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Child and Adolescent Psychotherapy Research

**Workshop for Clinicians and Researchers
at the Erica Foundation October 2008**

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Published by Ericastiftelsen (Erica Foundation)
Digital printed at Ericastiftelsen, Stockholm, (Erica Foundation)
Graphic design by Malvin Karlsson, Unna design
ISBN 978-91-633-5788-6
© Ericastiftelsen
Address
Odengatan 9
SE-114 24 Stockholm
Sweden
www.ericastiftelsen.se

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FOREWORD



THREE DAYS IN OCTOBER 2008 saw a gathering of thirty internationally known researchers in the field of child and adolescent psychotherapy together with clinically active child and adolescent psychotherapists. This workshop was arranged by the *Erica Foundation* in co-operation with the *European Federation for Psychoanalytic Psychotherapy* (EFPP). The aim of the workshop was to offer a platform for researchers and clinicians to meet and learn from each other; a dialogue about research results and how these can affect and be implemented in clinical work. The urgency of such a dialogue has grown with the increasing demand for psychiatric and psychological help for children and adolescents and the questions being raised in society about the effectiveness of psychodynamic psychotherapy.

This workshop can be regarded as the first international one of its kind focusing upon research in psychodynamic child and adolescent psychotherapy. It has been preceded by two European research meetings about child psychotherapy in general (with invited speakers from the USA), 1998 in Athens and 2000 in Oslo (Carlberg and Eresund, 1999; Boalt Boëthius and Eresund, 2000).

A third meeting was to have taken place in London 2002, but was cancelled.

The workshop was planned and arranged by Gunnar Carlberg, Associate Professor and Director of the Erica Foundation in Stockholm and Siv Boalt Boëthius, Professor at Stockholm University and member of the EFPP research group. Jenny Sima, licensed psychologist contributed in a most valuable way to the practical arrangements.

Invitations were sent to researchers and child and adolescent psychotherapists interested in research from a number of European countries as well as the USA. The participants came from Sweden, Norway, Denmark, England, Germany and the USA.

With the help of recorded lectures and notes from discussions Pia Eresund has with great carefulness written the text that forms the ground for this report. We hope that we have succeeded to some degree in reporting this information with all the colour, vigour and humour that were present at the time. These three days included many interesting meetings and enthusiastic exchanges of views; the atmosphere was very good throughout.

Added as appendixes are the program for the workshop, a list of participants and a brief description of the Erica Foundation, written by Britta Blomberg.

We wish to express our warm gratitude to all the participants who made this workshop such a stimulating experience and especially to Nick Midgley for his support to the organisers.

The workshop was made possible by generous grants from the Swedish Council for Working Life and Social Research (FAS) and Gålöstiftelsen.

Stockholm in September 2009

Gunnar Carlberg, Pia Eresund and Siv Boalt Boëthius



INTRODUCTION

The overarching theme of the workshop was: “*Research in psychodynamic child and adolescent psychotherapy: How to conduct research and how to implement the results in clinical praxis?*” The programme comprised four themes: *outcome research, process research, clinically-based research, and implementation*. The structure evolved from experiences from Group Relations’ Conferences (Brunner, Nutkievitch and Sher, 2006). Each theme was introduced by short lectures and was subsequently addressed in small group sessions. Ideas from the latter were then presented in the large group, where the discussion was led by the respective lecturers. This facilitated the expression of various opinions and views as well as candid discussions.

The meeting commenced with an open introductory lecture that was attended by a further approximately thirty persons from the Erica Foundation, Stockholm University and child and adolescent psychiatric units in Stockholm. The co-ordinator in the EFPP research group, Nick Midgley, who is responsible for research and development regarding child and adolescents at the Anna Freud Centre in London, presented a short overview of research in the area. ■



OVERVIEW OF THE RESEARCH ON INDIVIDUAL CHILD AND ADOLESCENT PSYCHODYNAMIC PSYCHOTHERAPY

Nick Midgley began by stating that he had never before seen so many experts in child psychotherapy research gathered in the same room, and that it was therefore an even greater challenge to present this overview. He also drew attention to the fact that the literature he referred to was almost exclusively written in English and that due to this there could very well be important studies that had been excluded from his overview.

Early research

Midgley said, “It has not been so good for my social life at work as a practising child psychotherapist to simultaneously conduct research” and related how colleagues at the Anna Freud Centre could look glassy-eyed and be in a hurry to get away when he talked about research. And when he wanted to talk about his therapeutic work with research colleagues they reacted in much the same way. Even if things had improved in recent years the actual relationship between researchers and psychotherapist has long been characterized by mutual distrust and even contempt.

This frosty relationship between the two professions had

been noted already twenty years ago by Mary Boston (1989), psychotherapist at the Tavistock Clinic in London. She expressed it in terms of there being a “minimal interaction between the two... or worse, active disparagement of the other” (p.15). At the same time there was even then an increasing pressure on psychotherapists to become involved in empirical research, not least in order to motivate the costs of child psychotherapeutic treatment within the general health care system. Boston was of the view that the two different fields should complement and enrich each other, and she conducted, with amongst others Dora Lush, Mary Boston and Eve Grainger (1991), clinical studies of psychotherapy with adopted and foster care children that have made major contributions to the development of treatment for children with early relationship disturbances.

Ten years later, at the end of the 1990s, child psychotherapy research lagged far behind adult psychotherapy research, even if some action was discernible. According to Jill Hodges (1999), child psychotherapists in general were not interested in research. The latter did not belong to the profession’s expectations or its “ethos” and psychotherapists did not receive any training in research methods. The measurement methods and scales then used in research were also so simple and crude that the results were of no interest to clinicians. It was also difficult to obtain funding for research.

The current situation

The position of research was soon to improve, which is also what Hodges predicted. Now – another ten years on – the situation has changed. Research has become more meaningful also for child psychotherapists, who have become more interested. Demands for “evidence” run through the whole care sector, the research methods have been developed and with the help of video and computer technology are becoming increasingly sophisticated. Courses in research methodology are currently included as a natural component in psychotherapy training and a number of programmes even offer facilities for doctoral studies.

The term “research” has gained a broader meaning and is no longer limited to studies of outcome after completed psychotherapy. The British tradition of “clinical workshops” focusing on special problem groups has resulted in important compilations of clinical experiences, such as Jan Anderson’s (2003; 2004) work on children with risk-taking and dangerous behaviour.

Midgley pointed out that the fact that it is today impossible to summarize in an hour all the empirical research that has been carried out shows the speed of current development. He referred to the following literature as “essentials for your bookshelf”

- *Change Processes in Child Psychotherapy* (Shirk and Russell, 1996)
- *Forskning om barn- och ungdomspsykoterapi* (Boalt Boëthius and Berggren, 2000). (The book contains many quotations in English from important articles and is the only book in Swedish that Nick Midgley has read – and with great interest!)
- *Psychotherapy for Children and Adolescents* (Kazdin, 2000)
- *Child and Adolescent Psychotherapy: a Systematic Review of Psychoanalytic Approaches* (Kennedy, 2004)
- *Process and Outcome research in Child, Adolescent and Parent-Infant Psychotherapy: A Thematic Review* (Kennedy and Midgley, 2007)

In addition to the above are two new books soon to be published – one edited by John Tsiantis and Judith Trowell (2010) as well as one edited by Nick Midgley et al. (2009).

The first question that research tried to answer was: Does it work? This question was too general and gave, even if for the most part it could be answered in the affirmative, no answers that could be of help in clinical work. Already in 1978 Barrett and co-workers formulated the question in a more specific way: “Which set of procedures is effective when applied to what kinds of patients with which set of problems and practiced by what sort of therapist?” (p.428).

Now it is above all the following questions that are examined:

1. What works for whom? A specific modality of treatment in relation to specific groups of children?
2. Process-outcome research. Investigate the processes that may lead to change

Many research studies have been conducted in later years. In Kennedy’s overview from 2004 the number was 32, of which six were randomised controlled trials (RCT). The reason that so few studies have been conducted with RCT is not only that the research method does not suit psychodynamic psychotherapy so well, but also that RCT-studies are extremely costly and pharmaceutical companies are not interested in funding psychodynamic

psychotherapy research. Unfortunately, in the general discussion, the lack of RCT-results is taken as lack of evidence. However, the clinical studies that have been conducted have many advantages in terms of quality. In contrast to most RCT-studies they have been conducted with clinical groups where children have serious disorders and multiple diagnoses. Many different outcome measures have been used and the results have been followed-up over a longer period – in certain studies up to 40 years, where interviews were conducted with adults who had received therapy as children (Midgley et al., 2006).

