Journal of Child Psychotherapy

Children's expectations and experiences of psychodynamic child psychotherapy

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Version of record first published: 22 Jun 2009

To cite this article: Gunnar Carlberg, Agneta Thorén, Susanna Billström & Fredrik Odhammar (2009): Children's expectations and experiences of psychodynamic child psychotherapy, Journal of Child Psychotherapy, 35:2, 175-193

To link to this article: http://dx.doi.org/10.1080/00754170902996130

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The aim of this study was to explore children’s expectations and experiences of psychodynamic child psychotherapy. Semi-structured interviews were conducted using self-rating instruments, drawing materials and a selection of toys. Ten children aged 6–10 years were interviewed prior to and after treatment (mean number of sessions = 99). The main results showed that most of the children, despite their young age, had the ability to give clinically valuable accounts, verbally or non-verbally, of their problems. A majority of the children expressed positive hopes and expectations about their forthcoming therapy as well as regarding the experience of therapy as positive or very positive after termination. Self-ratings of change showed a moderate degree of improvement in their problems. Pre-treatment attitudes were linked with post-treatment self-ratings of improvement. The importance of preparing the child and the family for therapy and of listening to the children’s experiences is highlighted.

Keywords: interview; child’s testimony; narrative; clinically based study; qualitative research; therapeutic alliance

Introduction

A dilemma within psychotherapy research where children are involved is that one voice is missing – that of the child (Stith et al., 1996). Evidence-based medicine (EBM) should be based on the integration of the best available research evidence with clinical expertise and patient values (Sackett et al., 2000). It is therefore important to collect information about psychotherapy from the child’s own perspective and to listen seriously to the child’s own testimony. An assumption sometimes made that many children in psychotherapy lack motivation and are unwilling to come to their psychotherapy sessions needs to be examined per se (Dew and Bickman, 2005). Child psychotherapists expect a child to show some ambivalence especially when the parents themselves show ambivalence. However, it is important to study the mechanisms behind this from the child’s perspective.

One obvious reason for the fact that very few studies have addressed children’s opinions of psychotherapy is the widespread notion that younger children are especially difficult to interview about emotional or abstract matters – not least regarding feelings concerning something not yet experienced, such as a forthcoming period of psychotherapy. To succeed in this endeavour, it is necessary to give children the...
opportunity to express their thoughts and feelings in ways that they feel comfortable. This can be accomplished by encouraging them to choose the most suitable mode of expression, verbal or non-verbal, for their particular developmental stage.

Children’s experiences have been studied in areas such as school, peer relationships and social environment (Christensen and James, 2000). At an early age, children are already able to share their thoughts and experiences on these matters if they are helped via various procedures. In child psychoanalytic psychotherapy, for example, toys are provided to act as a facilitator to the child’s unconscious phantasies. This is a well-established psychoanalytic method used to gain an understanding of the child’s inner world and, when making clinical assessments prior to treatment, to formulate an opinion on what might underlie the child’s difficulties (Rustin and Quagliata, 2000). However, surprisingly few studies have been carried out about children’s expectations and experiences of psychotherapy (Dew and Bickman, 2005).

A few studies have examined how adults retrospectively experience earlier child psychotherapy (e.g. Midgely and Target, 2005; Midgley et al., 2006). Such narratives can be an important source for understanding the therapeutic process and its beneficial elements.

Because there are big developmental differences between children of various ages, it is vital in an interview to communicate in a way that takes the child’s cognitive capacity and socio-emotional level into consideration. A comprehensive literature study of child interviews has shown that the way the interview situation is designed, the nature of the questions and the relationship between the child and the interviewer has a decisive effect on the responses elicited (Krähnähn and Blades, 2006). Examples of obstacles are the children’s tendency to give the answer that they believe is expected of them, and that children are more suggestible than adults with regard to responding in a certain way. The period of time between the interview and the event being investigated also has a major effect on the responses. Salomon and Pipe (2000) state that with the right help children can reliably recall events one year later. Reliability decreases, however, if the child only has access to verbal clues. The tendency of responses to be adjusted to suit leading questions appears to increase over time. This indicates the importance of posing open questions in order to elicit reliable responses (Jones and Pipe, 2002).

When non-verbal methods are used in child interviews, it is possible to get closer to the children’s developmental level and their natural way of expressing themselves. A meta-analysis of studies in which drawings are used to facilitate communication in child interviews shows that children’s active involvement in the interview situation increases. The drawings offer children clues that guide them through events and expectations and can assist them in structuring their narrative (Driessnack, 2005). Toys can also be used to facilitate responses from children in clinical interviews. It appears that the way in which toys and other facilitators are presented, the question that is to be answered, and the child’s developmental level are all of importance (Karen, 2006).

The child and parents’ expectations of psychotherapy have been discussed in some studies. Nock and Kazdin (2001: 155) define expectations as: ‘... anticipatory beliefs that clients bring to treatment and ... beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery’. Urwin (2007) developed The Hopes and Expectations for Treatment Approach (HETA) to generate a set of hopes and expectations from the parents and therapists before, during and after psychotherapy.
This instrument is valuable when measuring the effects of psychotherapy and in promoting good practice in the treatment and management of complex cases.

