

EXPLORING DEFENSE MECHANISM PATTERNS AND THEIR IMPACT ON
SYMPTOMATOLOGY AND EMOTION REGULATION IN CHILDREN
UNDERGOING REGULATION FOCUSED PSYCHOTHERAPY FOR
CHILDREN (RFP-C)

A THESIS SUBMITTED TO
THE INSTITUTE OF GRADUATE PROGRAMS
OF
İSTANBUL BİLGİ UNIVERSITY

EDLİN GÜLZARİ

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF MASTER OF ARTS
IN
CLINICAL PSYCHOLOGY

2025

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CHILDREN (RFP-C)**

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Date of Approval: 6/17/2025



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ABSTRACT

Defense mechanisms are strategies that serve to regulate distress. Regulation Focused Psychotherapy for Children (RFP-C) is a brief psychodynamic intervention that conceptualizes children's externalizing behaviors as defense mechanisms against overwhelming emotions. Accordingly, it is grounded in the premise that defense mechanisms play a critical role in child psychopathology, as they are closely linked to emotion regulation capacity and externalizing symptoms. This study used a play-based observational coding system, The Children's Play Therapy Instrument (CPTI), to examine how defensive functioning unfolds throughout RFP-C, and to explore its predictive relationship with treatment outcome, defined by symptom reduction and improved emotion regulation. Participants were 38 children (aged 6-12) who received RFP-C within a randomized controlled trial. Children's use of defense mechanisms were coded using the CPTI, from three sessions (beginning, middle, end). Outcomes were measured using the Strengths and Difficulties Questionnaire (SDQ) and the Emotion Regulation Checklist (ERC), completed by parents at pre- and post-treatment. Curve estimation analyses revealed that the use of adaptive defenses decreased mid-treatment but increased at the end of treatment; polarized defenses showed a steady increase over time; and inhibited defenses remained relatively stable. Hierarchical linear regression analyses showed that mean defense scores did not significantly predict symptom or emotion regulation outcomes. These findings suggest that defensive functioning in child psychotherapy may follow non-linear patterns. While defensive functioning did not predict outcomes directly, its observed shifts across treatment offer clinically relevant insight into how children engage with affective material over time. This study contributes to the growing literature on the role of defensive functioning in therapeutic change within psychodynamic psychotherapies for children.

Keywords: Defense Mechanisms; Externalizing Problems; Regulation Focused Psychotherapy for Children; Emotion Regulation; Child Psychotherapy

ÖZ

Savunma mekanizmaları, zor duygularla başa çıkmak için kullanılan stratejilerdir. Çocuklar için Düzenleme Odaklı Psikoterapi (RFP-C), çocukların dışsallaştırma davranışlarını, zor duygularla başa çıkmak için geliştirdikleri savunma mekanizmaları olarak kavramsallaştıran kısa süreli bir psikodinamik müdahaledir. Savunma mekanizmalarının, duygu düzenleme kapasitesi ve dışsallaştırma semptomlarıyla ilişkili olduğu ve çocuk psikopatolojisinde önemli bir rol oynadığı görüşüne dayanır. Bu çalışma, RFP-C sürecinde savunma mekanizmalarının nasıl değiştiğini ve bu değişimin tedavi çıktılarıyla olan ilişkisini, oyun temelli bir gözlem aracı olan Children's Play Therapy Instrument (CPTI) ile incelemektedir. Çalışmanın örneklemini bir randomize kontrollü çalışma kapsamında RFP-C alan 6-12 yaş arasındaki 38 çocuktan oluşmaktadır. Savunma mekanizmaları, tedavinin başlangıç, orta ve son aşamalarına denk gelen üç seans üzerinden CPTI ile kodlanmıştır. Semptomlar ve duygu düzenleme becerileri, ebeveynler tarafından tedavi öncesi ve sonrası doldurulan Güçler ve Güçlükler Anketi (SDQ) ile Duygu Düzenleme Ölçeği (ERC) ile ölçülmüştür. Eğri tahmini analizleri, adaptif savunmaların kullanımının tedavi ortasında azalıp tedavi sonunda yeniden arttığını; kutuplaşmış savunmaların zaman içinde arttığını; ketlenmiş savunmaların ise sabit kaldığını göstermiştir. Hiyerarşik doğrusal regresyon analizleri, ortalama savunma mekanizmaları sonuç değişkenlerini anlamlı şekilde yordamadığını göstermiştir. Savunma mekanizmaları sonuçları doğrudan yordamasa da, süreç boyunca savunma mekanizmalarında gözlenen değişimler, çocukların duygusal içerikle kurdukları ilişkinin zaman içindeki dönüşümüne dair önemli klinik bilgiler sunmaktadır. Bu çalışma, çocuklara yönelik psikodinamik psikoterapilerde terapötik değişimde savunma mekanizmalarının rolüne ilişkin geliştirmekte olan literatüre katkı sağlamaktadır.

Anahtar Kelimeler: Savunma Mekanizmaları; Dışsallaştırma Sorunları; Çocuklar için Düzenleme Odaklı Psikoterapi; Duygu Düzenleme; Çocuk Psikoterapisi



To my grandmother, whose spirit continues to guide me, even in her absence.

ACKNOWLEDGMENTS

First and foremost, I am profoundly grateful to my advisor, Pelinsu Bulut Özer, for standing by me through every challenge this thesis presented. Without their constant support, insightful guidance, and detailed feedback, this journey would have been impossible to navigate. I am deeply thankful for their unwavering presence at every step of the way, not only as an academic mentor but also as a source of encouragement during moments of difficulty. I feel incredibly fortunate to have had the opportunity to work under their guidance. I would also like to thank my jury member Sibel Halfon for their support and leadership as the principal investigator of the RCT on Regulation Focused Psychotherapy for Children, which made this thesis possible. I am extremely grateful for their thoughtful guidance and feedback throughout this process. It has been a privilege to contribute to the larger project they led with dedication. I would also like to express my sincere appreciation to my jury member Nur İnci Namlı for generously offering their time and expertise to be part of my thesis evaluation process. I am grateful for their thoughtful presence and contributions to this work.

I would like to extend my gratitude to the Center for Regulation Focused Psychotherapy for making this work possible, and specifically to Dr. Tracy Prout, Director of Research at the Center, whose training and guidance as part of the RFP-C clinician certification process laid the foundation for my work in this field. I am grateful for the opportunity to have been part of this community and for the knowledge and skills I gained through their leadership.

I would also like to thank my friends and family who have supported me throughout this process. I am deeply grateful to my parents, whose unwavering love, support, and belief in me have been constant sources of strength, reassurance, and encouragement. I am thankful to my brother for bringing lightness, humor, and laughter into even the most stressful moments of this thesis journey. I would like to thank my dear friends Ayşen Göncü, Bengi Omaç, Duru Eğrilmez, Kübra Arıkan, Maide Körlü Bulut, and Melike Albayrak, who have walked alongside me as fellow clinicians, classmates, researchers,

and as friends. Sharing this journey with them has been both a privilege and a source of strength. I would like to extend my thanks to Selin Kitiş, whose kindness, mentorship, and encouragement have been an immense source of support throughout this journey. I would also like to thank Esra Akça and Sinem Kılıç, whose support has extended far beyond this thesis. Throughout my years of training at Istanbul Bilgi University, they have been by my side with their kindness, knowledge, and willingness to help in every possible way. My biggest thanks go to my partner, for their endless support, patience, and love. They have been a great source of strength, an anchor, and a home. I could not have done this without them, and I am endlessly grateful for having them by my side throughout this journey.

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LIST OF ABBREVIATIONS

CADS:	Comprehensive Assessment of Defense Style
CAT:	Children's Apperception Test
CBT:	Cognitive Behavioral Therapy
CPQ:	Child Psychotherapy Q Set
CPTI:	Children's Play Therapy Instrument
DHP:	Dollhouse Play
DMCP:	The Defense Mechanisms Manual for Children's Doll Play
DMM:	Defense Mechanism Manual
DMRS-Q:	Defense Mechanism Rating Scale for Adults
DMRS-Q-C:	Defense Mechanism Rating Scale for Children
DSM-IV:	Diagnostic and Statistical Manual of Mental Disorders
ERC:	Emotion Regulation Checklist
MSSB:	MacArthur Story Stem Battery
ODD:	Oppositional Defiant Disorder
ODF:	Overall Defensive Functioning
PQS:	Psychotherapy Process Q Set
RFP-C:	Regulation Focused Psychotherapy for Children
SDQ:	Strengths and Difficulties Questionnaire
TAT:	Thematic Apperception Test

INTRODUCTION

Defense mechanisms are strategies that help individuals manage internal conflict and regulate emotional distress (American Psychiatric Association, 2000). While defense mechanisms serve a protective function, their rigidity, developmental appropriateness, and reality-distorting nature can influence individuals' overall functioning and determine whether they manage emotional conflict in adaptive (through defense mechanisms like problem-solving and humor) or maladaptive (through defense mechanisms like projection and splitting) ways (Cramer, 1991; Vaillant, 1994; Kernberg, 2000). In the past, many clinicians and researchers have conducted studies that establish links between defensive functioning and various psychological variables (Vaillant, 1976; Tanzilli et al., 2021; Hayden et al., 2021; Haan, 1974; Baxter et al., 1963; Perry & Cooper, 1989). In recent years, psychodynamic approaches to psychotherapy have increasingly emphasized the developmental significance and clinical utility of understanding defense mechanisms (Perry & Bond, 2012; Kramer et al., 2013; Babl et al. 2019; Prout et al., 2019).

Regulation Focused Psychotherapy for Children (RFP-C; Hoffman et al., 2016) is a manualized, short-term psychodynamic psychotherapy for children with externalizing difficulties, that highlights the significance of defensive functioning in child psychopathology. It conceptualizes disruptive behaviors not simply as symptoms, but as maladaptive defenses against intolerable emotions. Accordingly, in RFP-C, therapists intervene by identifying and interpreting the child's defenses in session, helping the child shift from less adaptive defenses toward more adaptive ones, ultimately improving emotion regulation and reducing symptomatology (Prout et al., 2019; Prout et al., 2022a).

Despite the centrality of defense mechanisms in both psychodynamic theory and RFP-C, empirical research on the trajectory of defenses throughout therapy – especially in children – remains limited. Very few studies exist that examine how defensive functioning changes over time, or how such changes relate to treatment outcomes, and most of these explore these questions in adult psychotherapy.

This thesis aims to address these gaps by investigating the trajectory and predictive role of defense mechanisms in children undergoing RFP-C. Utilizing the Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998) – a structured, play-based observational coding system – this study examines how children's use of adaptive, conflicted/inhibited, and polarized defenses changes across three treatment timepoints (beginning, middle, and end), and whether these patterns predict changes in symptomatology and emotion regulation.

The research questions guiding this thesis are:

- 1) How do defense mechanisms change over the course of RFP-C treatment?
- 2) Does defensive functioning predict therapy outcomes, particularly in terms of emotion regulation and symptomatology?

By examining defensive functioning both as a dynamic process that unfolds across therapy and as a predictor of treatment outcomes, this thesis contributes to the theoretical understanding of defense mechanisms as central to child development and psychotherapy. Utilizing data from a randomized controlled trial (RCT) of RFP-C the study uses a structured observational coding system to track changes in defense patterns and assess their relationship to improvements in symptoms and emotion regulation. In doing so, it offers theoretical, empirical, and clinical insights into the mechanisms of therapeutic change.

LITERATURE REVIEW

2.1. Defense Mechanisms

2.1.1. Definition

Defense mechanisms are strategies that individuals employ to protect themselves from excessive anxiety or uncomfortable feelings (American Psychiatric Association, 2000). They determine how individuals respond to emotional conflicts and manage internal and external stressors (American Psychiatric Association, 2000). Some defense mechanisms indicate better coping with difficult emotions, while others suggest difficulty coping with unpleasant feelings (Hoffman et al., 2016). Accordingly, defense mechanisms play a crucial role in resilience and emotion regulation, making their exploration essential for understanding therapeutic progress and symptom change (Prout et al., 2019).

2.1.2. Historical Background

Across the literature, defense mechanisms have been conceptualized and categorized in various different ways. Sigmund and Anna Freud were among the first to stress the importance of understanding and addressing defense mechanisms in psychotherapy. In *The Neuro-Psychoses of Defence* (1894), Sigmund Freud introduced the idea of repression as a defense mechanism and suggested that it shields individuals from distressing thoughts and feelings by pushing them out of conscious awareness. In *Inhibitions, Symptoms and Anxiety* (1926), Freud elaborated on the concept by referring to other defense mechanisms the ego uses to manage internal conflicts and anxiety, such as regression, sublimation, and denial. Building on her father's work, in *The Ego and the Mechanisms of Defence* (1936), Anna Freud provided a systematic framework for defense mechanisms and introduced the idea that these defense mechanisms can serve adaptive purposes. She made a distinction between defenses that are more primitive (less adaptive) and those that are more mature (adaptive). She suggested that there are four

factors that determine whether a person's use of defenses is normal or pathological: balance (use of a variety of defenses rather than a single defense), intensity, age-appropriateness (defenses that emerge too early or persist too long), and reversibility (defenses should not persist once the original threat has passed) (Freud, 1965). These early works laid the foundation for contemporary understandings of defense mechanisms as indicators of ego functioning.

2.1.3. Contemporary Views

In *The Development of Defense Mechanisms* (1991), Cramer synthesizes insights from previous theorists who propose that all ego functions develop in a predictable, chronological sequence. She proposes that as an integral ego function, defense mechanisms' emergence and evolution also adhere to a developmental sequence. Cramer's developmental model of defense mechanisms is based on two key ideas: The first is that defenses are chronologically ordered; and the latter is that each individual defense has a "life history" of its own. This model suggests that defenses emerge in a predictable sequence, aligned with the individual's cognitive and emotional development. Cramer pinpoints three categories of defenses via factor analysis, each associated with a different stage of childhood: denial, projection, and identification. She indicates that young children use denial, school aged children use projection, and adolescents use identification predominantly. She suggests that as development advances, children abandon earlier defense mechanisms, and begin to use defense mechanisms associated with the next stage of development. This model emphasizes that the adaptive or maladaptive use of defenses depends on their timing, context, and flexibility within the individual's life course. Cramer (1991) also differentiates between theorists who take a "horizontal" approach to categorizing defense mechanisms, and those who take a "vertical" approach. In horizontal approaches, the emergence of different defenses is organized along a timeline, arranged in chronological order. In vertical approaches, defenses are arranged hierarchically and classified based on characteristics like their complexity or the extent to which they distort reality (Cramer, 1991).

One of the most influential models of defense mechanism classification was developed by Vaillant et al. (1986). This hierarchy of defenses is an empirically supported classification system, in which defenses are categorized according to their level of maturity. According to Vaillant (1994), "level of maturity" refers to how adaptive and effective a defense is in managing emotional distress. More mature defenses allow for individuals to cope with stress in flexible, constructive, and prosocial ways, while immature defenses tend to be more rigid and reality-distorting in ways that can contribute to psychopathology. Vaillant's model combines developmental and pathological dimensions, grouping defenses into levels: "narcissistic/psychotic" (lowest level), "immature," "neurotic," and "mature" (highest level). Vaillant's work marks a transition towards empirically grounded, systematic classification models. His work also laid the groundwork for the integration of defense mechanisms into diagnostic frameworks. Elements of Vaillant's hierarchy of defense maturity were adapted by the American Psychiatric Association and incorporated into the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994) as "Defense Levels" (Hoffman et al., 2016).

The DSM-IV groups defenses into seven levels. In the high adaptive level, there is an optimal adaptation in response to stressors. Defenses included in this level of functioning are anticipation, affiliation, altruism, humor, self-assertion, self-observation, sublimation, and suppression. In the mental inhibitions (compromise formation) level, ideas, feelings, memories, wishes, or fears that might be too alarming are kept out of consciousness. Defense mechanisms used by those in this functioning level are displacement, dissociation, intellectualization, isolation of affect, reaction formation, repression, and undoing. In the minor image-distorting level, the image of the self, body, or others may be distorted for self-esteem regulation. Devaluation, idealization, and omnipotence are some of the defense mechanisms used in this level of defensive functioning. The disavowal level of defensive functioning involves pushing out of awareness of distressing or unacceptable stressors, impulses, ideas, emotions, or responsibilities, sometimes attributing them to external factors. Defenses included in this level of functioning are denial, projection, and rationalization. In the major image-distorting level, there are severe distortions of the image of the self or others. Autistic fantasy, projective identification, and splitting are three defense mechanisms used by those in this level of

defensive functioning. The defensive functioning of those in the action level manages internal or external stressors by taking action or by withdrawing. Acting out, apathetic withdrawal, help-rejecting complaining, and passive aggression are some defensive behaviors used in this category. The lowest level of functioning is the level of defensive dysregulation, in which the individual's defensive mechanisms fail to regulate their reaction to stressors, and this leads to a clear detachment from objective reality. Defense mechanisms used in this level of functioning are delusional projection, psychotic denial, and psychotic distortion (American Psychiatric Association, 1994).

Paulina F. Kernberg and her colleagues (2000) classified defense mechanisms in alignment with levels of personality organization: normal defenses (e.g., humor, suppression, sublimation) align with normal personality organization; neurotic defenses (e.g., repression, projection, intellectualization) correlate with neurotic personality organization; borderline defenses (e.g., splitting, denial, idealization) are linked to borderline personality organization; and psychotic defenses (e.g., de-animation, hypochondriasis, fusion) align with psychotic personality organization. This classification system emphasizes that defenses are intricately linked to an individual's overall psychological functioning (Kernberg, 2000).

Kernberg, Chazan, and Normandin (1998) emphasized the significance of defensive strategies in children's overall functioning when developing the Children's Play Therapy Instrument (CPTI). The CPTI assesses various dimensions of children's play behavior in therapeutic settings, including affective, cognitive, linguistic, and social levels, ultimately classifying children's play behavior based on their predominant defensive strategies (Chazan, 2002). These four play profiles were developed based on Vaillant's (1986) classification system (Chazan, 2002). These clusters were originally named 1) Normal, 2) Neurotic, 3) Borderline, and 4) Psychotic but were changed later as 1) Adaptive, 2) Conflicted/Inhibited, 3) Polarized/Impulsive, and 4) Disorganized (Chazan, 2002; These clusters will be further discussed in Section 3.2.1.3.1.). CPTI's clusters resembles the vertical categorization of the maturity of defenses, however there is a shift in terminology to ensure that the clusters accurately describe play activity rather than being directly

associated with pathology. This highlights defensive functioning as a key aspect of children's overall development (Chazan, 2002).