Overall findings

Nick Midgley then summarized the most important research findings in the field, but emphasized that as these are taken from relatively few studies and small numbers the conclusions must be tentative and subject to change:

1. Psychodynamic therapy helps. The magnitude of the effect is approximately 0.7, thus about the same effect as in other psychotherapy with adults. Three-quarters of those children receiving psychotherapy improve significantly more than untreated children.
2. The positive change process continues after the termination of treatment, i.e. there is a good so-called “sleeper effect”; as when this has been tested has also been shown to be maintained in the adult years (Schachter, 2004; Schachter and Target, in press; Midgley and Target, 2005; Midgley et al., 2006; Muratori et al., 2002; 2003).
3. Younger children and teenagers seem to benefit more from therapy than older children (Fonagy and Target, 1996; Target and Fonagy, 1994 a, b; Baruch et al., 1998; Sinha and Kapur, 1999; Gerber, 2004)
4. Less disturbed children seem to have been able to be helped by therapy once a week (Muratori et al., 2002, 2003; Smyrniotis and Kirkby, 1993; Fonagy and Target, 1996).
5. More disturbed children seem to need more intensive and longer treatment (Lush et al., 1998; Schachter and Target in press; Heinicke and Ramsay-Klee ,1986).
6. Children with internalised symptoms seem to benefit more from therapy than children with externalised symptoms. However, if children with externalised symptoms do not interrupt the treatment (which has been shown to be common) they also

benefit, especially if they also have anxiety symptoms (Baruch et al., 1998; Fonagy and Target, 1996; Muratori et al., 2002; 2003).

7. The psychotherapy may in certain cases be damaging for seriously disturbed children, e.g. if the therapy is too short or not sufficiently intensive, or if parallel work with the parents is lacking (Target and Fonagy, 2002; Szapocznik et al., 1989).

Psychotherapy has yielded good effect for the following types of disorders in children:

- Depression (Target and Fonagy, 1994b; Trowell et al., 2007; Horn et al., 2005)
- Children with poorly controlled diabetes (Fonagy and Moran, 1991)
- Anxiety disorders (Kronmüller et al., 2005; Target and Fonagy, 1994b)
- Behaviour disorders (Kronmüller et al., 2005)
- Personality disorder (Gerber, 2004)
- Specific learning difficulties (Heinicke and Ramsey-Klee, 1986)
- Pervasive developmental disorders (Reid et al., 2001)
- Eating disorders (Robin et al., 1999)
- Severely deprived children and children in foster care (Lush et al., 1998)
- Sexually abused girls (Trowell et al., 2002)

The above-mentioned studies have in England been shown to be important both for psychodynamic psychotherapy (PDT) to be included as a recommended form of treatment in public health care (NICE Guidelines) and for funding to be available for continued research. For example, thanks to a large depression study funding has been granted for a new study of PDT with teenagers suffering from depression.

Therapeutic process

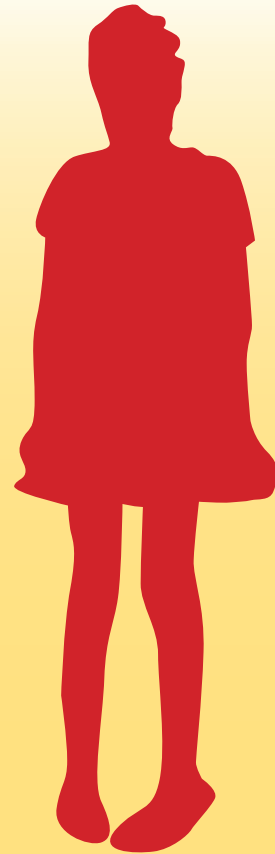
What we need now is, as pointed out by Kazdin (2000) and Stephen Shirk and Robert Russell (1996), are more studies of the therapeutic process that examine *why therapy works and how it works in different contexts*. We need to examine what happens during the therapy session, and to link it to changes in pathogenic processes or structures. Clinical case studies have provided us with valuable theories about therapeutic change, but these theories need to be tested in research.

Types of process research (Llewellyn and Hardy 2001)

1. Descriptive – develops measurement methods for important aspects of therapy, e.g. the quality of play or the therapeutic alliance, as well as studying what distinguishes PDT from other child therapies (e.g.: Shirk and Saiz, 1992; Chazan, 2002).
2. Hypothesis testing – the links between specific psychotherapy processes and treatment outcome (e.g: Fonagy and Moran, 1991; Gerber, 2004).
3. Theory development studies – develop theories about change, demands more complex design (e.g.: Carlberg, 1999; Harrison, 2003; Leuder et al., 2007).

Theory-developing research can above all, concluded Midgley, contribute with a deeper understanding of process in child psychotherapy and combine “what” (outcome) with “why” (understanding). This type of knowledge is essential in training and supervision. All concerned parties – the children and their families, administrators, purchaser of care, providers of funding, colleagues in other professions – benefit from a continuing dialogue between therapists and researchers. ■

OUTCOME RESEARCH



THE OPENING SPEAKER WAS Robert L. Russell, Professor of psychology at Pacific Graduate School of Psychology, USA. The title of his introduction was: *Approaches to measuring change in child psychotherapy.*

What have we done?

According to Orlinsky and Russell (1994), psychotherapy research, historically, can be divided into four periods.

1927–1954: Establishing Scientific Research

1955–1969: Searching for Scientific Rigour

1970–1983: Expansion and Organization

1984–2000: Consolidation & Reformulation

2001– : Comparative Biopsychosocial Developmentalism

At approximately the same time as Eysenck (1952) evaluated psychotherapy for adults – with negative results – Levitt (1957) evaluated child psychotherapy and also found that there was no difference in the outcome between those that had received treatment and those that had not. (After the lecture Russell added that he had examined Levitt's results and found that the therapy

had actually been very effective if controlled for length of time.) Unfortunately, Levitt's article did not succeed in galvanizing child psychotherapists in the same way that Eysenck stimulated adult psychotherapists into conducting their own research.

Nevertheless, according to Russell, child psychotherapy research can claim many "firsts", i.e. that new research methods were applied very early on. This began with Freud's description of process-outcome in the case study "Little Hans" (1909). It was also child therapy researchers who for the first time used such methods as time series analysis and narrative process. "If only we had taken the lead in those early days ...", said Russell regretfully.

Today, knowledge about psychopathology and how it develops has made great advances. It is now known that most psychiatric disorders in children are chronic or episodic/recurring. It is also known that disorders tend to occur in clusters, that comorbidity is common as well as that both symptom and type of disorder often change during the course of development. The picture of what we treat today has changed dramatically and this has in many ways changed attitudes towards treatment. One is no longer satisfied with descriptive diagnoses; now genetic, neuro-anatomic, neuro-chemical, neuro-functional and developmental analyses are also carried out. Russell emphasized that it is here that the psychodynamic analysis again becomes important and can offer guidance.

Traditional approaches

Outcome research has usually been conducted with naturalistic or experimental methodology, with either small clinical groups (often with only one case) or selected larger groups with a particular diagnosis, with either waiting list controls or randomized control groups. The definition of outcome has successively changed from "change" via "significant change" to "diagnostic change". The methods used to measure the results have also become increasingly sophisticated (Russel and Shirk, 1998; Russel et al., 2007). In the beginning one was satisfied with measuring the result after the completion of treatment. However, even here there has been a successive change so that today measures are made of both pre- and post-treatment as well as at a number of follow-ups.

Research usually concerns evaluating the effects of a brand name therapy, sometimes in comparison with another form of therapy. In certain cases a particular ingredient in a form of therapy is isolated, e.g. relaxation exercises, in order to examine the significance of various techniques that are included in a treatment.

What is happening now?

What is now applied in research can be called “*comparative biopsychosocial developmentalism*”. This means that in addition to measurements before and after, time series analyses are made whereby the development after every session is assessed, i.e. measure the process as outcome. Such a procedure is more in accord with what we now know about how psychopathology functions.

Further, measurements are collected from successful cases and models and from these are created “comparative growth standards” for different variables, e.g. “level of alliance” or “degree of acting out”. The development in new treatments can then be checked against these curves. It is possible to individualise, from diagnostic data, by calculating an expected curve for each particular case. Russell reported that it has been shown that results improve as soon as therapists are informed that their treatments are falling off their projected growth curve.

In order to evaluate outcome, nowadays biological measuring methods and neuro-chemical, brain-scanning etc. are used. The patients’ functioning is thus on several levels; biological, social and psychological.

Discussion

Robert Russell’s lecture was followed by sessions in the four small groups, whereby the discussion continued in the whole group. The groups summarized the following views and questions on their flip charts:

- Research should be seen as a support to knowledge that already exists
- Research should not interrupt or disturb the therapeutic work/process
- It is difficult to assess what are “successful” cases and “advances” or “improvements” – a complex concept that also seldom follows a direct upward curve
- How does research relate to the various aspects of “science/craft” vs. “art” that are encapsulated in the psychotherapy profession? The description of growth curves indicates that it is regarded more as a craft and does not consider the creative and relational dimension in psychotherapy

A certain amount of consternation had been awoken by Russell’s description of “biopsychosocial developmentalism” and above all the clinical application of “comparative growth standards”.