Midgley and Navridi (2006) discuss how parents’ motivation for their child starting therapy, their expectations about treatment and their ability to think about feelings are all related to dropout rates. Shuman and Shapiro (2002) describe the importance of parents having positive and correct conceptions and expectations before their child begins psychotherapy because this will affect the child’s expectations to a high degree. The authors emphasise that preparing the parents by giving them information prior to the therapy may lead to more positive expectations. They found that written material on its own did not show any effect. However, when it was combined with a video, it was effective in stimulating positive expectations in the parents, which then had a positive knock-on effect on the child. Nemiroff and Annunziata (2002) published *A Child’s First Book about Play Therapy*, intended for young children aged four to seven, for whom psychotherapy is considered. Parents can read it to their child or the child can read it with the help of the parents.

Anna Freud (1946) also highlighted the importance of preparation of and information to a child prior to therapy. However, we know that the ways in which this is done can vary, in some cases leading to the child being well informed, whereas in others, the child is left only with a very vague concept of therapy (Billström, 2003; Bonner and Everett, 1986). Incorrect or negative expectations in the child have been shown to be associated with a poorer treatment outcome and a greater dropout rate (Day and Reznikoff, 1980).

Expectations are also intimately connected with the creation of a therapeutic alliance, which is an important aspect in research on children’s conceptions before and after therapy. A therapeutic alliance that incorporates agreement regarding goals and methods in therapy, in addition to the bond that is developed between patient and therapist, has consistently been shown to influence outcome. Dew and Bickman (2005: 29) report several studies that find a significant link between outcome expectancies and client improvement. They believe that ‘... the relationship between expectancies and outcome may be mediated by the therapeutic alliance’.

The overarching aim of the current study was to explore and identify the range and type of experiences and expectations children express prior to and after child psychotherapy. For this purpose, a clinically valid method for interviewing young children needed to be developed and tested.

The questions addressed were:

1. How can children describe their problems and wish for help, prior to therapy?
2. What ideas and expectations of therapy can children express?
3. What post-treatment attitudes can children demonstrate regarding therapy?
4. How can children express their views of therapeutic effect?

**Methods**

The data analysed in this study is part of the Erica Process and Outcome Study (EPOS) (Carlberg, 2009). The EPOS evaluates goal-formulated, time limited psychotherapy in conjunction with parallel work with parents. The EPOS aims to explore the complex clinical reality in child and adolescent mental health services
through combining the study of process and outcome variables. To explore
children’s own attitudes towards psychotherapy, a small sample of child interviews
were conducted, prior to and after treatment, in this sub-study of EPOS.

**Design**

The present paper reports on children’s narratives of their experience of
psychotherapy. The chosen research method aimed to replicate clinical conditions
as closely as possible. This means that the children were not chosen according to
specific research inclusion criteria, nor randomised to different treatment or control
groups. Their common features were age (early school age), and the fact that they
had been assessed by their local child mental health services team to be in need of
individual child psychotherapy.

**Participants**

**Children**

The target population in this study comprised 10 children. The average age was eight
(median = 8, range 6–10 years). The older children functioned at a lower cognitive
level, which made them more comparable with children of early school age. Seven
participants were boys and three were girls. The families that participated in the
study came from different parts of Sweden. They had all required help for their
children at their local child and adolescent mental health service.

The children had at least one *DSM-IV* diagnosis (American Psychiatric
Association, 1994) at the start of psychotherapy. The most frequent Axis I diagnoses
were *Attention disorder and disruptive behaviour* (*n* = 6). Other diagnoses were
*Attachment disorder, Selective mutism* and *Depression*. Seven of the 10 children
fulfilled criteria for more than one diagnosis.

**Psychotherapists**

Ten psychotherapists worked with the children in this study. Of these, two were men
and eight were women. All but one of the psychotherapists were clinical
psychologists (*n* = 9); the other was a social worker (*n* = 1). All psychotherapists
were experienced clinicians within the psychodynamic field. During the study, they
were part-time students on a three-year specialist training course in child and
adolescent psychotherapy. All received weekly individual supervision from a senior,
psychoanalytically trained child psychotherapist throughout the treatment period.
Therapies were conducted within this theoretical and methodological framework.

**Procedures and treatment**

The children were assessed at their local mental health service or child and
adolescent psychiatric outpatient unit. The assessment followed standardised
procedures, aiming at deciding whether psychotherapy was the optimal intervention
for the specific child and his or her family. The assessment procedures included
psycho-diagnostic play sessions based on *The Erica Method* (Danielson, 1998), a
Swedish adaptation of Margaret Lowenfeld’s ‘World Technique’ (Lowenfeld, 1950).
In *The Erica Method*, the child is asked to construct his/her world in a sandbox by choosing from a number of carefully selected toys such as animals, cars, houses, cannons, people, etc. Both the form and the symbolic content are considered. Other projective methods like sentence completion and drawing tests were also used.

The therapeutic method was psychodynamic child psychotherapy, where concepts such as therapeutic containment, transference and counter transference are central working tools. The child psychotherapy consisted of one or two sessions per week over a period of one to two years. Parents were expected to attend their own sessions with another psychotherapist, once a week or at least every fortnight for parent work. Goals for the therapies were formulated and documented. Since clinical concerns took priority over the research component in this study, therapies came to be of different lengths. One therapy was terminated by 12 months, seven by 24 months and two continued beyond two years. The number of sessions ranged between 54 and 152 (mean = 99).