Across contemporary classification systems, defense mechanisms are usually understood within a hierarchical structure, ranging from more adaptive and flexible strategies to those that are more rigid, reality-distorting, and linked to psychopathology. While different models use varying terminology, they share common principles. Higher-level defenses are often described as "mature" or "adaptive," and they facilitate constructive coping, flexibility, and engagement with reality. Lower-level defenses are often described as "immature" or "maladaptive," and are characterized by rigidity and reality-distortion (Cramer, 1991; Vaillant, 1994; Kernberg, 2000). This hierarchical approach is also reflected in the CPTI, where children's play behavior is classified into four play profiles based on defensive functioning, mirroring other frameworks that distinguish between adaptive and maladaptive defense mechanisms (Chazan, 2002).

2.2. Child Psychotherapy and Defense Mechanisms

All play behavior has meaning. Children project their inner worlds onto play. Patterns, repetitions, and disruptions in play offer insight into the emotional challenges children are trying to navigate (Hoffman et al., 2023). Children's use of defense mechanisms during therapy sessions can be observed by clinicians in different ways (Hoffman et al., 2016). First, through the child's speech: changes in tone, sudden or loud speech, and marked hesitation in a child's tone can indicate defensive behavior. Second, through thought content: being easily offended, expressing distorted or unrealistic ideas, providing reasons that seem to distort the truth, or making unexpected statements about the clinician point to the use of defenses. Third, through thought process: disruptions and shifts in play or topic may reflect the child's discomfort with emerging difficult emotions and an attempt to avoid the anxiety-provoking subject. Fourth, through affect: incongruent affect, absence of affect, or an inability to discuss or express affect may signal use of defense mechanisms. Fifth and finally, through behavior: psychomotor changes, abrupt shifts in play, or refusal to engage in play may be indicative of defensive behavior

(Prout, 2023). Exploring children's use of defense mechanisms in therapy is fundamental for various reasons. First, by recognizing, identifying, and addressing defense mechanisms, therapists can help uncover the underlying meanings of a child's problem behaviors, as well as the hidden anxieties underneath these symptoms. Additionally, since disruptive behaviors often arise from difficulties in emotional regulation, addressing defense mechanisms can help children adopt healthier defensive strategies, fostering emotional growth and resilience. Bringing into conscious awareness the defensive strategies children use to avoid unpleasant emotions can enhance emotional awareness by helping children better understand their feelings. Furthermore, observing the shifts in children's use of defense mechanisms throughout the therapy process offers valuable insight into therapeutic progress and the effectiveness of interventions (Hoffman et al., 2016).

2.2.1. Common Defense Profiles of Children in Therapy

The emotional and behavioral difficulties children experience are categorized as internalizing and externalizing behaviors. Internalizing behaviors reflect struggles with emotions directed inward, while externalizing behaviors are characterized by outward expressions, including aggression and defiance (Achenbach & Edelbrock, 1978). Hoffman et al. (2016) view externalizing behaviors as maladaptive forms of emotion regulation: defenses children use to shield themselves from painful emotions. They propose that aggressive behaviors serve to protect the child by concealing these painful emotions and removing them from conscious awareness.

It is highlighted by Hoffman et al. (2016) that children with externalizing behaviors lack adequate control and mastery over their impulses. Correspondingly, they also indicate that children with externalizing behaviors frequently use avoidance, denial, and turning passive into active. In addition, they emphasize externalizing children's reliance on significant reality-distorting defenses like projection and denial. Similarly, Prout (2023) suggests that defenses frequently used by children with disruptive behaviors are identification with the aggressor, projection, denial, and projective identification. It has

been established in one study that externalizing disorders tend to correlate with immature and neurotic defense styles (Salehi Nezhad et al., 2010). This body of research highlights the intricate relationship between externalizing behaviors and the development of maladaptive defenses in children. Understanding these connections underscores the importance of addressing underlying defense mechanisms in therapeutic interventions for children with disruptive behaviors.

2.2.2. Empirical Research on Defense Mechanisms

Over the past several decades, several links between defense mechanisms and other psychological variables have been established (Cramer, 1991). Associations between defense mechanisms and different personality characteristics (Gleser & Ihilevich, 1969; Plutchik et al., 1979; Byrne, 1961; Vickers et al., 1983; Vaillant, 1976), psychopathology (Vaillant, 1976; Byrne, 1961; Perry & Cooper, 1989), relationship with primary attachment figures (Haan, 1974; Weinstock, 1967a; Weinstock, 1967b), cognitive functioning (Haan, 1973; Baxter et al., 1963), attachment type, and reflective functioning (Tanzilli et al., 2021; Hayden et al., 2021) have been established. In addition, previous literature consistently suggests that enhancements in the use of defense mechanisms are associated with improved symptom outcomes in psychotherapy, and that patients' use of defense mechanisms shifts during psychotherapy (Perry & Bond, 2012; Kramer et al., 2013; Babl et al. 2019). However, these findings have largely emerged from studies with adults, and research exploring how defensive functioning evolves in psychotherapy and how it relates to therapeutic outcomes in child psychotherapy remains limited.

2.2.2.1. Role of Defense Mechanisms on Therapy Process and Outcome

An important part of implicit emotion regulation is the ability to verbalize feelings (Torre & Lieberman, 2018). Katan (1961) explains that children with externalizing behaviors act upon their feelings before they can verbalize them. She emphasizes that by learning to name and verbalize their feelings, children can also begin to postpone action. Although there are currently no studies that have explored whether defense mechanisms predict

treatment outcome in child psychotherapy, studies conducted in adult populations suggest that as individuals begin to use more adaptive defense mechanisms (in other words, as they begin to cope with difficult emotions in more adaptive ways), their symptoms improve (Perry & Bond, 2012).

In a study conducted by Babl et al. (2019), it was found that both an increase in the use of adaptive defenses, as well as a decrease in the use of maladaptive defenses were associated with symptom improvement. Furthermore, it was also found that patients who began treatment with a higher overall defensive functioning score experienced greater symptom improvement compared to those who began with lower overall defensive functioning. Additionally, it was established by Albucher et al. (1998) that greater use of more adaptive defense mechanisms such as humor was linked to improvements in obsessive-compulsive and depressive symptoms. In a study conducted in 2009, Perry et al. found that in 3 out of 4 participants, overall defensive functioning increased as the patients improved. Similarly, Kramer et al. (2010) found that improvement in Overall Defensive Functioning (ODF) was a significant predictor of therapeutic outcome. Bond & Perry (2004) established that in patients who began long-term dynamic psychotherapy with clinically significant symptoms, symptom levels decreased and defense styles became more adaptive over time. They also found that this change in defense style was predictive of symptomatic change, but a direct causal relationship was not established. In a study conducted by Cramer and Blatt (1990), it was found that decline in the use of defenses in general was associated with reductions in psychiatric symptoms. In another study Cramer and Blatt (1993) conducted, they found that after about a year of treatment, patients showed a reduction in their overall use of defense mechanisms, which was significantly associated with a decline in bizarre and disorganized symptoms in most patient groups. Additionally, changes in defense levels were linked to improvements in both clinical symptoms and interpersonal functioning.

However, there are also mixed findings, indicating that changes in defensive functioning during psychotherapy may be more difficult to achieve. Hayden et al. (2021) established that while increased mentalization is a significant predictor of reduction in maladaptive defenses during psychotherapy, symptom reduction is only partially associated with a

reduction in maladaptive defenses. Hersoug et al. (2002), found that although patients experienced both symptom reduction and improvements in overall defensive functioning during brief dynamic psychotherapy, symptom reduction preceded change in overall defensive functioning, suggesting that shifts in defensive functioning may require more time to emerge.

In addition, there are several case studies available that illustrate how identifying and interpreting children's defenses can ultimately help them verbalize their feelings, use more adaptive defense mechanisms, and tolerate difficult emotions (Rice & Hoffman, 2014; Prout et al., 2018; Prout et al., 2015; Udwin et al., 2021). Moreover, these case studies also suggest that shifts in defensive functioning are associated with improvements in treatment outcomes, and emphasize the significance of defense mechanisms as facilitators of change in psychotherapy.

2.2.2.2. Trajectory of Defense Mechanisms in Psychotherapy

Although research on the trajectory of defenses in child psychotherapy also remains limited compared to research on adult psychotherapy, there are some studies available that explore the question of how children's use of defense mechanisms change in psychotherapy. Halfon et al. (2016), in a study conducted on three 6-year-old children, explored the trajectory of change in play profiles during long-term psychodynamic play therapy, using the CPTI. They found that although there was no complete transformation of play profiles, a significant decrease in the use of less adaptive play profiles was observed. Similarly, in a case study of one child that was identified to be a Conflicted Player, Chazan and Wolf (2002) observed a notable decrease in polarized defenses. In addition, although conflicted defenses remained dominant, they were increasingly accompanied by adaptive strategies. Defenses related to the disorganized cluster remained minimal throughout the treatment process. In another case study (Chazan, 2000), a 2-and-a-half-year old child's play was analyzed using the CPTI, at the beginning of treatment, and after 7 months of therapeutic intervention. Over the course of therapy, the child

transitioned from a profile dominated by disorganized defenses to one increasingly characterized by adaptive functioning, with some conflicted defenses still present.

In addition, there are several studies that have explored the trajectory of defense mechanisms in adult psychotherapy. Bond and Perry (2004) established that in long-term dynamic psychotherapy, defense styles become more adaptive. Similarly, Kramer et al. (2010) found that throughout the course of treatment, patients' defense patterns shifted to be more mature. Hersoug et al. (2002), established that by the end of a brief dynamic psychotherapy, patients use of adaptive defenses increased significantly. A study conducted by Kneepkens and Oakley (1996) revealed that depressed patients who were hospitalized showed greater use of mature defense mechanisms and lower use of immature defense mechanisms at discharge, compared to when they were first admitted. Kramer et al. (2013) found that patients going through psychoanalysis, psychodynamic psychotherapy, or cognitive therapy, experienced increased overall defensive functioning. A study conducted by Perry & Bond (2012) exploring how patients' use of defense mechanisms changes throughout the course of long-term psychotherapy, has found that lowest-level action defenses (acting out, apathetic withdrawal, etc.) decrease and high adaptive level defenses (anticipation, affiliation, etc.) increase during long-term psychotherapy. In another study conducted by Coccanari de' Fornari et al. (2011), it is indicated that immature defenses significantly decrease and mature defenses significantly increase in patients who undergo short term psychotherapy. Similarly, Babl et al. (2019) established that the overall defensive functioning of patients with depressive or anxiety disorders improved over the course of psychotherapy. It was found that patients use of adaptive defenses increased while their use of maladaptive defenses decreased over the course of treatment. Additionally, Blatt and Ford (1994) found that inpatients in a psychiatric hospital showed a reduction in the total use of defense mechanisms after undergoing long-term psychodynamically oriented therapy.

There are also some mixed findings that partially contradict previous literature. In a study conducted in 2021, Hayden et al. established that an increase in mentalization capacity of patients undergoing inpatient therapy was associated with decreased use of maladaptive defenses. However, the same study also established that there was no significant increase

in the use of adaptive defense mechanisms. Similarly, Akkerman et al. (1992) found that as patients improved symptomatically, they used fewer immature defenses, but their use of adaptive defenses did not change significantly.

Overall, previous literature illustrates that maladaptive defenses tend to decrease while more adaptive defenses become more prominent during psychotherapy, underscoring the importance of understanding how defense mechanisms evolve throughout treatment.

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

Regulation Focused Psychotherapy for Children (RFP-C), manualized by Hoffman, Rice, and Prout, is a short-term psychodynamic psychotherapy for children with externalizing difficulties, consisting of 16 child sessions and 4 parent sessions. It is grounded in the premise that all disruptive behaviors serve the function of protecting children from painful emotions, and therefore can be understood as defenses in their own right. This model of treatment aims to identify which emotion the child is avoiding, why, and how. By identifying and interpreting the child's use of defense mechanisms, clinicians aim to help improve the child's ability to tolerate and talk about difficult emotions, and use more adaptive defenses (Hoffman et al., 2016).

2.3.1. Theoretical Background

RFP-C's conceptualization of externalizing behaviors as defenses the child uses to avoid distressing emotions aligns closely with Kernberg and Chazan's (1991) perspective on disruptive behaviors. They, too describe children's aggressive behaviors as unconscious efforts of dismissing feelings that are too uncomfortable to tolerate. Their intervention approach emphasizes that by increasing children's ability to tolerate and verbalize difficult emotions, their externalizing behaviors can be reduced.

Bornstein's (1945) work, on the other hand, played a pivotal role in the emergence of the technique of defense interpretation. She was the first to introduce the technique of

addressing the defenses children use against unpleasant emotions – particularly those children who have difficulty expressing painful feelings.

Expanding upon this body of work, Hoffman et al. (2016) argue that all externalizing behaviors should be understood as maladaptive defense mechanisms because they serve the function of protecting children from painful emotions. They propose that because these behaviors function as defenses, they also operate as forms of implicit emotion regulation. Accordingly, they suggest that a regulation-focused approach to treating children with externalizing behaviors is essential. In line with this, RFP-C is based on the premise that if therapists identify and address the function and meaning of children's disruptive behaviors, children will begin to manage difficult emotions in more adaptive ways, and their externalizing behaviors will decrease – in other words, interpreting the defenses children use to shield themselves from difficult feelings can help children use more adaptive defense mechanisms, enhance their implicit emotion regulation abilities, and therefore result in a reduction in externalizing symptoms.

2.3.2. Goals of RFP-C

In RFP-C, the clinician communicates both to the child and to the parents that the child's behaviors have meaning. RFP-C aims to foster implicit awareness in children that the unpleasant feelings they are trying to avoid are not as dangerous or destructive as they think; that there are more adaptive and effective ways of handling these difficult emotions; and that these feelings will not overwhelm or harm the clinician. By gradually identifying and addressing the child's defenses, RFP-C clinicians aim to help children develop more adaptive ways of coping with difficult emotions (Hoffman et al., 2016).

2.3.3. The Triangle of Conflict

In RFP-C, the clinician tries to understand the meaning of the child's externalizing symptoms, and how these behaviors function to defend against difficult emotions (Hoffman et al., 2016). Malan's (1979) Triangle of Conflict is utilized as a frame for

clinicians to both understand, and help the child's parents understand the difficulties experienced by the child. In one corner of the triangle is the defense: the disruptive behavior or the symptom. RFP-C emphasizes that there is meaning to this behavior – that there are hidden, painful feelings underneath it that the child is trying to avoid. In the second corner of the triangle are these painful feelings. In the third corner is the inhibition: why these emotions must be avoided (Prout, 2023). For instance, a child may use acting out as physical aggression (defense) to avoid feelings of sadness (hidden painful feeling) because feeling sad is too embarrassing (inhibition) (Prout et al., 2018). The child's difficulties are conceptualized using this triangle, which is then utilized in parent sessions to reframe the child's externalizing behaviors as maladaptive defense mechanisms (Prout, 2023).

2.3.4. Defense Interpretations

Once the emotions the child is avoiding, how (through which defenses) these feelings are being avoided, and why these feelings need to be avoided are identified, the clinician begins to systematically address the child's defense mechanisms, by helping the child recognize what function these behaviors serve (Prout, 2023). These defense interpretations are “experience-near” interventions, meaning they focus on what is happening in the moment (Hoffman et al., 2016). In line with this, Hoffman and colleagues (2016) conceptualize the avoidance of unpleasant emotions and thoughts as analogous to the avoidance of external phobic situations. RFP-C clinicians try to prevent the child from engaging in avoidance mechanisms by noticing, identifying, and commenting on the child's defenses. The focus of the clinician is always on the observed defenses within the “in-the-moment” clinical interaction. The clinician avoids referring to information received from the child's parents, and refrains from “deep” interpretations. Through these experience-near interactions, the therapist observes and discusses the maladaptive defenses the child uses to avoid unpleasant feelings, with the ultimate goal of weakening these defenses and replacing them with more adaptive ones (Hoffman et al., 2016).

2.3.5. Procedure of RFP-C

The RFP-C procedure consists of three phases (Hoffman et al., 2016):

In the first phase, one introductory session is conducted with the parents, followed by two initial sessions with the child, and finally, one feedback session with the parents. In the initial sessions with the child, the therapist attempts to establish an alliance, help the child get acquainted with the toys in the room, and begin to identify the repetitive themes and disruptions in the child's play in order to understand which feelings the child is avoiding, and how. In the initial meetings with the parents, the clinician is expected to explain the RFP-C process in detail, empathize with the parents' difficulties as much as possible, and help them understand the meaning behind the child's difficulties.

In the second phase of treatment – sessions four through eleven, clinician addresses the ways in which the child manages difficult emotions in sessions. The clinician identifies and interprets the overt, maladaptive defense mechanisms the child is using. Throughout the treatment process, the clinician conducts brief weekly check-ins with the parents to establish and preserve the therapeutic alliance, offer support, provide feedback on the ongoing therapy process, assist them in understanding the child's difficulties, and help them discover strategies to manage the child's disruptive behaviors. After the tenth session, a parent session is conducted to evaluate therapeutic progress and prepare for the upcoming termination.

The third and final phase of treatment consists of sessions twelve through sixteen. This is the termination phase of treatment, with the primary goal of assisting the child in managing challenging emotions related to separation. The clinician continues to explore and discuss how the child is avoiding unpleasant feelings and thoughts, but shifts focus towards the upcoming separation. After the final session with the child, a final termination session with the parents is conducted.