Michael Rustin, Professor of sociology and researcher at the Tavistock Clinic, expressed concern that the therapy profession could become de-skilled if treatment is made too manual-based. He voiced the opinion that experienced clinicians already know what leads to positive change in the therapeutic process and that it is demoralizing to undervalue this knowledge. Furthermore, that we must fight the current trend towards mechanization of the profession, which is discernible from the desire of powers-that-be to control and minimise the costs of publicly funded care.

Robert Russell met the criticism by looking for more of a “both-and”-thinking instead of “either-or”, and “a synthesis at a higher level beyond the contradictions”. He referred to the fact that Freud had already emphasized the importance of an empirical attitude in therapy work, and was of the view that an insightful description of the process is an important part of the work that we need to re-invigorate.

Here Stephen Shirk remarked that empiricism can help clinicians remain open to alternative interpretations. “What if I am not seeing it as it could be seen?” is an important question for clinicians to ask themselves. Rolf Sandell suggested that narrative case studies need to be complemented with explorative analysis and “documentary evidence” in order to be persuasive.

Questions also arose about various learning styles with reference to current pedagogical research. Can similar processes be considered with regard to psychotherapy and how we train psychotherapists? We know, for example, that children on their own can develop various inner models for how they think when they count – multiply or divide – and that those children who think in a similar way to the teacher learn more rapidly than those with another inner model. ■

SECOND DAY

GUNNAR CARLBERG AND Siv Boalt Boëthius opened the following day with a short summary of the previous day's discussion about empiricism and outcome. They emphasized that even if we as clinicians perceive all our knowledge to be empirically-based and the continuing therapy process as the most important outcome, such responses do not work in the dialogue with the general public and politicians.

The challenge is to improve our way of communicating our knowledge to the world around us, and prospective psychotherapists need to be schooled early on in a greater awareness of the importance of keeping up to date with, and participating in, research in the field. An empirical attitude also entails being prepared to reject one's preliminary hypotheses if the results point in another direction, as well as accepting both qualitative and quantitative research methods. Current research on different styles of learning will also lead to the development of better, more individualised psychotherapy training. ■



PROCESS RESEARCH I

THIS THEME WAS INTRODUCED by Stephen R. Shirk, Professor of psychology at the University of Denver, USA, and the only one of the international participants who had attended the two earlier meetings. His lecture was entitled: *What happens in the therapy room? How can we create an understanding of the processes that lead to change?*

Stephen Shirk is above all interested in studying change processes in psychotherapy and in particular how the therapeutic alliance is formed and how it affects the process when working with depressed adolescents. He does not consider himself to be aligned with a particular theory but primarily with his clients, and his point of departure is pragmatism. He is interested in “whatever works” whether it be psychodynamic or cognitive. He made a link to the previous day’s discussion and Robert Russell’s appeal to move towards “both-and-thinking”. He maintained that in psychotherapy one needs to use several different theoretical perspectives that complement one another, as well as to try to combine the perspectives of the clinician and researcher. That there are not two “cases” that are identical does not mean that there are not similarities in the form of general patterns or

regularities, that can be found in studies of larger groups of patients and that can be useful in clinical work with an individual case.

Process research is not a matter of answering the question: Does it work? At the present time when psychodynamic therapy is so challenged it is hardly a question that benefits open and creative thinking. Shirk said, “It is not possible to think openly and creatively under threat”, and recommended that in this workshop we should put the effectiveness issue to one side and instead address the questions: “What can research provide for clinicians?” and “What can clinicians contribute to research?”

Shirk also referred to Freud’s narrative case study Little Hans. The latter can be said to constitute the beginning of child therapy research, which for a long time comprised detailed case studies, conducted by the therapist as participating observer. Gradually one began to try to measure therapeutic interventions and children’s behaviour, e.g. play, and compare different cases with the same symptomatology. However, most of the studies carried out up until the 1980s used a descriptive methodology.

One then began to correlate process with outcome, e.g. examine the connection between early alliance and symptom changes, as well as to examine how unique components in a particular type of therapy, such as psychodynamic interpretations, correlate with the outcome. Many intricate quantitative measurements and correlation calculations were made, until it was realised that the therapy process is not only affected by the number of interventions of a particular type, but also by the interventions’ fit and the context in which they are made. It is therefore essential to develop more complex research designs in which many different aspects of the process are studied. Furthermore, according to Shirk, it is obvious that research so far has been all too focused upon therapeutic technique and too little interested in relationship processes.

Shirk suggested that we are dealing with two different sorts of process. On the one hand the therapeutic process and on the other the pathogenic process in the patient. Psychotherapy can be regarded as the rehabilitation of pathogenic processes in the brain. We know that people with a strong tendency for stress reactions – a measurable physiological variable – can become less stress-vulnerable when they go in therapy. Research suggests that a relationship with a close significant other helps the regulation of stress and one can therefore assume that the stress reduction is due to the therapeutic alliance.

The major challenges for continued research are to:

- Specify core processes – e.g. accuracy of intervention, level of empathy, facilitation of emotion/symbolic expression
- Identify intervention targets: pathogenic or functional mechanisms (What are we trying to change?) – e.g. ego strength (frustration tolerance, affect modulation etc.), interpersonal representations (working models)
- Achieve a consensus on relevant outcome – e.g. symptom reduction, functional impairment, quality of relationships

It would be naive to assume that there is a homogenous model for psychodynamic child therapy. According to Fonagy (1999) there are at least three main models, with many sub-groups, and these emphasize different change processes:

- Insight and interpretation (A. Freud)
- Corrective object relations (Bowlby)
- Mentalization and reflective function (Fonagy and Target)

Theory can be translated into researchable models by

- Defining core constructs
- Selecting or developing valid measures
- Specifying relationships among constructs
- Testing hypothesized associations among variables

In order to, e.g. study the process in mentalization-based therapy one can, according to Shirk, investigate whether and if so, how, play in psychotherapy leads to an enhanced symbolisation ability and if/how this in turn leads to an improved mentalization ability. How can we measure this? Another example can be the “therapeutic relationship as a core change process”. The hypothesis can then be: the character of the alliance between child and therapist will predict treatment gains. A number of questions immediately arise:

- How to conceptualize the alliance (or more broadly the therapeutic relationship) in psychodynamic child therapy?
- Is the alliance distinct from transference?
- Should the alliance be conceptualized as an attachment relationship?
- If an attachment relationship, can children report, or are the most important features unconscious?
- What then, are the implications for measurement?

In order to examine how the alliance impacts outcome one must thus also examine other variables that lie near at hand.

Stephen Shirk concluded by asking the small groups to consider the following question: “If you really had to put your money on investigating some aspect of child therapy – what would you then invest in?”

Discussion

Important aspects raised in the group sessions were the therapist’s ability to be attentive, “present” and to offer a secure attachment and “containment”. The therapist’s ability to manage the feelings of shame that children often expose them to was also raised as an important aspect.

Furthermore, it was pointed out that there is a need for more case studies and the building up of a qualitative database, making it possible to continually examine what goes on in the therapy: types of play, the therapist’s activity and the therapist’s thoughts and feelings. However, here it is important to be aware of the complexity of therapeutic interventions. These involve many different qualities such as tone of voice, content, frequency and they act together in an intricate way with the child’s degree of awareness, the child’s emotional state, as well as the time dimension.

One group had raised the question of whether the increased focus on research in psychotherapy training could possibly lead to trainees “internalizing doubt instead of hope”. If that was the case what would it mean for the clinical work?

The subsequent discussion to a great extent concerned research on large cohorts and the problem that those cases included in large studies may have very different underlying pathologies, even if they have the same DSM-IV diagnosis. Is there anything to be learned from multiple cases or is the gap too great asked Robert Russell and put his finger on the experience of many that in large studies one does not take into account “the ineffables” or “the existential human condition”. How can the ineffable be reconnected in research so that it can become meaningful for clinicians? ■



PROCESS RESEARCH II

TWO CLINICAL RESEARCH PROJECTS were then presented, one British and one Swedish.

Charlotte Jarvis, psychotherapist, researcher, teacher and supervisor in London, gave a presentation entitled: *How and what can we learn from our patients?*

Jarvis began by directing attention to gender dynamics in the co-operation between researchers and clinicians. It is a case of two different cultures, i.e. a research culture that is obviously competitive and that has for a long time been male dominated, and a child psychotherapeutic culture that has to a great extent been developed by and is still dominated by females. The clinicians' insecurity in the face of research is reflected in the way women have traditionally regarded research.

Jarvis has worked at *Open Door*, a psychoanalytic consultation unit for young people (12–24 years) in central London. The unit has integrated assessment with the help of questionnaires and scales in the treatment and Jarvis' experience of this has been positive for both patients and therapists. In the case of adolescents it is often difficult to grasp and formulate the central problems, something that can be essential in order to justify continued sessions.