**Child interviews**

The children were interviewed before and after therapy. The two interviewers, both female, were registered psychologists with long experience of child psychiatric work. Each child met only one interviewer. The interviewer had no prior knowledge of the children or their problems. The first interview was carried out approximately one week before the start of therapy. The second interview was conducted one to four weeks after the termination of therapy. In the two cases where therapies were to be continued, the second interview was still carried out approximately two years into the treatment, after discussion with the therapist regarding the best timing. All interviews were conducted at the local outpatient unit where the child would attend or had attended psychotherapy. The interviews were carried out in a neutral consulting room and lasted approximately an hour.

**How the interviews were conducted**

One part of the interview consisted of an ordinary semi-structured verbal dialogue, adjusted to the child’s age and developmental level. An interview guide (appendices 1 and 2) was prepared and tried out through test interviews with some clinical but non-participating children of the same ages. The interviewers were instructed to use the questions in the guide freely without regard to their internal order, to facilitate spontaneous narratives. Open questions could be followed with more directive ones. The interviewer also used follow-up questions in order to obtain conscious, verbal statements to ensure that the child’s non-verbal expression was correctly understood.

In addition to the verbal questioning, the child was asked to do specific drawings (self-portrait/my family when we are doing something/my therapist and me when we are doing something) and to complete a validated self-estimation questionnaire, ‘*I think I am*’ (Ouvinen-Birgerstam, 1999). The questionnaire covers five categories of self-concept: physical appearance, skills and talents, psychological well-being, relationships with family, relationships with others.

To facilitate and elaborate expressions of thoughts and feelings during the interview, the child was encouraged to draw freely and to use a set of dolls, dolls’ furniture and even a small sandbox, in order to mirror earlier assessment experiences as well as expectancies regarding future activities in therapy. The choice of materials
was made with a view to replicating methods commonly used in Sweden for assessment and psychotherapy.

An easy-to-use five-point rating instrument for children was also constructed for the purpose. This consisted of a transparent plastic tube, which the child filled with balls, painted with smiling faces, up to different levels depending on his or her feelings. One ball meant little enthusiasm, while five balls filled the tube to the top and clearly showed a high level of appreciation. The initial intention had been to let the child choose between both smiling and sad faces during rating. However, test interviews showed that this idea was too complicated for the children to handle so the instrument was finally modified to the simpler grading of only one dimension (smiling).

**Pre-treatment interviews** began with a short introductory part in which the parents also participated. Information regarding the purpose and the framework of the interview was given. Questions were put to the parents and child together concerning the child’s familiarity with the unit and his or her preparedness for the therapy, which would soon commence. The parents were invited to join their child again for the conclusion of the pre-treatment interview. The individual part of the interview (approximately 45 minutes) began with the interviewer explaining the ethical considerations taken and obtaining the child’s consent. The child was informed that he or she was one of several children being interviewed on the subject, and that names and facts that might lead to recognition were to be excluded from future presentation. In the case of quotation, the child was told that no one but the child himself would be able to recognise a statement. The non-verbal material was demonstrated. The child was allowed to practice with the rating scale in relation to general questions about everyday life such as school experiences and free time preferences. The rest of the interview covered questions concerning the children’s own notions of their need for help and of starting therapy and meeting with the therapist, as well as their expectations of how things would turn out in therapy. Further questions concerned the children’s reflections on their parents’ wish for help as well as their earlier contact with the unit.

**Post-treatment interviews** were carried out in the same manner but this time without the parents’ participation. The children were reminded of the earlier interview and were initially requested to talk a little about themselves today. Further questions concerned their experiences of therapy, the relationship with the therapist and feelings concerning the ending of therapy. For the two children whose therapies were to be continued, questions about ending were naturally modified. Again, the children were offered the opportunity to express themselves through non-verbal methods. They were also encouraged to bring up anything that they felt had been overlooked by the interviewer.

**Data processing**

The interviews were audio-recorded and then transcribed by the interviewer. The textual data was explored inductively using systematic content analysis to generate thematic categories. Directly after the interview, the interviewer had made notes on impressions, situational circumstances and the child’s state during the interview, context information that was valuable in the later analysis of data.

The responses to the pre-treatment interviews were analysed (Stage 1) and compiled into various response categories following the interview questions. When play and symbolising with dolls was used for some questions, the interviewer then
mirrored to the child how she perceived what the child had meant. If the child verified the description, this symbolic expression was included as a thematic response. At this stage, individual pictures of child experiences came up.

In order to obtain a more coherent picture of the group’s experiences, the responses were thereafter compiled into various question areas (Stage 2), such as: what the children recalled from the assessment and earlier contacts; experiences of problems; what the children knew about the coming therapy; expectations of therapy; the children’s feelings about the parents’ participation; how it felt to be interviewed. In this process, the child’s main characteristic response patterns for each question were sought, to exclude the possibility of double assignment to different categories in a single question area.

Finally, interpretations of the responses were discussed in the research group (Stage 3) of which the two interviewers were members. Consensus assessments were sought in the discussions. At this stage, data from the ‘I think I am’ questionnaires and the children’s drawings were also considered. In our study, the results from the ‘I think I am’ were analysed qualitatively, not comparing the child’s ratings with normative data. Instead, a qualitative content analysis was used to get a fuller picture of the child’s self-perception, in addition to other non-verbal methods. The three stages in the processing of the pre-treatment interview described above were repeated for the post-treatment interview. A last stage entailed compiling data from the pre- and post-treatment interviews with regard to the study’s research questions.

