Mentalization Based Time-Limited Psychotherapy with Children and Parents

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Introduction

What therapeutic elements constitute a mentalization based short-term model for children, the MBT-C? What toys and material for emotional expression does an MBT-C therapist keep in the psychotherapy room? How can we measure the changes that we aim to achieve? These are only some of the questions targeted and discussed during two full, fascinating and friendly days at the Erica Foundation, Stockholm, in April 2013. Twelve clinicians, especially interested in mentalization based work with children and parents, gathered to share inspiration, experience and knowledge.

This workshop was the third meeting for this international interest group, even though the constellation has changed slightly for every meeting. The group met for the first time in 2011 and for the second time in 2012, both occasions at the Anna Freud Centre, London. Nick Midgley was the coordinator of these meetings. This time the turn had come to The Erica Foundation to host the meeting.

Inspirational it was indeed, with presentations of experiences, therapeutic models and research from five different countries, as well as two parts of the workshop especially assigned to discussion and presentation of research and training. Two days passed quickly with lots of generous sharing of ideas, exchanging of thoughts, and rewarding discussions.

To document the workshop Karin Lindqvist was assigned to take continuous notes. The final text has emerged in collaboration with Agneta Thorén and has also been approved by the participants. The report aims at capturing and integrating some of the information and thoughts shared at the workshop. The text is divided into chapters such as assessment of mentalization, clinical models and research. In the interest of protecting patient’s integrity, no case reports are included. Some unpublished research results were also excluded. At the end of the report all participants are listed with contact details.

The Erica Foundation (www.ericastiftelsen.se) was founded 1934 and is nowadays commissioned by the Swedish government and Stockholm County Council to provide psychotherapeutic treatment for children, adolescents and their families as well as run university level training in child- and adolescent psychotherapy. Training and clinical activities are integrated with research. The work is based on psychodynamic theory, developmental psychology research, psychotherapy research as well as clinical experience.

The clinical staff, about 15 people, represents a spectrum of specialists within child and adolescent psychotherapy, psychiatry, education, supervision and research. The Erica Foundation has worked with mentalization informed short-term therapy since 2008, when a pilot project on the therapy model was started. In 2009 a research project was initiated, with data being analyzed at the time of this workshop. Today a permanent group of clinicians work with short-term therapy. Training in mentalization based short-term therapy for children and parents is an integrated part of the training program for psychotherapists, and a separate course on the therapy model is held at the Erica Foundation.

Stockholm September 2013

Gunnar Carlberg
Director of the Erica Foundation
Assessment of Mentalization

Karin Ensink introduced the workshop with a presentation on the development and assessment of mentalization.

DEVELOPMENT OF MENTALIZATION AND SELF-REPRESENTATION

Mentalization

Development of mentalization relies on several factors. Attachment is known as a prerequisite for development in general, and most likely it also precedes the development of mentalization. In particular, mentalization theory underlines the importance of congruent marked affect mirroring in infancy as an important factor for development of mentalization capacity as well as self-regulation and agency. Mentalization is operationalized as Reflective Functioning (RF), defined as the manifestation of mentalization in language.

A strong correlation has been found between parents’ and their children’s RF. Research has also found that attachment in mothers correlate with their own RF, and that their RF in turn correlates with that of their child. This has led to RF being labeled as possibly bridging “the transmission gap”, explaining the transference of attachment patterns from parent to child. Parents with high mentalization abilities ideally continue to mentalize with their children throughout their development, helping to interpret difficult interpersonal situations, the child’s reactions as well as the child’s personality.

For older children, pretend play has shown to be an important factor in developing mentalization as well as the capacity for understanding the difference between reality and pretend. Judith Dunn (1991) also found that different families talk about mental states to different extents and believes that this might be one explanation for variations in mentalization capacity in children. Furthermore, individual differences in IQ, biological maturity, motivation and interest will affect development of mentalization. Ensink points out that children will develop differently even if they are in the same family. This is probably due to temperament and personality – whilst some children actively seek out interpersonal relationships and contexts where mentalization can be developed, other children are not as interested.

Self-representation

At the age of three, children can typically recognize and name affects in others. Recognition of affects in oneself is more difficult and develops at about age four. At this age an understanding of causes and consequence also begins, becoming more complex during the following years. At age four an understanding of false belief also takes form. Most children can describe what they like and dislike at the age of five, but when asked to describe themselves they will typically answer with physical characteristics (e. g. “I am blonde, tall, with blue eyes”). Not until the age of seven or eight the ability for characterization of self is developed, making it possible for children to describe themselves with personal characteristics. Along with the capacity for self-representation a capacity for characterizing relationships also takes form. The capacity for self-representation has gained increased
attention in mentalization theory and practice. In the Children Attachment Interview (CAI; Target et al., 2000), originally asking for descriptions of attachment figures and the relationships to them, Mary Target pointed to the importance of also capturing the self-representation. The CAI therefore now begins with asking the child to describe itself with three words. This question captures a lot about identity and many clinicians have started to also include this question in the Adult Attachment Interview (AAI).