Adolescents with externalised symptomatology in particular often break off the contact if one does not succeed in getting them to feel that “something is wrong inside” and here questionnaires can actually help. Completed forms can also show risks for self-destructive acting out, something that often does not emerge in the initial sessions.

The collected results from ratings and questionnaires were followed carefully in supervision and conferences, and this affected how one reasoned about and developed the work of the unit. That the effects of the treatment for the most part proved to be significantly positive contributed to increasing the self-confidence of the clinicians. However, as usual, one obtained poor results with the more acting out adolescents and many did not attend their sessions and terminated the contact. The parents remained, with their anxiety. It was then decided to start a special “Parent Consultation Service” (PCS) where parents could receive support even if the adolescents themselves did not want to attend. From the beginning one built in a system with regular evaluation, including amongst other things a stress index, SIPA (Stress Index for Parents of Adolescents). The team met every week to become acquainted with and to try to understand what the measurements expressed.

The measurements showed that the adolescents who one had sought help for had severe symptoms and easily fell within “the clinical sector”. Furthermore, the parents showed high scores for feelings of guilt and incompetence as parents. Relationship problems were also severe. This was well in accord with and further illuminated what had emerged during the sessions.

Jarvis said that the relationship with the parents is a key factor for mental health even during the adolescent years, and she referred to a number of studies from recent years. Many studies confirm that *authoritative parenting* is the most effective. According to Jarvis psychotherapists have to a great extent neglected parents of teenagers. “There is no such thing as an adolescent.”

In the shaping of parental support Jarvis started out from psychoanalytic theory, above all Britton’s theories about ego development, but also to a great extent from attachment theory. In actual fact, as time went on the work became similar to that with parents and infants. Just as in working with adolescents the measurements helped the therapists to achieve a meaningful dialogue and to be able to focus upon the areas where change was needed.

PCS also attained statistically significant outcome measures, which gave increased self-confidence and – not least – continued funding.

Jarvis suggested that we need to question and investigate the validity in various situations of this model of long-term therapy that is traditionally used. From the beginning there was no time limit for the contacts within PCS and a small group of parents continued to attend sessions for a long time, but made little noticeable progress. A short-term model was therefore introduced comprising six sessions, which also yielded statistically significant results. According to Jarvis the time limit helped insecure parents develop their own problem solving ability instead of becoming passively dependent on an authoritative therapist. The goal is, after all, that the parents themselves become authoritative and able to guide their children in the latter's development of independence. However, it is important to keep the door open for follow-up sessions.

Jarvis concluded by emphasizing that the outcome measures during treatment had functioned as an important source of information for the therapists, patients and parents. The six years with continual evaluation in this way has also helped to develop constructive ideas about psychoanalytic work with adolescents and their parents.

More about the study of PCS is to be found in Jarvis' article, *Parenting problems: research and clinical perspectives on parenting adolescents* (2005).

Agneta Thorén, psychotherapist and researcher at the Erica Foundation, took the floor and spoke about: *Children's expectancies and experiences of psychodynamic child psychotherapy*.

Asking the children themselves about their experiences of treatment is not usual, but within the frame of the Erica Foundation's EPOS-project Agneta Thorén and the research group have carried out a sub-study with child interviews.

Three girls and seven boys in the age range 6–12 years were included in the study. They were all patients within child and adolescent psychiatry, fulfilled the criteria for at least one DSM-IV diagnosis and had been assessed as being in need of and suitable for a time-limited two-year psychotherapy. They were interviewed prior to therapy and after its termination. The interviews were conducted by a psychotherapist who had not participated in the assessments or treatments. In the interviews a self-rating form ("I think I am") was used as well as drawings, and scenery with dolls that represented the therapy situation. A rating scale with five small balls that were pushed into a plastic tube was also used.

In the introductory interviews seven of the ten children gave clear expressions of the need for help with emotional problems

such as loneliness, poor self-esteem, depressive feelings, and disturbed behaviour. All except one expressed positive expectations of the therapy.

After the termination of therapy positive changes had occurred for most of the children as expressed in the interview situation. The children experienced that family relationships above all had improved, whereas peer relationships in several cases were still experienced as problematic. All except two had experienced the therapy as very positive. Those two who were not positive had been negative from the beginning, thought that others had caused their problems, and it was therefore “unfair” that they had to go in therapy.

In the study it could thus be established that there is a clear connection between the children’s expectations of the therapy and the result of the treatment. This underlines how important it is to work with the child’s own motivation for treatment. Furthermore, continued studies of this type can provide the foundation for deeper knowledge about when child psychotherapy can be of help – or not. The study was also presented in an article published in the *Journal of Child Psychotherapy* (Carlberg et al., 2009).

Discussion

After the presentations of clinical research projects there were more group sessions that resulted amongst other things in the following questions and suggestions:

- How to give appropriate weight to what the specialist clinicians know and still be able to hear the views of patients?
- What constitutes the child’s consent to treatment?
- How to ascertain information from patients and parents without disturbing the process or (post treatment) stir things up unhelpfully?
- How will the outcome of treatment that helps patients not to get worse be picked up and appreciated?
- How to prepare patients and parents for therapy?
- The ending of therapy.
- What does it mean for the process whether or not one from the start builds in a follow-up?
- Is there a risk that today power is being removed from the profession by introducing a research agenda – and a concept of evidence – that clinicians do not feel a part of? ■



CLINICALLY-BASED RESEARCH

This theme was introduced by Michael Rustin, Professor of sociology at the University of East London and guest professor at the Tavistock Clinic. His introduction was entitled: *How do we and can we stimulate clinically-based research?*

Michael Rustin explained how the programme for training in practice-based research at the Tavistock Clinic in London has evolved over the past twenty years. All prospective psychotherapists now go through a certain amount of training in research, and those who want to can continue for a further two years in order to obtain a PhD. There is also the opportunity for already qualified child psychotherapists to complement their training with a research qualification. At present there are 38 research students registered and this number will quickly increase.

One may think that a psychology department would be a more likely partner for the Tavistock than a sociology department. However, according to Rustin this would have been hindered by the experimental direction and the current scepticism towards psychoanalytic theory. The sociology department is more open to debate and conflict, more used to complex questions and more interested

in qualitative research methodology, according to Rustin. He added that similar co-operation is to be found in other parts of England.

Rustin emphasized that in actual fact clinical research has existed for a long time and that there was already a great deal of knowledge stemming from it. It is now a question of reflecting upon and describing the knowledge in a way that makes it credible and comprehensible also for other clinicians. Rustin made the point that it was a matter of research *in* psychotherapy and not research *on* psychotherapy. One must understand the field in order to contribute knowledge to it, and it is therefore a matter of urgency that clinicians themselves train as researchers. It is also the clinicians who know what is interesting to investigate and how one can go about it.

Those research questions that are examined at the Tavistock spring also mainly from experience of patient work. From these one can formulate a question of interest for other practitioners and select a researchable material. Even if this only concerns a single case the choice is of course important. Which of the hundreds of sessions is to be examined further because it is considered to be representative and reliable material? With regard to the methodology for analysing the material Rustin said that a version of “grounded theory” is the usual choice.

Gunnar Carlberg then took the floor to talk about how Siv Boalt Boëthius, at the end of the 1980s, had introduced the Erica Foundation to research that included the institution as a whole, as well as how the attitude to research work had subsequently changed rapidly. Many compilations, evaluations and clinical case-studies have been made at the Erica Foundation. Carlberg himself has carried out research on change processes - turning points in child therapy and is currently conducting a comprehensive research project within the frame of a multi-centre study called EPOS (The Erica Process and Outcome Study). There is, for example, a database currently with information about 150 child psychotherapies. The research climate is currently characterised by the discussion about evidence.

In conclusion Carlberg emphasized the importance of carrying out small scale studies that combine qualitative and quantitative methods and the importance of engaging students and psychotherapists in clinically-based research. In order to awaken interest the results of studies need to be fed back to the clinicians. In the future we need co-operation in larger studies and to create

meeting places for researchers and clinicians. Workshops such as the present one can be a fruitful model in the work of stimulating research and in beginning to plan major international studies.

Discussion

A shorter discussion followed in the large group. In the USA there appears to be more of a division between researchers and clinicians than in England. According to Shirk clinicians in the USA are not as committed to research and he believed that this was partly because we live in a “digital” age, when what is communicated must be unambiguous and simple, and people do not have the patience to immerse themselves in rich and complicated qualitative data. ■

THIRD DAY

IN HER FEEDBACK on the final day of the workshops Siv Boalt Boëthius referred to the gender issue raised by Charlotte Jarvis. The way in which one discusses research questions in this field is perhaps reflected in the fact that most researchers are male and most child psychotherapists are female. There is also an evident gender problem with regard to who seeks and receives treatment. Amongst the younger children it is mostly boys, whilst in adolescence it is the reverse, i.e. it is mostly girls who seek help and go in therapy. Process research can perhaps help here in developing methods for reaching girls earlier and engaging more teenage boys in treatment.

