09-23)

- Strengths and Difficulties Questionnaire - Parent version (SDQ-P; Goodman, 2001) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Strengths and Difficulties Questionnaire - Parent version (SDQ-P; Goodman, 2001) is a 25-item scale that asks parents to rate their children's emotional and behavioral difficulties on a 3-point Likert scale, ranging from 0 = not true to 2 = very true. The questionnaire is composed of five subscales: Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, Peer Problems and Prosocial. In addition, the SDQ-P yields Internalizing Difficulties, Externalizing Difficulties and Total Difficulties scale scores. SDQ-P was demonstrated to be a valid and reliable scale for use in Turkish children and adolescents (Yalın et al., 2013).
- Turgay DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) Disruptive Behavior Disorders Rating Scale (T-DSM-IV-S; Turgay, 1994) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Turgay DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) Disruptive Behavior Disorders Rating Scale (T-DSM-IV-S; Turgay, 1994) is based on DSM-IV diagnostic criteria and examines hyperactivity/impulsivity, inattention, opposition-defiance, and conduct disorder. Symptoms are scored on a four-point Likert scale (0= not at all, 1=

just a little, 2= quite a bit, and 3= very much). T-DSM-IV-S has shown good reliability and validity.

Primary (Original) * ICMJE

Same as current

Secondary (Current) [*] ICMJE

(Submitted: 2023-09-23)

- Me and My Feelings Questionnaire (M&MF; Deighton et al., 2013) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Me and My Feelings Questionnaire (M&MF; Deighton et al., 2013) is a child-report measure consisting of total short 16-items: 10-items of emotional difficulties scale and 6-items of behavioral difficulties scale. It is scored on a 3-point likert scale (0 = "never expressed", 1 = "sometimes expressed", 2 = "always expressed"). Total score of scales are calculated as the sum of item scores with threshold values 10 for the emotional difficulties and six for the behavioral difficulties. Higher scores of each set of difficulties indicate the probability of mental health problems. The scale has been adapted to Turkish with good reliability and validity (İlnem, 2020).
- Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) is a parent-report measure of children's emotion regulation characteristics and involves 24-items rated on a 5-point likert scale (1 = "never" to 5 = "always"). It taps into two factors one of which is emotional lability and negativity defined as arousal, anger dysregulation, and mood changes; and the second is emotion regulation defined as socially appropriate emotional displays, empathy, and emotional selfawareness. The scale has been adapted to Turkish with good reliability and validity (Batum & Yagmurlu, 2007).
- The Emotion Awareness Questionnaire (EAQ-30; Rieffe et al., 2008) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - The Emotion Awareness Questionnaire (EAQ-30; Rieffe et al., 2008) aims to identify how children and adolescents feel and think about their feelings. The EAQ (30 items) was designed with a six-factor structure describing six aspects of emotional functioning: (1) Differentiating Emotions, (2) Verbal Sharing of Emotions, (3) Not Hiding Emotions (formerly Acting Out), (4) Bodily Awareness of Emotions, (5) Attending to Others' Emotions, and (6) Analyses of Emotions. Respondents are asked to rate the degree to which each item is true about them on a three-point scale (1 = not true, 2 = sometimes true, 3 = often true). The scale has been adapted to Turkish with good reliability and validity (İnceman, 2017).
- The Children's Global Assessment Scale (CGAS; Schaffer et al., 1983) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2)]
  - The Children's Global Assessment Scale (CGAS; Schaffer et al., 1983) is a numeric scale (from 1 to 100) used by mental health clinicians to rate the global functioning of children under the age of 18 on a scale of 0 to 100. 90- 81 range is scored when there is "good functioning in all areas; security in family, school, and with peers with only transient difficulties and everyday worries"; 50-41, when there is "moderate degree of interference in

functioning in most social areas or severe impairment of functioning in one area"; and 20-11, when there is "need for considerable supervision to prevent hurting others or self or to maintain personal hygiene or gross impairment in all forms of communication". The scale has been adapted to Turkish with good reliability and validity (Gökler et al., 2004).