One possible factor influencing the development of self-representation might be IQ. However deficits in this capacity have also been seen in children with histories of physical abuse, where many are completely unable to describe themselves. This may be the root of the identity disturbances seen in adults with Borderline Personality Disorder (BPD), making it an important area of intervention as well as giving clues about the development of the disorder.

ASSESSING MENTALIZATION
Ensink began by stating that a model of child psychopathology entails several aspects such as attachment, social cognition/mentalization, genetics (also conceptualized as temperament or personality), trauma, family and social context, internal conflicts, and identity. When doing research, however, we typically just look at one or a few of these aspects. Whilst there is a beauty in this simplification it also inevitably means that it is impossible to capture the entire complexity of what you observe. This highlights the importance of carefully choosing your measurements methods regarding to your research questions.

When considering mentalization and psychopathology several factors are important to assess. Firstly we need to recognize frank deficits in mentalization: Are there any? We also need to identify the domain of the deficits: Does it involve affective understanding, implicit or explicit mentalization, self or others etcetera? Furthermore we need to identify the cause of the deficit: Is it mainly due to organic reasons, neglect or personality? This knowledge is required to answer the last question: Can the deficit be remediated and if so how? If the deficit is due to organic reasons it might not be efficient to work with the child’s mentalization capacity, but rather aim at improving the parents mentalization skills to improve the parent-child relationship. If the deficit is because of neglect there might be room for therapeutic interventions where the therapist can scaffold the child. If the child’s personality affects the deficit and the child is not interested or motivated to improve it, are there any ways to help the child to develop those skills anyway, and is it worth it?

Preschool Children
There are several ways of assessing mentalization in children aged three to five. One straightforward way is by observation of the child as it interacts with other children or adults in school or preschool. A classic but, due to more targeted assessment tools, mostly outdated approach is to assess theory of mind with a false belief test. Another quite old way of assessing mentalization is using the Denham’s Affect Knowledge Test (Denham, 1986), a puppet interview assessing socio-emotional understanding in children. For some children the puppets can be distracting and there is a risk of children getting more involved in the experiment than in the actual task. A more recently developed assessment task is the Test of Emotional Comprehension (Pons & Harris, 2005). This easily used measure assesses both affective understanding and theory of mind, and has a quite cognitive focus. However the task is probably more useful in clinical settings than in outcome research, as it measures quite generic mentalization capacities that most likely are not the target for therapeutic interventions.
Other measures assess facial recognition and interpretation. Using facial morphing it has been found that, like BPD patients, children with aggression problems identify negative affect at an earlier point than others. The origin of this capacity could be partly genetic, but it could also be explained as a survival mechanism in traumatized children, who rely, or previously have been relying on being able to detect negative affects quickly in their (potential) abusers. Furthermore it has been found that some children (and adults) can reliably detect facial expressions, but consistently give them malevolent attributions. This problem in attribution rather than in detection is a possible area for intervention, also making this measure interesting in mentalization research. A method for assessing play (Kernberg, Chazan & Normandin, 1998) has also been adapted for assessing mentalization.

**Children 7-12**

The *Affect Task* (Fonagy et al., 2000) is designed to assess affective understanding in interpersonal contexts and has been successfully tested for validity and reliability. Another measure assessing more cognitive-linguistic aspects of theory of mind is *Happe’s Strange Stories* (Happé, 1994). This measure involves concepts such as figures of speech, white lies or irony and succeeding requires understanding of the importance of the intent of the speaker. With children in this age it is also possible to rate RF using the *Child Reflective Functioning Scale* (Ensink, 2003) on the *Child Attachment Interview*, asking the children to reflect on their relationship with their primary caregivers. The *Kusche’s Affective Interview-Revised* (Kusche et al., 1988) is another well-used interview designed to assess affective understanding in children. This measure has also been successfully used in outcome studies. The *Mirror Interview* (Kernberg & Buhl-Nielsen, 2007) is a structured interview given to the subject when in front of a mirror. This can be used to assess mentalization as well as affective reactions about the embodied self. RF has a positive correlation of 0.5 with children’s affective reactions to themselves in the mirror, suggesting a link between the capacity to think about oneself and the objects and the embodied self.