2.3.6. Empirical Research on RFP-C

2.3.6.1. Outcome Research

Outcome research on RFP-C has demonstrated promising outcomes for children with externalizing behaviors in terms of oppositional defiant disorder (ODD) symptom reduction and improvements in emotion regulation. First, a pilot study (Prout et al., 2019) was conducted, consisting of three children with ODD and other externalizing behaviors receiving RFP-C. A significant improvement was established in all three participants' ODD symptoms. In the two participants with higher levels of externalizing symptoms at the beginning of treatment, a greater improvement was observed. The other participant, who started the treatment process with a lower level of symptoms, showed sufficient progress to be considered recovered. In addition, clinically significant enhancements in emotion regulation were observed in all three participants.

These findings were further supported by a randomized controlled trial conducted by Prout et al (2022a). The sample of this study was much larger, consisting of 43 school-aged children randomly assigned to either a waitlist control group or to RFP-C. A clinically significant reduction in ODD symptoms was observed in children who received RFP-C. More specifically, 26.5% of participants were classified as recovered, 52.9% were classified as improved, and 20.6% experienced no change. Although participants' symptoms improved significantly, no significant change in explicit emotion regulation was observed. It is indicated that implicit emotion regulation may be a more relevant target for future research, since RFP-C is built on the premise that defense mechanisms and implicit emotion regulation are conceptually intertwined, and that a regulation-focused approach is essential for treating externalizing behaviors. If defenses operate at an implicit level, then improvements in implicit emotion regulation may be a primary driver of therapeutic change (Prout et al., 2022a).

Another pilot study (Storey et al., 2023) consisting of twenty-one students with ODD symptoms from six different public schools in New York City, assessed the feasibility and effectiveness of RFP-C through a school partnership. In addition, this treatment was

delivered remotely due to the COVID-19 pandemic, offering insight into the effectiveness of RFP-C in an online setting. A significant improvement in children's ODD symptoms was observed, indicating that RFP-C can be effectively delivered remotely. These findings also support the feasibility of implementing psychodynamic interventions into school-based mental health services (Storey et al., 2023).

2.3.6.2. Process Research

Process research in RFP-C aims to examine how certain factors contribute to the outcomes mentioned above: reduction in symptoms and improvement in emotion regulation. Understanding process research is highly important because it can help identify mechanisms of change in child psychotherapy. In one study (Prout et al., 2018), three expert clinicians utilized the Child Psychotherapy Q Set (CPQ; Schneider & Jones, 2009) to establish a prototype of an ideal RFP-C session. The study established a significant positive correlation between the RFP-C process prototype and psychodynamic and child-centered play therapy process prototypes. No significant correlation between the RFP-C process prototype and cognitive behavioral therapy (CBT) process prototype were found. Lastly, the study also established the centrality of reflective functioning in the RFP-C prototype. This study also provides a framework for assessing clinicians' adherence to RFP-C principles, in future studies.

A different study by Kufferath-Lin et al. (2021) examined the parent sessions in RFP-C using the Psychotherapy Process Q Set (PQS; Jones, 1985) to determine which aspects of the psychotherapy process are characteristic of the parent sessions in RFP-C. The findings of this study showed that unlike child sessions, RFP-C parent sessions had the strongest correlation with CBT process prototype and were moderately correlated with short-term psychodynamic supportive-expressive therapy and reflective functioning prototypes. These findings suggest the importance of understanding the specific therapeutic processes in parent work that contribute to outcome in child psychotherapy.

Prout et al. (2022b) further explored the therapeutic factors and mechanisms of change in RFP-C. In this study, sixty sessions from twenty children with disruptive behaviors

undergoing RFP-C were analyzed using the CPQ (Schneider & Jones, 2009). It was found that the RFP-C process was significantly correlated with all of the previously established prototypes (Psychodynamic Therapy, Cognitive-Behavioral Therapy, Child-Centered Play Therapy, and Reflective Function). In addition, therapists' adherence to the RFP-C process prototype strengthened over time. It was also established that greater adherence to the Psychodynamic Therapy prototype predicted better outcomes in terms of symptom reduction. Therapists' attunement, responsiveness, and nonjudgmental stance were found to be the some of the common factors across RFP-C sessions. An interesting finding of this study was that higher adherence to the RFP-C prototype was not associated with a decrease in ODD symptoms. This study not only contributes to our growing understanding of how common therapeutic factors such as attunement and responsiveness, play into treatment outcomes, but also raises important questions about the specific mechanisms through which RFP-C facilitates change.

2.4. Measurement of Defense Mechanisms in Children

One tool for measuring defenses in children is The Defense Mechanism Manual (DMM; 1991) developed by Phebe Cramer, which is a tool designed for use with the Thematic Apperception Test (TAT; Murray, 1943) and the Children's Apperception Test (CAT; Bellak & Bellak, 1941). In the DMM, the components of Cramer's three defenses (denial, projection, and identification) are organized into seven scoring categories. Raters use these scoring categories to evaluate the presence of these defenses in the stories children create about TAT/CAT pictures.

Laor and colleagues (2001) stress the importance of operationalizing defense mechanisms and indicate that Cramer's measurement tool is limited in that it only focuses on three defense mechanisms. To address this, they develop the Comprehensive Assessment of Defense Style (CADS). The CADS is a parent-report measurement tool used to evaluate children's use of defense mechanisms in difficult situations, consisting of a questionnaire that operationalizes each defense mechanism in terms of observable behaviors (Laor et al. 2001). Unlike measurement tools that capture defensive functioning within the clinical

setting, the CADS reflects parents' perceptions of their child's defensive behaviors across a variety of situations.

Tallandini and Caudek (2010) developed a tool to observe and evaluate the presence of defense mechanisms in dollhouse play (DHP). In this tool, children are given a semistructured DHP task in which they are asked to think of the dolls as their own family, and the house as their own house. The DHP session is divided into four episodes that represent different family life episodes. Then, children freely and spontaneously narrate these episodes without interference. The recordings of these DHP's are then scored based on a list of twelve defense mechanisms (Tallandini & Caudek, 2010).

Based on the premise that most tools created to evaluate defense mechanisms are either designed for use in adult populations, or only applicable to verbal measurements, Nimroody et al. (2019) have developed The Defense Mechanisms Manual for Children's Doll Play (DMCP). Nimroody and colleagues built on existing coding systems to develop a comprehensive measurement tool for assessing the manifestation of defenses in play. The DMCP was initially designed to assess selected story stems from the MacArthur Story Stem Battery (MSSB; Bretherton, 1990), but can be utilized to evaluate use of defenses in other types of play. 32 different defense mechanisms are coded in the scoring of the DMCP. In the DMCP, in contrast to other measurement tools for assessing children's defense mechanisms, raters evaluate both verbal and nonverbal responses to standardized play scenarios designed to elicit conflict (Nimroody et al., 2019).

In 2021, Di Giuseppe et al. modified the Defense Mechanisms Rating Scale Q-Sort for adults (DMRS-Q) to develop the Defense Mechanisms Rating Scale Q-sort for Children (DMRS-Q-C), a tool for evaluating children's use of defense mechanism in a developmentally appropriate manner. The DMRS-Q-C is comprised of 60 items that raters sort based on observable behaviors, to evaluate children's defensive functioning (Di Giuseppe et al., 2021).

2.4.1. The Children's Play Therapy Instrument (CPTI)

The Children's Play Therapy Instrument (CPTI) is a tool used to analyze children's play behavior in therapeutic settings (Kernberg et al., 1998). There are several levels of analysis, each analyzing a different component of the child's play behavior. All levels of analysis will be described in further detail in section 3.2.1.3.1., but a brief outline of the instrument is as follows: first, the child's activity throughout the session is segmented; next, a descriptive analysis is conducted; next, the play is analyzed structurally, where the child's affective, cognitive, dynamic, and social levels are explored; and finally, a functional analysis is conducted.

In the final category, the child's overall functioning level is determined by rating the defensive strategies the child uses to cope with difficult situations. Accordingly, the CPTI provides a structured framework for understanding the psychological mechanisms children use to cope with difficult emotions (Kernberg et al., 1998). Based on the premise that defenses are closely connected to an individual's overall psychological functioning, the CPTI categorizes children's functioning level into four distinct play profiles, each characterized by the use of different defense mechanisms: The Adaptive Play Profile indicates healthy coping and problem-solving, through the use of defenses like affiliation and altruism. Children in the Conflicted/Inhibited Play Profile use defenses like rationalization and isolation of affect, reflecting emotional suppression and internal conflict. The Polarized/Impulsive Play Profile is characterized by direct expression of anxiety and aggression through the use of defenses like projection, omnipotent control, and splitting, while the Disorganized Play Profile involves chaotic responses to stress and difficulties in emotional integration, such as the use of fragmentation and psychotic denial (Chazan, 2002).

Unlike tools like the DMM (Cramer, 1991) and DHP (Tallandini & Caudek, 2010), which rely on children's verbal abilities, the CPTI evaluates defenses through both non-verbal and verbal expressions in play (Chazan, 2002). Tools like the DMM (Cramer, 1991), DMCP (Nimroody et al., 2019), and DHP (Tallandini & Caudek, 2010) provide children with a structured task or prompt. The CPTI differs in that observers can rate how defenses

manifest in free play, which allows for the spontaneous and natural expression of defenses that might not emerge within the constraints of structured tasks (Chazan, 2002). CPTI's classification of defensive functioning offers valuable insight into the child's overall psychological functioning, making it extremely useful in understanding how children cope with difficult emotions and situations. Hence, we have opted to use the CPTI to evaluate how children's use of defense mechanisms changes throughout therapy.

2.5. Current Study

Previous literature demonstrates important links between defensive functioning, resilience, emotion regulation, and overall functioning. Despite this, specifically in the field of child psychotherapy, two critical questions remain less studied: What happens to defense mechanisms during psychotherapy? How does defensive functioning impact therapy outcomes, particularly in terms of emotion regulation and symptom improvement? RFP-C stands out as a groundbreaking approach for treating children with externalizing difficulties by shifting the focus from purely behavioral frameworks to an emotion regulation focused perspective. Its central focus on defenses provides hope for advancing our understanding of the role of defense mechanisms in therapeutic processes. Despite its innovations, there is still a large gap in literature, regarding how defenses evolve throughout child psychotherapy process, especially in RFP-C, and how defenses relate to therapy outcomes. This study seeks to address these critical gaps, aiming to foster a deeper understanding of defense mechanisms and explore their implications for both research and clinical practice.

Regarding this gap, the hypotheses in this current study are indicated as follow:

- 1) Defense mechanisms associated with the Adaptive Play Profile will show a linear increase from the beginning to the end of therapy in children undergoing RFP-C.
- 2) Defense mechanisms associated with the Polarized/Impulsive Play Profile will show a linear decrease from the beginning to the end of therapy in children undergoing RFP-C.

- 3) The strength of defense mechanisms associated with the Polarized/Impulsive Play Profile will predict significant change in outcome; suggesting that lower polarized defense mechanism scores will be associated with lower externalizing symptom scores and higher emotional regulation scores.
- 4) The strength of defense mechanisms associated with the Adaptive Play Profile will predict significant change in outcome; indicating that higher adaptive defense mechanism scores will be associated with lower externalizing symptom scores and higher emotional regulation scores.
- 5) Due to mixed findings in the literature, no directional hypothesis is made for defense mechanisms associated with the Conflicted/Inhibited Play Profile, with an exploratory focus on examining how they evolve throughout therapy and relate to outcomes.

METHOD

3.1. Randomized Controlled Trial (RCT)

3.1.1. RCT Introduction

The present study, which aims to investigate the evolution of defense mechanisms in children undergoing RFP-C and how these defense mechanisms are associated with changes in externalizing symptoms and emotion regulation, was conducted as part of a Randomized Controlled Trial (RCT) at Istanbul Bilgi University. The RCT was intended to assess the effectiveness of RFP-C against a Parenting and Child Social Skills Group Intervention (PSSG). The sample for the present study consists of patients who participated in the RCT and were randomly allocated to the RFP-C treatment condition. An overview of the RCT will be provided first, followed by a detailed description of the selection criteria. Further information regarding the RCT can be found in the clinical study protocol provided in Appendix C (Protocol No: NCT06060353).

3.1.2. RCT Sample

The recruitment process for the RCT began in September 2023. The therapy phase of the study began in October 2023 and ended in November 2024. Participants were recruited through flyers distributed to nearby school counseling services and social media announcements.

The inclusion criteria for the RCT are specified as follow: a) Children exhibiting problems at clinical levels of externalizing symptoms, as assessed by the Strengths and Difficulties Questionnaire (SDQ) - Parent Version (Goodman, 2001); b) children aged between 6 and 12 years; and c) parent(s) able to attend four sessions of parent meetings. The exclusion criteria are as follow: children with a) solely internalizing problems and non-clinical problem levels as assessed by the SDQ; b) primary diagnosis of psychosis or eating

disorders as assessed by the Schedule for Affective Disorders and Schizophrenia for School-Age Children (KSADS-PL; Kaufman et al., 1997); c) risk for suicide and/or severe violence risk as assessed by the KSADS-PL; d) children currently enrolled in another psychosocial treatment; e) children with intellectual disability or major developmental delay as assessed by the KSADS-PL & the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999) f) families with high risk of domestic abuse; g) parents with acute psychosis as assessed by the Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV; First et al., 2015); h) parents with severe substance abuse and dependence as assessed by SCID; i) parents with intellectual disability as assessed by WASI; and j) parents with acute risk of harm to self and others as assessed by the SCID. The outcomes of the WASI assessments indicate that the average scaled scores are 8.17 for mothers, 8.38 for fathers, and 9.3 for children.

A total of 311 applicants were assessed for eligibility. 178 participants were excluded because they did not meet the inclusion criteria or because they could not be reached. 133 participants were invited for a clinical interview to be further assessed for eligibility. 53 of these applicants were excluded for a variety of reasons. Further information regarding the acceptance process can be found in the Consolidated Standards for Reporting Trials (CONSORT) Flow Diagram provided in Appendix B.

A total of 80 participants who met the criteria were randomly assigned to either the RFP-C intervention group or the PSSG control group. Specifically, 40 participants (50%) were assigned to the RFP-C intervention group, while the remaining 40 participants (50%) were assigned to the PSSG control group.

3.1.3. RCT Interventions

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

RFP-C (Hoffman et al., 2016) is a short-term psychodynamic psychotherapy for externalizing children aged 6-12, aiming to help improve children's ability to tolerate and talk about difficult emotions, and use more adaptive defenses. The treatment is comprised

of 16 child sessions and 4 parent sessions and consists of 3 phases. The first phase consists of introductory sessions with the child and the parents and is concluded with a feedback session with the parents. The second phase is the main body of treatment, where the therapist attempts to identify and interpret the maladaptive defense mechanisms of the child. After the 10th session, a parent session is held to evaluate progress and prepare for termination. The final phase of treatment is the termination phase, where the clinician aims to help the child navigate difficult emotions related to separation. After the last child session, a final session is held with the parents. Background theoretical information regarding RFP-C is provided in section 2.3.1.

Nineteen therapists whose ages range from 24-31 (mean = 25,67; SD = 2,08) and experience levels range from 0-2 years delivered the RFP-C intervention. 47,37% had 0-1 years of experience (N = 9) and 52,63% had 1-2 years of experience (N = 10). 94,74% (N = 18) of the therapists administering the intervention were female and 5,26% were male (N = 1). The clinicians underwent a training program that lasted a total of 8 hours. In addition, each clinician received 90 minutes of RFP-C group supervision per week from Dr. Sibel Halfon and Dr. Can Büyükaşık, throughout the duration of the therapy process.

3.1.3.2. Parenting and Social Skills Group (PSSG)

PSSG is a 12-week group psychotherapy program designed to support children experiencing emotional difficulties and their families. Child and parent groups are conducted simultaneously, to enhance both children's and parents' emotional and social development. In the parent group, parents work on emotion regulation, strengthening their bond with their children, enhancing parenting skills, managing parental stress, and cultivating hope for the future. In the children's group, the focus is on helping children improve social skills, build self-confidence, enhance self-expression, recognize and regulate emotions, strengthen empathy and interpersonal relationships, enhance problem-solving abilities in social situations, and improve their play skills.

3.1.4. Ethical Approval

The study entitled “A Pragmatic Randomized Controlled Trial of Regulation-Focused Psychotherapy for Children with Externalizing and Comorbid Internalizing/Externalizing Problems (RFP-C)” obtained ethical approval (no: 2023-40224-120). Verbal consent from children and written consent from parents was obtained. Ethical Approval Form for the RCT is presented in Appendix A.

3.1.5. RCT Data Collection

Demographic information was obtained from each participant prior to the beginning of treatment. Outcome measures capturing children’s emotion regulation and symptom levels (described in further detail in section 3.2.1.2.) were collected prior to the beginning of treatment (Timepoint 0), at the middle of treatment (Timepoint 1; 9th week), at the end of treatment (Timepoint 2; 20th week), and at 6-month follow up (Timepoint 3).

Process measures used to analyze children’s play behaviors (described in further detail in section 3.2.1.3.) were collected at Timepoints 0 (first child session), 1 (11th session), and 2 (last child session). All sessions were both audio and video recorded and coded by research assistants that received training. If the sessions corresponding to these timepoints were unavailable due to recording issues, the child’s absence, or lack of play, the closest available session was coded instead.

3.2. Current Study

3.2.1. Data Collection Tools

3.2.1.1. Sociodemographic Information Forms

The sociodemographic information form collected from participants includes information about the child's sex, age, prior therapy history, as well as the family's socioeconomic background, educational level, and marital status.

3.2.1.2. Outcome Measures

3.2.1.2.1. Strengths and Difficulties Questionnaire - Parent version (SDQ-P)

The SDQ-P (Goodman, 2001; presented in Appendix D) was used to measure children's emotional and behavioral difficulties. It is a parent-report measure consisting of 25 items, which are rated on a 3-point Likert scale (0 = not true, 2 = very true). The questionnaire is structured into five subscales: Emotional Symptoms (items 3, 8, 13, 16, 24), Conduct Problems (items 5, 7, 12, 18, 22), Hyperactivity-Inattention (items 2, 10, 15, 21, 25), Peer Problems (items 6, 11, 14, 19, 23), and Prosocial (items 1, 4, 9, 17, 20). Additionally, the measure also provides composite scores for Internalizing Difficulties, Externalizing Difficulties, and Total Difficulties. Higher scores indicate higher levels of problem behavior.