- Parental Stress Index - Short Form (PSI-SF; Abidin, 1983) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Parental Stress Index - Short Form (PSI-SF; Abidin, 1983) is a 36-item parent-report scale.The PSI-SF contains 36 items divided into three subscales, each composed of 12 items: "Parental distress"; "Parent-child dysfunctional interaction"; "Difficult child". Each item is rated on a 5-point likert scale from 1 = "strongly disagree" to 5 = strongly agree". The PSI-SF gives three subscores and a total distress score. The scale has been adapted to Turkish with good reliability and validity (Ertan et al., 2008).
- Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)]
  - Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is an instrument measuring emotion regulation problems in adults (to be used with parents in the current study). The scale comprises 36 items that are rated on a 5- point likert scale from 1 = "almost never" to 5 = "almost always", with higher scores indicating a difficulty of emotion regulation. The scale produces scores on the following subscales: (a) lack of awareness of emotional responses; (b) lack of clarity of emotional responses; (c) nonacceptance of emotional responses; (d) limited access to effective strategies; (e) difficulties in controlling impulsive behavior when experiencing negative affect; and (f) difficulties in engaging goal directed behavior when experiencing negative affect as well as a total disregulation score. The scale has been adapted to Turkish with good reliability and validity (Yiğit & Güzey-Yiğit, 2017).

Secondary (Original) [*] ICMJE

Same as current

Other Pre-specified (Current)

(Submitted: 2024-08-19)

- Adverse Childhood Experiences Scale (ACE; Dube et al., 2004) [Time Frame: Time Frame: Baseline (T0)]
  - Adverse Childhood Experiences Scale (ACE; Dube et al., 2004) is a parent-report scale to assess retrospectively forms of abuse, neglect, and household dysfunction (i.e., witnessing domestic violence, separation and mental illness in the family) in the current study. Scores range from 0-10 on the ACE, with the latter representing full exposure at some point in the first 18 years of life, to all forms of household dysfunction and abuse detailed in the questionnaire.It has a parent and a child version. The scale has been adapted to Turkish by Gunduz et al. (2018).
- The Therapeutic Alliance Scale for Children-revised (TASC-r; Creed &Kendall, 2005) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2)]
  - The Therapeutic Alliance Scale for Children-revised (TASC-r; Creed &Kendall, 2005) is a 12-item tool that measures alliance across the three dimensions of task, bond and goals and covers both positive and negative aspects of therapeutic alliance. Each response is rated

on a four point Likert scale (i.e. "not at all like my client" to "very much like my client"). It has been found to have adequate reliability and validity in Turkey (Bulut, et al., 2023).

- Wechsler Abbreviated Scale of Intelligence (WASI-II; Weschler, 1999) [Time Frame: Time Frame: Baseline (T0)]
  - Wechsler Abbreviated Scale of Intelligence (WASI-II; Weschler, 1999) is a brief measure of verbal and nonverbal intelligence administered by trained researchers to parents and children.

Other Pre-specified (Original)

(Submitted: 2023-09-23)

- Adverse Childhood Experiences Scale (ACE; Dube et al., 2004) [Time Frame: Time Frame: Baseline (T0)]
  - Adverse Childhood Experiences Scale (ACE; Dube et al., 2004) is a parent-report scale to assess retrospectively forms of abuse, neglect, and household dysfunction (i.e., witnessing domestic violence, separation and mental illness in the family) in the current study. Scores range from 0-10 on the ACE, with the latter representing full exposure at some point in the first 18 years of life, to all forms of household dysfunction and abuse detailed in the questionnaire.It has a parent and a child version. The scale has been adapted to Turkish by Gunduz et al. (2018).

    Wechsler Abbreviated Scale of Intelligence (WASI-II; Weschler, 1999) is a brief measure of verbal and nonverbal intelligence administered by trained researchers to parents and children.
- The Therapeutic Alliance Scale for Children-revised (TASC-r; Creed &Kendall, 2005) [Time Frame: Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2)]
  - The Therapeutic Alliance Scale for Children-revised (TASC-r; Creed &Kendall, 2005) is a 12-item tool that measures alliance across the three dimensions of task, bond and goals and covers both positive and negative aspects of therapeutic alliance. Each response is rated on a four point Likert scale (i.e. "not at all like my client" to "very much like my client"). It has been found to have adequate reliability and validity in Turkey (Bulut, et al., 2023).