**Adolescence**

The CAI adapted for adolescents is applicable for assessing RF in this age group. There are a few self-report measures developed for assessing mentalization in adolescents, with the *Reflective Functioning Questionnaire-Adolescent* (RFQ-A; Sharp et al., 2009) being one of them. The original questionnaire, developed for use in adult samples, was developed to follow the principles of the RF scale of the AAI. However, the RFQ-A has relatively low correlations with other measures of mentalization. Yet another way of measuring mentalization capacity in adolescents is using the *Movie for the Assessment of Social Cognition* (MASC; Dziobek et al., 2006). The MASC does not only assess undermentalizing but also possible overmentalizing, common in BPD. One measure specifically sensitive to implicit non-verbal theory of mind is the *Reading the Mind in the Eyes Test* (RMET; Baron-Cohen et al., 2001) where the subject is asked to infer mental states from photos of eye regions. The RMET can be used with children in various ages as well as adolescents and adults. Finally, some facial morphing tests are adapted for teenagers as well.

**RESEARCH**

Today there are a few studies on children and mentalization. Correlations have been found between different concepts close to mentalization (e.g. RF, ToM and emotional
understanding) and depression, anxiety as well as externalizing behavior problems. RF has been found to be as important as personality as a contributor to psychopathology. It is however important to note that this does not mean that all depressed, anxious or aggressive children have mentalization deficits, although it is safe to assume that mentalization is an important area of clinical research. For example, Ensink points out that aggression sometimes can be a maladaptive defense rather than due to mentalization deficits.

Research on mentalization is difficult, especially if we are using mentalization as a treatment outcome measure. Firstly, as always, we need to consider whether our clinical sample has mentalization deficits to start with. Secondly we need to consider what aspects of mentalization we want to improve and in what way our treatment improves these aspects. For many patients or patient samples mentalization deficits might be subtler and regarding other aspects than commonly considered when thinking about mentalization. Since different measures of mentalization capture different aspects to different degrees, these considerations will be crucial in choosing an appropriate measure.

At the Université Laval in Canada, Ensink and colleagues have studied children traumatized by sexual abuse. In their studies, traumatized children scored significantly lower on RF than non-abused children. This regarded general RF as well as self and other RF. Children abused in their own families had even lower RF than children abused outside of the family. This research contributes to showing the impact of trauma on mentalization. It is hypothesized that the nature of sexual abuse might be so overwhelming that it inhibits mentalization. Ironically mentalization is a key factor in dealing with trauma. This is probably what makes these children vulnerable to later depression, and the low self-RF is possibly a vulnerability factor in the development of personality disorders. Whilst low RF concerning others leads to difficulties in interpersonal relationships, RF concerning the self is a prerequisite for psychic health making low self-RF an even bigger risk factor.

When looking at children’s narratives about sexual abuse it was also found that none of the children were able to give a contained account of the abuse. This was interpreted as the cognitive apparatus not being mature enough to cope with this challenge and instead becoming disorganized. In children this can lead to lapses into super-hero omnipotent revenge, inappropriate rationalizations, overly detailed automatum-like accounts with flat dissociated affects or as rapid oscillations between forgetting and remembering.

Ensink concluded the presentation by stating that the findings suggesting the role of mentalization deficits in several psychiatric groups beg the question of whether our treatments target mentalization sufficiently. It also suggests that some measure of mentalization might be appropriate in clinical outcome studies. Furthermore the links between trauma, RF and identity in the development of personality disorders in adolescence need to be further investigated.
Time limited work with children and parents – Presentations of some clinical models

During the workshop, several clinicians and researchers presented their psychotherapy models. The Erica Foundation held a presentation of their time limited mentalization based work with children and parents, where Anders Schiöler and Jan-Olov Karlsson presented the model and Kristina Berglund-Fries and Helena Vesterlund presented a case report from working with a child and its parent. Unni Tanum Johns presented the Norwegian model of Developmentally Directed Time Limited Psychotherapy with Children, with focus on intersubjectivity and time. Nicole Muller presented the time-limited model from De Jutters Centre in Haag, the Netherlands, focusing on assessment and different patient groups, together with a highlighting case example. The following chapter is an attempt to integrate these presentations into one description of how one can work with time-limited psychotherapy with children and parents.

THE MODELS

Tanum Johns emphasized that the aim of the therapy is not to complete a change, but rather to stimulate development and help the child to get back on the developmental track. The model emphasizes the importance of a developmental understanding of the child’s symptoms and difficulties as well as the developmental needs and potentials of the child.

The Norwegian approach is clearly relational with an emphasis on intersubjectivity, meaning that a view of the child as dialogic and intentional from birth is a fundament of the model. Using the non-verbal affective dialogue the therapist strives to create emotional attunement in the relationship. A lot of the interaction and communication about feelings takes place in form of play, with the therapist being active and responsive and engaging in play if that is regarded as helpful. The focus is mainly in the here and now of the therapeutic relationship. The therapist tries to convey to the child that he is someone who wants to help, and that he is interested in the experiences of the child. Confirming the child’s gestures, thoughts and feelings, as well as exploring the child’s intentions, the therapist aims at strengthening the child’s self-agency (1).