Furhermore, Siv Boalt Boëthius was of the opinion that the discussions during the workshop had achieved a good balance between research- and clinical issues – the sort of balance that is necessary for continuing the work.

Gunnar Carlberg expressed a hope that now, on the final day of the workshop, one could – with the pragmatic theme of how research can be put into practice – formulate more explicit goals for continued work in the field and for more meetings of this type. ■



IMPLEMENTATION

THE FINAL THEME, IMPLEMENTATION, was introduced by Cathy Urwin, psychotherapist and researcher from the National Health Service and Tavistock Centre, who spoke about: *How are research findings implemented in clinical praxis? Bridging the gap.*

Cathy Urwin suggested that implementation actually consists of two things. On the one hand it concerns clinicians' own need to develop their practice and obtain material for making clinical decisions, and on the other, to convey research results in order to make care more effective – a political agenda. For the political agenda and the governing of British care organisations the “NICE Guidelines” from the National Institute of Clinical Excellency have attained great importance, and these are based chiefly on results from quantitative RCT-research. However, those cases that clinicians work with are more complex and often are not suitable for the methods recommended.

Urwin pointed out that one can actually challenge “guidelines” within a certain period after they have first been presented. Furthermore, it is only a matter of guidelines, not absolute directives. Urwin gave some examples of special types of problems

where the recommendations did not appear to be in accord with the evidence. However, clinical implementation is guided by qualitative or “conceptual” research. Urwin referred to several examples, amongst others the study that Jarvis had presented here, as well a study by Jeffrey Baruch et al. (1998) that led to the development of a new treatment model for acting out teenagers.

This type of research can be generated by so-called conceptual lines – lines of thought that in turn are generated in clinical workshops where one discusses experiences of cases with similar problems. For example, workshops on autism in the 1970s produced important ideas; both the problems with three dimensionality and the difference between undrawn and with-drawn autistic children, ideas that then can be tested in qualitative studies and possibly contribute to method development.

One example of this is Jan Anderson’s (2003; 2004) qualitative study of risk taking children. Anderson compiled a picture of these children using several different sources of information. She concluded that what they had in common was the lack of an internal censor, that they had not negotiated the family triangle and acted out unresolved issues around regression. They appeared to lack the feeling of safe haven that most people bear within and which provides resilience. Instead these children bore a feeling of an inner unsafe haven which drove them to constant external risk taking. This interpretation proved to be useful in communication with other professional groups in co-operation about children, as it made it possible to understand that it was a matter of an inner dynamic.

According to Urwin process research concerns:

- Output
- Process as process

As a researcher in developmental psychology Urwin (2007) is above all interested in the latter, i.e. in the development that occurs in therapy.

Urwin also highlighted the need to more closely examine the dogma of the discipline. One example is the assumption that breaks in therapy are very important and may affect the process. However, this dogma has, according to Urwin, never actually been examined in a study.

It would also be valuable to study how the therapist’s initial assessment of what could be attained with a treatment is in accord with what really happens. With the help of Carlberg’s “turning

points” (1997; 1999) Urwin has recently analysed and described a therapy case that did not develop as well as she had believed it would.

To listen to the patients – the children and their parents – and to encourage them to talk about their experiences of therapy is important and can also provide psychotherapy with more external validity. Urwin concluded by showing some expressive computer pictures that a 12-year old autistic boy, after three years of intensive psychotherapy, had sent to his therapist. With these pictures he wanted to show “normal people” how it felt to become over-loaded and have an “autism attack” where one loses control over one’s behaviour.

Discussion

This lecture also generated a lively discussion. Views and questions that arose were amongst others:

- Clinicians feel bombarded with demands for more work and also a constant stream of new information/knowledge. It is of course important to integrate research and clinical work, but one also needs to allow for separate spaces, between which one can move.
- Implementation can run into obstacles when therapists want to continue working in the way they have been doing despite that new results show that the patients would be better helped with another method. What do we do when the results do not confirm what we want to believe?
- How can we develop research that awakens curiosity rather than fear in clinicians?
- How can we inform purchasers of care and politicians in a good way, so that we can retain our autonomy and our status as specialists? Who is to actually “own” the research results – politicians, bosses or clinicians? How relevant for the field is the research literature that is published?
- How can we manage the problems of implementing results from research that is conducted in other countries/cultures? ■



PANEL DISCUSSION

THE WORKSHOP WAS CONCLUDED with a panel comprising Eilis Kennedy, Child and Adolescent Psychiatrist at the Tavistock Clinic, Celeste Schneider Assistant Professor at St. Mary's College, researcher and psychoanalyst candidate and Rolf Sandell, Professor emeritus, Linköping University and psychoanalyst.

All three expressed their appreciation of the efficient way the workshop had been arranged and carried out and were of the opinion that it had to a great degree facilitated the exchange of thoughts.

Eilis Kennedy maintained that the evidence movement actually can be of more help than harm to child psychotherapy. The whole movement started with the aim of questioning professional dogma and vested interests in different types of medical practice, such as pharmaceutical companies. It is already the case that the research that has been conducted on therapy for depression in children and adolescents has resulted in the NICE Guidelines now recommending psychotherapy as treatment for such symptoms. Similarly, the fact that pharmaceutical companies have concealed studies with negative outcome as well as findings that indicate

that antidepressive medication has a limited effect on children and adolescents has attracted much attention.

A key question concerns whether research is carried out on clinical populations, in naturalistic conditions or if it is a matter of so-called efficacy research in a university environment. Nowadays one has gone over increasingly to conducting naturalistic studies or so-called effectiveness studies in which one examines how therapy works with typical comorbid patients treated by typical therapists working in typical units. Kennedy reminded us here that the size of the effect seems to be greater for the pure research therapies than for the clinical therapies.

Furthermore, said Kennedy, it is important that we are aware of our own prejudices and vested interests, so that we keep ourselves open to the insight that we can harm more than help. This is a risk that has always characterised the art of healing and until quite recently was very great. We also need to be able to work on several different levels, from the molecular to the political, thus also at the societal level. And in research one must abandon the fixation on comparison of various “brands” in treatment and focus more on contextual and common factors.

Celeste Schneider raised, amongst other things, the issue of how research manages the great complexity of the therapeutic processes; how we describe, analyse and convey what happens in the therapy room. Furthermore, how we will be able to create a climate in which clinicians and researchers will be able to meet without being hindered by feelings of insecurity, shame and doubt that can inhibit curiosity and open communication. She felt hopeful, enriched and exhilarated by the conference, but also uncertain as to how to be able to better cope with the differences in opinion and the conflicts— that which here has been referred to as “yes-but” instead of the more constructive “both-and”.

Celeste Schneider formulated the following questions:

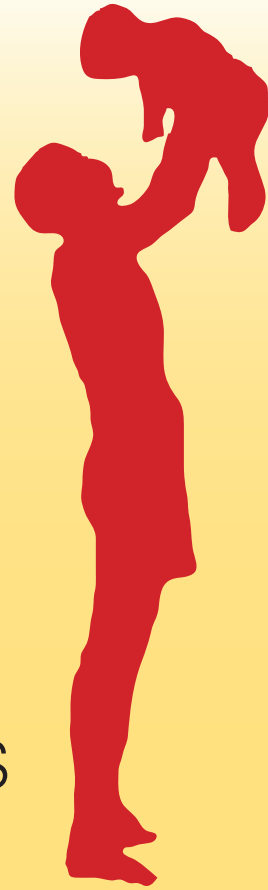
- How can we incorporate the more subtle aspects of the clinical process in a research programme that is aimed at “progress”?
- How can we better tolerate the distance/difference between research and clinical practice?
- How can we nurture a research culture that embraces complexity instead of reductionism?

A prominent theme during the workshop was, according to Rolf Sandell, the importance of variance, heterogeneity and complexity

– and as a result of the necessity to be able to see things from many perspectives, to be aware of and manage “both-and”, despite the fact that it entails a certain amount of tension and conflict. We thus need to be able to work as – or together with – both clinicians and researchers. We need to interest ourselves in both process and outcome and to remember that the outcome is also a process that continues after the termination of therapy – so-called sleeper effect. We need to see both inner processes and external actions/behaviour. Research needs to be conducted using both qualitative and quantitative methods, with both case studies and group studies. Knowledge is needed in both general and differential psychology.

Sandell referred to one of his own studies (2005) that showed very large variations between both the psychotherapists’ way of working and the patients’ reactions to psychodynamic therapy and he concluded with a further Winnicott-travesty: “There is no such thing as treatment!” ■

CONCLUDING COMMENTS



ROBERT RUSSELL MAINTAINED THAT there are after all commonalities which need to be underscored in psychotherapy processes and that we need to study this more closely. He has himself examined a number of time series-studies of processes in different types of therapy and subsequently identified four-five different types of basic structure.