Trial Description

Brief Title * ICMJE

Randomized Controlled Trial of Regulation-Focused Psychotherapy (RFP-C)

Official Title *§ ICMJE

A Pragmatic Randomized Controlled Trial of Regulation-Focused Psychotherapy (RFP-C) for Children With Externalizing Problems

Brief Summary *

Regulation Focused Psychotherapy for Children (RFP-C) is a manualized, time-limited psychodynamic treatment for children with externalizing symptoms. RFP-C also holds the potential to treat a wider range of psychopathology, including comorbid internalizing conditions, because it aims to improve emotion regulation which is a transdiagnostic component of childhood mental health. This study will replicate previous findings supporting the efficacy of RFP-C. It will test the effectiveness of RFP-C in parallel groups via a pragmatic Randomized Controlled Trial (RCT) conducted at Istanbul Bilgi University's outpatient clinic in Istanbul, Turkey with a sample of 80 children with externalizing and comorbid internalizing/externalizing problems in comparison to a parental awareness and child social skills group. Primary outcomes will be child externalizing problems and oppositional defiance problems. The treatment's effectiveness and change mechanisms will be investigated both at the end of treatment (primary endpoint) and at 6-month follow-up (secondary endpoint). The project results will provide preliminary answers about the active ingredients of RFP-C, help improve therapeutic interventions, and design optimal treatments for externalizing problems.

Detailed Description

Not provided

Study Type * ICMJE

Interventional

Study Phase * ICMJE

Not Applicable

Study Design *§ ICMJE

Allocation
Randomized

Interventional Model
Parallel Assignment

Masking
Single (Outcomes Assessor)

Primary Purpose
Treatment

Condition * ICMJE

- Childhood Externalizing Disorder
- Childhood Oppositional Defiant Disorder
- Childhood Conduct Disorder

Intervention * ICMJE

- Behavioral: Regulation Focused Psychotherapy (RFP-C)
  - Regulation-focused psychotherapy for children (RFP-C; Hoffman, Rice, & Prout, 2016) is a manualized, psychodynamic play therapy. Through 20 sessions (16 with the child and four parent meetings), RFP-C allows the child to understand the ways distressing affects are avoided and to explore alternative ways of coping with unpleasant affect. The clinician works to increase the child's understanding that all behavior, especially oppositional and disruptive behavior, has meaning in the service of emotional and behavioral regulation. This work is also done with the parents to better support the child in achieving symptom reduction and increased emotion regulation.
- Behavioral: Parental Awareness and Child Social Skills Group
  - Parental awareness and child social skills group is a manualized group psychotherapy that involves twelve parallel sessions conducted separately with parents and children. The parent group involves modules related to psycho-education, role-play and awareness building activities on child needs & rights, child temperament, praise & acceptance, child play, limit setting, anger management, transmission of parenting styles through genograms and family trees. With children, the groups involve psycho-education and play based activities to build awareness on children's rights, temperament, feelings, play & relationship skills, empathy & praise, anger management.

Study Arms * ICMJE

- Experimental: Regulation Focused Psychotherapy (RFP-C)
  - Interventions:
    - Behavioral: Regulation Focused Psychotherapy (RFP-C)
- Active Comparator: Parental Awareness and Child Social Skills Group
  - Interventions:
    - Behavioral: Parental Awareness and Child Social Skills Group

Publications

(Includes general and study results' publications, and Pubmed publications referencing this study by ClinicalTrials.gov Identifier (NCT Number))

- Hoffman, L., Rice, T., & Prout, T. (2015). Manual of Regulation-Focused Psychotherapy for Children (RFP-C) with externalizing behaviors: A psychodynamic approach. Routledge.