Ethical considerations

The study was approved by the local ethical committee. Parents and children gave their informed consent.

Results

The primary aim of this study was to explore the participating children’s expectations and experiences of therapy. The presentation of results follows the research questions focusing on the children’s account of problem areas, their hopes and aims and their post-treatment attitudes towards therapy and its beneficial power.

Children’s pre-treatment descriptions of problems and wish for help

Despite their young age, most of the children showed a surprisingly good capacity to give the interviewer clinically valuable accounts, verbally or non-verbally, of their problems prior to therapy. Three of them talked of central problems concerning aggressive behaviour and trouble-making, which were most often parent–child-related conflicts.

Fred finds it hard to express his problems directly, but points to an abstract painting on the wall saying that he would like therapy to help him to “not end up like that”, specifying the motive as “war and fights”. He presumes his parents wish he would become “nicer” through therapy.

Anne can’t think of much that bothers her, but when the interviewer asks her, among other things, if she may have a tendency to easily end up in quarrels with others, she admits: “Yes. That’s how things are for me”. Through the self-concept questionnaire
she allows herself to be more open concerning her problems. She gives a picture of a lot of conflicts at home; mostly she is the one who gets angry. She often feels sad when she cannot have things her way. She answers “maybe” when asked if she feels happy.

Four of the children spoke of central problems concerning social isolation and low self-esteem.

Bo conveys that others think of him as “inferior”, that he has an “ugly room” at home and “boring things” to play with. Schoolmates “tease” him and “throw things” at him. Not even in the eyes of his parents does he feel respected or loveable. In the self-concept questionnaire, Bo elaborates on these themes, again declaring that peers are mean to him and that he feels alone, very sad and very different from the rest.

Susanne says that she doesn’t feel at ease in school. Her classmates don’t let her join their play during free time. “I ask them to, but they keep saying no . . . lots of excuses”. In the self-concept questionnaire, she clearly depicts her low self-esteem. She does not like herself particularly, she feels ugly and too short. She is often in a bad mood and does not feel happy. She thinks she is different from other children and feels lonely.

Finally, three of the children could not think of anything that was bothering them or at least found it hard to express their problems verbally. Consequently, they did not easily acknowledge any need for help. However, in indirect ways this group communicated troubles, which to varying degrees indicated aggressive control problems.

Adam says he thinks he is “already as nice as he can be”. The only thing he would like to improve is his skill in maths in school. However, in an indirect way, using the dolls, he shows problems with aggressive impulse control but denies this when confronted. In the self-concept questionnaire, he depicts himself as quite happy with his life and with himself, but admits to not being particularly calm and thoughtful.

Carl rejects his mother’s information to the interviewer that he has a problem with temper tantrums. He can’t think of anything he wants to change in himself – apart from improving his skills in reading. He has no idea why he has been recommended for therapy. He says he has ADHD but that this is not anything he can help. In the self-concept questionnaire, however, he admits having a problem with controlling his temper. He assumes his parents are disappointed in him.

As seen in the above examples, the children took the opportunity to express themselves in a more detailed and expansive way by means of the ‘I think I am’ questionnaire. Here they were free to indicate different problem areas as well as strengths.

It was not obvious to all the children that their problems could be linked with something they could get help with or change in therapy. As seen in the above examples, some of them did not seem to have reflected upon the question and did not want to or were unable to do so in the interview situation. Instead, they named things other than their expressed problem that they wanted to change, such as improving various abilities. However, four expressed a wish to receive help with their problems in relationships or communications with others (to make friends; to make others stop teasing; to be able to talk more freely etc.), which seemed to exhibit a wish for inner change, to a greater or lesser extent.

In summary, we learn from these 10 children, all of whom had been recommended for psychotherapy by child mental health professionals, that they were experiencing a substantial degree of emotional distress. While some reported
central problems regarding aggression or social isolation, others found it hard to admit to having any problems at all. Behind the denial of difficulties in this latter group, one found a way of indirectly expressing his problems with aggression. It was not obvious to all the children that therapy was something that might help them with or change their presenting problem.

**Children's pre-treatment ideas of and expectations of psychotherapy**

Even though most of these children did not seem particularly well prepared for therapy, often not knowing the name of the therapist or the frequency of sessions to come, results showed that most of them had positive conceptions and hopes regarding their forthcoming therapy. They expressed a curiosity about what was going to happen and whom they were going to meet. Many referred to memories from the assessment, which for most of them seemed to have been a positive experience. Four expressed positive or very positive expectations.

Bo thinks it will be “excellent” and “great fun” to begin therapy. He imagines himself being initially “stressed” and “shy”, but after a while feeling “more and more” at ease, enjoying the contact with the therapist. He communicates high expectations concerning their relationship. He hopes they will “do a lot of fun things, otherwise I might feel sad”, he says. He would like to play with the sand, paint and use clay but also do role plays together with the therapist. When asked to rate his expectations by means of the rating scale, he fills the tube up to the top (five balls).

Five children expressed more neutral or moderately positive expectations regarding their forthcoming therapy.

Erik visualises himself playing in the sand while the therapist is watching. He expresses a wish that the therapist will “help” him when he plays “… if there is something difficult that I can’t do”. Using the dolls he shows how the therapist and the boy “say hello” to each other. He believes that his parents want him to go to therapy because it “will be fun” for him. He would like the therapist to help him with the problem of other children harassing him at school, as well as improve his skills in “tree climbing”.