All presented therapy models work with time-limitation and a calendar, mutual focus (also called “motto”) and parental work. A typical therapy in Sweden and Norway consists of 12 sessions, after three initial meetings, with slightly more sessions in the Dutch model. However, it is important that the model can be handled flexibly, as there for example sometimes may be need for more initial sessions (2). There is also the possibility to prolong therapy if needed. In Norway and Sweden, the parental work typically is parallel to the child’s therapy, using another therapist. In the Netherlands, the parents have slightly fewer sessions, with the same therapist as the child.

1 Material from Karlsson and Schiöler’s presentation is referred to as (1). Material from Tanum Johns’ presentation is referred to as (2). Material from Muller’s presentation is referred to as (3).
ASSESSMENT FOR THERAPY

Muller presented the model for assessment at De Jutters Centre, consisting of three parts: Assessment of attention regulation, emotion regulation and mentalization (Verheugt-Pleiter, Zevalkink & Schmeets, 2008). Assessment of attention regulation also includes senso-motor regulation. Aspects such as sensitivity to sound, light and touch are taken into account, as well as motor development and focusing skills. In assessment of emotion regulation any notions of emotions connected to the self, others or in relations, or notions of effects of emotions are assessed. Ways of dealing with emotions as well as possible under- or overregulation of emotions in the child are also looked for. When considering mentalization capacities you ask yourself whether the child has any representation of itself or of others, if there is any attunement towards others, any curiosity towards others or itself, as well as any fantasy.

Techniques for assessment can be talking to the child about developmental issues such as friends, interests and longings. Assessment can also entail drawings, such as drawing a tree, or drawing together and making up a story. The child can also create a family genogram, for which at De Jutters shells are used. The child is asked to pick a shell for each family member, and place them to describe the family. The choosing and placing of shells can be very descriptive of the child’s view of the family and a good starting point for talking about representations of self and others, now and retrospectively. Furthermore a family session is common in the assessment phase, as well as contact with the school.

MUTUAL FOCUS

All psychotherapy models presented in this chapter have a mutual focus as an important part of the model. In the first sessions the therapist observes and listens to everything the child conveys, verbally as well as non-verbally, trying to integrate it into a focus for the therapy. The mutual treatment focus represents a time perspective and can be related to Sterns concept of "key metaphor", representing relational and emotional central themes (Haugvik & Johns, 2006). Another comparison can be made to "Leitmotifs" in music (Johns, 2008), which functions as reminders of the key concept of the music (2).

The focus becomes a joint point of departure as well as a direction for the therapy, and is an important part in forming the therapeutic alliance (1). In the focus, the therapist helps the child to know what is going to happen in the therapy. Many children are sent to therapy by parents or other adults, and do not know why they have come. The task of stimulating agency and participation in the child therefore becomes an important one in the beginning phase of therapy. The focus becomes an important part of this work, functioning as an invitation to the child to engage in the therapy process. The focus and the calendar work as ways of conveying to the child that its own actions have meaning, helping the child to create a feeling of ownership of its own time. The focus also works as a way of helping the child in directing attention and regulating

The motto marks the playfield.
emotions in the therapy (2).

It is important that the focus bears meaning to the child, creating an experience that "this is about me" (2). The therapist conveys by the focus that he is someone who wants to help the child and who knows about the child’s difficulties (1).

The starting point in focus formulation is the reason for the family seeking help. However, the focus must not be a problem description. Rather it is supposed to be a support to the therapeutic direction by pointing to the child’s resources and skills, and what can be developed in therapy. It also stimulates parental reflective functioning by directing the parent’s attention to the child’s inner world. Furthermore it helps the child’s mentalization by conveying that he or she is held in mind, and stimulates the child to be interested in its own feelings and thoughts. This way the focus becomes a model for both parents and child for how one can “hold someone’s mind in mind”. The focus also helps the therapist, directing him to a mentalizing approach towards both parents and child (1).

By using material from the initial sessions the therapist can formulate a focus that resonates in both child and parents. Countertransference feelings can capture relevant themes as well as feelings that the parents might have towards the child. Using these feelings in the focus can be helpful in bringing curiosity of both parents and child. The child’s own use of metaphors related to its experiences in play can be helpful in formulating the focus in a way that the child can relate to (1).