The two externalizing scales are the Conduct Problems and Hyperactivity-Inattention subscales. The Conduct Problems scale assesses behaviors such as aggression, defiance, and rule-breaking, with items like "Often has temper tantrums or hot tempers". The Hyperactivity-Inattention scale captures behaviors related to restlessness and concentration difficulties, with items like "Easily distracted, concentration wanders". The externalizing composite score is calculated by adding the conduct and hyperactivity-inattention scores. The two internalizing scales are the Emotional Problems and Peer

Problems subscales. The Emotional Problems subscale evaluates symptoms like nervousness, fears, and unhappiness, through items like “Nervous or clingy in new situations.” The Peer Problems subscale assesses difficulties children experience in social settings, with items like “Has at least one good friend.” The internalizing composite score is calculated by adding the emotional and peer problems scores. The total composite score is generated by adding the externalizing and internalizing scores together. The prosocial subscale is not included in any of the composite scores.

The SDQ (Goodman, 2001) demonstrates acceptable internal consistency coefficient (mean Cronbach α : .73). The internal consistency coefficients for the subscales used in the present study are as follow: .63 for Conduct Problems, .77 for Hyperactivity-Inattention, .67 for Emotional Problems, and .57 for Peer Problems. The questionnaire also demonstrates acceptable construct validity, supported by its five-factor structure, and strong predictive validity, with high scores significantly increasing the likelihood of clinical diagnoses (Goodman, 2001).

The Turkish version of the SDQ (Yalin et al., 2013) retains the original five-subscale structure and composite scoring. It has demonstrated acceptable internal consistency for all subscales except for the Peer Problems subscale. Specifically, Cronbach’s α values are .73 for Emotional Problems, .66 for Conduct Problems, .79 for Hyperactivity-Inattention, .28 for Peer Problems, .77 for Prosocial Behavior, and .81 for the Total Difficulties Score. The Turkish SDQ has also shown sufficient validity in distinguishing between clinical and non-clinical populations.

For the present study, children’s raw total Externalizing Difficulties scores (consisting of the Conduct Problems and Hyperactivity-Inattention subscales), Internalizing Difficulties scores (consisting of Emotional Problems and Peer problems) and Total SDQ score were utilized. The internal consistency coefficients for the subscales in our data are as follow; .777 for Externalizing Difficulties, .747 for Internalizing Difficulties, and .818 for Total Difficulties.

3.2.1.2.2. Emotion Regulation Checklist (ERC)

The Emotion Regulation Checklist (Shields & Cicchetti, 1997; ERC; presented in Appendix E) was used to assess children's emotion regulation and was completed by participants' mothers. It is a 24-item parent-report measure that assesses 2 key factors: the first, Emotional Lability and Negativity, characterized by arousal, mood instability, and difficulties in regulating anger; and the second, Emotion Regulation, which encompasses socially appropriate emotional expressions, empathy, and self-awareness of emotions. A sample item for the Lability/Negativity subscale is "Exhibits wide mood swings" and the Emotion Regulation subscale includes items like "Is empathic toward others." The items are rated on a 5-point Likert scale (1 = "never" to 5 = "always"). The total ERC score is computed by reversing the scores of negatively weighted items and calculating the average of all 24 items. Higher total scores reflect better emotion regulation capacity.

The ERC (Shields & Cicchetti, 1997) demonstrates acceptable internal consistency coefficient ($\alpha = .96$ for Lability/Negativity; $\alpha = .83$ for Emotion Regulation; $\alpha = .89$ for the composite total score.). The measure is significantly correlated with other established measures of emotion regulation, supporting the ERC's criterion validity.

The scale was adapted into Turkish by Batum and Yağmurlu (2007) and demonstrated good internal consistency coefficient ($\alpha = .73$ for Lability/Negativity; $.75$ for for Emotion Regulation). Construct validity was established through significant correlations between ERC scores and both parent and teacher-reported externalizing difficulties.

In the present study, the internal consistency coefficient for the Total Emotion Regulation score was $\alpha = .787$. Internal consistency was good for the Lability/Negativity subscale ($\alpha = .831$) and poor for the Emotion Regulation subscale ($\alpha = .571$). For the present study, children's Total ERC scores were utilized.

3.2.1.3. Process Measures

3.2.1.3.1. Children's Play Therapy Instrument (CPTI)

The CPTI (Kernberg et al., 1998) was used as a process measure in the present study to assess the defensive functioning of children undergoing RFP-C. The CPTI is an observational coding system designed for the systematic evaluation of children's play activity. The CPTI is structured into three levels of analysis:

In level one, the child's activity during the session is segmented into four different categories: Pre-Play, Play Activity, Non-Play, and Play Interruption. Pre-Play refers to the phase where the child prepares for play. Play Activity starts when the child becomes fully engaged in play. Non-Play encompasses behaviors and activities that do not involve play, and Play Interruption occurs when the child disengages from the play session for a period of time that exceeds 18-22 seconds. This segmentation creates a "play narrative" that serves as a reference for the subsequent levels of analysis (Kernberg et al., 1998).

Level two is the dimensional analysis of play activity. The longest play activity segment in the session is selected and analyzed across several different domains. First, the descriptive components are assessed: 1) the category of play activity, 2) the inhibition and facilitation levels of play activity, and 3) the spatial realms of play activity. Next, a structural analysis is conducted: affective, cognitive, and dynamic components are rated. Finally, an analysis of the child's adaptive functioning is conducted. In this section, the observable play behaviors of the child are categorized based on specific defensive strategies, organized into four Play Profiles: Adaptive, Conflicted/Inhibited, Polarized/Impulsive, and Disorganized, each of which reflecting distinct defensive functioning patterns used to manage emotional challenges (Kernberg et al., 1998). A brief version of the CPTI coding manual, focusing on the Functional Analysis Level, is provided in Appendix F. The defense mechanisms for each play profile have been categorized based on Chazan's (2002) Play Profiles and Halfon's (2017) "Play Profile Constructions". A summary of the categories can be found in Table 3.1.

The Adaptive Player is flexible, playful, curious resilient, insightful, self-aware, and is able to self-regulate. They can play without interruption, and regulate difficult emotions. They can cope with challenges constructively. This cluster of defensive functioning is characterized by the use of adaptive defense mechanisms. These defenses are future-oriented, focused on problem-solving, and geared towards channeling overwhelming anxiety into hope (Chazan, 2002; Halfon, 2017).

The defensive strategies these children use are as follow:

1) Adaptation: The child effectively accommodates to a circumstance; 2) Anticipation: The child plans and prepares for what might come next; 3) Problem-solving: The child effortfully and systematically tries to find the solution to a problem; 4) Sublimation: The child transforms wishes or impulses into socially acceptable and creative activities; 5) Altruism: The child handles their own emotional distress by focusing on others' needs; 6) Affiliation: The child displays an ability to be part of a group and seek support and help from others; 7) Humor: The child laughs, makes jokes, sees play as funny, amusing, and pleasurable; 8) Self-assertion: The child expresses their needs, wants, and opinions in a confident but non-aggressive manner; 9) Self-observation: The child can reflect on their thoughts, feelings, or actions (Chazan, 2002; Halfon, 2017).

The Conflicted/Inhibited Player engages in play that reflects their unresolved issues. They have difficulty initiating, facilitating, and sustaining play activity. They experience a struggle between their emotions and unconscious needs. This type of play lacks a seamless creative flow and is rigid in structure. These children have often experienced insufficient parental nurturing and regulation, and thus develop a self-reliance on their intellect. Their affective range is restricted and narrow, and their play is usually somber, silent, and alone (Chazan, 2002; Halfon, 2017).

The defensive strategies these children use are as follow:

1) Doing-undoing: The child engages in play activity, then reverses or cancels it; 2) Compulsive behaviors: The child is fixated on organizing and arranging objects to prevent loss of control; 3) Intellectualization: The child addresses the emotional aspects of play in a detached, factual, objective manner; 4) Rationalization: The child provides rational

but false explanations for the play activity; 5) Isolation of affect: The child separates ideas from the anxiety-provoking feelings associated with them, appearing indifferent; 6) Negation: The child downplays or ignores the importance or meaning of something, pretending to not care about something that is anxiety-provoking for them; 7) Reaction formation: The child transforms something that evokes anxiety into its opposite, and disguises it as a source of pleasure; 8) Regression: The child reverts to behavior typical of a younger age; 9) Turning aggression against the self: The child redirects an inappropriate urge towards themselves, in order to prevent hurting another person; 10) Somatization: The child is absorbed with their physical symptoms (Chazan, 2002; Halfon, 2017).

The Polarized/Impulsive Player depicts extreme anxiety, and is scared of becoming overwhelmed by difficult, intense feelings. These children's play is rigid, lacks flow, centers around aggression, and may include abrupt interruptions or shifts. They cope with difficult emotions through movement, and through the use of defenses that rigidly separate good and bad, and deny frightening aspects of reality (Chazan, 2002; Halfon, 2017).

The defensive strategies these children use are as follow:

1) Denial: The child rejects the reality of a traumatic or painful emotion or experience; 2) Splitting: The child separates conflicting attributes of themselves, and fails to accept the threatening aspects as a part of themselves; 3) Projection: The child attributes to another person the emotions, qualities, wishes, roles, and thoughts that they are refusing to acknowledge; 4) Primitive idealization: The child views the other person or object as uniquely valuable and all-powerful; 5) Primitive devaluation: The child depicts either themselves or another person as completely devalued, disgusting, unimportant, and lacking of any redeeming qualities; 6) Omnipotent control: The child seeks to become all-powerful, domineering, and thus achieve control over the external world (Chazan, 2002; Halfon, 2017).

The Disorganized Player experiences a catastrophic level of anxiety that poises a risk of completely overwhelming their existence. These children lack spontaneity, warmth, joy,

and experience deficits in communication. Their affective expressions may be underdeveloped and bizarre. Their play is rigid, repetitive, and stereotyped. These children lack the differentiation between internal and external, and between self and other. Children on the autism spectrum experience deficiencies in their communication, language, and social abilities, as well as their capacity for symbolic play, explaining why their play is most likely to be classified as disorganized. Additionally, children who have experienced neglect, abuse, or severe emotional deprivation may also engage in this type of play (Chazan, 2002).

The defensive strategies these children use are as follow:

1) Annihilation fears: The child displays an extremely strong fear of loss and destruction of self; 2) Freezing: The child becomes immobile and unresponsive in the face of overwhelming emotions or situations; 3) Lack of a coherent verbal or nonverbal narrative: The child is unable to form a meaningful, organized, and consistent narrative in play, reflecting a disorganization in their thoughts and feelings; 4) Neologisms: The child invents and utilizes new and unusual words; 5) Severe destructive ideation: The child enacts play scenarios that involve extreme destruction and harm, suggesting considerable emotional distress; 6) Autistic withdrawal: The child insulates themselves from their surroundings, becomes disengaged and detached, often becoming engrossed in repetitive behaviors; 7) Distortion: The child alters and misrepresents objective reality in play; 8) Psychotic denial: The child rigidly rejects reality, often becoming detached and dismissing proof of an event or emotion; 9) Delusional projection: The child misattributes their skewed and inaccurate beliefs to others and perceives these distortions as reality; 10) Fragmentation: The child experiences disruptions in their perception of time, space, and body, resulting in feeling disconnected and disintegrated; 11) Concretization: The child transforms intangible and internal experiences, thoughts, and feelings into physical and tangible forms, depicting a skewed representation of reality (Chazan, 2002; Halfon, 2017).

Table 3.1. Defense Mechanisms in the Children's Play Therapy Instrument (CPTI)
Categorized by Play Profile

Play Profile	Defense Mechanisms
Adaptive	1) Adaptation 2) Anticipation 3) Problem-solving 4) Sublimation 5) Altruism 6) Affiliation 7) Humor 8) Self-assertion 9) Self-observation
Conflicted/Inhibited	1) Doing-undoing 2) Compulsive behaviors 3) Intellectualization 4) Rationalization 5) Isolation of affect 6) Negation 7) Reaction formation 8) Regression 9) Turning aggression against the self 10) Somatization
Polarized/Impulsive	1) Denial 2) Splitting 3) Projection 4) Primitive idealization 5) Primitive devaluation 6) Omnipotent control
Disorganized	1) Annihilation fears 2) Freezing 3) Lack of coherent narrative 4) Neologisms 5) Severe destructive ideation 6) Autistic withdrawal 7) Distortion 8) Psychotic denial 9) Delusional projection 10) Fragmentation 11) Concretization

The CPTI training was held between August 2024 and September 2024. A total of 6 coders received a 7-hour online training that took place over 3 separate sessions. The training involved a comprehensive overview of the CPTI coding manual, viewing sample video clips, in-training coding exercises, as well as independent coding assignments. Throughout the training process, weekly meetings were held to discuss any questions regarding the coding. After the training phase ended, interrater reliability was calculated for the independent coding assignments, yielding a Cronbach's alpha of at least .70. Sessions with interrater reliability below the .70 threshold for Cronbach's Alpha were reevaluated by the raters.

3.2.2. Data Collection

80 participants who signed the consent forms and were randomly assigned to intervention groups were contacted by research assistants before the beginning of the therapy process in order to collect data. The outcome measures (SDQ and ERC) were delivered to parents digitally. This was repeated at the middle of treatment (after the 6th session for PSSG and after the 9th session for RFP-C) and at the end of treatment (after the final session for each intervention group). Each session was audio and video recorded, and transcribed. For the process measures, CPTI was coded by a total of 6 coders. Sessions were blindly assigned to the coders. For each child, a total of three sessions corresponding to the beginning (1st child session), middle (11th session), and end (final child session) phases of treatment were coded. If the sessions matching these timepoints were unavailable, the nearest session was coded instead. Each session was coded by two independent coders. After interrater reliability was calculated, sessions with interrater reliability below the .70 threshold for Cronbach's Alpha were reevaluated by the raters. Weekly meetings were held to discuss any disagreements or questions. Good to excellent interrater reliability was observed among coders, with values ranging from .70 to 1.00 ($M = .897$, $SD = .07$). To assess agreement on the defense scores used in the current study, intraclass correlation coefficients (ICC) were calculated. The results indicated poor to moderate interrater reliability: $ICC = .53$ for Adaptive, $.42$ for Inhibited, and $.61$ for Polarized clusters. The average ICC across clusters was $.52$ ($SD = .10$), reflecting acceptable agreement.

However, the relatively lower reliability for the Inhibited cluster may reflect challenges in identifying conflicted or inhibited defensive behaviors.

3.2.3. Data Analysis

The collected data was analyzed using SPSS software. First, scores for the selected timepoints (pre-treatment and post-treatment) were computed for the Total SDQ score, as well as the Internalizing and Externalizing Difficulties subscales of the SDQ. Next, children's emotion regulation scores were computed using the Emotion Regulation Checklist (ERC) Total Score for pre-treatment and post-treatment timepoints. Lastly, scores for each play profile from the CPTI (adaptive, conflicted/inhibited, and polarized/impulsive) were calculated for three key timepoints: beginning, middle, and end of therapy. As defenses associated with the Disorganized Play Profile are frequently seen in children on the autism spectrum or children who have experienced neglect, abuse, or severe emotional deprivation (Chazan, 2002), and these were among the exclusion criteria for the RCT, the Disorganized Play Profile was excluded from the analyses. For the remaining 3 play profiles, a mean score was calculated using the scores gathered at three timepoints that indicate the strength of each category throughout the RFP-C process. These mean scores were used in regression models to predict changes in outcome. As each Play Profile is characterized by a group of defensive strategies, the terms "Play Profile" and "defense cluster" will be used interchangeably, moving forward.

For hypotheses 1, 2, and 5, Regression via Curve Fitting was conducted in order to track the changes in each defense cluster over time. Using time as the independent variable and defense scores at three timepoints (T0, T1, and T2) as the dependent variable, curve estimation analyses were conducted for each defense cluster (adaptive, inhibited, and polarized) to explore changes in defense mechanisms over time. Both linear and quadratic models were tested.

For hypotheses 3, 4, and 5, a Linear Regression analysis was conducted to analyze how the strength of the defense clusters predicts changes in Internalizing, Externalizing, and Total Difficulties scores, and Emotion Regulation scores. Separate regressions were

conducted for each outcome variable: SDQ Internalizing Score, SDQ Externalizing Score, SDQ Total Score, and ERC Total Score. In each model, the T0 score for the relevant outcome variable was entered as a control variable to control for pretreatment scores, and mean defense cluster scores (Adaptive, Inhibited, Polarized) were entered in the second block as predictor variables. Results are indicated in section 4.2.



RESULTS

4.1. Sample for the Current Study

The sample for the current study focuses on 40 participants who were assigned to the RFP-C intervention. One participant was identified as an extreme outlier, with values falling beyond ± 3 standard deviations from the sample mean on Adaptive_T2, and was therefore excluded from all analyses. In addition, one participant who had missing data on process measures at all three timepoints (beginning, middle, and end of treatment) was also excluded from the analyses, resulting in a final sample of 38 participants. Table 4.1 provides an overview of the remaining sample's demographic characteristics. The participants' ages range from 6-12 ($M = 8.66$, $SD = 1.83$). 71.05% of participants were male ($n = 27$) and 28.95% were female ($n = 11$). 52.63% of participants only experienced clinically significant externalizing problems ($n = 20$), while 47.37% experienced clinically comorbid problems ($n = 18$).

Table 4.1. Demographic Characteristics of the Participants

Baseline Characteristics	<i>M (SD)</i>	<i>N (%)</i>
Child Characteristics		
Age	8.66 (1.83)	
Gender		
Female		11 (28.95%)
Male		27 (71.05%)
Clinical Characteristics		
Externalizing		20 (52.63%)
Comorbid Internalizing and Externalizing		18 (47.37%)
Family Characteristics		
Marital Status		
Married		36 (94.74%)
Divorced		2 (5.26%)

Note. M = Mean. N = 38.