Margaret Rustin pointed to the importance of the surroundings, above all parents and school, and that this is not sufficiently illuminated in research.

Michael Rustin returned to the issue that certain ways of using research results can be damaging by making therapists lose confidence.

Nick Midgley, in his role as EFPP co-ordinator and having been allotted the task of concluding the workshop, quoted his Japanese teacher's recurring expression: "Nevertheless – therefore!". He considered that this conjunction could summarise the "both-and" attitude that is essential in order to proceed with the complex task of continuing to develop the clinical work, evaluate, research, analyse and assess research results as well as conveying this knowledge to society.

There was great interest in following-up this workshop in a couple of years. Midgley suggested that the next one should be held in London. Margaret Rustin presented the following ideas from the group she had been a member of regarding the structure of the next workshop:

1. Presentation of clinical practice influenced by some form of research finding
2. Dialogue in action between researchers and clinicians
3. Dialogue between clinical researchers and academic researchers
4. Perhaps located in a university context, including students
5. Investigate collaboratively specific clinical phenomena, e.g. breaks
6. Discussion of confidentiality issues

Further subjects for discussion suggested by the group were how one applies for ethical approval as well as funding. There was a consensus that it was essential to proceed to a more specific level and discuss concrete examples. Stephan Hau, Assistant Professor in psychology at Linköping's University and psychoanalyst, mentioned a project that would be interesting to discuss, namely the research carried out by Leuzinger-Bohleber et al. in Frankfurt, where psychoanalytic therapy and CBT were evaluated for children with ADHD (2006).

In conclusion Robert Russell informed us that a special interest group for child and adolescent psychotherapy research is being formed within the Society for Psychotherapy Research (SPR).

Some reflections

It could be interesting to compare the Stockholm meeting with the two previous ones in Athens and Oslo. At these meetings the aim was almost exclusively to stimulate more research and to arouse interest in research amongst clinicians. Enthusiasm was great. Now the discussion was more focused upon the complexity of the issue and the integration needed. The risks and problems that are part and parcel of research, e.g. that research results, if they are interpreted carelessly and one-sidedly, can be used to justify reducing resources in the public health sector were also addressed. It was also established that it is important to be aware that methods giving a good effect in a certain culture or a particular context perhaps do not work so well in other circumstances. The question was also raised as to whether schooling in an empirical approach already during training would undermine the professional

confidence that is needed in the psychotherapist's professional practice, by "internalising doubt instead of hope".

Certain differences in the view of psychotherapy and research amongst the workshop participants certainly contributed to the more problematic issues being illuminated. A certain fear of change was expressed, e.g. in the above-mentioned question of professional confidence. However, basically there was a consensus that psychotherapists need to learn how to carefully examine their approach, their interventions and the development of the therapeutic interplay.

The fact that this problematizing emerged in the discussions also reflects a more mature and sober attitude to psychotherapy research. Pioneering enthusiasm has settled. We know how fragile and context-dependent the therapeutic process is and we now also realise what an enormous amount of work is necessary to research it in a just manner. However, this does not mean that we should not continue with this endeavour. It is something we must do if we want psychodynamic child and adolescent therapy to continue to exist as a treatment alternative. ■

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APPENDIX 1

PROGRAMME

RESEARCH IN PSYCHODYNAMIC CHILD AND
ADOLESCENT PSYCHOTHERAPY

How to do research and how to implement the results
in clinical praxis?

PROGRAMME

Friday October 17th

13.00–14.15

Registration for workshop participants

14.30–15.30

OPEN INTRODUCTORY LECTURE

Overview of the research on individual child and adolescent
psychodynamic psychotherapy

Presentation: Nick Midgley

Moderator: Gunnar Carlberg

15.30

Coffee/Tea and sandwich

16.15–16.30

Aims of the workshop

Siv Boalt Boëthius and Gunnar Carlberg

16.30–17.00

OUTCOME RESEARCH

Approaches to measuring change in child psychotherapy.

Introduction and chair: Robert L Russell

17.05–18.10

Work in four small groups

Group leaders:

Eve Grainger and Anna Lundh

Anne Holländer and Margaret Rustin

Liselotte Grünbaum and Björn Salomonsson

Britta Blomberg and Tine Heede

18.15–19.00
Work in the large group
Chair: Robert L Russell

19.00
Buffet at the Erica Foundation

Saturday October 18th

08.45–09.00 Brief feedback from the preceding day
Siv Boalt Boëthius and Gunnar Carlberg

09.00–09.30
PROCESS RESEARCH I
What happens in the therapy room? How can we create an understanding of the processes that lead to change?
Introduction and chair: Stephen R Shirk

09.30–10.30
Work in four small groups

10.30
Coffee/Tea

11.00–11.45
Work in the large group
Chair: Stephen R Shirk

11.45
Lunch at the Erica Foundation

13.15–13.45
PROCESS RESEARCH II
How and what can we learn from the patients?
Introduction and chair: Charlotte Jarvis

13.45–14.00
Children's experiences of child psychotherapy: Agneta Thorén

14.05–15.00
Work in four small groups

15.05–15.45
Work in the large group
Chair: Charlotte Jarvis

15.45 Juice and fruit

16.00–16.30

CLINICALLY BASED RESEARCH

How do we and can we stimulate clinically based research?

Introduction and chair: Michael Rustin

16.30–16.45

Examples from the Erica Foundation: Gunnar Carlberg

16.45–17.30

Sharing of ideas in the large group

Chair: Michael Rustin

19.30 Dinner at “Clas på Hörnet” a restaurant nearby
the Erica Foundation

Sunday October 19th

09.00–09.15 Brief feedback from the preceding day

Siv Boalt Boëthius and Gunnar Carlberg

09.15–9.45

IMPLEMENTATION

How are research findings implemented in clinical praxis?

Bridging the gap.

Introduction and chair: Cathy Urwin

9.50–10.40

Work in four small groups

10.45–11.30

Work in the large group

Chair: Cathy Urwin

11.30

Coffee/Tea and sandwich

12.00–13.00

Summarizing comments

Co-chairs: Siv Boalt Boëthius and Gunnar Carlberg

Panel and discussion in the large group.

Eilis Kennedy, Nick Midgley, Rolf Sandell, Celeste Schneider

13.00

Lunch at the Erica Foundation

APPENDIX 2

LIST OF PARTICIPANTS

Research in psychodynamic child and adolescent psychotherapy: How to do Research and how to implement the Results in Clinical Praxis?

Britta Blomberg, licensed psychologist and licensed psychotherapist is working at The Erica Foundation as child and adolescent psychotherapist, supervisor and teacher.

She is a member of the Swedish Association for Child and Adolescent Psychotherapy and a Swedish delegate for the EFPP, Child and Adolescent Section. She is also a member of the organizing committee of the EFPP ongoing workshop on Infant Observation. She initiated the founding of a Swedish journal of child and adolescent Psychotherapy Mellanrummet, and is the main editor.

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Siv Boalt Boëthius. PhD, professor em, licensed psychotherapist and psychoanalyst, member IPA and ISPSO (International Society for Psychoanalytic Study of Organizations). Past Director of the Erica Foundation, chair of the European Federation for Psychoanalytic Psychotherapy (EFPP) 2003–2007 and member of the EFPP research group. Main research areas are child psychotherapy, group supervision and social processes in groups and organizations with a number of articles and books in these areas. Member of the advisory/editorial board of Journal of Child Psychotherapy, Small Group Research and Organisational and Social Dynamics.

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Gunnar Carlberg, PhD, Associate Professor, Director of the Erica Foundation in Stockholm since 2002. Licensed psychologist and psychotherapist with various publications within e.g. psychodynamic developmental psychology and child psychotherapy research. His doctoral research was on Turning points in child psychotherapy. Psychotherapists' experiences of change processes. Current research interests are outcome and process research including the use of qualitative methods. He is the project leader of the Erica Process and Outcome Study (EPOS).

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Pia Eresund, PhD, authorised psychologist and psychotherapist. Partly retired, working privately. Member of the board of the Swedish National Association for Psychotherapists. Her research is described in JCP Vol 33 No 2, August 2007, p.161–180: Psycho-dynamic psychotherapy for children with disruptive disorders.

Co-author with Björn Wrangsjö of a recent book about disruptive disorders in children, “Att förstå, bemöta och behandla bråkiga barn” (Studentlitteratur, 2008)

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Eve Grainger, Consultant Child and Adolescent Psychotherapist for the North-East London NHS Foundation Trust, and Clinical Lead for “The Listening Zone” Young People’s Counselling Service, based in Barking in Essex. Current research interests: how to develop appropriate tools and measures to identify, describe and evaluate processes of internal change?

