A Review of the Effectiveness of Psychodynamic Therapy for Children with Externalizing Psychopathology

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Summary
Psychodynamic therapy is viable in helping children with externalizing disorders by targeting emotion regulation and relational roots for lasting changes.

Abstract
This review examines the effectiveness of psychodynamic therapy (PDT) for children with externalizing psychopathology, including Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). Taking from psychoanalytic theory and combining insights from modern developmental psychology and neuroscience, PDT offers a unique approach that emphasizes emotional regulation, unconscious processes, and relational dynamics. Unlike behaviorally focused interventions such as Cognitive Behavioral Therapy (CBT), PDT examines the underlying meaning behind disruptive behaviors and creates long-term psychological development through secure therapeutic relationships rather than looking purely at surface symptoms. Overall, studies show that PDT is at least as effective as CBT and other behavioral therapies in reducing externalizing symptoms, along with additional benefits for internalizing problems and also long-term outcomes. Standardized and short term models display additional positive results, showing the possibility of scalability and a wider application within therapies. Despite these strengths, PDT still faces barriers. These barriers include limited large-scale randomized controlled trials, differences within practices, a difficulty in measuring the unconscious changes and practical obstacles such as stigma, clinician training gaps, and accessibility issues. Studies suggest that future directions in PDT should include allowing caregiver involvement, developing situational appropriate and adapted modes of therapy, public education of modern psychodynamic treatment, using neurobiological and observational outcome measures, and expanding brief, manualized PDT models. Overall, PDT offers a strong alternative mode of treatment to symptom focused treatments by working with the emotions beneath the disruptive behaviors. With continued research, advocacy, and possible integrations, PDT holds significant promise within the field of child mental health care.

Keywords

Psychodynamic Therapy, Externalizing Disorders, Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder, Emotion Regulation, Object Relations Theory, Ego Psychology

Introduction

Psychodynamic therapy (PDT) is a clinical approach rooted in psychoanalytic theory and informed by developmental psychology, attachment theory, and contemporary neuroscience (Abass et al., 2013; Midgley et al., 2017). It works on the thoughts of the idea that a child's thoughts, behaviors, and emotional responses have symbolic meaning rooted within early relational experiences (Fonagy & Target, 1996). This internal world, shaped by formative interactions, becomes how the child looks at and responds to the world.

Despite differences between psychodynamic schools, several main ideas persist. First, symptoms are usually expressions of unconscious conflicts or unresolved relational issues,

especially those in relation to early object relations (Conway et al., 2012). Next, problematic behaviors may function as defenses against overwhelming internal states or emotions (Prout et al., 2022). Finally, therapeutic change is believed to occur mostly through the relationship between the therapist and child, especially through the ‘transference dynamic,’ wherein the child reenacts earlier attachment patterns within the therapeutic relationship (Fonagy & Target, 1996).

Within the psychoanalytic perceptions of externalizing disorders, two major theoretical frameworks have gained prominence, Ego Psychology and Object Relations Theory. Ego psychology interprets externalizing behaviors, such as impulsivity, defiance, and aggression, as reflections of developmental issues within ego functioning. The ego, which is responsible for controlling and balancing internal drives with external reality, is believed to be underdeveloped or overwhelmed in children with externalizing psychopathology (Conway et al., 2012). These children often struggle with reality testing, frustration tolerance, and emotional regulation because their ego does not have the ability to organize complex emotional experiences into coherent and manageable forms. In this view, impulsive or aggressive behaviors may not necessarily be ‘intentional misbehavior’ but rather a failure of internal control mechanisms. For example, a child who lashes out in the classroom may be reacting to an internal state of disorganization caused by perceived criticism or failure. The therapeutic goal from an ego psychology standpoint is to strengthen the child’s ego capacities—improving their ability to delay gratification, regulate emotions, tolerate frustration, and solve internal conflict more easily. In clinical work, this often involves helping the child identify and talk about affective experiences, promoting reflective functioning, and offering ideas that help insight. By helping the child identify and talk about affective experience, the therapist supports the development of ego strength and fosters the child’s ability to tolerate, reflect on, and regulate emotions over time. As ego strength builds, the child is better able to manage distress and act with intentionality rather than reactivity.