Recruitment Information

Recruitment Status *	ICMJE
Active, not recruiting	

Enrollment (Estimated) *§ (Submitted: 2023-09-23)	ICMJE
80	

Original Enrollment (Estimated) *§	ICMJE
Same as current	

Study Start Date (Actual) *§	ICMJE
2023-09-01	

Primary Completion Date (Estimated) *
2025-05-01 (Final data collection date for primary outcome measure)

Study Completion Date (Estimated) *§	ICMJE
2025-06-01	

Eligibility Criteria * ICMJE

Inclusion Criteria:

1. Children must be between the ages of 6-12 years of age
2. Meet criteria for clinical levels of externalizing problems on the SDQ
3. Parent(s) able to attend four sessions of parent meetings

Exclusion Criteria:

1. Solely emotional problems and non-clinical problem levels (as assessed by the SDQ)
2. Primary diagnosis of psychosis or eating disorders (as assessed by KSADS-PL)
3. Risk for suicide and/or severe violence risk (as assessed by KSADS-PL)
4. Current enrollment in another psychosocial treatment
5. Intellectual disability or major developmental delay (e.g. moderate/severe autism spectrum disorder) (as assessed by KSADS-PL & WASI)
6. Families with high risk of domestic abuse
7. Parents with acute psychosis (as assessed by SCID)
8. Parents with severe substance abuse and dependence (as assessed by SCID)
9. Parents with intellectual disability (as assessed by WASI)
10. Parents with acute risk of harm to self and others (as assessed by SCID)