The focus should be short, easy to understand for both child and parents, and raise recognition as well as curiosity and hope. Themes of the focus are often related to control, autonomy, dependency or self-esteem. The focus formulation is exploratory and/or affect regulatory (1). Furthermore it needs to raise recognition and give meaning to the parents. For the treatment to be successful, the parents have to give permission to the change process suggested by the focus, making this an important alliance task also with the parents. Last but not least, the treatment focus must always contain resources and hope (2). Muller also underlined the importance of finding a motto even if the child has problems agreeing on one. This is the goal of the first part of the therapy and will help you as a therapist, as well as the parents, in the therapeutic work.

“Focus traps”
Avoid formulating focuses that are easy to fail, such as ”less scuffle at home” or ”dare to be more brave”. Achievement based focuses are by definition also easy to fail, and they do not stimulate mentalization as they are not focused on the representational world of the child. The same goes for focuses based on behaviors or symptom reduction. Furthermore the focus needs to be formulated in mentalizing language and stimulate mentalizing (1).
WORKING WITH TIME AND TIME LIMITATION

Drawing on intersubjective theory, and also inspired by theories behind other time limited psychodynamic psychotherapies (e.g. Mann, 1973), all therapy models presented during the workshop sees time and the time limitation as a significant aspect of the treatment. Tanum Johns gave a review of some of the theories about time fundamental to their model in her presentation.

Modern developmental research show that time is an organizing factor in early development, where experiences happen on the basis of sequences and repetitions. Furthermore, rhythm, closely connected to time, is a basis for shared focus of attention. Tavrethten meant that sharing a mutual basic beat is the first intersubjective experience. Helen Christie wrote that trauma consists of a breakdown in the experience of continuity and coherence, making restoration of sense of time a crucial healing element. When it comes to the significance of time in psychotherapy, Tydén (2002) showed that time limitation in therapy had a function in itself, increasing self-representation in children, regardless of the length of the therapy (2).

What is short term?
Muller raised the question in her presentation what “short-term” really means, and how many sessions a “short-term therapy” ideally consists of. At De Jutters, a short-term psychotherapy includes three diagnostic sessions, 12-15 treatment sessions and one follow up session. In the group of more severely disturbed patients therapies are about twice as long, but still mostly under 50 sessions, meaning that they still are time limited in psychodynamic terms. The treatments differ regarding intensity, sometimes with sessions every week and sometimes every two weeks. Muller meant that “less often can be more”, and with many patients it is actually preferable with a less intensive format. No difference in success has been detected at the clinic (3). In line with Tanum Johns’ point that it is not the “shortness” of the therapy that is of importance but the time-limitation in itself, it is discussed that “time-limited” might be a better term than “short-term” when describing these therapies. Also, many patients and especially not children do not find a 12-session therapy “short” but rather a significant time. Us labelling the therapies “short-term” might be undervaluing the significance of these therapies, making it sound like they are just shorter versions of “real therapies”, and not therapies in their own rights standing on own theoretical fundament.

Phases in therapy
Tanum Johns described that the therapy consists of three phases. The aim in the beginning phase is to create a helping relationship: to work out "what we are going to to together" and "who we are going to be for each other". The middle phase is characterized by actually working together. The ending phase is a very important part of the therapeutic work. For many children in therapy, things earlier in life have ended abruptly without possibilities for preparation or processing. In therapy there is an opportunity for an ending for which the child can prepare as well as be angry and sad about it. Therefore it is important that there is indeed preparation as well as sharing of emotions. At the very end, the therapist can provide a metaphoric story or a symbol for the work that has been done together. This can be a story the therapist has written, or a symbolic small thing. The point is to do something that is clearly symbolic, that mirrors development and continuation for the child (2).
When to end therapy
When is a good time to end psychotherapy with a child? Muller suggested some criteria for termination: When the child has developed a capacity for identifying and expressing feelings; when the child is developing stable internal relationships and forming a coherent self, and when there is a developing capacity to enter relationships. No progress at all should also be an indication to stop therapy: there is no reason to go on and pretend that there is a working therapy when it is not (3).

Working with a therapy calendar
An important part of the therapy, closely related to the importance of time, is working with a visual calendar. The calendar works as a mean of helping the child create its own story about the therapy process, which in turn is a way of developing self-history (Haugvik & Johns, 2006). It also becomes an overview of the child’s own time. This influences participation and development of self-agency, in line with the theories of Stern.

The calendar helps the child in constructing a coherent narrative.

In the beginning of therapy, the therapist presents the calendar to the child. The child writes the numbers and chooses a sheet as a cover for their calendar. Taking part in creating the calendar is important for the child to feel that the calendar really belongs to them. The child then draws something from each therapy session. This work can bear many functions in the therapy. For example, some children want the therapist to guess what they are going to draw, which creates opportunities to be curious and think aloud about the child. The drawing can become an important interpersonal ritual in the therapy, contributing to the rhythm of the therapeutic relationship. Sometimes children also reconstruct experiences using pictures from earlier in therapy. In this way the calendar helps the child in constructing a coherent narrative about the therapy process and its’ own development (3).