In contrast, object relations theory emphasizes the internalization of early caregiver relationships and how these internal "objects" shape the child’s affective and interpersonal world. According to this theory, children with externalizing disorders often have internalized insecure, inconsistent, or hostile caregiver representations, which may influence how they relate to others or interpret more complex social cues (Fonagy & Target, 1996; Prout et al., 2022). For example, a child who experienced a neglectful or emotionally unavailable parent may internalize the belief that others are unreliable or rejecting as well. As a result, this child might become oppositional or controlling in relationships as a defensive strategy to avoid vulnerability and being ‘hurt’. ADHD symptoms from this view may come from early relational trauma that slowed the development of attention control and affected regulation mechanisms. Therapy from an object relations view focuses on the relationship between the child and therapist. Through consistent and purposeful engagement, the therapist may offer a new relationship experience that contrasts with past relations. Over time, the child may begin to change their internal object representations, creating a more stable sense of self and others, and with it, more adaptive ways of managing emotion and behavior. Most importantly, object relations therapy not only focuses on symptom reduction but also seeks to change the child’s internal world by offering a secure and healing relationship

experience. The use of interpretation, affect regulation within the transference, and developmental support are incredibly important to this view.

CBT VS PDT

Psychodynamic therapy (PDT) and cognitive-behavioral therapy (CBT) are two fundamentally different approaches in their perceptions of psychopathology and in the mechanisms by which therapeutic change will occur. These differences are especially important when looking at the treatment of children with externalizing disorders, such as ADHD, ODD, and CD (Conduct Disorder). CBT is focused on learning theory and cognitive psychology. It focuses on identifying and modifying 'maladaptive' cognitions and behaviors through specifically curated interventions, often following standardized instructions (Prout et al., 2022). The therapist typically teaches the child specific skills, such as problem-solving, emotional regulation, and behavioral self-monitoring. Reinforcement strategies, such as token economies or praise systems, are often used to encourage these adaptive behaviors. For example, a child with oppositional behaviors might be taught to use coping strategies like deep breathing or self talking to manage anger, while at the same time being rewarded for following rules or completing tasks (Prout et al., 2022). CBT emphasizes physically observable outcomes and symptom reduction. Progress is usually tracked through behavioral checklists, parent and teacher reports, and goal attainment. As such, CBT is considered highly evidence-based and has been widely adopted in school and outpatient settings, especially because it is time-limited, cost-effective, and focused on physical results (Midgley et al., 2021).

However, the CBT model has limitations, especially in its ability to address the real emotional and relational roots of behavior. Critics argue that CBT's more symptom focused view may lead to short term results without resolving deeper underlying developmental or attachment-based challenges (Prout et al., 2022). This may explain why some children relapse or continue to experience difficulties once the outside reinforcers are removed or the therapy is no longer present.

In contrast, PDT is based on the idea that behavioral symptoms, especially those involving aggression, defiance, or inattention, are the physical results of unconscious emotional conflict and developmental disruption or delay (Fonagy & Target, 1996). PDT emphasizes the importance of early relationships, unconscious processes, and internal working models in shaping a child's affect regulation and behavioral functioning. The therapist's goal is not only to change behavior, but to help the child develop and create a real understanding of their emotions and relationships, helping foster long term personality growth and emotional resilience.

Unlike CBT, PDT is generally less structured and more individualized. The therapy process involves the interpretation of play, transference, and affective communication, with the therapist acting as both a reflective mirror and secure attachment figure (Fonagy & Target, 1996; Prout et al., 2022). Through repeated and specific emotional interactions, the child is able to fix and change more negative internal object representations and defenses. For example, a child who sees others as threatening or untrustworthy due to past trauma may, over time, begin to

experience the therapist as safe and reliable—allowing the child to create a more secure relational model. This new relational experience, in which the therapist becomes a consistent and secure figure, not only helps repair the child's internal working model of relationships but also lays the foundation for healthier attachments outside of the therapy room. Over time, this shift may generalize to the child's interactions with parents, peers, and other important individuals in their life. Similarly, PDT recognizes the importance of working with parents and caregivers. Parent work is often worked in to understand family dynamics, create and help reflective functioning, and support the child's emotional development in the home environment (Midgley et al., 2021). This systemic part allows the therapy to influence not only the child's internal world but also the relation they have with the environment that may have caused symptoms.

Ultimately, both PDT and CBT have demonstrated the ability in treating externalizing disorders, but they differ in many ways . CBT has been proven to be effective for teaching behavioral skills and reducing specific symptoms, especially in the short term. On the contrary, PDT, while having a less empirically established foothold in what is considered 'traditional outcome metrics,'offers a developmentally sensitive, emotionally integrative approach that may help foster more enduring change for children whose difficulties are rooted in early relational trauma or disrupted attachment processes (Prout et al., 2022; Midgley et al., 2021). More and more it seems, clinicians and researchers advocate for approaches that integrate the structured techniques of CBT with the emotional depth and relational insight of psychodynamic therapy (Prout et al., 2022).