Sex/Gender * ICMJE

Sexes Eligible for the Study:
All

Ages * ICMJE

6 Years to 12 Years (Child)

Accepts Healthy Volunteers *§ ICMJE

No

Location Countries ICMJE

Turkey

Removed Location Countries

Administrative Information

NCT Number ICMJE

NCT06060353

Other Study ID Numbers [*] ICMJE

RFP-C

Has Data Monitoring Committee

No

U.S. FDA-regulated Product *§

Studies a U.S. FDA-regulated Drug Product
No

Studies a U.S. FDA-regulated Device Product
No

Product manufactured in and exported from the U.S
No

IPD Sharing Statement ICMJE

Plan to Share IPD:
No

Current Responsible Party *

Sibel Halfon, Istanbul Bilgi University

Original Responsible Party *

Same as current

Current Study Sponsor * ICMJE

Istanbul Bilgi University

Original Study Sponsor * ICMJE

Same as current

Collaborators ICMJE

Center for Regulation Focused Psychotherapy

Investigators ICMJE

Not provided

PRS Account

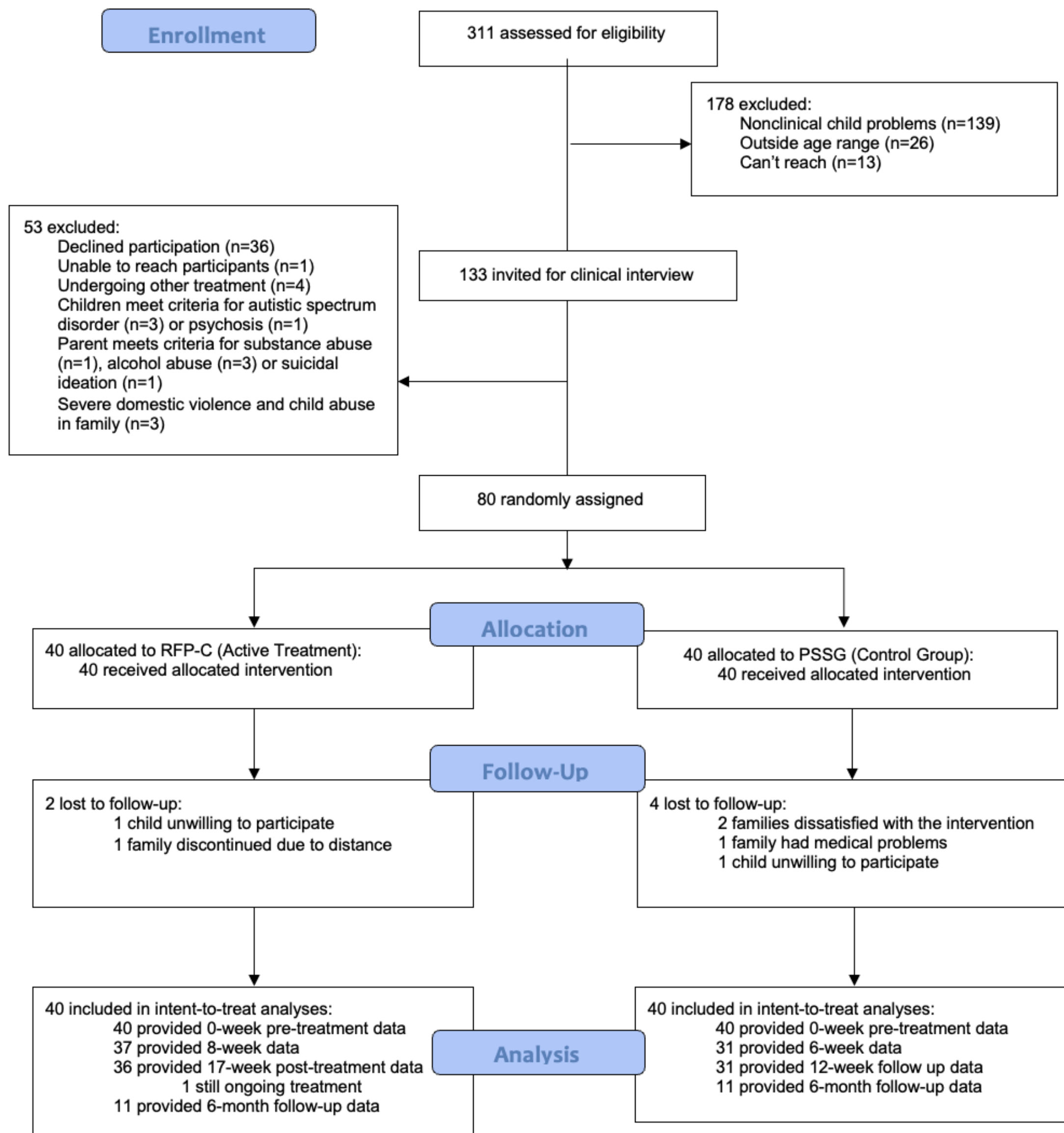
Istanbul Bilgi University

Symbol Legend

*	Required
*§	Required if Study Start Date is on or after January 18, 2017
[*]	Conditionally required
No Symbol	Unmarked fields are optional. If no information is provided, fields will be labeled as "not provided"
ICMJE	Data element required by the International Committee of Medical Journal Editors (https://www.icmje.org/recommendations/browse/publishing-and-editorial-issues/clinical-trial-registration.html) and the World Health Organization ICTRP (https://www.who.int/clinical-trials-registry-platform)

Appendix C. The CONSORT (Consolidated Standards for Reporting Trials) Flow Diagram

Figure 1. Study Flow Diagram



Note: RFP-C= Regulation Focused Psychotherapy for Children; PSSG = Parenting and Child Social Skills Group.

Appendix D. The Children's Play Therapy Instrument

SEGMENTATION

The child's activity in the session is segmented into four categories. These four categories are: Pre-Play, Play Activity, Non-Play and Interruption.

Segmentation of the child's activity in this manner permits an overall view of the ebb and flow of an entire session. It delineates a child who cannot play from a child who can; it highlights the experience of a child who undergoes play interruptions, and contrasts it with the experience of a child capable of sustained play activity.

In order to start the segmentation:

1) View the tape/transcript in its entirety. Become familiar with the general progression of the session.
2) Divide the tape into segments, categorizing each segment as Pre-Play, play, non-play, interruption as defined below (see category definitions).
3) Child's activity must be for more than 18-22 seconds to be considered a Pre-Play activity segment, a Play Activity segment, a Non-Play segment or an Interruption.