4.2. Results

4.2.1. Descriptive Statistics

First, descriptive statistics for all variables will be provided. As indicated in section 2.2.2, the data for outcome measures (SDQ, to assess changes in symptoms, and ERC, to assess changes in emotion regulation) and process measures (CPTI, to explore children's defense use) were obtained at the beginning (Timepoint 0), middle (Timepoint 1), and end (Timepoint 2) of treatment. Descriptive statistics for defense scores of each defense cluster (adaptive, inhibited, and polarized) at each time point (T0, T1, and T2), mean defense scores, and outcome variables (SDQ Internalizing, SDQ Externalizing, SDQ Total, and ERC Total at T0 and T2) are presented in Table 4.2. T1 scores of outcome measures were not included in the analyses and are therefore not reported in the descriptive statistics.

Skewness and kurtosis values were examined to assess the normality of all variables. Values within the -3 to $+3$ range were considered acceptable for statistical analyses (Kline, 2011). Descriptive statistics presented indicate that skewness and kurtosis scores for all variables fell within the acceptable range.

Table 4.2. Descriptive Statistics

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	Skewness	Kurtosis
Adaptive_T0	38	3.38	0.57	2.5	4.5	0.04	-1.28
Adaptive_T1	37	3.08	0.36	2	4	-0.26	1.81
Adaptive_T2	33	3.17	0.37	2.5	4	0.87	0.69
Mean_Adaptive	38	3.24	0.36	2.5	4.5	0.77	3.13
Inhibited_T0	38	2.65	1.06	1	5	0.29	-1.06
Inhibited_T1	37	2.81	0.87	1	4.5	-0.05	-0.74
Inhibited_T2	33	2.79	0.82	1.5	4	0.42	-1.25
Mean_Inhibited	38	2.74	0.56	1.5	3.5	-0.20	-1.08
Polarized_T0	38	2.33	1.12	1	4.5	0.47	-1.02
Polarized_T1	37	2.81	1.14	1	5	0.11	-1.21
Polarized_T2	33	2.89	1.11	1	5	-0.08	-1.29

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	Skewness	Kurtosis
Mean_Polarized	38	2.62	0.90	1	4.2	0.15	-0.85
SDQ_Internalizing_T0	38	9.84	3.92	2	17	-0.13	-0.73
SDQ_Internalizing_T2	36	6.25	3.08	0	15	0.71	0.94
SDQ_Externalizing_T0	38	13.05	2.10	11	20	1.16	1.64
SDQ_Externalizing_T2	36	7.78	3.63	1	14	-0.12	-0.88
SDQ_Total_T0	38	22.90	4.34	14	31	-0.08	-0.50
SDQ_Total_T2	36	14.03	5.51	6	29	0.54	0.09
ERC_Total_T0	38	2.63	.38	1.8	3.4	0.11	0.06
ERC_Total_T2	36	2.80	.34	2.2	3.6	0.17	-0.61

Note. M = Mean; SD = Standard Deviation; SDQ = Strengths and Difficulties Questionnaire; ERC = Emotion Regulation Checklist. N values vary across timepoints and measures: For defense scores at T1 one participant dropped out before the midpoint; for defense scores at T2 again four participants dropped out before the end of treatment and one did not engage in play activity therefore defense scores could not be coded. For SDQ and ERC scores at T2 outcome data could not be collected from two parents.

An additional descriptive analysis was conducted to examine the total frequency of each defense mechanism observed across all sessions and participants. Figure 4.1 presents frequency of individual defense mechanisms and Figure 4.2 presents the total frequency of defense mechanism clusters observed across all sessions. Adaptive defenses were the most frequently coded ($n = 342$), followed by polarized/impulsive ($n = 316$) and conflicted/inhibited defenses ($n = 258$). Disorganized defenses, on the other hand, were much less frequently coded. These findings are in line with previous literature (Salehi Nezhad et al., 2010; Prout, 2023; Hoffman et al., 2016).

Figure 4.1. Frequency of Individual Defense Mechanisms Observed Across Sessions

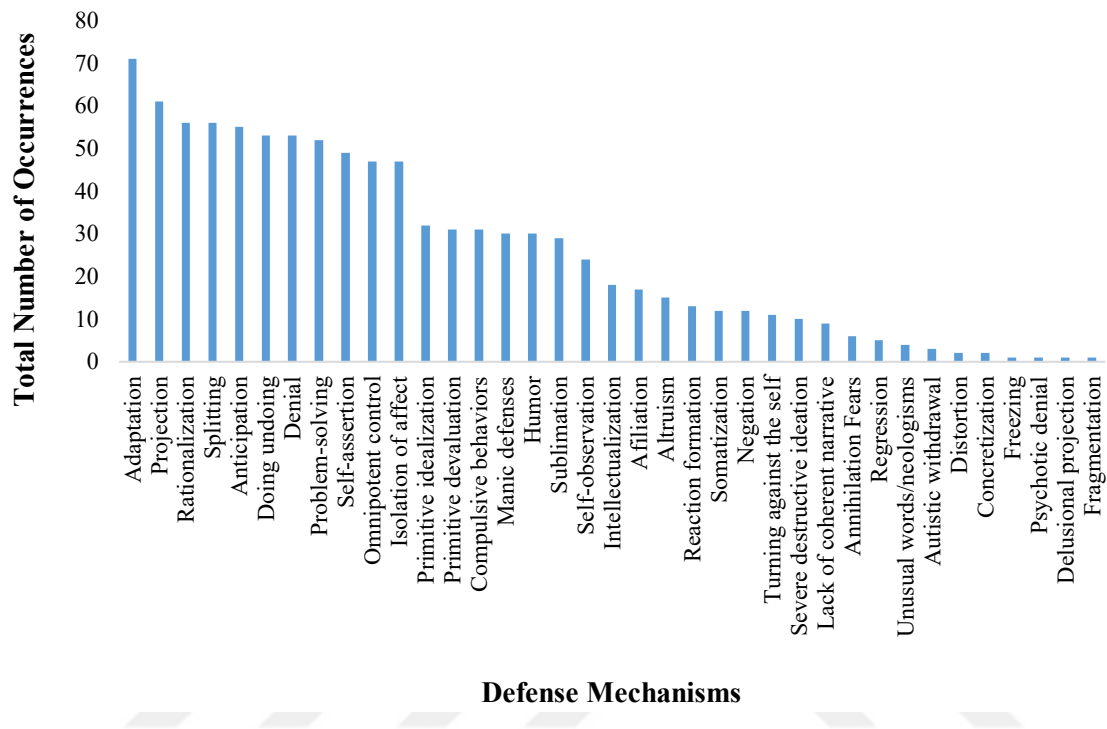
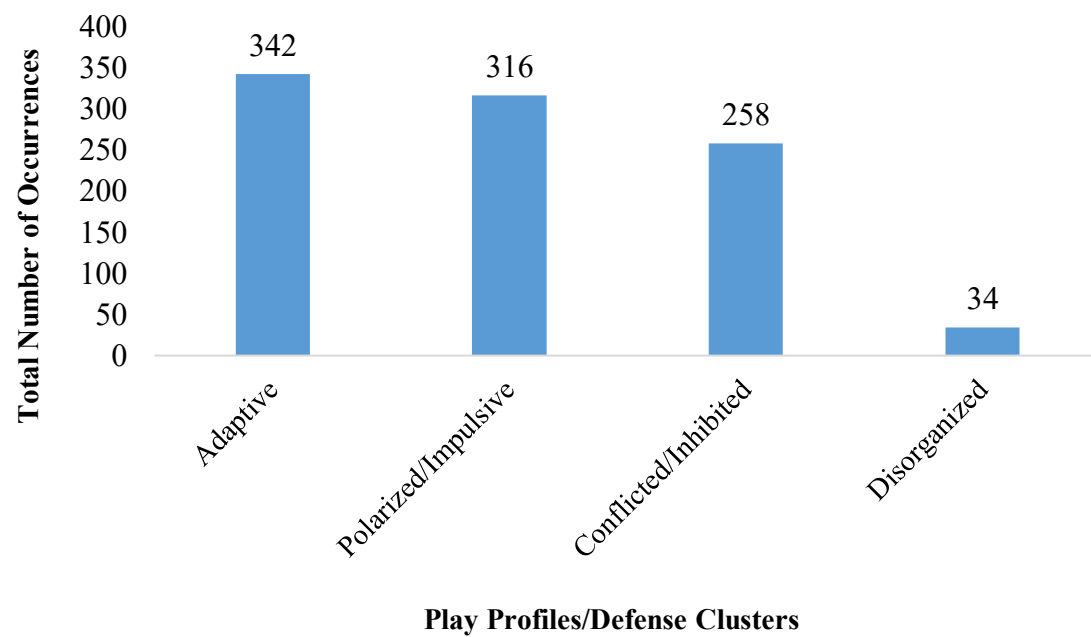


Figure 4.2. Frequency of Defense Mechanism Clusters



4.2.2. Correlations

A bivariate Pearson correlation analysis revealed several significant associations. For instance, mean adaptive and mean polarized defenses were negatively correlated ($r = -.567, p < .01$). Mean inhibited and mean polarized defenses were negatively correlated ($r = -.527, p < .01$). Post-treatment emotion regulation scores and post-treatment total symptoms scores were negatively correlated ($r = -.642, p < .01$). Post-treatment emotion regulation scores and post-treatment Externalizing scores were also negatively correlated ($r = -.614, p < .01$).



Table 4.3. Correlations

	1	2	3	4	5	6	7	8	9	10	11
1. Mean_Adaptive	-										
2. Mean_Inhibited	-0.194	-									
3. Mean_Polarized	-.567**	-.527**	-								
4. SDQ_Ext_T0	0.001	-0.016	0.014	-							
5. SDQ_Ext_T2	0.097	-0.039	0.019	0.217	-						
6. SDQ_Int_T0	-0.140	-0.041	0.071	-0.058	-0.046	-					
7. SDQ_Int_T2	-0.194	0.151	-0.075	-0.061	.345*	.544**	-				
8. SDQ_Tot_T0	-0.126	-0.045	0.071	.432**	0.066	.875**	.457**	-			
9. SDQ_Tot_T2	-0.045	0.059	-0.030	0.109	.851**	0.274	.786**	0.299	-		
10. ERC_T0	-0.123	0.222	0.118	-0.277	-.332*	-0.073	-0.185	-0.200	-0.322	-	
11. ERC_T2	0.046	0.067	0.069	-0.215	-.614**	-0.241	-.425**	-0.321	-.642**	.707**	-

Note. SDQ_Ext = Externalizing Symptoms as assessed by the Strengths and Difficulties Questionnaire; SDQ_Int = Internalizing Symptoms as assessed by the Strengths and Difficulties Questionnaire; SDQ_Tot = Total Symptoms as assessed by the Strengths and Difficulties Questionnaire; ERC = Emotion Regulation Checklist Total Score. ** . Correlation is significant at the 0.01 level (2-tailed). * . Correlation is significant at the 0.05 level (2-tailed).

4.2.3. Change in Outcome Measures

Paired-samples *t*-tests were conducted to assess changes in children's symptoms and emotion regulation from pre- to post-treatment. SDQ Externalizing scores significantly decreased from pre-treatment ($M = 13.00$) to post-treatment ($M = 7.78$), $t(35) = 7.27$, $p < .001$. SDQ Internalizing scores decreased from $M = 10.06$ to $M = 6.25$, $t(35) = 5.92$, $p < .001$. SDQ Total Difficulties scores dropped from $M = 23.06$ to $M = 14.03$, $t(35) = 5.52$, $p < .001$. ERC scores, indicating emotion regulation capacity, increased from $M = 2.65$ to $M = 2.80$, $t(35) = -2.44$, $p = .021$. These findings suggest that the outcome measures captured statistically significant therapeutic improvements in both symptom reduction and emotion regulation. Results are presented in Table 4.4.

Table 4.4. Paired Samples T-Test (N = 38)

Variable	Pre-Treatment Mean (T0)	Post-Treatment Mean (T2)	<i>t</i>	<i>df</i>	<i>p</i>
SDQ	13.0	7.78	7.27	35	<.001
Externalizing					
SDQ	10.06	6.25	5.92	35	<.001
Internalizing					
SDQ Total	23.06	14.03	5.52	35	<.001
ERC	2.65	2.8	-2.44	35	.021

Note. SDQ = Strengths and Difficulties Questionnaire; ERC = Emotion Regulation Checklist.

4.2.4. Change in Defense Mechanisms Over Time

To test hypotheses 1, 2, and 5, investigating how the use of defense mechanisms changed throughout the course of therapy, curve estimation analyses were conducted separately for each defense cluster (adaptive, inhibited, and polarized). Both linear and quadratic trends were tested to assess patterns of change across the three time points. Figure 4.3 presents the trajectories of defense clusters across time, and full curve estimation results are displayed in Table 4.5.

The analysis revealed a significant quadratic trend for adaptive defenses, $F(2, 105) = 4.42$, $p = .014$, $R^2 = .078$, $\beta_1 = -0.494$, indicating a U-shaped trajectory. Adaptive defenses tended to decrease mid-treatment (T1), before rising again at the end of treatment (T2). Meanwhile, polarized defenses showed a significant linear trend, $F(1, 106) = 4.63$, $p = .034$, $R^2 = .042$, $\beta_1 = 0.287$, suggesting a steady increase over time. For inhibited defenses, neither the linear model ($p = .577$, $R^2 = .004$, $\beta_1 = 0.074$) nor the quadratic model ($p = .648$, $R^2 = .007$, $\beta_1 = 0.261$) was statistically significant, suggesting relative stability in the use of these defenses throughout therapy.

**Figure 4.3. Change in Defense Mechanism Scores (Adaptive, Inhibited, Polarized)
Across Treatment Timepoints (T0, T1, T2)**

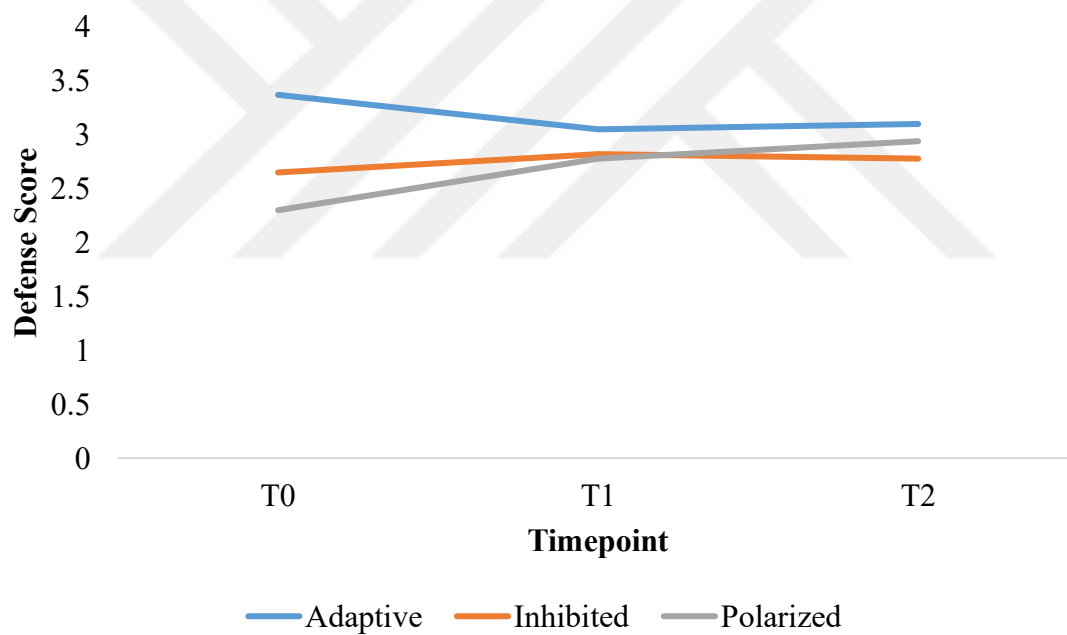


Table 4.5. Curve Estimation Results for Defense Mechanism Scores Over Time

Defense	<i>df1</i>	<i>df2</i>	<i>F</i>	<i>p</i>	<i>R</i> ²	β_1
Adaptive (Linear)	1	106	0.230	0.631	0.039	-0.112
Adaptive (Quadratic)	2	105	4.420	0.014	0.078	-0.494
Inhibited (Linear)	1	106	0.310	0.577	0.004	0.074
Inhibited (Quadratic)	2	105	0.440	0.648	0.007	0.261
Polarized (Linear)	1	106	4.630	0.034	0.042	0.287
Polarized (Quadratic)	2	105	2.330	0.103	0.049	0.681

4.2.5. Predictive Value of Defense Mechanisms on Outcome Measures

Four separate hierarchical linear regression analyses were conducted to examine whether mean scores of adaptive, inhibited, and polarized defenses predicted outcome measures at the end of treatment (T2), after controlling for baseline (T0) levels. Full results of the regression analyses are presented in Table 4.6.

None of the mean defense scores emerged as significant predictors of externalizing, internalizing, or total symptom levels of SDQ. For SDQ Total, adaptive ($p = .408$), inhibited ($p = .563$), and polarized ($p = .464$) defenses were non-significant. Similarly, for SDQ Internalizing, adaptive ($p = .484$), inhibited ($p = .456$), and polarized ($p = .445$) defenses did not predict outcomes. For SDQ Externalizing, adaptive ($p = .474$), inhibited ($p = .729$), and polarized ($p = .353$) defenses were also non-significant predictors.

In the model predicting ERC Total outcome scores, none of the mean defense scores contributed significantly to the model: adaptive defenses ($p = .796$), inhibited defenses ($p = .637$), and polarized defenses ($p = .545$) were all non-significant predictors.