Overview of Externalizing Pathology

Externalizing psychopathology refers to a group of disorders characterized by behaviors that are disruptive, aggressive, noncompliant, and otherwise projected outwardly toward the environment (Laezer, 2015). These behaviors not only break age-appropriate social norms and disrupt family or classroom environments but they also challenge children's capacity to form secure relationships and regulate their emotions, which are core developmental processes that psychodynamic approaches aim to support. The most prevalent conditions under this category include Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Attention-Deficit/Hyperactivity Disorder (ADHD), all of which highlight different developmental pathways through which externalizing behaviors may emerge.

Oppositional Defiant Disorder (ODD) is usually diagnosed in early to middle childhood and involves a pattern of constant defiance, frequent temper outbursts, argumentative behavior and a constant refusal to comply with rules or requests from authority figures. Children with ODD might struggle with controlling negative affect and are often characterized by chronic irritability and low frustration tolerance. These emotional regulation difficulties may lead to relation disruptions at home and in school (Prout et al., 2022). From a psychodynamic perspective, ODD underscores the importance of addressing underlying affective states and children's capacity to rely on caregivers and authority figures without experiencing them as threatening or overwhelming.

Conduct Disorder (CD) exhibits more severe externalizing symptoms and is often diagnosed in older children and adolescents. CD includes behaviors such as physical aggression toward people or animals, breaking items, lying, theft, and serious violations of societal norms (Seiffge-Krenke & Volz, 2024). CD is associated with a higher risk of developing antisocial personality traits in adulthood and is often found with substance use disorders, especially in more adolescent populations. Looking at CD from a psychodynamic perspective emphasizes the role of early attachment ruptures, unmet emotional needs, and maladaptive defenses in shaping behavior.

Attention-Deficit/Hyperactivity Disorder (ADHD), although more neurologically based, is often included in externalizing disorders because of its behavioral symptoms. ADHD is marked by developmentally inappropriate levels of inattention, lack of impulse control, and hyperactivity that may interfere with academic, social, and home functioning (Fonagy & Target, 1996). Children with ADHD may appear restless, or distracted, and they often have issues sustaining attention on tasks or complying with directions. These symptoms may result in academic underachievement, peer rejection, and increased family stress. From a psychodynamic perspective, ADHD symptoms may complicate the child's ability to engage in reflective functioning and sustain relational work in treatment and highlights the need for developmental attuned intervention that help children develop regulation and support dynamics between caregivers and their children.

These disorders frequently happen at the same time. For example, children diagnosed with ADHD often show similar symptoms as ODD or CD, which may make diagnosis and treatment planning difficult (Fonagy & Target, 1996). Beyond their symptom clusters, these conditions are all similarly rooted in relational disruptions, inabilities to regulate, and unmet emotional needs. In turn, psychodynamic therapy offers a unique way to address these challenges by attending to the emotional underpinnings of disruptive behaviors, fostering secure therapeutic relationships that may be positively internalized, and helping children and their parents work through conflicts that may be driving their maladaptive patterns of behavior.

Furthermore, externalizing disorders are associated with increased risk of academic failure, school dropout, peer problems, family conflict, and greater risk of involvement with the juvenile justice system (Laezer, 2015). Longitudinal studies suggest that, without early and effective intervention, externalizing problems may persist into adolescence and adulthood, contributing to lifelong issues in occupational, interpersonal, and mental health functioning. Epidemiological studies estimate that ODD tends to range between 1% and 11% in school-aged children, with higher rates in boys and in children from high-stress or low-resource environments (Prout et al., 2022). ADHD is one of the most commonly diagnosed psychiatric conditions in childhood, affecting roughly 3% to 5% of children in the United States (Fonagy & Target, 1996). CD prevalence is lower but increases with age and is more commonly diagnosed in boys during adolescence (Seiffge-Krenke & Volz, 2024). All in all, externalizing disorders represent a big public health concern because of their high prevalence, repetitive nature, and potential to break normative development. Understanding and developmentally sensitive treatment approaches are necessary to help both the behavioral manifestations and the underlying emotional and relational issues associated with these conditions.