Only one out of the 10 children expressed a negative attitude towards the forthcoming therapy. This child gave a deliberately provocative account of what he and the therapist, whom he had not yet met, would do together.

Data further showed that even young children can express what they would like to do – and not do – in therapy. Five said they wanted to play. Some of these mentioned the soft sand in the sandbox, which they remembered from the assessment, and looked forward to using this therapeutic tool again. Others said they would like to play war-games or other games involving role-play together with the therapist. Half of the group said they would like to draw, paint or use clay, and just as many mentioned conversations with the therapist as one of the expected activities. Three said they expected to have fun with or joke with the therapist.

It was harder for the children to think of something they did not want to do in therapy. The few who did express themselves in this respect, asserted that they did not want “to be given tasks” by the therapist. Nor did the idea of being observed by the therapist seem to be a fully pleasant expectation.

In summary, a majority of the children expressed positive conceptions and high hopes regarding their forthcoming therapy. Four showed very positive expectations.
(five of the five possible balls). On the whole, the children had clear visions of what they would like to do in therapy. Their verbal accounts corresponded well to the self-ratings.

**Children’s post-treatment attitudes regarding psychotherapy**

In the post-treatment interview, six children expressed a considerable appreciation of their experiences of therapy. Their understanding of their problems and the reasons for being sent to therapy seemed to have expanded and deepened. A number of them now confessed to the interviewer that the reasons for them starting therapy were actually because of problems they had with their parents. Three of them mentioned that there had been incidents of their parents using physical punishment.

David reveals to the interviewer that one of the reasons for him being in therapy was that his parents beat him. He used to feel very sad, “the saddest boy in school”. He liked his therapist and always found it enjoyable meeting her. They usually played games together. But he didn’t like it when they “talked”, something he found “very boring”. The interviewer gets the impression that the relationship with the therapist was highly appreciated by David. Now, when therapy has come to an end, he admits still having the therapist in his mind. He remembers the last therapy session in detail. He now finds it “very peculiar” not going to therapy anymore. “You still think you will go there . . . even though you won’t”.

Two children communicated a more neutral or moderate attitude towards their therapeutic experiences.

Hanna tells the interviewer that she and the therapist used to sit around a table, communicating mainly through drawings. She appreciated this and says it was “fun”. Most of the time she enjoyed meeting the therapist (three balls), sometimes it felt particularly great (five balls). She never felt bad about coming to sessions, but when it was time to end therapy, she felt it was just right. She enjoys having more time left for staying in school, playing with friends. She denies ever having the therapist in her thoughts.

However, there were two children who expressed negative feelings towards therapy. They seemed to have had a somewhat negative attitude to the overall idea of therapy from the beginning, even if one of them indicated moderate expectations (three balls) by means of the rating instrument. In their opinion, it was someone else who wanted them to have therapy. Their attitudes indicated a feeling of unfairness. During the treatment period, they had usually felt ashamed and didn’t want to tell anybody in school where they were going twice a week. They said they would rather have been in school, playing with friends, or with their siblings at home.

Carl remembers playing different games with the therapist. He used to win and enjoyed these games. But apart from these enjoyable moments, he was actually never keen on going to therapy. He would rather have stayed in school playing with friends. In his opinion, it was his mother who wanted him to go to therapy owing to the frequent battles between them. When therapy ended, he felt quite relieved. When asked to rate his appreciation of the therapeutic experience, he puts one ball in the tube.

However, six considered that they had been able to talk freely with friends about the fact that they were attending therapy, even if they had not wanted to go into details. Three had only told one or two friends and did not want everyone to know.
Analysis of individual attitude ratings pre- and post-treatment showed predominantly consistent patterns. In seven of 10 cases, the children’s valuation of therapy after termination could be predicted from their attitude prior to therapy. Thus, those who expressed positive expectation before the start of therapy gave a positive assessment after the termination of therapy, etc. Of the remaining three cases, two of the children made a more positive final judgement than their expectations prior to therapy led us to believe. Only one child was more negative in his final judgement than in his initial expectations.

In summary, the majority of children expressed positive or very positive experiences of their therapy. Their verbal accounts corresponded well to the self-ratings. For a couple of the children therapy was associated with negative feelings. Results further showed consistent patterns in individual attitude ratings prior to and after therapy.

Children’s views of therapeutic effect

As has been demonstrated above, the majority of children showed positive attitudes towards their therapy and their relationship with the therapist. However, this did not imply that they expressed an overstated appreciation of the therapeutic effect on their problems. Instead, their opinions in this respect seemed to be rather thoughtful and balanced. Seven rated their improvement as moderate, indicating a difference of two to three balls out of five possible between pre- and post-ratings.

Anne declares to the interviewer that the quarrels in her family were something she wanted therapy to help her with. The situation is now “much, much better”, she asserts. Today she feels more inclined to listen to her parents, even if she still gets rather angry occasionally. She rates her emotional well-being before therapy at a moderate level (three balls), compared to five balls afterwards. She also finds her relations to peers to be “better than before”. In the self-concept questionnaire, however, she gives a similar picture of her problems as before therapy; they are still concentrated on the area of aggression in relation to peers/family. Despite these troubles, she finds herself mostly in a good mood and doesn’t feel alone. She considers herself to be “someone who does not easily give up”.