Discussion
At the end of the presentation the time limitation was discussed. Is there a risk that the ending, with the therapy being so short, becomes a new trauma for families that recently have experienced losses? At the Erica Foundation this has not been experienced as an issue. As the therapy focuses on resources and getting mentalization back on track, the family is hopefully capable of continuing on their own after therapy. Also, there are risks, such as creating dependency, in long-term and open-ended therapies as well. The time limited model is inspired by James Mann, who underlined the importance of the ending being definite to create possibilities of working with the separation and feelings linked to it. In the Norwegian model there is the opportunity to prolong the therapy with another calendar. This decision is not made at the end of the therapy but in the middle, if needed. However, Tanum Johns pointed out, the therapist shall convey to children that they are not supposed to be in therapy for long, they are supposed to be out in the world, doing other things!

PARALLEL PARENTAL WORK
Parallel work with parents and child means that parents as well as the child get their own physical and mental space where they can be understood. On a more abstract level this makes room for both perspectives, opening possibilities for an expansion of intersubjectivity between them. Hopefully this will enhance mentalization in both parents and child (2).
The parental work at the Erica Foundation is mainly inspired by Arietta Slade (2008), with the overall aim to increase Parental Reflective Functioning (PRF). Parents with low PRF often tend to focus on the child’s (bad) behavior. The therapist’s task is to help the parents turn their thoughts and interest towards thoughts and feelings rather than behavior of the child (1).

The parent therapist has several different tasks. One important aspect of the work consists of psycho-education about mentalization. Part of this is giving the parents a parent guide about mentalization. Using metaphors in the focus and in working with the parents, the therapist creates a reflective play-space as well as helps the parents empathize with the child. Apart from debriefing, there must also be space for reflection on specific situations (1).

In many cases it is not possible to get the parents to reflect on the child’s mental states right away. Firstly the therapist has to convey interest in what is in the parents’ minds, and try and understand their feelings. This way the therapist works as a model for a reflective stance, conveying that he is holding the parent’s mind in mind. Keeping a not-knowing stance, with the therapist being active, curious and seeking clarity, also conveys this. The therapist is constantly underscoring links between behavior and mental states, as well as noting the relations between the parent’s mental states and those of the child. Advice and guidance are always based on a common desire to understand the emotional context of a specific situation (1).

Firstly the therapist has to convey interest in what is in the parents’ minds, and try and understand their feelings.

Tanum Johns meant that the Norwegian psychotherapy model fits well with Bordin's alliance model (1979), emphasizing 1) agreement on the goal of the treatment 2) agreement on tasks and 3) an emotional bond developing between patient and therapist. Working with and talking about the alliance can also function as a way of stimulating mentalization and intersubjectivity. In a study on the treatment model from 2006, Haugvik and Tanum Johns used two questions at the end of each session with the parents: 1) What (from the session) has been useful for you? and 2) What has been useful for your child? Not only is this a way of assessing, as well as working with, the alliance in the treatment, it is also a way of stimulating mentalizing capacity in the parents (2).

**PATIENT GROUPS**

At De Jutters Centre, two different groups of children seeking therapy have been detected. One group includes children with avoidant or pre-occupied attachment style, with some difficulties with attention and emotion regulation although not all the time. These children have some capacity for mentalization. They can recognize or name the reasons why they have come to therapy and it is typically not too hard to think of, or agree on a focus for the therapy. There are typically “good enough” parents, or in other words a “safe haven”. The diagnosis is often attachment related but not reactive attachment disorder. The symptom picture commonly is a combination of internalizing and externalizing problems. Often there has been a disruptive event in the child’s life such as complicated grief, loss of an attachment figure or a parent with a psychiatric diagnosis. Fonagy has labelled this a “mild mental process disorder”.
The other group consists of children with disorganized attachment style. Typically they have difficulties in attention and emotional regulation as well as mentalization all or almost all of the time. They are often chronically traumatized. These children can generally not recognize the reason why they have come to therapy and they cannot name, recognize or commit to a mutual focus. One of the reasons for the difficulties in finding a mutual focus is that these children have trouble with self-representation and to gain a feeling that “this is me”, since the feeling of “me” is so fragmented. There are typically also huge problems in the relation with the parents. Fonagy has labelled this a severe mental process disorder (3).

These two different groups of children have been the topic of much discussion at the clinic. Can a short time format be applied in both these groups or does the latter one require longer and/or more intensive psychotherapy? Muller considers the first group as more appropriate for short-term therapies whilst the latter typically need longer therapies. At the moment however, all therapies start as short-term, with possibilities to prolong if needed. (3).