Objectives

This paper aims to empirically review the literature on psychodynamic psychotherapy as it applies to children with externalizing disorders. Despite the widespread impact of these disorders, research on PDT remains close to none, when in comparison to cognitive-behavioral and neuropsychological models (Conway et al., 2012). The review focuses on the following areas important to clinical practices including: (a) diagnostic frameworks informed by psychodynamic theory, (b) theoretical orientations within PDT, (c) common treatment challenges, (d) clinical case illustrations, (e) mechanisms of therapeutic change, and (f) specific therapeutic techniques. By exhibiting PDT's contributions, the paper looks to help inform clinicians looking for deeper, relationship focused alternatives or combinations to more traditional behaviorally oriented treatment approaches. Given the mixed success and potential drawbacks of commonly used interventions such as medication and behavior therapy, especially in long-term outcomes (Midgley et al., 2021), the field may benefit from looking at the role of psychodynamic methods, again, in addressing externalizing disorders.

Theoretical Models of Psychodynamic Therapy

Psychodynamic therapy encompasses several theoretical models that offer distinct perspectives on the origins and treatment of externalizing psychopathology in children. Two of the most influential ideas are ego psychology and object relations theory. Each provides a unique and different lens through which to understand how aggressive, impulsive, or disruptive behaviors may reflect on deeper internal and relational disturbances.

Ego Psychology

Ego psychology conceptualizes externalizing symptoms, such as impulsivity, disorganization, and aggression, as behavioral manifestations of disruptions in ego functioning (Fonagy & Target, 1996). Within this framework, the ego is viewed as the central regulatory system responsible for integrating experiences, balancing internal drives and external reality, and managing impulses (Jones, 2011). Children with externalizing disorders are thought to have underdeveloped ego capacities, which impair their ability to regulate affect, delay gratification, and adapt to environmental demands. Specifically, behaviors commonly associated with ADHD and ODD, such as poor impulse control, emotional dysregulation, and disorganized action, may stem from the ego's limited capacity for secondary process thinking. Jones (2011) describes how children with weakened ego functions will often struggle to differentiate between internal and external stimuli, leading to overstimulation or a failure to meaningfully work with their environment. This overstimulation, in turn, may cause the hyperactivity and distractibility seen in many children with externalizing disorders.

Furthermore, deficits in executive functioning are frequently observed in these children, such as poor planning, limited emotional control, and inattention - and are consistent with impaired ego functioning (Jones, 2011). Rather than looking at these behaviors purely through a neurodevelopmental lens, ego psychology allows clinicians to look at how disruptions in self-organization and developmental trauma may have hurt the child's regulatory capacities. In therapy, the goal from an ego psychological standpoint is to strengthen the ego's integrative functions. This includes helping the child process overwhelming affective experiences, improve

their reality testing, and develop higher-order skills for emotional and behavioral regulation. Interpretive work, emotional containment, and play-based interventions are commonly used to build the child's capacity for self-reflection and impulse control (Fonagy & Target, 1996).

Object Relations Theory

Object relations theory shifts the focus from the structural functions of the ego to the quality of the child's internalized relationships (Ainsworth, 1969), especially those from primary caregivers like mothers, fathers or other forms of parents. These early relational experiences form the foundational templates (or "internal objects") that guide future interpersonal functioning and emotional regulation (Fonagy & Target, 1996). If early caregiving is disrupted, whether through experiences like trauma, neglect, inconsistent availability or hostility, children may end up creating negative relation ideas that may be characterized by fear, mistrust or aggression (Ainsworth, 1969). These internalized experiences shape how the child views themselves and others, and influence how they interpret social cues and relate to others. This often leads to defensive behaviors like projection, splitting or acting out (Leuzinger-Bohleber, et al., 2010). In children with externalizing disorders like ADHD or ODD, these internalizations often come out behaviorally. Namely, a child who experienced an emotionally unstable or rejecting parent may end up developing an expectation that others will respond with hostility or not respond at all. Ultimately, the child may behave aggressively or provocatively, in essence "testing" this belief in new relations, like those with friends and teachers. (Fonagy & Target, 1996; Conway, 2012). Projection is a key defense mechanism in object relations theory. A child may externalize negative feelings or intolerable emotions, like rage or shame, by 'projecting' them to others. This dynamic may lead the child to perceive others as hostile or threatening, and in a way reinforce the child's maladaptive behaviors and relational conflict (Conway, 2012). This feedback loop ends up reinforcing mistrust and rather aggressive relations, further alienating the child from those who want to support them and constantly manifesting the very relation failures that they fear. In this framework, externalizing behaviors are not just "bad behavior" to be gotten rid of but are to be understood as real communications that come from early relational failures. As a result, they require a deeper relational repair, not just behavioral correction. This understanding lines up with finds from studies that indicate relational interventions, especially those that focus on a child's early attachment history, may have incredibly and, most importantly, lasting changes (Conway, 2012; Leuzinger-Bohleber et al., 2010)