Table 4.6. Predictive Value of Defense Mechanisms (Mean Adaptive, Mean Inhibited, Mean Polarized Scores) on Outcome Measures (SDQ Total, SDQ Internalizing, SDQ Total, ERC Total)

Outcome Measure	Defense Score	β	t	p
SDQ Total	Mean Adaptive	.166	0.84	.408
	Mean Inhibited	-.122	-0.59	.563
	Mean Polarized	.156	0.74	.464
SDQ Internalizing	Mean Adaptive	.132	0.71	.484
	Mean Inhibited	-.147	-0.75	.456
	Mean Polarized	.158	0.78	.445
SDQ Externalizing	Mean Adaptive	.149	0.73	.474
	Mean Inhibited	-.070	-0.35	.729
	Mean Polarized	.200	0.94	.353
ERC Total	Mean Adaptive	.048	0.26	.796
	Mean Inhibited	.109	0.48	.637
	Mean Polarized	.163	0.61	.545

Note. All models include baseline T0 scores as control variables; SDQ = Strengths and Difficulties Questionnaire; ERC = Emotion Regulation Checklist.

DISCUSSION

The trajectories and predictive value of defense mechanisms in Regulation Focused Psychotherapy for Children (RFP-C) were examined in this study. It was hypothesized that adaptive defenses would increase steadily (Hypothesis 1), and polarized defenses would decrease steadily over the course of therapy (Hypothesis 2). It was further hypothesized that lower polarized defense mechanism scores would be associated with lower externalizing symptom scores and higher emotional regulation scores (Hypothesis 3), whereas higher adaptive defense mechanism scores would be associated with lower externalizing symptom scores and higher emotional regulation scores (Hypothesis 4). In addition, an exploratory hypothesis was formulated for examining how inhibited defenses evolve throughout therapy and relate to outcomes (Hypothesis 5).

Curve estimation analyses revealed that adaptive defenses decreased mid-treatment and increased again by the end, indicating a significant U-shaped quadratic trend. This finding suggests that Hypothesis 1 is partially supported, in which we predicted a steady linear increase. Meanwhile, a significant linear increase was observed for polarized defenses, suggesting that children's use of polarized defenses increased steadily over the course of therapy. This finding was contrary to Hypothesis 2, which had predicted a linear decrease. On the other hand, no significant change was observed for inhibited defenses. In addition, regression analyses using mean defense scores did not support hypotheses 3 and 4, as no significant associations were found between mean defense scores and SDQ or ERC outcomes.

5.1. Interpretation of Findings

5.1.1. Trajectories of Defense Mechanisms

The present study examined how children's use of defense mechanisms evolved over the course of Regulation Focused Psychotherapy for Children (RFP-C). The analyses

revealed that adaptive defenses followed a quadratic trajectory, decreasing in the middle of treatment and rising again at the end of treatment. This U-shaped pattern diverged from our hypothesis of a linear increase, suggesting that defensive functioning may follow a non-linear trajectory in short-term psychodynamic therapy.

This observed pattern is partially consistent with Halfon et al. (2016), who found that children in psychodynamic play therapy frequently oscillated between adaptive and defensive play profiles over time in long-term psychodynamic therapy, rather than showing steady progression. These oscillations were interpreted as part of the therapeutic process, offering children the chance to experiment with new strategies, return to older ones when overwhelmed, and gradually move toward more adaptive forms of regulation. However, their case series was limited to three children with internalizing profiles and cannot be directly generalized to externalizing populations. Research indicates that internalizing and externalizing behaviors are associated with distinct patterns of defense mechanisms (Noam & Recklitis, 1990). Other single-case CPTI studies (Chazan & Wolf, 2002; Chazan, 2000) have observed shifts away from disorganized or polarized profiles toward more adaptive functioning, but these changes occurred over longer treatment durations and within highly individualized contexts. The potential relevance of treatment length is supported by Bond and Perry (2004), who found that clear patterns of change in defensive functioning often failed to emerge within the first two years of psychotherapy and that longer treatment was needed to observe meaningful trends. Therefore, existing literature on children offers suggestive but limited guidance for interpreting group-level trends in short-term treatment.

In contrast, research exploring the trajectory of defense mechanisms in adult psychotherapy predominantly supports a linear increase in adaptive defenses (e.g., Bond & Perry, 2004; Babl et al. 2019; Hersoug et al., 2002; Kramer et al., 2013). Adult psychotherapy research consistently indicates that overall defensive functioning and use of adaptive defense mechanisms increases significantly across treatment. These studies often rely on the DMRS and track mean defensive functioning scores over many months of therapy. However, generalizing these findings to child psychotherapy is problematic for several reasons. First, children's defensive functioning is still maturing and less

consolidated than adults', making it more vulnerable to short-term fluctuations (Cramer, 1991; Di Giuseppe et al., 2020) – which may explain the oscillating patterns observed in child psychotherapy research. Furthermore, the CPTI and DMRS differ in what they capture: the CPTI reflects broader dimensions of play organization, while the DMRS captures finely graded hierarchical defenses. These developmental and methodological differences may explain why oscillations in defensive functioning are more frequently observed in child psychotherapy. Moreover, treatments in these adult studies often span longer time frames (e.g., 40+ sessions), whereas the current study examined changes within a 16-session model.

It is also possible that the dip in adaptive defenses observed mid-treatment reflects a temporary loss of regulatory control as more difficult affect becomes accessible. Hayes et al. (2007) suggest that psychological change does not always follow a linear trajectory; instead, it may unfold in abrupt, nonlinear shifts. These shifts are often preceded by a period of increased variability and disruption of established patterns, which can create the conditions necessary for reorganization. In psychotherapy, this period of destabilization frequently involves intense emotional arousal. When individuals are able to process and make sense of these emotional experiences, this disruption can serve as a catalyst for deeper and more enduring change. Similarly, Galatzer-Levy (2009) conceptualize that therapeutic processes often involve oscillations between order and disorder, with temporary destabilization serving as a precursor to reorganization. Similarly, Bond and Perry (2004) observed high variability in defensive functioning during the early stages of long-term psychodynamic therapy, suggesting that stable improvement often emerges only after initial fluctuations.

It was hypothesized that polarized defenses would decrease in a linear manner. In contrast, the analyses revealed that polarized defenses showed a significant linear increase. This finding diverges from previous studies. For instance, Halfon et al. (2016), in a study utilizing the same coding instrument (CPTI) to examine therapeutic play profiles in children receiving psychodynamic play therapy, observed fluctuations between defensive and adaptive play profiles but did not report a consistent increase in the use of polarized defenses. One possible explanation for this discrepancy lies in sample

characteristics: Halfon et al.'s study focused on three children with separation anxiety, representing an internalizing symptom profile, whereas the present study focused on a larger number of children with clinically elevated externalizing symptoms. As mentioned above, children with internalizing and externalizing symptom profiles have been found to have distinct patterns of defense mechanisms (Noam & Recklitis, 1990), which may account for part of the divergence in findings between the present study and Halfon et al.'s study.

Although the literature assessing the trajectory of defense mechanisms in child psychotherapy is limited, studies exploring the same question within adult psychotherapy also yield findings that suggest a decline in immature defenses: Bond and Perry (2004) observed a decline in maladaptive defense styles in long-term dynamic psychotherapy, and Coccanari de' Fornari et al. (2011) reported that immature defenses significantly decreased over the course of short-term therapy. Babl et al. (2019) also found a reduction in maladaptive defenses among patients with depressive and anxiety disorders. Taken together, these studies suggest that a reduction in immature defenses is often observed as therapy progresses. The current study's finding of an increase in polarized defenses therefore diverges from much of the existing literature.

Unlike many therapies that work indirectly through insight or support, RFP-C explicitly focuses on identifying and interpreting defense mechanisms (Hoffman et al., 2016). This may lead to a heightened visibility and frequency of polarized defenses throughout the therapy process. Furthermore, the increase in polarized defenses may reflect therapeutic engagement rather than regression. In RFP-C, defensive behaviors are conceptualized as efforts to manage overwhelming affect (Hoffman et al., 2016). Accordingly, such expressions are viewed as clinically meaningful opportunities for intervention: therapist interpretations focus on linking the child's behavior to underlying affect in the moment. Rather than signaling regression, the emergence of observable polarized defenses may thus reflect therapeutic engagement with affectively charged material.

Additionally, studies conducted on adult populations use a different classification system for defenses, and the study was conducted on a population that is significantly different than that in this study in terms of age and clinical characteristics. The divergence in

findings may also partly be related to differences in sample characteristics, as well as methodological differences in how defenses were operationalized and coded. Lastly, since previous literature suggests that clear patterns of change in defensive functioning often emerge after two years of psychotherapy (Bond & Perry, 2004), it is possible that the short-term nature of RFP-C contributed to the divergence in findings.

There was no directional hypothesis made for inhibited defenses in the present study. The analyses revealed that there were no significant changes in inhibited defenses over time. This finding is somewhat consistent with Babl et al.'s (2019) finding that neurotic-level defenses remained stable during psychodynamic psychotherapy. Although the present study used the CPTI and Babl et al. used the DMRS, and these two tools rely on different classification systems, there is conceptual overlap between the neurotic-level defenses in the DMRS and the Inhibited defenses in the CPTI: The CPTI's inhibited cluster includes defense mechanisms like undoing, intellectualization, rationalization, isolation of affect, and reaction formation, which are also defenses categorized under the neurotic level in the DMRS. Similar findings were also reported by Halfon et al. (2016), who observed no consistent reduction in the inhibited play profile.

There are several plausible explanations for the lack of significant change in inhibited defenses. First, although RFP-C is specifically structured to address externalizing behaviors and emphasizes moment-to-moment interpretation of observed defense mechanisms (Hoffman et al., 2016). As such, it may be less focused on the types of internally regulated, cognitively mediated defenses that characterize the CPTI's Inhibited cluster, such as rationalization, intellectualization, and isolation of affect. These defenses may not be the primary target of intervention within RFP-C and therefore may remain stable over the course of treatment. Furthermore, children with externalizing symptoms have been found to rely more heavily on defenses that align with the Polarized cluster in the CPTI, such as projection, denial, and identification with the aggressor (Hoffman et al., 2016; Prout, 2023). Since the sample of the study consisted of children with externalizing and comorbid difficulties, it is likely that inhibited defenses were less dominant in their overall defensive repertoire. Given the predominance of polarized defenses in this population, therapists may have focused their interventions on the more

overt and dysregulated defenses that were most accessible in the therapeutic setting. Moreover, as an intervention specifically developed for externalizing children, RFP-C is structured around interpreting externalizing behaviors as defenses against painful emotions (Hoffman et al., 2016). As such, therapist attention may have been directed primarily toward these observable defense patterns, leaving more internally regulated defenses like those in the Inhibited cluster relatively unaddressed.

5.1.2. Predictive Value of Defense Mechanisms on Outcome Measures

Hypotheses 3 through 5 proposed that mean adaptive, inhibited, and polarized defense scores across therapy would predict symptom and emotion regulation outcomes. However, hierarchical linear regression analyses indicated that none of the mean defense scores significantly predicted SDQ Total, SDQ Internalizing, SDQ Externalizing, or ERC scores at the end of treatment. This lack of finding diverges from a substantial body of research suggesting that defensive functioning is closely tied to therapeutic outcome (e.g., Perry & Bond, 2012; Kramer et al., 2010; Babl et al., 2019; Perry et al., 2009; Cramer & Blatt, 1993). However, the entirety of the previous literature exploring the question of whether defensive functioning relates to treatment outcomes consists of research on adult psychotherapy. In addition, these studies examined change in defensive functioning, rather than mean levels. For example, Babl et al. (2019) found that changes in defense use – particularly increased adaptive and decreased maladaptive defenses – predicted symptom improvement in adult psychotherapy. In the present study, although mean scores were not predictive, defensive functioning did show significant change over time, particularly for adaptive and polarized clusters. Similarly, Perry and Bond (2012) also demonstrated that changes in defensive functioning were predictive of symptom improvement, further supporting the value of modeling change rather than static levels. Previous research has emphasized that defensive functioning is not a static trait but is expected to evolve over the course of treatment (Perry & Henry, 2004). It is possible that the degree of change in defensive functioning, rather than average levels across sessions, is more closely tied to therapeutic outcomes, because mean scores may not capture the

dynamic processes of change that occur throughout therapy. To our knowledge, no studies have examined whether mean scores across multiple timepoints predict therapy outcome.

Another possible explanation lies in the relationship between the outcome measures and the defense construct itself. While the CPTI captures implicit emotion regulation processes embedded in children's play and narrative structure, the ERC assesses explicit, adult-reported behaviors related to emotional expression and control. This measurement discrepancy may partially explain why defensive functioning did not significantly predict ERC scores: the CPTI may be indexing deeper, unconscious strategies not directly observable to caregivers. Moreover, defenses are often mobilized within the therapeutic context, while the ERC reflects functioning in the child's broader social environment. As a result, the lack of association between these measures may reflect not an absence of change, but differences in what aspects of regulation each tool is designed to detect.

5.2. Clinical Implications

The findings of the present study offer several implications for clinical practice, particularly for psychotherapists working with children who present with externalizing difficulties, within short-term, defense-focused psychotherapies such as RFP-C. First, the observed fluctuation in defensive functioning underscores the importance of viewing defenses not as fixed traits, but as dynamic, shifting strategies that reflect the child's evolving engagement with affective material. Therapists should be prepared for temporary intensification of maladaptive defenses such as projection, splitting, or identification with the aggressor, particularly mid-treatment, and avoid interpreting such patterns as signs of treatment failure. Instead, these defenses can serve as entry points for therapeutic intervention, offering clinicians opportunities to interpret and regulate overwhelming affect in the moment.

Second, the non-linear trajectory of adaptive defenses highlights the need for therapists to recognize that the use of adaptive strategies may fluctuate during the course of treatment. Such fluctuations and temporary dips may coincide with emotionally challenging stages of treatment, particularly when previously avoided affect comes into

focus. Clinical training and supervision in short-term child psychotherapy should prepare therapists to anticipate these patterns and maintain therapeutic consistency without prematurely interpreting them as signs of poor progress or clinical deterioration.

Third, the lack of association between mean defense scores and treatment outcome suggests that tracking change over time – rather than relying on averaged levels across treatment – may offer a more accurate picture of therapeutic progress and may be more informative for clinical decision-making. Mean scores can obscure important session-to-session fluctuations that reflect how children respond to different emotional demands or interventions. Accordingly, therapists and supervisors should be cautious in using static or averaged measures as sole indicators of therapeutic progress.

Fourth, the apparent discrepancy between in-session observations and caregiver-reported outcomes underscores the importance of integrating multiple sources of clinical information. In this study, the observed increase in polarized defenses might appear to be a lack of therapeutic progress. However, concurrent improvements in parent-reported symptom and emotion regulation scores indicate that meaningful change may still be occurring outside the therapy room. This finding highlights the importance of recognizing that an increase in observable defenses during sessions may not indicate a lack of progress. Therapists should interpret such shifts in the context of broader changes in the child's functioning, as reported by caregivers, and use ongoing caregiver input to better understand how emotional and behavioral changes are manifesting outside the therapy room.

Finally, the coordinated movement of adaptive and polarized defenses across treatment offers important insights into the therapeutic process. Rather than operating in isolation, defenses appear to shift in tandem, consistent with Chazan's (2002) view that defensive functioning operates as part of a dynamic system. The steady increase in polarized defenses, occurring alongside the eventual partial recovery of adaptive defenses, may reflect the child's engagement with heightened affective material within a containing therapeutic context. From this perspective, rather than representing regression, the emergence of polarized defenses may reflect the child's engagement with unprocessed affect that became accessible as therapy progressed. When accompanied by emerging

adaptive functioning, such shifts may represent a rupture-repair process that facilitates deeper integration, and signal psychological flexibility rather than disorganization, particularly within the containing therapeutic environment provided by RFP-C. This capacity to oscillate between different modes of regulation may be a marker of therapeutic progress in child psychotherapy. Therapists should be attuned to these dynamic patterns and recognize that these moments may offer important opportunities for emotional growth and therapeutic change, particularly when they take place within a consistent and containing therapeutic relationship.

Taken together, these findings highlight the importance of maintaining a flexible, process-oriented stance when working with defensive functioning in child psychotherapy. Therapists are encouraged to attune to both the form and timing of defenses and to maintain a stance of curiosity and collaboration when these defenses appear, as this may enhance their capacity to support children's developing emotion regulation. Rather than pathologizing the presence of inhibited or polarized defenses late in therapy, therapists may benefit from viewing the continued – or even increased – use of these defenses as indicators of therapeutic engagement and opportunities for regulation. These findings underscore the value of working with, rather than against, defenses in child therapy, particularly within models like RFP-C that treat defenses as central to both formulation and intervention.

5.3. Limitations and Future Directions

It is important to acknowledge the limitations of the present study. First, the study did not utilize data from the follow-up (T3) timepoint, which limits the ability to explore whether changes in defense mechanisms observed during treatment predict longer-term outcomes. Without a follow-up timepoint, the study could not test potential indirect pathways, such as whether improved defensive functioning facilitates emotion regulation, which in turn contributes to later symptom reduction. Another limitation is the reliance on mean scores, which may have obscured meaningful changes in defensive functioning across therapy. Future research would benefit from using change-based analyses.

A second set of limitations concerns the demographic composition of the sample. The study's sample size was relatively small, which may limit how much the findings can be generalized to other groups of children. Future studies with larger and more diverse samples would allow for a more thorough exploration of the relationships between defensive functioning, emotion regulation, and symptoms. Furthermore, the sample was composed of predominantly male participants (71.05%), potentially limiting the generalizability of the findings, particularly given that defensive functioning, presenting symptoms, and emotion regulation processes may differ across genders (e.g., Di Giuseppe et al., 2020; Laor et al., 2001). In addition, potential confounding variables such as age and gender were not controlled for in the analyses. Considering that developmental stage and gender-related socialization processes may influence the presentation of symptoms, emotion regulation capacities, as well as defensive functioning, future research would benefit from testing for their potential moderating effects. Studies that account for the child's presenting problem or referral type – such as whether difficulties are primarily externalizing, internalizing, or relational – would also provide more nuanced insights into how defensive functioning interacts with clinical presentation.

Third, although the CPTI data were coded by trained raters and interrater reliability was assessed and found to be acceptable, observer-rated systems inherently carry certain limitations. Even when interrater agreement is strong, observer-rated systems remain susceptible to bias, as raters' interpretations may still be shaped by their prior knowledge, assumptions, or the context in which coding takes place (Mahtani et al., 2018).