Despite his rather negative overall attitude towards therapy, Carl admits that his situation at home has changed. The frequent battles between him and his parents have become fewer. Today they behave more gently towards each other, he says, and repeats that he is very happy about this. In the self-concept questionnaire, he gives a clearly positive account of his present view of himself. He feels happy in relation to his parents, his teachers and his peers. He has high hopes for the future. If there is something he feels discontented with, it is his clumsiness and also his lack of skills in singing, playing and drawing.

A couple of children considered their improvement to be substantial, grading the difference to four to five balls out of five possible.

In contrast to his pre-treatment denial of problems, Adam now admits to the interviewer that he had to go to therapy because of his habit of frequently getting into fights both at school and at home. At the time he felt “very bad” (no ball), today he finds things are going “great” (five balls). Also, in the self-concept questionnaire, he mentions his tendency to get angry. However, most often he feels happy nowadays.

The interviewer notices that Bo spontaneously uses a self-calming strategy, which implies thinking before acting. Bo reports that there is a more relaxed atmosphere at home nowadays; he and his parents do not lose their temper as quickly as before. The
main change for him is that his parents do not use physical punishment anymore. He gives an account of a much better overall situation, “even if things aren’t perfect yet”. Also in the self-concept questionnaire, he depicts an undoubtedly more positive view of himself – even if not yet perfect. He now feels he is doing pretty well at school, “at least if I think the best I can”. Peers are now kinder to him and he feels he has plenty of friends. Occasionally he might think that others do better than he does, and he feels somewhat different from the rest. Even if he sometimes might feel sad and lonely, he still considers himself happy. “I don’t love myself, no, but I pretty much like myself”, he asserts.

One of the children, who also expressed negative attitudes towards therapy, rated the perceived change pre–post therapy as zero (no ball). It was interesting to note that in eight cases a clear association was found between the individual children’s pre-treatment hopes and expectations towards therapy and their post-treatment opinion of the therapeutic effect and improvements in symptoms.

In summary, seven children reported a moderate degree of improvement in their problems after therapy, while two reported a substantial change. Results showed a relationship between pre-treatment expectations towards therapy and post-treatment opinions of the therapeutic effect.

Discussion

The results show that it is possible to get close to the children’s own experiences of themselves and their forthcoming or just completed therapy with the interview method used. Even young children and children with major difficulties were able to convey important experiences and expectations. The children mainly described positive expectations of the therapy, which is in contrast to the impression often held that children could lack motivation for therapy.

The majority of children expressed positive or very positive overall experiences of their therapy after termination. Of course, children in psychotherapy can occasionally show a reluctance to come to sessions once they have become engaged in the process of therapy. The reason behind negative therapeutic reactions can be connected to transference issues, for example, or to ongoing conflicts around the child in the family and/or the wider network. For a couple of the children in this study the idea of therapy seemed associated with negative feelings. There was a clear association between pre-treatment expectations towards therapy and post-treatment opinions of therapeutic effect.

Views expressed about the outcome of the therapies were surprisingly differentiated. The children’s positive feelings regarding their therapeutic experiences were not, as one might have expected, over-generalised in the area of perceived change. Instead, both verbal descriptions and self-ratings of change showed that the children themselves considered there had been a more moderate degree of improvement in problems. Seven children indicated a difference of two to three balls out of five possible.

Despite different personalities and problem areas, the children in the study mostly displayed great interest and pleasure in the interview situation. They easily understood how to use the rating instrument and seized the opportunity to express themselves through drawings and play with toys. These tools helped the children to remember prior events, and stimulated them to give more details in their verbal accounts.

It was not always a straightforward process to interpret the children’s responses. The child’s perspective does not always appear to be logical seen from an adult perspective. The child who expressed in the interview that he wanted to become...
better at climbing trees understood that the therapy might help but he did not have a realistic picture of what it would actually entail. Perhaps the child had imagined that if he improved his skills, his self-esteem would grow, which in turn would lead to better friendships? From a child’s perspective, it is perhaps not illogical, when asked what might improve his or her life, to express a wish to be better at singing or climbing trees.

In the first interview, we saw that the children referred to the experience of just having gone through an assessment at the unit. The children generalised from the earlier experience rather than thinking freely about what the forthcoming therapy may mean. For example, most children expected that the therapy would mean play or drawing. Two children who did “not want to be given tasks” were almost certainly thinking back to the projective testing in the assessment phase.

In the planning of the study, it was discussed whether the interviews would have a negative effect on the psychotherapy processes and the establishment of a therapeutic alliance. In order to examine this, some questions were put to the therapists with the help of a questionnaire after the children had attended their eighth therapy session. None of the therapists reported that the interview had had any decisive, positive or negative, effect on the therapy process. Four of the therapists reported that the child reflected in some way upon the experience of being interviewed. One therapist said that the child had been helped by the interview to formulate his problem. Two therapists reported that the interview had created a greater clarity for the child concerning his or her own difficulties and the reason that therapy had been initiated. One therapist said that the interview might have led to a slight transient confusion. In this case, the child had commented in the first session on “the other woman who also had a sandbox”.