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Sari Granström, MD, Child and Adolescent Psychiatrist, adult psychiatrist and licensed psychotherapist. Head of the clinical department of the Erica Foundation in Stockholm, Sweden. Special areas of interest are children and trauma, children and war, working with parents in psychotherapy and integration of psychotherapeutic and neurobiologic knowledge in treatment.

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Liselotte Grünbaum, registered MSc of psychology, specialist and supervisor of psychotherapy and child psychology, in private practice in Copenhagen, external part time lecturer at the University of Aalborg. Founding member and course organiser of the Danish Association of Psychoanalytic Child and Adolescent Psychotherapy, since 1997 supervisor and teacher at the Danish training programme for psychoanalytic child and adolescent psychotherapists. Member of the EFPP research group, formerly coordinator of this group, and of the EFPP’s Child and Adolescent Section. Research interests: qualitative methods for studying the psychotherapy process, psychotherapy with severely deprived or traumatised children and adolescents, and supervision of psychoanalytical psychotherapy.

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Stephan Hau, Associate Professor, PhD, Psychoanalyst (IPA, SPF, DPV), teaches Clinical Psychology at the Department of Behavioural Sciences and Learning (IBL), Linköping University, Department of Psychology, Stockholm University, and at Kassel University, Germany. Research interests include psychotherapy research and (experimental) dream research. He also has a private practice in Stockholm.

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Tine Heede, Psychoanalytic therapist (DSPBU Denmark) as well as specialist in child psychology. For the last 3 1/2 years chief psychologist at the residential home for early deprived children between 6 and 16 years of age, Nebs Møllegård, Denmark. Before that chief psychologist at a pediatric ward at Hillerød Hospital. At Nebs Møllegård an on going evaluation study of milieu therapy within three institutions. My research interests effect studies and psychological testing as outcome measurements.

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Anne Holländer, MSc, private practice Køge, Denmark, member of the EFPP Executive as a delegate from the Child & Adolescent Section. I am joining the workshop on the behalf of the EFPP Executive. I am very interested in how EFPP can support research in psychoanalytical Child & Adolescent Psychotherapy, especially how to implement the results in clinical praxis.

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Charlotte Jarvis, Consultant Child and Adolescent Psychotherapist: trained at Tavistock Clinic Workplaces: Open Door, YPCS-Psychotherapist 1992–1995; Brandon Centre for Psychotherapy: 1995–1998; Open Door, Young People's Consultation Service; Director 1998–2007; Current: Freelance- consultation and project development; teaching & lecturing. Professional offices: Trustee, Child Psychotherapy Trust 1989–2000, Committee Member: ACP Research Committee- 2006–2008, Chair ACP Research Committee- 2008–

Research Interests: adolescence and young adulthood; parenting adolescents; parenting; evaluation measures and clinical practice; brief psychotherapy frameworks; service delivery. Additional professional interests/experience: Lecturing and teaching; Supervision; Early onset psychosis; Group Relations; Role consultation.

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Ellis Kennedy is a Consultant Child and Adolescent Psychiatrist in the Child and Family Department of the Tavistock Clinic, London. She is interested in the development and evaluation of psychological treatments and has undertaken two reviews of the research evidence for psychoanalytic child psychotherapy. In addition she is involved in an RCT evaluating a psychotherapeutic intervention for couples expecting their first child and a study looking at the influence of therapist factors on the outcome of a large RCT of the treatment of adolescent depression. She has been commissioned by Wiley to edit 'The Handbook of Child and Adolescent Psychiatry: An Evidenced-Based Guide.'

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Anna Lundh MD, Child and adolescent psychiatrist at CAMHS Stockholm County. PhD student at Department of Clinical Neuroscience, Karolinska Institutet.

Ongoing project evaluating Children's Global Assessment Scale, CGAS, as outcome measure in a large scale clinical setting. Development of CGAS training program for two settings: seminars and interactive studies with CD. Follow-up 12 months after training.

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Nick Midgley is a Child and Adolescent Psychotherapist and Head of Programme for Adolescents and Young Adults at the Anna Freud Centre, London. He is also an honorary lecturer at the Centre for Psychoanalytic Studies, University of Essex, UK. Nick's doctoral research was on the long-term follow-up of child analysis and his current research interests include studying the 'mechanisms of change' in psychotherapy and the use of qualitative methods in child psychotherapy research.

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Fredrik Odhammar is a licensed psychologist, psychotherapist and supervisor at the Erica Foundation in Stockholm, Sweden. He is also a PhD student at the University of Stockholm. In his research he has a special interest in therapist and alliance variables related to clinical process and outcome in child psychotherapy.

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Robert L. Russell, PhD, Professor and Director of Clinical Training in the APA approved PhD program at PGSP received MA degrees in psychology (Duquesne University) and linguistics (University of North Carolina, Chapel Hill) before receiving his doctorate in clinical psychology at Clark University. He completed his internship at Judge Baker Guidance Center with an appointment at Harvard University. Prior to assuming the DCT at PGSP, Dr. Russell held appointments as Professor of Pediatrics at the Medical College of Wisconsin, where he was also the Director of Research within the Child Development Center. He has also held appointments at the University of Kentucky, New School for Social Research, and Loyola University Chicago. His main emphases in research include developmental psychopathology, child and adolescent communication disorders, processes of change in psychosocial treatments, and narrative psychology. He is particularly interested in how social communication competence affects adjustment across childhood/adolescence and how language processes in psychotherapy can lead to positive clinical outcomes.

In terms of clinical practice, Dr. Russell has held a small private practice for over 20 years focusing on children/adolescents with learning and psychiatric disorders. He has also focused on children/adolescents in the arts (theater, film, plastic arts) with adjustment difficulties.

A recipient of awards for research, teaching, and community service, Dr. Russell exemplifies the practitioner-scientist model that orients PGSP's PhD program.

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Margaret Rustin is a Consultant Child Psychotherapist at the Tavistock Clinic, London, and an Honorary Affiliate Member of the British Psychoanalytical Society. Until recently she has been head of the Child Psychotherapy discipline at the Tavistock Clinic, and has had a major involvement in the development of the Tavistock Clinic-University of East London Professional Doctorate in Child Psychotherapy. She has written widely on child psychotherapeutic practice.

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Michael Rustin is Professor of Sociology at the University of East London, and a Visiting Professor at the Tavistock Clinic. He is an Honorary Affiliate Member of the British Psychoanalytical Society, and Chair of its Applied Section. He has had a major role in the development of the academic accreditation of Tavistock

Clinic programmes at the University of East London, including the Professional Doctorate in Child Psychotherapy and other Professional Doctorates. He teaches research methods to students on the Child Psychotherapy Professional Doctorate programme.

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Björn Salomonsson, MD, is a training psychoanalyst and a child and adolescent psychoanalyst, member of the Swedish Psychoanalytical Society. He is running an RCT-study; the Mother-Infant Psychoanalysis Project of Stockholm (MIPPS). It compares results of psychoanalytic treatments of infants and mothers with treatments-as-usual. It is based at the Child and Adolescent Psychiatric Unit of the Karolinska Institute, Stockholm, in cooperation with a similar project at the Anna Freud Centre, London; the Parent-Infant Psychotherapy (PIP) study headed by professor Peter Fonagy. From 2001 to 2006, he was chair of the Child Forum of the European Psychoanalytic Federation. He is a member of la Société Européenne pour la Psychanalyse de l'Enfant et de l'Adolescent, Paris.

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Rolf Sandell is Professor (em.) in clinical psychology, Linköping University, now teaching at Stockholm University. As a director and consultant he is involved in several research projects in psychotherapy and general psychological treatments. He is a member of the Swedish Psychoanalytical Society and is in part-time private practice.

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Celeste Schneider PhD, Adjunct Associate Professor Saint Mary's College, California; Adjunct faculty Long Island University; Psychoanalytic candidate at the San Francisco Center for Psychoanalysis. Research Interests: Child and adolescent psychotherapy process research; Infant observation.

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Stephen Shirk, PhD, is Professor of Psychology and Director of the Clinic for Child and Family Psychology at the University of Denver. Dr. Shirk received his PhD in clinical psychology in 1983 from the New School for Social Research in New York City. He subsequently completed a post-doctoral fellowship at Harvard Medical School in clinical research. Dr. Shirk is a past-president of the Society of Clinical Child and Adolescent Psychology, Division

53 of the American Psychological Association. He currently serves as a consulting editor for the *Journal of Consulting and Clinical Psychology*, *Journal of Clinical Child and Adolescent Psychology*, *Clinical Psychology: Science and Practice*, and the *Journal of Cognitive Psychotherapy*. Dr. Shirk is a member of the U.S. National Institute of Mental Health (NIMH) review committee for Child and Family Interventions. Since 2000, Dr. Shirk has received external funding for his research on the development and treatment of adolescent depression. Along with his collaborators, he recently completed an NIMH funded project examining cognitive-behavioral therapy for depressed adolescents in school-based clinics. Dr. Shirk's primary research focus is on the implementation of evidence-based treatments for adolescents, especially depression treatments, in clinical service settings including schools and community clinics. A major thrust of his recent work has been on therapist strategies that promote treatment engagement and alliance.