These two models are best understood as complementary rather than mutually exclusive. Ego deficits, such as impaired impulse control, limited capacity for reflection, and poor affect regulation, often co-occur with distorted internal object relations, such as internalized representations of hostile or potentially absent caregivers. These vulnerabilities created while in development often interact (Jones, 2011). For example, a child with affected ego functions may have issues trying to regulate stronger emotions brought on by insecure or traumatic early relationships, while negative internal object relations may further weaken ego functioning by creating anxiety, mistrust or a 'defensive acting out' (Jones, 2011; Leuzinger-Bohleber et al., 2010). By looking deeply into both frameworks, clinicians may create a more holistic case idea and design specific therapeutic interventions that not only target the surface behavioral issues but also the structural, ego-based organization of the psyche. This integrated approach allows

each framework to compliment each other well and foster both better self-regulation and healthier relational engagements

Evidence for PDT

Emerging research suggests that PDT may be an increasingly recognized intervention for externalizing disorders, especially when looking at long-term change rather than focusing solely on symptom suppression (Midgley et al., 2021; Conway, 2012). In a study of 73, 6-11-year-olds diagnosed with ADHD and/or ODD, Laezer (2015) compared long term psychoanalytic therapy without medication to short term behavioral therapy with optional methylphenidate. Both of these groups exhibited statistically significant reductions in ADHD and ODD behaviors and also reductions in externalizing problems through parent and teacher reports (Laezer 2015). Most importantly, there were no statistically significant differences within symptom reduction between the two groups, suggesting that potentially psychodynamic therapy may be as effective as medication supported behavioral interventions (Laezer, 2015).

Laezer (2015) also described an important distinction between psychoanalytic therapy and behavioral interventions such as CBT: while both displayed statistically significant reduction in externalizing symptoms such as hyperactivity and oppositional behavior, psychoanalytic therapy created stronger improvements in decreasing internalizing symptoms as well, such as anxiety and emotional withdrawal. These were not shown to be significantly improved throughout behavioral therapy (Laezer, 2015). These symptoms are more often than not overlooked within behavior focused treatments but are incredibly important to a child's overall psychological health (Fonagy & Target, 1996). Psychoanalytic therapy's ability to look at and address these deeper, more internal emotional conflicts suggest that it not only helps symptoms but also seems to bring about structural personality change, helping the children to have a better understanding and manage their more complex emotions. Importantly, follow-up data from Laezer (2015) indicated that the treatment gains from psychoanalytic therapy were maintained one year post-treatment, whereas children in the behavioral group required continued medication to sustain improvements.

Additional studies further support the efficacy of PDT. Prout et al. (2022) developed a short-term, manualized psychodynamic intervention known as Regulation Focused Psychotherapy for Children (FRP-C), which targets emotion regulation in children diagnosed with ODD. The treatment focuses on helping children develop more adaptive ways of expressing and processing complex emotions such as frustration and anger, rather than directly acting them out behaviorally. Children who received RFP-C demonstrated significantly greater reductions in oppositional behaviors compared to children in the control group receiving traditional CBT, showing that short-term psychodynamic interventions may yield measurable benefits when focused on targeting emotion regulation (Prout et al., 2022). This may be attributed to the addressing of the underlying affective and relational drivers of oppositional behavior, such as relational disruptions, inabilities to regulate, and unmet emotional needs, rather than just focusing on the out right behaviors. By helping children process anger and frustration in a therapeutic relationship, PDT may directly target emotional dysregulation and produce stronger outcomes than CBT in this study.

Furthermore, Seiffge-Krenke and Volz (2024) investigated long-term psychodynamic therapy for adolescents with comorbid externalizing and internalizing disorders, which is a population that is often identified by more complex emotional and behavioral challenges. These children typically present with co-occurring symptoms (i.e., comorbidities) such as aggression, impulsivity, and rule-breaking (externalizing), alongside anxiety, depression or social withdrawal (internalizing) (Seiffge-Krenke and Volz, 2024). This comorbidity creates a complex clinical profile that is difficult to be treated by short-term and symptom-specific interventions. The study found that long-term psychodynamic therapy did not just lead to a reduction of both externalizing and internalizing symptoms, but also created meaningful progress within two domains: affect regulation (i.e., a child's ability to tolerate, express and process emotions in a socially adaptable way) and interpersonal functioning. Children with comorbidities usually have intense emotional states, like shame, rage or fear, that may overwhelm potentially underdeveloped coping systems (Seiffge-Krenke and Volz, 2024). This may lead to shutting down emotionally (withdrawal, dissociation) or acting out (aggression or defiance). Throughout the course of the therapy, many participants showed improvement to recognize and verbalize emotions, reflect on internal experiences and most importantly, manage impulses. This in turn led to a reduction of expressing distress through destructive behaviors (Seiffge-Krenke and Volz, 2024).