A couple of children who also expressed negative feelings towards therapy prior to and post-treatment remind us of results from a long-term follow-up study by Midgley et al. (2006). They draw attention to negative comments made by former patients. One third of the interviewees described how therapy “… made certain aspects of their lives (at the time) worse” (Midgley et al., 2006: 265). In the current study, we found how a negative attitude to the overall idea of therapy from the beginning was followed by a negative attitude after therapy. In the opinion of two children, it was someone else who wanted them to have therapy. Their attitudes indicate a feeling of unfairness. During the treatment period, they usually felt ashamed and did not want to tell anybody in school where they were going twice a week. They told us that they would rather have been in school, playing with friends or with siblings at home. Findings like this point to the importance of preparing the children themselves for the start of therapy. Of course, this does not diminish the obvious importance of establishing a positive working alliance with the parents.

Further evidence-based studies may strengthen our ability to recommend individual psychodynamic psychotherapy for children who would most benefit from this form of treatment.

**Strengths and limitations**

There is a great need for clinically based studies to be carried out, i.e. of therapies that are conducted within standard child psychiatric services (Fonagy, 2003; Midgley, 2004). Despite the small group, an important strength of this study is that it was carried out in this kind of setting. Child mental health professionals from
different child and adolescent psychiatric units in the public sector selected the patients using clinical criteria. Thus, in contrast to many efficacy studies, the present study considered children with complex problems who had already been selected for psychotherapy. In this type of multi-centre study it is, however, more difficult to have control over assessment routines and to co-train raters.

Since the data in this study excludes therapeutic process data or other contextual information of the cases, the stance taken was to pay close attention to the children’s manifest expressions about themselves and their treatment experiences, rather than to interpret a latent meaning to their reports. Naturally, access to additional therapeutic material could have shed valuable light on the interview data. Further analyses will relate the present results from child interviews to therapists’ reports on therapy outcome and change in the child’s internal functioning as well as parents’ reports of child improvements.

In future studies, an interview procedure with the parents ought to be built in prior to and after therapy. This would be in a more structured way than the interview normally carried out by a child psychotherapist before and after an ordinary clinical assessment, or at the end of treatment and would illuminate the parents’ own experiences of their contact with the unit and the help received by their child and their family. Furthermore, important information could be collected about what they have understood of the information they have received and how they have informed the child about the current therapy. What parents communicate to their child about these matters is influenced by their subjective expectations. Parents may also have different expectations from the therapist regarding the contact, which is a potential source of misunderstandings and may even lead to a premature ending of the therapy. The congruence between the child’s initial attitude to the therapy and the child’s statements about the benefit of the therapy shown in our findings demonstrate, in accordance with Dew and Bickman (2005), that the outcome can to a certain extent be influenced by information.

Implications
Studies such as the present one can increase our knowledge about the children’s own experiences of psychotherapy. How the child’s motivation is related to the information received before therapy constitutes an important area for future studies. Listening to the child can help us become better in assessing when individual psychodynamic child psychotherapy is the treatment of choice. Dew and Bickman (2005) suggest that the therapeutic alliance may constitute a mediator between expectancies and outcome. The present study illustrates a way to explore this area further.

Data collection from the therapies in this study, provided by the therapists, parents and the parents’ therapists, enriches the view of therapeutic processes and treatment outcome. The central focus on the view of the therapies from the children’s perspective, however, provides additional, important data in this much needed area. This is the piece of the puzzle that is often missing.

Acknowledgements
This work was supported by Stockholm County Council and Gålö Foundation. We wish to express our gratitude to research assistant Jenny Sima for her contribution to this study and to Nick Midgley for valuable comments on an earlier draft of the manuscript.
References


Appendix 1. Child interview, prior to therapy

A. Introductory part with child and parents together (approximately 15 minutes)

Introduction of the interviewer and the purpose of the interview
Mostly it’s the parents or other grown-ups who suggest that a child should attend psychotherapy. My co-workers and I are particularly interested in what the children themselves think of their therapy. To find out, I interview children from different parts of Sweden shortly before they start therapy and again when the therapy is over. You are one of these children.

A short search into the family’s use of terms for the concepts of ‘therapy’ and ‘therapist’.

Explanation of the frames of the interview
When we have made acquaintance with each other, Mum and Dad will get a questionnaire to fill out in the waiting room. You and I will stay in the room doing the interview. At approximately . . . o’clock we will join them again for a short moment and then say good-bye.

Introduction of the audio recorder
Demonstration of the audio recorder. The child is encouraged to try it.

Explanation of the purpose of recording.
Information given about the erasure of audio tape when study is over.

Information on ethical considerations
Explanation of confidentiality according to the Swedish Health and Medical Services Act. Declaration that there is no exchange of information between the interviewer and the therapists concerning the child’s problems or attitudes towards therapy. Declaration that publication of results will guarantee anonymity.

Questions concerning the child’s preparation for therapy
When was the assessment?
How many times has the child visited the local unit?
How have the parents prepared the child for attending therapy?
Has the child yet met his/her therapist? Is the name of the therapist known?

B. Individual child interview (approximately 45 minutes)

Elaboration on the ethical considerations
The child is informed that he/she is one of several children being interviewed on the subject, and that names and facts that might lead to recognition will be excluded from presentation of results. In the case of quotation, no one but the child him/herself could recognise statements.

Reminder of the purpose of the interview and demonstration of methods
I am interested in anything children might think concerning themselves and their therapy. There are no right or wrong answers to my questions. It is what you feel that interests me. If there is something you don’t understand, just say so, and I will explain it to you. And if there is something you say that I don’t get, I will ask you to say some more about it to help me understand. Sometimes you might find it easier to show me what you mean, by doing a
drawing or using the small dolls. You can also use this rating tube to show me how you feel about things. (Demonstration of non-verbal material. Letting the child practice.)