Activity Type Definitions

a. **Pre-Play Activity** – In Pre-Play Activity the child is "setting the stage" for play. He picks up a toy, begins to explore it, manipulate it, and may give it symbolic meaning. The predominant purpose is exploration and preparation for the Play Activity.

    - In order to distinguish Pre-Play from Play Activity the vignette or session must be viewed in its entirety. Since defining the category of

the child's activity is dependent upon context cues embedded within the entire sequence, it is often necessary for the rater to go back and forth, viewing the transition between activities several times before reaching a decision about classification.

- ***If the child is clearly preparing for a higher level of play, then, the preparation is classified as Pre-Play. If the child does not proceed to a more advanced level of play, but remains sorting, aligning, or constructing with toys (Not preparation for advanced play), this segment of the child's activity can be classified as Play Activity.***
- There may be pre-play within a play segment. For example, the child pauses, chooses a new toy, and then, continues his Play Activity that has now become somehow altered. To be coded as pre-play, it needs to be more than 18-22 seconds. Thus, Pre-Play does not only occur at the beginning of playing however you need to make sure that this is preparation for a higher level of play. With inhibited children, they will often play much of the time organizing the toys which is itself part of the play structure (then this gets reflected in the inhibition code.)

b. Play Activity – The child becomes engrossed in playful activity often indicated by adult/child exhibiting one or more of the following behaviors:

1) An expression of intent (e.g. Let's play), followed by play activity.
2) Actions indicating initiative, such as, definition of roles, "This dolly will be the teacher;" verbally suggesting, "we can both climb the mountain."
3) An expression of specific positive or negative affects such as glee, delight, pleasure, surprise, anxiety or fear.
4) **Focused concentration with toy or person**, (may be in response to therapist's activities, reflecting child's engagement with therapist).
5) Purposeful use of toy objects, or physical surround.

The ending of a Play Activity is signaled by one, or several behaviors, including the following:

1) A clear termination of action, e.g. the child drops the object, or set of objects, he has been using;
2) A shift to Non-Play activity, e.g. the child stops jumping and starts talking to the therapist about an unrelated topic;
3) A change in the activity focus, e.g. the child moves from the doll house to listening to a story being read; or,
4) The impression the theme of the play has been "played out" (Play Satiation), as if the child is finishing a story.

In order to decide whether to open a new play segment, or a play segment please look for these indications:

-The child must even if briefly stop the other activity, shift his/her focus to a new activity and show a mental recognition that he has started a new activity. He also must state that he will now start something else. He will purposefully use the new set of toys he has discovered. His attention as well as affect tone must shift. He can say things like:
"Let's play with this now!"
"Now, bring me that box to play with"
"Let's begin playing now" (after exploring for a while)
"Let's decide what to play next"

If the child says the things above but continues the same activity, then do not start a new play segment.

Sometimes the child does not show a clear shift of focus, however within the same play segment, he prepares to play a higher order game (symbolic play or board game). For example, he was playing symbolically with

soldiers, and then suddenly he says look I found a ball and then uses the balls to prepare to play bowling. In that case, that part of the segment where he starts preparing becomes a new pre-play segment and is counted as pre-play and when he begins higher-order play, that is counted as play. (Had he not prepared for a higher order play but only shifted from one activity to next without clear indications, then it would be the same play segment).

c. **Non-Play Activity** –This category includes all activities or behaviors of the child outside the realm of Play Activity.

Examples of Non-Play activities are numerous for instance, reluctance, eating, reading, doing homework, conversing with the therapist, participating in putting away toys.

All these activities, or behaviors, have in common the absence of involvement in a Play Activity. The child must have no contact with any toys. If a child has a toy in his hand that he manipulates (even hand in sand (coded as motor activity)) while doing any of the "non-play" activities, this is **NOT** to be coded non-play.