Meaning of Evidence:

Mechanisms of Change

The primary mechanism of change in PDT is thought to involve improved emotional regulation that is usually achieved through a secure therapeutic relationship, transference work, and exploration of unconscious processes (Fonagy & Target, 1996; Prout et al., 2022; Conway, 2012). From this perspective, externalizing behaviors, like aggression or defiance, are understood as manifestations of emotional dysregulation rooted in early relational issues or internal conflicts (Fonagy & Target, 1996; Leuzinger-Bohleber et al., 2010)

The emotional dysregulation is worked through within this therapy by helping the children slowly build the ability to see, tolerate and communicate their emotional states, instead of letting them go through impulsive or oppositional behaviors (Prout et al., 2022; Gilmore, 2002). For example, as explained above, Prout et al., 2022 describes, Regulation Focused Psychotherapy for Children, which is specifically designed to help build emotion recognition and labeling in children with ODD. This exhibits how structured psychodynamic interventions may support regulatory capacities (Prout et al., 2022).

The therapist, while working with the children, becomes an example of a consistent and attuned attachment figure, and the relationship within the therapy helps correct emotional experiences through interpretative work and empathic engagement within the transference (Fonagy & Target, 1996). These relationships help the child to have a more 'healthy' reflective model of themself and for others (Jones, 2011; Conway 2012). As the child's internal world becomes more connected, the need for negative defense mechanisms, like acting out or splitting, tends to decrease (Leuzinger-Bohleber et al., 2010).

Additionally, PDT encourages the building of mentalization, which is similar to a synthetic empathy, or the ability to understand one's own and other's mental state. This lack of

mentalization is often observed in children with externalizing psychopathology (Fonagy & Target, 1998). Improvements in mentalization support interpersonal functioning and reduce conflictual behavior, contributing to deeper psychological change.

Comparative Outcomes

When compared to other conventional or structured treatments, PDT seems to be at least equally effective in reducing core symptoms of externalizing disorders. Laezer (2015) reported no significant difference between long-term PDT and behavioral therapy (i.e., CBT) with medication in reducing ADHD and ODD symptoms. Nonetheless, PDT showed more improvement within internalizing symptoms like anxiety and depression, and these benefits persisted post-treatment without ongoing medication (Laezer, 2015).

PDT's unique value lies in its focus on developmental change. While CBT mainly focuses on changing dysfunctional thoughts and behaviors in the moment (Prout et al., 2022), PDT seeks to uncover the unconscious meaning and emotional origins of these behaviors; they are often linked to unresolved fear, grief, or internalized aggression (Fonagy & Target, 1996; Conway, 2012). Long-term follow-up studies, like those reported by Seiffge-Krenke and Volz (2024), suggest that PDT may facilitate deeper identity formation and social integration, especially for children with histories of trauma or attachment disruption. PDT may be especially useful because of its focus on therapeutic relationships and essentially 'changing the story' (Midgley et al., 2021).

Finally, PDT displays promise in populations that do not respond well to behavior focused methods. Children with deeper interpersonal difficulties or those who do not not have great reactions to external control may end up benefiting more from an intervention that focuses on emotional meanings and relation patterns (Conway, 2012). By helping build internal growth instead of just purely symptom and behavior management alone, PDT seems to address the broader developmental context of psychopathology, helping build support for more long-term help.

Limitations and Future Directions

Methodological challenges

Research on the effectiveness of PDT for externalizing disorders is limited by methodological challenges. One issue is the lack of real large-scale randomized control trials that end up directly comparing PDT with other evidence based interventions like CBT (Midgley et al., 2021). Existing studies like Laezer (2015) above give an interesting outlook into PDT and some initial evidence, but more in-depth and multi-site trials with larger samples are needed to generalize this information across a larger population (Midgley et al., 2021).