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Jenny Sima, MSc, licensed psychologist. Working fulltime at the Unit for Educational Psychologists in the City of Stockholm with children and families in a segregated area where school difficulties often are combined with transcultural, environmental and emotional difficulties and trauma. Research interests: Participating in a study concerning psychodynamic child psychotherapy at the Erica Foundation.

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Birgit Svendsen, Associate Professor, Department of Psychology, Norwegian university of Science and Technology, Trondheim, Norway. Research interests; making the therapists' implicit knowledge explicit. One way to get explicit knowledge is by analyzing videotapes of the therapeutic processes and to interview the therapists. My PhD work is concerning what therapists do to present themselves as helper for the child in the initial phases of psychotherapy and how this seems to develop the alliance. To understand the development of the therapeutic relationship and the alliance, we need concepts that grasp what actually "goes on" in the therapeutic processes.

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Agneta Thorén, PhD, is specialized in developmental research at the University of Stockholm, Sweden, where she did research on congenitally blind children's development of language and self related to parental communicative styles during early childhood. She is also a clinical psychologist and child psychotherapist at the Erica Foundation, Stockholm, an institute providing psychotherapy for children and adolescents, professional training at university level, and research. Her clinical interest includes children with communication difficulties and cognitive dysfunctions as well as parent-child-psychotherapy.

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Cathy Urwin, PhD, is a psychotherapist with children and adults working in the National Health Service and in private practice in the UK. She holds a post at the Tavistock Centre as Consultant Child and Adolescent Psychotherapist and Research Fellow. She has a background in developmental psychology teaching and research and her clinical interests include work with under fives and with children with autistic spectrum and social-communication difficulties. Current research includes: the evaluation of developmental progress in child psychotherapy from the perspectives of parents, therapists and patients and the nature and role of parent work; the use of infant observation as a research methodology; the social and emotional dynamics of baby groups.

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Tor Wennerberg, is a former journalist who is currently in the fourth year of the five-year clinical psychology program at the University of Stockholm. He writes regularly about psychological issues for popular publications like the Swedish daily newspaper, Dagens Nyheter. His primary field of interest is attachment theory, especially as it intersects with theories of intersubjectivity and mentalization. At present, he is working on a book about attachment trauma, with particular focus on the disorganized attachment category. The aim of the book is to make the findings of attachment researchers easily accessible to an audience of Swedish psychotherapists.

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Majlis Winberg Salomonsson, MSc, is a training psychoanalyst and a child and adolescent psychoanalyst, member of the Swedish Psychoanalytical Society. She is also a Child and Adolescent Psychotherapist. She is working in full time private practice in Stockholm with adults, children and adolescents. At the Erica foundation she is teaching and supervising at courses in Child and Adolescent psychotherapy, in Short-term therapy for young people, and in Supervision. She is supervising and teaching psychoanalysis and psychotherapy at different Institutes in Sweden and Denmark. Since 1996 she is teaching psychoanalysis at the Swedish Psychoanalytic Institute on subjects such as Freud's early writings, sexuality in psychoanalytic theory, child- and adolescent development and psychoanalysis. During many years she was on the board of the Psychoanalytic Training Institute in Sweden. Since 2005 she is a member of the IPA Committee on Child and Adolescent Psychoanalysis, COCAP. She is a member of the editorial board of Mellanrummet, Journal of Child and Adolescent Psychotherapy.

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APPENDIX 3

THE ERICA FOUNDATION – HISTORY AND SOME CURRENT ACTIVITIES

BRITTA BLOMBERG

During the early 1920's some attempts were made to start Child Guidance Clinics (CGC) in Sweden. In those days it was usual for a paediatrician to see the child briefly and for a psychiatric social worker to meet the mother. Fathers were seldom involved in the treatment.

In 1933 the first permanent CGC started and one year later, in 1934, The Erica Foundation was formed. While the CGC usually offered counselling for parents, treatment at The Erica Foundation focussed on both the child and the parent/s. Parallel with this, a few child- and adolescent psychiatric wards started in the ordinary children's hospitals as "observational clinics" with the aim of "observing" more severe cases. From the late 20's child and adolescent psychiatry developed along these two lines: one with the emphasis on guidance, prevention and psychotherapy, the other with a more psychiatric orientation.

Similar developments took place in many western countries in the late 20's, but in Sweden the idea about prevention for mental welfare developed early and spread within the ordinary health system.

Hanna Bratt, a former teacher and headmistress, had a vision of helping those children with difficulties whom she met in schools. She saw difficulties that could not easily be mended by pedagogical methods and it was her strong belief that every child has an inside life. Further, she believed that it is the adult's way of becoming acquainted with this inside life that makes psychological change possible.

She visited London in 1933 and met, amongst others, Margareth Lowenfeld at The Institute of Child Psychology and was inspired

by the way sand, water and some toys were used in the encounters with the children. She started to take on young private patients, some of them referred by the first psychoanalyst in Sweden, Poul Bjerre. With some dedicated colleagues she founded The Erica Foundation in 1934. The institute started in her flat and later on moved to other addresses in Stockholm. The neighbours complained about the “noisy children”, and they had to move around for some years until in 1949 they finally arrived at Odengatan where the institute still has its home.

The name Erica refers not to a girl’s name, but to the flower Erica Tetralix – a kind of heather that survives under the most harsh conditions in barren ground. It is said to have been Hanna Bratt’s favourite blossom, and has remained a symbol for this soon-to-be 75 year old institute’s endurance over the years.

Training

When the therapeutic work with children and adolescents started at the Erica Foundation, there was no such thing as psychiatrists, specializing in children and adolescents. Psychologists and psychotherapists (these specializations came around the mid 1950’s in Sweden) also did not exist. The staff usually comprised, apart from the psychiatrist and the headmaster, preschool teachers or others interested in the field. The first (one year) course started already in 1937. The course was in Child Developmental Psychology and prophylactic treatment, as well as psychopathology and how to work with these states in children – a really new concept in those days. In 1942 the first trained psychotherapist, a psychologist by the name of Gudrun Seitz, started to work at the institute. She had trained in London and with her competence it was possible to arrange a two-year course, specializing in child psychotherapy, to be taken after the basic training of one year. This started in 1948 and quite early on The Erica Foundation had a 2–3 year training program in psychotherapy. In the late 50’s the applicants shifted to psychologists and psychiatrists. Since 1948 this psychotherapy training – with many modifications over the years (it is now 2 + 3 years) – has been offered to 12 students every other year.

For the past 30–40 years we have offered many different kinds of training programs at the institute:

- Assessment and diagnostics for psychologists working with children
- Supervision and consultation (for licensed psychotherapists) started in the early 1980’s

- CPD (Continuing Professional Development) for licensed psychotherapists)
- Training for special needs teachers working with children with pervasive conduct and emotional disorders
- Courses in developmental psychology for psychiatrists and paediatricians

Clinic

While the training programs are open to applicants from all over Sweden, the patients attending the Erica Foundation are from the Stockholm County Council catchment area. The institute is financed by the state for most of our training programs and the patients are paid for by the county council. This means that treatment is free of charge. We meet approximately 100 new patients every year, apart from the ongoing work with children, adolescents and their parents.

During the past years we have also received financial support for reaching out to young adults, up till 25 years of age. Most of our patients, however, are children 3–12 years and adolescents, as well as their parents.

A preschool for children with pervasive contact and emotional disorders is also integrated in our clinical work. This started in the mid 1970's inspired by the work of Margaret Mahler. There are two groups, one in the morning and one in the afternoon, each with four children. Each child attends psychotherapy or psychoanalysis with our staff. The parents attend separate sessions or joint sessions together with the child.

Research

The research carried out at the Erica Foundation is one of the topics at this workshop. Research has always been a natural part of the Erica Foundation. Already in the 40's and 50's the Erica Method, a standardized method for using toys and sand trays in clinical assessment, was developed and a doctoral thesis on symptoms and psychopathology of the patients at the Erica Foundation was published. In 1999 Gunnar Carlberg published his thesis on turning points in child psychotherapy.

During the past two decades, under the leadership of Siv Boalt Boëthius and Gunnar Carlberg, research at the Erica Foundation has had an important impact on the staff and has also influenced child and adolescent psychotherapists in Sweden.

Integration

Most important at The Erica Foundation is the integration between research, training and clinical work. Our teachers are skilled and experienced clinicians and are involved in various kinds of research projects. All three parts, i.e. research, training and clinical work, form a fertile soil for new and creative development within the field of treatment for children, adolescents and their parents.

For further information about The Erica Foundation, please visit www.ericastiftelsen.se.



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ISBN 978-91-633-5788-6