Finally, although the CPTI offers a valuable system for identifying defense mechanisms through children's play, the structure of its clusters (adaptive, inhibited, polarized, disorganized) does not map directly onto the developmental hierarchies proposed by Vaillant (1986) or the more granular categorization used in the DMRS-Q-C (Di Giuseppe et al., 2020). This limits the comparability of the findings to other studies in the broader defense mechanism literature. More fundamentally, assessing defense mechanisms in children presents unique challenges. Unlike adults, children often express defenses nonverbally and symbolically – through play themes, affective tone, and narrative disruptions – rather than through explicit verbal reflection or insight (Hoffman et al.,

2016; Hoffman et al., 2023). As a result, measuring defenses in children relies heavily on the clinician's interpretation of behavior within a symbolic and relational context, which complicates efforts to achieve objective, consistent measurement.

Future research would benefit from incorporating follow-up data to evaluate whether defensive functioning predicts delayed and longer-term improvements in symptoms and emotion regulation. In addition, replication with alternative defense coding systems, such as the DMRS, could help determine whether similar patterns emerge across different theoretical frameworks. Furthermore, future studies should explore the predictive value of change-based defense scores, rather than mean levels. Accounting for variables such as symptom profile, developmental stage, and gender may also offer more precise insights. Finally, future studies could also examine specific defense mechanisms, rather than broader clusters, to better understand how individual patterns of defensive functioning develop over time and respond to therapeutic intervention.

CONCLUSION

This study examined how defense mechanisms evolve throughout the course of Regulation Focused Psychotherapy for Children (RFP-C), a manualized, short-term psychodynamic intervention targeting externalizing behaviors, and whether changes in defensive functioning predict symptom and emotion regulation outcomes. Despite the centrality of defense mechanisms in psychodynamic theory, empirical research on their trajectory and clinical utility in child psychotherapy remains scarce. By using a play-based observational coding system (CPTI), the study offered a developmentally appropriate method for assessing changes in implicit regulatory processes across treatment. The findings revealed that adaptive defenses followed a non-linear (U-shaped) trajectory, polarized defenses increased steadily, and inhibited defenses remained relatively stable. Mean defense scores did not predict symptom or emotion regulation levels at the end of treatment. These results contribute to a growing understanding of how defensive functioning facilitates change and evolves in short-term psychodynamic interventions with children. Taken together, the findings underscore the importance of adopting a process-sensitive and developmentally grounded lens in child psychotherapy research. By tracing how defenses unfold over time and relate to therapeutic outcomes, this study contributes to a growing understanding of the mechanisms of change in play-based, defense-focused interventions. It highlights that defensive functioning is not static and that its clinical meaning may shift depending on the therapeutic context and phase of treatment. Accordingly, this study helps address a notable gap in the literature. It also opens important avenues for future research to better capture the dynamics of therapeutic change in children.

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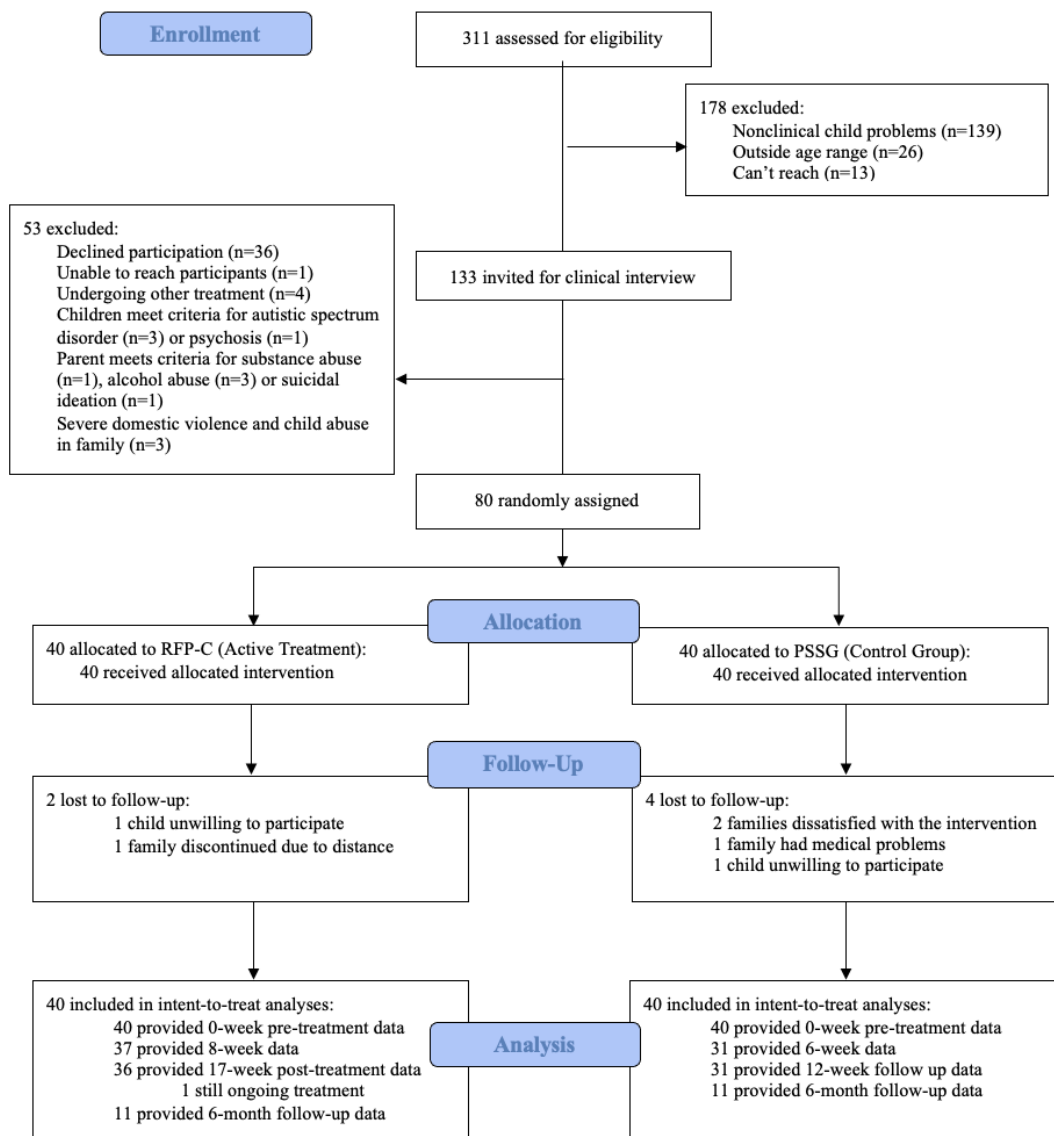
APPENDICES

Appendix A. Result of the Evaluation by the Ethics Committee

Result of the Evaluation by the Ethics Committee is available in the printed version of this dissertation.



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



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

Appendix C. Clinical Study Protocol

6/1/25, 1:44 AM

Study Details | Randomized Controlled Trial of Regulation-Focused Psychotherapy (RFP-C) | ClinicalTrials.gov

ClinicalTrials.gov

NIH National Library of Medicine
National Center for Biotechnology Information



The U.S. government does not review or approve the safety and science of all studies listed on this website.

Read our full [disclaimer](https://clinicaltrials.gov/about-site/disclaimer) (<https://clinicaltrials.gov/about-site/disclaimer>) for details.

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

Study Details Tab

Study Overview

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.

Feedback

<https://clinicaltrials.gov/study/NCT06060353>

1/14

Official Title

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

Conditions ⓘ

Childhood Externalizing Disorder Childhood Oppositional Defiant Disorder
Childhood Conduct Disorder

Intervention / Treatment ⓘ

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

Other Study ID Numbers ⓘ**Study Start (Actual)** ⓘ

2023-09-01

Primary Completion (Estimated) ⓘ

2025-05-01

Study Completion (Estimated) ⓘ

2025-06-01

Enrollment (Estimated) ⓘ

80

Study Type ⓘ

Interventional

Phase ⓘ

Not Applicable

Resource links provided by the National Library of Medicine

[FDA Drug and Device Resources](https://clinicaltrials.gov/fda-links) (<https://clinicaltrials.gov/fda-links>).

Contacts and Locations

This section provides contact details for people who can answer questions about joining this study, and information on where this study is taking place.

To learn more, please see the [Contacts and Locations section in How to Read a Study Record](https://clinicaltrials.gov/study-basics/how-to-read-study-record#contacts-and-locations) (<https://clinicaltrials.gov/study-basics/how-to-read-study-record#contacts-and-locations>).

This study has 1 location

Turkey

 **Istanbul, Turkey, 34060**
Istanbul Bilgi University

Participation Criteria

Researchers look for people who fit a certain description, called [eligibility criteria](#). Some examples of these criteria are a person's general health condition or prior treatments.

For general information about clinical research, read [Learn About Studies](https://clinicaltrials.gov/study-basics/learn-about-studies) (<https://clinicaltrials.gov/study-basics/learn-about-studies>).

Eligibility Criteria

Description

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)

Ages Eligible for Study ⓘ

6 Years to 12 Years (Child)

Sexes Eligible for Study ⓘ

All

Accepts Healthy Volunteers ⓘ

No

Study Plan

This section provides details of the study plan, including how the study is designed and what the study is measuring.

How is the study designed?

Design Details

- Primary Purpose ⓘ : Treatment
- Allocation ⓘ : Randomized
- Interventional Model ⓘ : Parallel Assignment
- Masking ⓘ : Single (Outcomes Assessor)

Arms and Interventions

Participant Group/Arm ①	Intervention/Treatment ①
Experimental: Regulation Focused Psychotherapy (RFP-C)	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.
Active Comparator: Parental Awareness and Child Social Skills Group	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.

What is the study measuring?

Primary Outcome Measures

Outcome Measure	Measure Description	Time Frame
Strengths and Difficulties Questionnaire - Parent version (SDQ-P; Goodman, 2001)	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 (Yalin et al., 2013).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)
Turgay DSM-IV (Diagnostic and Statistical Manual of Mental Disorders,	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,	Time Frame: Baseline (T0), Mid-Treatm

Fourth Edition) Disruptive Behavior Disorders Rating Scale (T- DSM-IV-S; Turgay, 1994)	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.	ent (T1), End of Treatm ent (T2), 36th week (T3)
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Secondary Outcome Measures

Outcome Measure	Measure Description	Time Frame
Me and My Feelings Questionnaire (M&MF; Deighton et al., 2013)	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 (İlçin, 2020).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)
Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997)	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	Time Frame: Baseline (T0), Mid-Treatment

	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).	ent (T1), End of Treatment (T2), 36th week (T3)
The Emotion Awareness Questionnaire (EAQ-30; Rieffe et al., 2008)	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 (Inceman, 2017).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)

The Children's Global Assessment Scale (CGAS; Schaffer et al., 1983)	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).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2)
Parental Stress Index - Short Form (PSI-SF; Abidin, 1983)	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).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)
Difficulties in Emotion	Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is an instrument	Time Frame:

Regulation Scale (DERS; Gratz & Roemer, 2004)	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 dysregulation score. The scale has been adapted to Turkish with good reliability and validity (Yiğit & Güzey-Yiğit, 2017).	Baseline (T0), Mid-Treatment (T1), End of Treatment (T2), 36th week (T3)
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Other Outcome Measures ⓘ

Outcome Measure	Measure Description	Time Frame
Adverse Childhood Experiences Scale (ACE; Dube et al., 2004)	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).	Time Frame: Baseline (T0)

The Therapeutic Alliance Scale for Children-revised (TASC-r; Creed &Kendall, 2005)	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).	Time Frame: Baseline (T0), Mid-Treatment (T1), End of Treatment (T2)
Wechsler Abbreviated Scale of Intelligence (WASI-II; Weschler, 1999)	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.	Time Frame: Baseline (T0)

Collaborators and Investigators

This is where you will find people and organizations involved with this study.

Sponsor ⓘ

Istanbul Bilgi University

Collaborators ⓘ

- Center for Regulation Focused Psychotherapy

Publications

General

These publications are provided voluntarily by the person who enters information about the study and may be about anything related to the study.

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

Study Record Dates

These dates track the progress of study record and summary results submissions to ClinicalTrials.gov. Study records and reported results are reviewed by the National Library of Medicine (NLM) to make sure they meet specific quality control standards before being posted on the public website.

Study Registration Dates

First Submitted ⓘ

2023-09-23

First Submitted that Met QC Criteria ⓘ

2023-09-23

First Posted ⓘ

2023-09-29

Study Record Updates

Last Update Submitted that met QC Criteria ⓘ

2025-04-28

Last Update Posted ⓘ

2025-05-01

Last Verified ⓘ

2025-04

More Information

Terms related to this study

Keywords Provided by Sibel Halfon, Istanbul Bilgi University

Regulation Focused Psychotherapy
Implicit Emotion Regulation
Externalizing Problems

Additional Relevant MeSH Terms

Attention Deficit and Disruptive Behavior Disorders
Neurodevelopmental Disorders
Mental Disorders
Conduct Disorder
Oppositional Defiant Disorder

Plan for Individual Participant Data (IPD)**Plan to Share Individual Participant Data (IPD)?**

No

Drug and device information, study documents, and helpful links**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

Appendix D. Strengths and Difficulties Questionnaire - Parent version (SDQ-P)

GÜÇLER VE GÜÇLÜKLER ANKETİ (SDQ-Tur)

AB⁴⁻¹⁷
İZLEM

Her cümle için, Doğru Değil, Kısmen Doğru, Tamamen Doğru kutularından birini işaretleyiniz. Kesinlikle emin olamasanız ya da size anlamsız görünse de elinizden geldiğince tüm cümleleri yanıtlamanız bize yardımcı olacaktır. Lütfen yanıtlarınızı çocuğunuzun **son bir ay içindeki** davranışlarını göz önüne alarak veriniz.

Çocuğunuzun Adı:

Kız / Erkek

Doğum Tarihi:

	Doğru Değil	Kısmen Doğru	Kesinlikle Doğru
Diğer insanların duygularını önemser.	☐	☐	☐
Huzursuz ve aşırı hareketlidir, uzun süre kıpırdamadan duramaz.	☐	☐	☐
Sıkça baş ağrısı, karın ağrısı ve bulantı şikayetleri olur	☐	☐	☐
Diğer çocuklarla kolayca paylaşır. (yiyeceğini, oyuncakını, kalemini v.s.)	☐	☐	☐
Sıkça öfke nöbetleri olur yada aşırı sinirlidir.	☐	☐	☐
Daha çok tek başınadır, yalnız oynama eğilimindedir.	☐	☐	☐
Genellikle söz dinler, büyüklerin isteklerini yapar.	☐	☐	☐
Birçok kaygısı vardır. Sıkça endişeli görünür.	☐	☐	☐
Eğer birisi incinmiş, morali bozulmuş yada kendini kötü hissediyor ise ona yardımcı olur.	☐	☐	☐
Sürekli elleri ayakları kıpır kıpırdır yada oturduğu yerde kıpırdanıp durur.	☐	☐	☐
En az bir yakın arkadaşı vardır.	☐	☐	☐
Sıkça diğer çocuklarla kavga eder yada onlarla alay eder.	☐	☐	☐
Sıkça mutsuz, kederli yada ağlamaklıdır.	☐	☐	☐
Genellikle diğer çocuklar tarafından sevilir.	☐	☐	☐
Dikkati kolayca dağınılır. Dikkatini toplamakta güçlük çeker.	☐	☐	☐
Yeni ortamlarda gergin yada huysuzdur. Kendine güvenini kolayca kaybeder.	☐	☐	☐
Kendinden küçüklere iyi davranır.	☐	☐	☐
Sıkça yalan söyler yada hile yapar.	☐	☐	☐
Diğer çocuklar ona takarlar yada onunla alay ederler.	☐	☐	☐
Sıkça başkalarına (anne baba, öğretmen, diğer çocuklar) yardım etmeye istekli olur.	☐	☐	☐
Bir şeyi yapmadan önce düşünür.	☐	☐	☐
Ev, okul yada başka yerlerden çalar.	☐	☐	☐
Büyüklerle çocuklardan daha iyi geçinir.	☐	☐	☐
Pek çok korkusu var. Kolayca ürker.	☐	☐	☐
Başladığı işi bitirir, dikkat süresi iyidir.	☐	☐	☐

Belirtmek istediğiniz başka düşünce ya da duygunuz var mı?

Lütfen sayfayı çeviriniz - arka sayfada birkaç soru daha var

Bu kliniğe gelmeye başladığınızdan bu yana çocuğunuzun sorunları:

Çok daha kötü	Biraz daha kötü	Hemen hemen aynı	Biraz daha iyi	Çok daha iyi
☐	☐	☐	☐	☐

Bu kliniğe devam etmek diğer yönlerden yardımcı olmakta mı? (örn: bilgilendirilme ya da sorunların daha katlanılabilir hale getirilmesi)

Kesinlikle Hayır	Biraz	Oldukça Fazla	Çok Fazla
☐	☐	☐	☐

Son bir aydır, çocuğunuzun aşağıdaki alanların birinde ya da daha fazlasında güçlükleri olduğunu düşünüyor musunuz: duygular, dikkati toplama, davranış yada başkaları ile geçinebilme?

Hayır	Evet-Biraz	Evet-Oldukça Ciddi	Evet-Çok Ciddi
☐	☐	☐	☐

Eğer yanıtınız "evet" ise, lütfen aşağıdaki bu güçlüklerle ilişkin soruları yanıtlayınız.

- Bu güçlükler çocuğunuzun sıkıntıya sokuyor yada moralini bozuyor mu?

Kesinlikle Hayır	Biraz	Oldukça Fazla	Çok Fazla
☐	☐	☐	☐

- Bu güçlükler aşağıdaki alanlarda, çocuğunuzun günlük yaşamını etkiliyor mu?

	Kesinlikle Hayır	Biraz	Oldukça Fazla	Çok Fazla
Ev yaşamı	☐	☐	☐	☐
Arkadaş ilişkileri	☐	☐	☐	☐
Sınıf içi öğrenme	☐	☐	☐	☐
Boş zaman etkinlikleri	☐	☐	☐	☐

- Bu güçlükler size ya da ailenize zorluk yaşıyor mu?