Furthermore, there seems to be not many longitudinal studies that look at the long-term impact of PDT on the developmental trajectories and prolonged symptom reduction. Although follow up studies have been made, it seems longer follow ups are needed to see whether improvements seen through these therapies are stable or to be influenced by outside factors (Midgley et al., 2021; Conway, 2012).

Additionally the broader literature on PDT for externalizing disorders within children is quite lacking compared to other methods of intervention (e.g., CBT) and an increase into the amount of high quality and peer reviewed research should be a necessity. This lack of literature continues to build the still lack of usage of PDT within clinical practices despite its theoretical promise and strengths.

Variability and Standardization

Another large challenge faced is the variability within the psychodynamic approaches. Clinicians often vary in how they conceptualize and implement PDT, leading to gaps within the treatment deliveries and outcome measurements (Midgley et al., 2021). To continue building the field, researchers need to identify and set a standard for core mechanisms of change within PDT and help build standardized treatment protocols based on these. Regulation Focused Psychotherapy for Children is an example of this kind of needed standardization, exhibiting that manualized PDT approaches may still keep the therapeutic depth but at the same time also offer replicability and consistency (Prout et al., 2022). Further work on these protocols is a necessary step.

Historically, PDT has faced significant criticisms for the lack of clearly defined outcome measures. The unconscious and symbolic processes it works with are just incredibly difficult to quantify using traditional metrics within psychology (Fonagy and Target, 1998; Midgley et al., 2021). Future research is necessary to create reliable and valid processes that are able to measure the change in the ideas such as mentalization, affect regulation, and internal object representations.

New developments within electroencephalography, functional magnetic resonance imagining, and other neuroimaging approaches offer the possibility of looking at and locating biomarkers for a treatment response. These tools may end up validating the neurobiological impact of PDT and give meaningful brain-based evidence for internal psychological change (Midgley et al., 2021). Observational measures and third party reports from those of teachers and caregivers may also be considered as indication of progress.

Developmental Considerations

Children usually struggle to communicate these internal experiences and their symptom presentation may be different based on age, language development and how issued the relational standpoint is (Fonagy & Target, 1996). This results in challenges in both assessment and therapeutic work. Parent involvement seems to be crucial, not only for gathering information about symptom changes but also for supporting the generalization for therapeutic positives to school and home environments (Widener, 1998).

Future directions should work in parent management training into PDT, helping caregivers understand and how to respond to their child's emotional needs better. Changing PDT to be developmentally appropriate, for example through something like play therapy or art-based intervention, may potentially help engagement and insight from the younger children (Gilmore, 2005).

Integrative models that end up combining PDT with behavioral strategies like reward systems may also be useful. These more 'hybrid' approaches may look at both the symbolic and more surface behavioral parts of externalizing psychopathology and may prove effective within children with more varied needs (Prout et al., 2022).

Practical Barriers

Several practical barriers have slowed down the widespread use of PDT. One major barrier is the persistent stigma surrounding the use of psychodynamic therapy. This stigma is often associated with outdated and rather caricatured views of what people understand of Freudian theories, which are irrelevant to contemporary practices of PDT (Midgley et al., 2021). These misconceptions play a role in parents and caregivers being reluctant to attempt a psychodynamic based intervention. Widespread education efforts must be taken in order to clarify to the public what modern PDT has and to spread its evidence based potential, especially within the pediatric sector. Future efforts should have public education campaigns that aim to clear up the aims and structure of psychodynamic therapy.

Additionally a shortage of trained PDT trained clinicians, even more so those of who that are to work with children. Most training programs within psychology and psychiatry put more emphasis behind the widespread use of cognitive behavioral methods, which results in fewer clinicians that are able to deliver psychodynamic treatment effectively (Midgley et al., 2021). Furthermore, such training that exists now is rather expensive and incredibly time intensive, usually needing personal therapy, immersion within psychodynamic theory and even long term supervision. These are all related to the previously stated barriers and other issues. To address this, institutions should work in training that offer easily accessible and developmentally adapted psychodynamic treatment.

Access is also further stopped by issues within health coverage and service availability. In many healthcare systems, quick and manualized treatments like CBT are more often to be within the coverage of health insurance than long-term treatments like PDT. The financial disincentive makes it rather difficult for clinicians having a reason to offer psychodynamic therapies and for families to keep within the more long-term treatments of PDT. Developing shorter-term manualized versions of PDT like that of RFP-C, which are a whole lot easier and quicker to implement and evaluate might help fix this gap and help with more insurance support.