Working with the latter group of more disorganized children is very different from working with the first group, Muller states. “With disorganized children, everything happens in the relation, keeping it constantly under pressure. These disorganized children try to tell you something with the relation that they cannot tell you in any other way”(3).

Tanum Johns said that it is an old belief that short-term child psychotherapy only works with neurotic children with good enough family environments. At the clinic in Oslo a different picture has been found, and the focus of the therapy actually helps families with more complex problems and environments to come to therapy (2).
Leezah Hertzmann from the Tavistock Centre for Couple Relationships presented a model for working mentalization-based with parents in entrenched conflict. The Parenting Together Service started in 2008 as a response to the large number of parents seeking help, still in conflict years after being divorced. The parents seeking were in extreme states of mind and other psychoanalytic treatment did not seem to help, but rather make it worse. The children in the families often displayed emotional as well as behavioral difficulties. The center worked closely with Nick Midgley and Mary Target at the Anna Freud Centre to develop and adapt MBT-F for this population, also bringing the long and rich heritage of psychoanalytic knowledge gathered and theories of the couple relationship developed at the Tavistock Centre over the last 60+ years. The aim of the treatment is to foster the capacity of parents to mentalize on their difficulties in co-parenting, keeping the experience of their child as a central and uniting focus between them.

Parents seeking help at the Parenting Together Service are often separated or about to separate. Many have been to court repeatedly over contact or residency of the child, and many make allegations of abuse. The parents seeking are often not only in non-mentalizing, but in anti-mentalizing states.

Parents that divorce become physically separated, but emotionally and psychically they are still linked through their children. Albeit this link they still have to deal with grief and bereavement on many levels. When separating as parents, there is bereavement not only of the former partner, but also of the history together, the everyday life and not least the future that was planned and dreamed of together. The child becomes a symbol for the relationship, containing parts of both partners genetically as well as psychologically. Partners often project the other partner onto their children, seeing the qualities they most hate about their partner in their child. This is very distressing for the children and difficult to work with clinically. Parents that find it most hard to grieve often behave as if the child only belongs to them, becoming furious at the idea that they will have to share. Many of these parents want to disavow the restrictions of time and reality, ignoring the fact that the separation means that they probably will have less time with their children, the loss of fantasies and hopes for the future as well as who their partner really is instead of the “monster” that they see before them. The relationship is often complex, with on the one hand an engagement in (conscious or unconscious) hatred from both parents, keeping the relationship alive and on the other hand a wish to sever all links between them. Thinking about the child that they have together becomes a reminder that they will always be connected, at the same time as the parents often live in a phantasy that they will be able to “brush out” or annihilate the other parent completely.

The parents seeking are often not only in non-mentalizing, but in anti-mentalizing states.

THE TREATMENT FRAME
Parents can come alone, with an ex partner, with a new partner, or in larger constellations. The therapy dose is six to twelve sessions (with possibilities for prolonged therapy), following
two assessment sessions. Since these patients have potential for dysregulation and for damaging themselves, weekly meetings are recommended to help them manage. All therapists are psychoanalytically trained and work in co-therapy pairs. The training for the psychotherapists is manualized. Review sessions are built in the method, and follow up or top up sessions are added as needed. Parents are asked to undertake homework tasks as part of the treatment.

THE TREATMENT

The treatment contains many of the core interventions from MBT, such as slow motion, stop and rewind, perspective taking, and positively reinforcing apparent mentalization.

Since this is a child-focused treatment there are also interventions with the child in mind. The parents in treatment can completely drop their children from their mind when they get into an argument. When the therapist ask the parents "Where was the child when you got in to this argument?", the parents often have no idea at all, Hertzmann said. An important task for the therapists is therefore to get the child back into the parents mind and foster curiosity about the child’s experiences. The therapists always attend to what kind of space the child seems to have in the parents’ mind. Sometimes, countertransference feelings can be helpful in this. It is not uncommon, Herzmann says, that a therapist experiences physical symptoms or emotions only to find out that these symptoms or emotions are shared by a child in the family.

The therapists interrupt when interactions get too heated. If parents leave the therapy too unregulated they are much more likely to act out afterwards. As in other MBT models, the therapists also work as models for mentalizing. The therapist saying "if I was in your shoes" can work as an introduction to the fact that the therapist actually has a mind. The therapist couple also works as a model for two minds meeting, by talking aloud with each other, thinking together about the therapy process.

The question came up in the group during the presentation whether it could create envy for the separated couple to see a well functioning therapist couple. Hertzmann replied that this is very much the case, and how could it not? The therapists represent a thinking couple, two minds coming together, and the parents often cannot other than attack this.