IMPORTANT NOTE: A CHILD MAY PLAY MANY DIFFERENT THEMES OR DIFFERENT TYPES OF PLAY WITHOUT ANY BREAKS: IN THAT CASE, IF THE CHILD DOES NOT CLEARLY SIGNAL THE ENDING OF ONE PLAY ACTIVITY BUT KEEPS PLAYING EVEN IF USING DIFFERENT MEDIUMS, IT IS STILL CONSIDERED ONE PLAY SEGMENT.

d. **Interruption** –An interruption is marked by the absence of the child in the play session for more than 18-22 seconds. For example, the child goes to the bathroom, goes out to see parents, goes to get materials for playing.

Continuity and Discontinuity Between Play Activity Segments

- The rater then designates the Play Activity segment as Continuous (C), or Discontinuous (D). ONLY PLAY ACTIVITY SEGMENTS RECEIVE THIS CODE.

- Continuity between Play Activity segments is noted whenever the child's activity or narrative indicates a connected, unfolding theme. For instance, the child begins playing with fire engines at the start of the session, then there is an interruption and after the child returns to the fire engine theme later on in another play segment.

- Discontinuity between Play Activity segments is noted whenever the child's activity or narrative indicates a new theme or activity. For example, the child play with the doll house, then there is an interruption and in the next play segment the child plays with the ball.
- **IMPORTANT NOTE:** If the session starts with a play segment, then there is no prior activity to compare and give a C or D code. This initial play segment receives N/A (888) for this code.

Once you are finished with the segmentation:

1) Identify the number of segments in the session.
2) Identify the number of C play segments.
3) Identify the number of D play segments.
4) For each segment, first write the session segment number (session 1, segment 1 = 1.1)
5) For each segment, identify the activity type.
6) For each segment, identify the activity duration (in seconds).
7) Identify the longest play segment. Only this segment will be subject to future codes. The exception is if you have a MC or FC segment, first code the MC

or FC segment and then identify the longest segment that comes after the MC/FC segment.

Regulation and Modulation of Affect

Within the same category of affect how different intensities are expressed and how easily these oscillations occur within the child's control, i.e. from annoyance to irritability to anger to rage.

When coding this category ask yourself these questions:

- How does the child show different intensities of the same affect? For example, one moment child is upset that he can't find a toy he wants and the next moment he starts to tantrum. This is clearly a child who can't regulate his sadness.
- After the child show intense affect, is the child able to modulate the affect to return to equilibrium? For example, a child gets so angry that he starts hitting the therapist and is unable to calm down unless he leaves the room. This is clearly a child who can't modulate his anger.

Please rate on a scale of 1-5 using the following anchors:

1. Very Rigid: Child's feelings rise suddenly and he can't calm down, ends up showing very extreme feelings or tantrums. He is stuck in that affect state and gets disorganized. Alternatively, child is unable to show any affect and is flat throughout the play.

2. Rigid: Feelings rise relatively suddenly and child has difficulty controlling the feeling.
   For example, the child starts out playing a theme, which evokes disruptive feelings (i.e. anxiety, shame, anger etc.) and child finds a way to stay away from the feelings.

Examples:

- Child finds a doll with a broken arm, says his father broke his arm and afterwards only arranges the toys.

- While the child is drawing, he gets anxious that he can't draw well and has difficulty drawing again.

- Child is anxious to be alone with the therapist, asks "is this an experiment" and plays alone the rest of the session not interacting with the therapist.

3. Medium: Child has moderate control over feelings. Even though he does not completely dismiss the feeling, **he can also at times show difficulty sustaining it.** There may **be disruptions in the play narrative, even though the child does not stop playing out that theme.**

Examples:

- A feeling rises quickly and child starts looking for another toy. Then the same feeling is played out, it rises, child gets a new toy, again plays out that theme.

4. Flexible: Child has considerable control over feelings, does not get stuck in one intensity or stay away from a disruptive state. Even though there may be one or two occasional disruptions, **the child is able to continue to express the feeling in an optimal range.**

5. Very Flexible: Child has **full control over different intensities of a feeling that gets expressed without disruptions in the narrative**

Affects Expressed by the Child while Playing

An array of emotions expressed by the child while playing.

Affect is included either when an affect theme is expressed in the play (e.g., one animal hitting or saying "I hate you" to another animal) or when affect-laden content is referenced (e.g., "This is a gun") or non-verbal expression of emotion in the play narrative.