Kesinlikle Hayır	Biraz	Oldukça Fazla	Çok Fazla
☐	☐	☐	☐

İmza:

Tarih:

Anne / Baba / Diğer (lütfen belirtiniz):

Yardıminiz için teşekkür ederiz

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Appendix E. Emotion Regulation Checklist (ERC)

Lütfen aşağıdaki cümleleri okuyun ve çocuğunuz için en uygun olan sayıyı daire içine alın. Cevaplarınızı çocuğunuzun son 6 ay içindeki davranışlarını göz önüne alarak veriniz. **Eksiksiz doldurduğunuzdan emin olunuz.** Teşekkürler.

	Nadiren/ Neredeyse Hiç	Bazen	Sık Sık	Her Zaman
1. Neşeli bir çocuktur.	1	2	3	4
2. Duygu hali çok değişkendir. (Çocuğun duygu durumunu tahmin etmek güçtür çünkü olumlu bir duygu halinden olumsuz bir duygu haline çabucak geçer.)	1	2	3	4
3. Yetişkinlerin arkadaşça veya nötr yaklaşımlarına olumlu karşılık verir.	1	2	3	4
4. Bir faaliyetten diğerine kolaylıkla geçer; sinirlenmez, endişelenmez, sıkıntı duyma ya da aşırı derecede heyecanlanmaz.	1	2	3	4
5. Üzüntülü ya da sıkıntılı durumların çabucak üstesinden gelebilir. (Örneğin, duygusal sıkıntı yaratan olaylardan sonra surat asmaz, endişeli veya üzgün durmaz.)	1	2	3	4
6. Kolayca hüsrana uğrar.	1	2	3	4
7. Yaştlarının arkadaşça veya nötr yaklaşımlarına olumlu karşılık verir.	1	2	3	4
8. Kolayca sinir krizi/öfke nöbeti geçirmeye eğilimlidir.	1	2	3	4
9. Hoşuna giden bir şeye ulaşmayı erteleyebilir. (Örneğin, kendi sırasını bekleyebilir.)	1	2	3	4
10. Başkalarının sıkıntılarında keyif duyar. (Örneğin, başka biri incindiğinde ya da cezalandırıldığında güler, başkalarıyla alay etmekten zevk alır.)	1	2	3	4
11. Heyecanı başa çıkabilir. (Örneğin, çok hareketli oyunlarda kontrolü kaybetmez ya da uygun olmayan durumlarda aşırı heyecanlanmaz.)	1	2	3	4
12. Mızız ve yapışkandır.	1	2	3	4
13. Her an ortalığı karıştıran enerji patlamaları ve büyük heyecanlar yaşayabilir.	1	2	3	4

	Nadiren/ Neredeyse Hiç	Bazen	Sık Sık	Her Zaman
14. Yetişkinlerin sınır koymalarına sinirlenir.	1	2	3	4
15. Üzüldüğünü, kızdığını veya korktuğunu söyleyebilir.	1	2	3	4
16. Üzgün ve sıkıntılı görünür.	1	2	3	4
17. Başkalarını oyuna katmaya çalışırken aşırı enerjiktir.	1	2	3	4
18. Duygularını göstermez. (Yüzü ifadesizdir.)	1	2	3	4
19. Yaşitlarını arkadaşça veya nötr yaklaşımlarına olumsuz karşılık verir (örneğin, kızgın bir ses tonuyla konuşabilir ya da korku gösterebilir.)	1	2	3	4
20. Dürtülerine kapılarak davranır.	1	2	3	4
21. Başkalarıyla empati kurar. (Örneğin, başkaları üzgün ya da sıkıntılı olduğunda ilgi gösterir.)	1	2	3	4
22. Başkalarının rahatsızlık verici bulacağı kadar enerjik ve heyecanlı davranır.	1	2	3	4
23. Yaşitlarının düşmanca saldırgan veya müdahaleci davranışlarına karşı uygun olumsuz duyguları (kızgınlık, korku, öfke, sıkıntı) gösterir.	1	2	3	4
24. Başkalarını oyuna katmaya çalışırken olumsuz duygular gösterir.	1	2	3	4

□

Appendix F. The Children's Play Therapy Instrument (CPTI) Coding Manual

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.

FUNCTIONAL ANALYSIS

This level of observation assesses the child's play behaviors that manifest specific coping/defensive strategies. These strategies fall along a spectrum and are grouped into four clusters. Cluster One contains strategies within the adaptive domain; Cluster Two contains strategies within the conflicted domain; Cluster three contains strategies within the polarized / rigid domain; Cluster four contains strategies within the severe anxiety / isolated domain.

At this level, even though you are assessing coping strategies, these are part of the various parameters that combine to produce play activity. The patterns, or profiles, of play activity reflect a specific child's experience of himself and others while playing, as well as his strategies for coping and adaptation. Therefore, please use your previous observations to assess the child's general play pattern which also includes coping strategies listed below.

All Functional Analysis ratings use the 5-point scale.

- | | | |
|---|------|--------------------------|
| 1 | | None Observed |
| 2 | | Observed At Times |
| 3 | | Observed Some Times |
| 4 | | Observed Most Times |
| 5 | | Observed All of the Time |

Adaptive Play Profile/Strategies

Please rate to what extent you observe some or all these characteristics. Ratings of play activity that suggest adaptive strategies to contribute to a child's style of playing include:

- The child uses materials available in the room to play. (**Adaptation**)

Example: Child uses the Legos because "We don't have small dolls."

- The child anticipates what might happen next in the play activity. (**Anticipation**)

Example: In preparation for an operation, the child plays at being the surgeon by putting all the stuffed animals in the hospital.

- The child transforms and enjoys playing at messing using available play materials. (**Sublimation**)

Example: Child plays with glue on the table, smearing its surface and himself, then begins to use finger paints to make a picture of his house.

- Child solves a problem while playing. (**Problem solving**)

As the blocks tumble, the child places the larger blocks on the bottom.

- Child is pleased with the product of his play activity.
- Child uses humor to express himself while playing. (**Humor**)
Example: (A 7-year-old child, while laughing) "Boo! I scared you!"
- Child seeks comfort, support, or help from others to deal with emotions or challenges. (**Affiliation**)
Example: A child builds a block tower but gets frustrated when it keeps falling. Instead of quitting, the child turns to the therapist and asks, "Can you help me build this? We can do it together!" reflecting a need for support in handling the situation.
- Child manages their own emotional discomfort by focusing on the needs of others and offering help or kindness. (**Altruism**)
Example: A child sees a toy with a broken arm and says, "I'll fix you and make you feel better," while pretending to care for the toy. This shows the child managing their own discomfort by focusing on the toy's needs.
- Child expresses their own needs, desires, or opinions directly and confidently, without being aggressive. (**Self-assertion**)
Example: A child says, "I want to play with the blue blocks now," and firmly takes the blocks from the toy area, clearly stating their preference and setting a boundary.
- Child reflects on their own behavior, feelings, or thoughts. (**Self-observation**)
Example: While playing with a dollhouse, the child acts out a doll feeling sad about a lost toy and says, "Just like when I lost my toy and felt sad," reflecting on their own emotions through the play.

Conflicted/Inhibited Play Profile/Strategies

Please rate to what extent you observe some or all these characteristics. Ratings of play activity that suggest inhibition and conflict contribute to a child's style of playing include:

- Segmentation of child's activity may have one or several interruptions.
- Play activity and Non-Play activity may alternate in succession.
- Child may show difficulty initiating play.
- Child demonstrates poor facilitation of the play activity.
- Overall hedonic tone is muted and tends to be either neutral interest, or somber. When the conflict is intense the child may exhibit signs of overt distress.
- The child may be painfully aware he is playing and overly sensitive to/or self-conscious about engaging in play activity.

- Play activity is inhibited by the child using avoidance, withdrawal, obsessional strategies or by ignoring the play situation. Play activity may exhibit regressive aspects, appearing to be play activity expected for a younger child. There may be uncertainty about playing (anxiety about adequacy) or alternatively, the assumption of an attitude that inhibits the emergence of playfulness, for example, the child adopts a serious, intellectual pose and recites factual information.

Conflicted/Inhibited Coping Strategies

- The child builds a tower and then knocks it down, and then rebuilds it, and then, knocks it down again. **(Doing & Undoing)**
- Child is preoccupied with ordering things for fear that things may get out of control. **(Compulsive Behaviors)**

Examples: Child obsessively orders the doll house every time he has to deal with the parental couple.

The child gives the baby doll the bottle, then takes it away, mid then gives it back, only to take it away again
- The play activity deals with the emotional implications of the play in a neutral, factual, objective way. *"I am changing my experience into one of thoughts."* **(Intellectualization)**

Example: "Here comes the fireman. He knows all about putting out fires." (Child goes into detail describing what the fireman knows about burning buildings.)
- The child explains the play activity to the therapist using acceptable but false reasons. "I will give myself a different reason to avoid worry." **(Rationalization)**

Example: The child puts the family of dolls to sleep on the bed except for the baby, which she puts on the floor, stating that there is no more room on the bed.
- In the play activity ideas are separated from their threatening affects. The result is often an apparent indifference. "I can think about this and not feel it." **(Isolation of affect)**

Example: Child gives the therapist a "poisonous cake" with a flat face.
- The child cannot continue playing with a selected person or object. He turns away, does not resume his original focus and acts as though the object or person is no longer there. **(Negation)**

Child loses during monopoly, is clearly upset but pretends not to care.

- Play activity arousing fear or anxiety is turned into its opposite and becomes disguised as a source of pleasurable enjoyment. **(Reaction Formation)**

Example: Child breaks the head of a doll because he loves the doll so much.

- The play activity is characteristic of a younger child. **(Regression)**

Example: A 7-year-old looks for an object to be a blankie or sucks on a doll's bottle while talking baby talk, or a school-aged child wants to make a big mess or characters keep having to go to the bathroom while skating.

- An unacceptable action or feeling expressed by a different character or person in the play is redirected by the child who then punishes himself. **(Turning Aggression Against the Self)**

Example: (Child) "Batman just shot his own weapon directly at himself."

- The child or one of the characters is preoccupied with physical symptoms. *"My body is speaking for me."* **(Somatization)**

Example: In the play activity, the little boy doll stays home from school because he has a headache.

Polarized/Impulsive Play Profile/Strategies

Please rate to what extent you observe some or all these characteristics. Ratings of play activity that suggest polarization or impulsivity contribute to a child's style of playing include:

- Brief segments of Play Activity or Lack of Continuity Between Segments of Play Activity or Interruptions of Play Activity.
- Play Activity may be ended by avoidance or play disruption.
- ~~Macrosphere~~ is primary domain of Play Activity
- Aggression, and anger are dominant feelings expressed in play activity.
- Role representation has developed, but representation of roles is not stable and may transform involuntarily.
- Representations of play objects are often magical and possess destructive magical powers.
- Themes and topics of the play are centered about aggression (fighting, war), power struggles (good vs. bad) and breaking rules.
- Language is used to verbalize roles and describe ongoing play actions.

- Social Level of the play rarely involves other persons interactively and consists of primarily of solitary dialogues in the presence of the others.
- Only slight recognition by the child of his role as participant in play. The boundary with reality is permeable, leaving the child close to experiencing his play roles and surround as real. The passage of time has little organizational value as the child seems to live only in the immediate moment.
- Coping/Defensive strategies rely on splitting off frightening images of helplessness and presenting as idealized powerful images. Occasionally characterizations might emerge expressing victimization or weakness in counterpoint to the overpowering images. Alternatively, these roles may be enacted in interaction where the child asserts himself as leader, or person who determines the rules. Other aspects of reality are denied and not allowed to enter consciousness. Aspects of safety in the playroom may become an issue as well.

Polarized/Impulsive Coping Strategies

- The child negates the reality of a painful or traumatic feeling, or event, person, or object in the external world and makes believe it did not happen. **(Denial)**

Example: The girl doll is about to be eaten by the dinosaurs and goes on peacefully eating her ice cream.
- The scary or threatening feeling is not recognized as an attribute of the self, or of the other person. **(Splitting)**

Example: The doll is so very good at the beginning of the session and is played with; then she (the doll) is so bad, she is abruptly thrown away. Each part of the play activity may be accompanied by intense polarized affect.
- In the play activity, qualities, feelings, wishes, thoughts, or roles which the child refuses to acknowledge are attributed to another person or toy. **(Projection)**

Example: A 7-year-old who attempts to break the toys says "the other kids must have broken the toys. It is their fault."
- While playing the other person or object is highly valued because of his/its unique qualities. This person or object is then perceived as all powerful. **(Primitive Idealization)**

Example: (Child, referring to one of the play characters) "Sam is a great player, and he is so smart. He can never be beaten."
- In the child's play either he himself, another person or object is completely devalued and rejected as being disgusting or dismissed as unimportant with no redeeming qualities. **(Primitive Devaluation)**

Example: (The child playing teacher, to her student, played by the therapist)

"You are stupid; you are too dumb to answer the questions. See how I do it!"
(Proceeds to draw scribbles on the blackboard.) "I'll Show you!"

- The child attempts to control the external world by being all-powerful and plays about his expectation to be treated in a "special" way. (**Omnipotent Control**)

Example: (Child playing with his mother and therapist) "I'm the boss of the universe. You guys stand up here, don't talk, I'm the superhero, I'm the one to talk, shut up, you are out."

Disorganized Play Profile/Strategies

Please rate to what extent you observe some or all these characteristics. Ratings of play activity that suggest disorganization contribute to a child's style of playing include:

- Difficult to determine beginning, middle and end phases of Play activity. The child may initiate play but does little coherent to facilitate its unfolding. Inhibition or Interruption of play activity may occur, alternatively when play activity begins it may be subject to intense, abrupt disruptive outbursts.
- Play activity may be limited to sensorimotor levels, consistently below expectations for the child's chronological age. For example, play may occur primarily within the autosphere, play centered about the body and its sensations.
- Overall hedonic tone may vary greatly with no clearly consolidated affective experience.
- Affect is primarily nonspecific to the stimulus (object or person) that evoked it and may therefore may many times be inappropriate.
- Character roles are not clearly articulated. Imitation of glimpses of a character (for example, striding in a gait like Dad) may be observed, but these "bits" of a role are not integrated into an articulated play identity.
- Representation of persons or objects may contain elements of the bizarre, with transformations occurring that the child cannot control.
- Social level of play may consist of isolated play unaware with some intervals of playing alone with intermittent connection to an adult or other children. Reciprocal and cooperative play activity are not observed.
- Extreme anxiety may be manifested in play activity by the following behaviors: and freezing (confining himself to minimal expressions in gesture, language, or self-expression); lack of a coherent verbal or nonverbal narrative; unusual forms of words (neologisms); overwhelming feeling states (fear, manic laughter, anxiety, somatic discomfort); forms of relating that are disjointed and cannot be grasped using the usual means of understanding the experience of another person.

- The child may be extremely dependent upon another person, peer or adult, to sustain his play activity.

Disorganized Coping Strategies

- Child depicts a strong fear of complete destruction or loss of self. (**Annihilation fears**)

Example: While playing with a doll house, a child repeatedly says, "If we don't keep the house safe, it will be destroyed," and spends a lot of time setting up elaborate defenses. This play reflects the child's underlying fear of the house—or themselves—being completely annihilated.

- Child becomes temporarily immobile or unresponsive when faced with overwhelming emotions or situations, often as a way to cope with fear or stress. (**Freezing**)

Example: While engaging in a play scenario where a toy robot is "broken," a child stops all play activity and stares at the toy robot, remaining motionless and silent as if overwhelmed by the situation.

- Child shows difficulty in maintaining a consistent and organized story or sequence in their play, which can reflect confusion or disorganization in their thoughts or feelings. (**Lack of a coherent verbal or nonverbal narrative**)

Example: In a play session with a dollhouse, a child randomly places dolls in different rooms and engages in fragmented dialogues, shifting from one topic to another without any clear structure or coherence.

- Child creates or uses new, invented words or unusual terms that don't fit typical language use, which can reflect their unique cognitive or emotional processes. (**Neologisms**)

Example: A child uses the word "squishibop" to describe a toy that changes colors, explaining that "squishibop" means something that can magically transform.

- Child expresses thoughts or play scenarios centered around intense destruction or harm, reflecting significant distress or emotional turmoil. (**Severe destructive ideation**)

Example: A child draws a picture of a city being demolished by a giant robot, with detailed depictions of buildings collapsing and people fleeing, indicating intense feelings about destruction.

- Child becomes detached or disengaged from play or social interactions, often retreating into their own world or focusing on repetitive behaviors. (**Autistic withdrawal**)

Example: A child becomes engrossed in arranging and re-arranging a set of blocks in a specific pattern, completely ignoring the therapist's attempts to engage in conversation or suggest different activities.

- Child alters or misrepresents reality in their play or expressions. (**Distortion**)

Example: A child draws a person with exaggerated, unrealistic features—such as an enormous head and tiny body—while insisting that this is how people really look, showing a distortion of physical reality.

- Child shows a complete and rigid refusal to acknowledge reality, often to the point of being disconnected from or rejecting any evidence of an event or feeling. (**Psychotic denial**)

Example: A child continues to interact with a toy as if it is alive and talking back, despite the therapist's attempts to explain that the toy cannot talk, showing a denial of the toy's inanimate nature.

- Child attributes their unrealistic or distorted beliefs to others and believes those distortions are real. (**Delusional projection**)

Example: A child insists that their toy is controlling their thoughts, saying, "The toy is making me think bad things." The child becomes distressed, showing an extreme belief that the toy has a real impact on their mind.

- There are disruptions in the child's experience of their body, space, or time, often leading to feelings of disconnection or disintegration. (**Fragmentation**)

Example: A child pauses and says, "Is time stuck? It feels like it's not moving," showing a sense of being trapped in a moment.

- Child turns abstract, internal experiences or thoughts into tangible, physical forms in a way that reflects a distorted perception of reality. (**Concretization**)

Example: A child believes their drawings can actually control events in the real world, like thinking that a drawing of a storm will cause real weather changes.