The length and intensity of traditional PDT may also have issues for families, especially those with less financial resources, tight schedules, or transportation uncertainty. Long-term therapy might not be feasible for parents that have many responsibilities, especially without seeing some sort of short-term outcomes. This lack of quick outcomes may further deter caregivers and parents and end up creating premature ending of therapy or a reduced engagement. A possible solution could potentially be in creating and designing a sort of stepwise or modular intervention that starts out with brief engagement focused work that may expand into more intensive and rigorous therapy if needed. This way, parents are able to receive short-term positive outcomes and feel more comfortable in keeping the children within the therapy as needed.

Finally there are several cultural/ linguistic barriers to the access of PDT. Much of what is of psychodynamic literature and training seem to be that of Western and Eurocentric perspectives,

which may not connect as well or be applicable to more diverse populations. Cultural adaptations of PDT, such as adding in cultural values; linguistic nuances; and potentially culturally appropriate metaphors, would be necessary if a more widespread implementation of PDT would be undertaken. These are all essential to make sure of equal care within an increasingly diverse population of patients.

Future directions should prioritize expanding the current public knowledge of PDT, such as getting rid of stigmas, increasing affordable and culturally appropriate training programs, improving upon insurance coverages, and developing modular, shorter duration treatment models (potentially in integration with CBT) to meet the needs of an increasingly diverse and under-resourced communities.

Conclusion

Psychodynamic therapy shows an effective and underutilized model for addressing externalizing psychopathology within children. Looking in on deep rooted psychoanalytic theory and supported by developmental psychology and neuroscience, PDT offers a different and nuanced understanding of children's disruptive behaviors, viewing the behaviors as expressions of internal conflicts, relational traumas and emotional dysregulation, rather than mere symptoms (Fonagy & Target, 1996; Conway, 2012). Unlike behavior focused approaches, like CBT, PDT looks to change the child's internal world by supporting insights, mentalization and emotional growth (Prout et al., 2022).

Evidence has long suggested PDT may be just as effective as behavioral interventions in lowering externalizing symptoms and potential offerings of additional long-term benefits, especially for internalizing symptoms and developmental resilience (Laezer, 2015; Seiffge-Krenke & Volz, 2024). Models that have been standardized, such as RFP-C, exhibit that PDT is able to be both structured and time-limited all while maintaining therapeutic benefits (Prout et al., 2022).

Despite all of this, PDT continues to face many obstacles to a wider adoption, including lack of large scale RCT's, variability in practices, challenges in measuring unconscious changes, and systemic barriers such as stigma, lack of training and insurance limitations (Midgley et al., 2021). Many of these obstacles stem from the lack of literature and work within the mode of therapy, and to ensure PDT is accessible and effective, future research should prioritize rigorous and large scale studies, cultural adaptations and a development of scalable models.

By the integration of caregiver involvement, play based interventions and potential hybrid strategies that borrow from CBT approaches, it seems PDT may become more attuned for development and engaging for children (Gilmore, 2005). Combining these psychodynamic insights with behavioral supports may help improve emotional expressions, reduce resistances, and support therapeutic benefits in everyday settings such as homes and within schools. Furthermore, adding parental participation may foster an emotionally supportive and beneficial environment that may mirror and extend the benefits made within the therapy room.

Play-based techniques and expressive modes of therapy such as drawing and storytelling are able to bridge between complex emotional states and children's lack of verbal capacities in some instances, making psychodynamic work more accessible and understandable for younger patients (Gilmore, 2005; Gilmore 2000). Hybrid and modular approaches may not only increase flexibility and inclusivity, but at the same time reduce logistical barriers like time investment and costs.

Through the continued refinement, education and advocacy, psychodynamic therapy seems to have the potential to have a critical role in the treatment landscape for childhood externalizing disorders, especially if possibly combined with modern tools, family based approaches and cultural sensitivity. These advancements not only improve the therapeutic benefits, but also make sure that these interventions are personalized, based around context, and responsive to the realities of diverse families. Embedding PDT within a possible multidisciplinary care team, school service, or even community outreach programs may even further improve its accessibility and impact. As mental health systems move to a more integrative and preventative models, PDT seems to offer a comprehensive framework that lines up both clinically and socially.

Ultimately, the benefit of PDT lies in its ability to address not just surface level behavior, but additionally the meaning and emotions complexity behind said behavior, offering children and their families a path to lasting psychological improvements and healthier relational patterns. It is through this depth oriented lens that PDT gives a transformative alternative to symptom focused treatments, allowing children to not just behave better, but also the ability to feel, relate and grow in more adaptive ways.

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