In general, combinations of emotional expression and emotion word and content themes get higher intensity ratings than the theme alone or emotional expression alone.

Please rate on a scale of 1-5 using the following anchors:

The general criteria for the 1–5 intensity ratings are:

1. No evidence
2. Reference to affect content or very mild expression
3. Reference to affect content with special emphasis, which implies experiencing (such as personal referent) plus mild/moderate expression
4. Stronger current experiencing, which includes:
    a. Clear expression of feeling plus action.
    b. Strong action alone.
    c. Strong affect alone.
5. Very strong feeling state, which includes:
    a. Action plus very strong feeling state.
    b. Extremely strong affect.
    c. Extremely strong action.

Anger/Aggression

Expression of anger; fighting, destruction, or harm to another character or object; or reference to destructive objects (guns, knives) or actions (breaking).

1. No evidence

2. Reference to aggressive content. (Examples: Here's a toy gun; Here's a knife; This is broken.) or very mild expression in body.

3. Personalized reference to aggressive content with mild/moderate expression. (Examples: "I have a knife;" "I'll break it." "Let's fight; "No—I don't want to do that.")

4. Action plus dialogue; strong feeling state; strong theme word. (Example: Hitting plus "You're stupid"; "I hate you"; "Here is a bomb that is going to explode.")

5. Strong action and strong dialogue; extreme emotional theme. (Examples: "I'll kill you;" "I'm going to beat your brains to a pulp;" actions of shooting or stabbing.)

Anxiety/Fear

Expressions of fear and anxiety. Content such as school anxiety, doctors visits, fears, concern about punishment, and worry. Actions of fleeing and hiding, agitation.

1. No evidence

2. Reference to fearful theme. (Examples: "Oh—it's time for school"; "It's time to go to the doctor.") or very mild expression in body

3. More direct fearful theme with mild/moderate affect (Examples: "We're going to get in trouble"; "Let's hide from them"; "There's a monster over there"; "I see a ghost.")

4. Clear expression of fear or anxiety; combination of theme and strong affect. (Examples: "I'm scared"; "The monster's coming after me"; "Mom's gonna spank me" [with feeling].)

5. Very strong theme plus fearful affect. (Examples: "I'm scared, he'll kill us"; "Don't let him hurt me"[while hiding].)

Happiness/Pleasure

Expression of positive affect that denotes pleasure, happiness, having a good time, enjoyment, and contentedness.

1. No evidence

2. Reference to content involving happiness, pleasure, satisfaction, general preference statements. (Examples: “This is nice”; “Saturday is the best day of the week.”) or very mild expression

3. Subjective reference to fun and amusement with mild/moderate expression

4. Activity plus affective expression. Strong feeling state; strong action alone (jumping up and down with happy expression). (Examples: I feel happy [with feeling]; “Whee, this is fun”; Singing happily; Dancing happily; “I really like this.”)

5. Combination of two of the following: emotional expression, theme, or action (At least one at extreme level or two at strong level). Extreme emotional words also scored. (Examples: “I love this”[with action]; jumping and laughing.)

Sadness/Hurt

Expression of illness, physical injury, pain, sadness, loneliness.

1. No evidence

2. Non-personalized reference to sadness/hurt (conversational tone). (Examples: “Sally got hurt yesterday”; “Joe was in the hospital.”) or very mild expressions.

3**. Personalized reference to sadness/hurt** (conversational) with mild/moderate expression (Examples: “Sally was crying yesterday”; “Sometimes I cry.”)

4. Statement of sadness/hurt action; stronger verbal statement; more intense sad action (experiencing). (Examples: “Ouch that hurts”; “Boy am I sad”; Whimpering; Whining; “I don’t want you to go.”)

5. Strong verbal statement of sadness/hurt with action; use of very strong sad/hurt words; or very intense current experiencing of sadness/hurt. (Examples: “I don’t want the shot” [while crying]; “This hurts” [while crying]; Moaning in pain.)