**General questions concerning pre-school/school**
What grade are you in?
How do you like being at pre-school/school? (Rating tube)

**Questions concerning assessment**
Tell me something you remember from the assessment (when you were here and met X).
What did you do?
How did you feel coming here for assessment? (Rating tube)

**The self-estimation questionnaire ‘I think I am’**
The interviewer reads the questions and the child marks the choices.

**Drawings**
Draw a self-portrait.
Do a drawing of your family when you are doing something.

**Questions concerning conscious self**
Say something good/you like about yourself.
Say something you find problematic/don’t like about yourself.
Say something you would like to be changed about yourself.

**Questions concerning therapy and therapist**
Why is it, do you think, that children may sometimes go to therapy?
Why will you soon attend therapy?
Do you know how often (or what days in week) you will come for therapy?
In what ways do you think therapy could be of help for you? What would you like to be changed/improved?
What improvements do you think your parents wish for?
How do you feel about your parents also meeting with a therapist?
What do you imagine you and your therapist will do in therapy? How do you imagine the room? (Show with dolls, drawings)
What would you like to do in therapy? (Show with dolls, drawings.)
Is there something you would not like to do?
Do a drawing of you and the therapist doing something in therapy.
When you think of the therapy that will soon start, how do you feel? (Rating tube)

**C. Conclusion part with child and parents together** (approximately 5 minutes)
The interviewer and the child fetch the parents from the waiting room.

**Time for questions and reflections**
How did the child find it being interviewed? (Rating tube)

**Reminder of post-therapy interview**

**Appendix 2. Child interview, after therapy**

**A. Introductory part**

Reminder of the last interview and of the purpose of the interviews
Do you remember that we have met before? I did an interview with you just before you were going to start therapy. And now, when therapy has ended, I’m back for a second interview.
My co-researchers and I are interested in understanding more about the help children need when they have different kinds of problems. We want to listen to the children themselves. That is why I will interview you and some other children about their experiences of therapy, to hear what they think of the help they have got.
Reminder of ethical considerations
What you will tell me about your feelings and attitudes towards therapy is something I will not tell your therapist, your parents or teachers. When we write a report later on about what we have learnt from you and other children, we’re going to take out your name and any facts that are special to you, so that nobody will recognise you.

Introduction of the audio recorder

Explanation of the frames and methods for the interview

The interview will take approximately an hour.
I am interested in anything children might think concerning themselves and their therapy. There are no right or wrong answers to my questions. It is what you feel that interests me. If there is something you don’t understand, just say so, and I will explain it to you. And if there is something you say that I don’t get, I will ask you to say some more about it to help me understand. Sometimes you might find it easier to show me what you mean, by making a drawing or using the small dolls. You can also use this rating tube to show me how you feel about things. Do you remember? (Demonstration of non-verbal material.)

B. Individual child interview

General questions concerning school and interests
What grade are you in now? How do you like being at school? Say something you like/dislike in school, as well as something in between. Show me how you feel about it. (Letting the child practice with the rating tube.)
What do you like doing in your spare time? (Rating tube)

The self-estimation questionnaire ‘I think I am’
Since it was a long time since we met, I would like you to fill in this form, letting me to know a bit more about how you think of yourself today.
The interviewer reads the questions and the child marks the choices.

Drawings
Draw a self-portrait.
Do a drawing of your family when you are doing something.

Questions concerning therapy and the relationship with the therapist
If you were to explain to a friend what therapy is, what would you say?
What were the reasons that made you attend therapy?
What did you think about it at the time?
What did you want to be changed/improved by therapy? Do you think that was the same as your therapist wanted?
Tell me about some particular episode you remember from therapy. (Show with dolls, drawings).
What did you usually do in therapy? How did you like that?
Do you remember something your therapist used to say? How did you like that?
Say something you find good about therapy. Say something you find bad about therapy.
Mostly, how did you like being with your therapist? In the beginning, and later on?
How do you feel about the number of sessions per week? Enough/too often/too seldom?
If you compare your relationships with other grown-ups with your relationship with your therapist, what would you say is special about a therapist?

Questions concerning parents’ sessions
Your parents also came to see a therapist; what do you think they talked about?
Did you join in in their sessions? How did you like that?
Did your parents meet your therapist sometimes? How did you like that?
Did you and your parents sometimes talk at home about the therapy?
Questions concerning friends and siblings
Did you talk to your friends about your therapy? What did you say? How did they react?
How do you think your brother/sister felt about you going to therapy?

Questions concerning change
How are things for you today? At home? With friends? In school?
Say something that is better than before? Something that is worse?
When we met before therapy, I recall you told me that . . . [this and that] . . . was troubling
you, do you remember? Show me with the rating tube how you felt about it at the time. If you
compare it with today, show me how you feel about it nowadays.

Questions concerning ending therapy
Do a drawing of you and the therapist when you are doing something.
How much did you like your sessions/seeing the therapist? (Rating tube)
How did you feel about ending therapy? Was it at the right time or would you have wanted to
end earlier/later?
Do you think of the therapist sometimes? On what occasions? Do you think of something the
therapist said/used to do?
Now therapy is over and you have more spare time, how do you spend it?

C. Conclusion part

Time for questions and reflections
Is there something you would like me to know about your therapy that we have not talked
about?
How did it feel being interviewed? (Rating tube)