Example of a focus formulation:

“"It seems that sometimes you both feel quite anxious and frightened, perhaps because both of you really want to be good parents, and because of all the demands that parenting your children places on you since you separated. (Self-representation)

As a result of this, Laura may try to get Max's support and attention by really showing her feelings of anxiety. M may see this as confirmation that he is failing to be a good father or husband — and may withdraw in despair and self-defence. The more Max withdraws, the more Laura may try to get through to him. Both of you end up even more anxious, frustrated with each other and feeling as if you are all alone. (Object representation)

This then makes you both feel angry and it seems that this can easily set off a nasty argument. (Characteristic affect)

Then Oscar tries to intervene in your arguments to stop your conflict, and this is often followed up by your being called in to the school because he is in trouble. (Effect of this on the child)"
THE FORMULATION
The therapists use an interpersonal-affective focus, adapted from Lemma (2010) focusing especially on a) self-representation, particularly how the patients see themselves as a co-parent; b) object representation, meaning how they see the other as a parent; c) the characteristic affect; and d) the effect of the above on the children.

THE THERAPIST TEAM AND THE PRACTICAL WORK
Working with this group is a complicated and challenging task, Hertzmann said, full of complexities and paradoxes. The therapist team is affected by working with such high levels of conflict and hostility. This makes it even more important to work with the clinicians as a mentalizing team. Not only the therapists are affected but the conflicts in the patients become apparent on all levels of the organization. Even the organizer in the reception, being in touch with the patients, need to be minded by the team, and get help to stop and mentalize.

Hertzmann was asked how the team handles all the hostility that comes with treating parents in conflicts without splitting the team itself. "The capacity for splits is enormous", Hertzmann answered. "The idea of a couple state of mind is very important in dealing with this. Even if parents do things that look horrible to us, we need to remind ourselves that they are holding the projections from the other parent, and in fact acting as a couple. The therapists always look for splits in the couple, because if you miss them they will come out to bite you".

At the moment the clinic is conducting a randomized controlled study, “Parents in Conflict – Putting Children First”, on the treatment model, with a psycho-educational program as a comparison group. The primary outcome will be reduction in manifest anger between co-parents, with parental reflective function, decrease in blame attributions, improvements in parenting alliance, improvement in child and parental well-being, decrease in parenting stress and improvement in family functioning as secondary outcome measures.

At the end of the presentation, we could not help but ask Hertzmann what you get out of this work as a therapist. Do you actually see progress? "Yes you do", Hertzmann reassured. "I think what is rewarding about it is the use of the model. The clinicians are interested in the model and very interested in therapeutic technique. When you see parents report that they have been parents together, and when parents see that the child is trying to bring them together to talk, and they let it happen, that is very moving.”
Research At The Erica Foundation: Short-Term Psychotherapy With Children And Their Parents

As a reply to the increasing poor mental health in children and the need for short-term treatments, the Erica Foundation conducted a study to investigate the effectiveness of their short-term mentalization informed treatment (STPP). Agneta Thorén presented the naturalistic study with a total number of 39 patients divided into two groups. One group consisted of 17 children in the ages 4-11 years and their parents, and a second group of 22 adolescents or young adults in the ages 16-23 years. The patients were quasi-randomized to treatment or waiting list. Follow-ups were conducted at six and twelve months after the end of therapy.

The outcome questions were "What are the short- and long-term effects of STPP?" and "Which patients seem to be best suited for STPP?" Children’s self-reports were made using a ball tube, an instrument making it easier for children to report and rate feelings in a non-abstract way.

The process questions were "How is time-limitations, focus and separation used as therapeutic agents?" and "What can be gained from the parallel parental work?"

Results showed that STPP led to a substantial decline in main diagnoses. Comorbidity was also greatly reduced. The results were maintained, with a slight sleeper effect, at follow up.

The preliminary conclusion from the study, whose full outcome and process results will be published elsewhere, is that mentalization informed short term therapy with children and parents is a promising treatment, resulting in lesserened pathology in children with a range of ages and diagnoses.

The ball tube
Training In Mentalization Oriented Short-Term Psychotherapy For Children And Parents

Anders Schiöler presented the Erica Foundations ongoing work with training child psychotherapist in mentalization oriented time limited psychotherapy for children and parents. The student group consists of 12 participants meeting half a day, once a week, for seven months. A prerequisite is that the participants have at least previous basic psychotherapy training. It is preferable if they are able to work in teams at their clinics, and finally the participants need to have previous experience in working therapeutically with children.

The aims of the training are to provide the participants with knowledge and experience of assessment, principles of frames and settings of therapy, formulation and presentation of focus for the therapeutic work as well as using therapeutic interventions based on mentalization theory.

The training consists of seminars and workshops, often making use of clinical vignettes, literature studies as well as supervision. The training occasions usually consist of a 90 minutes seminar followed by 90 minutes of group supervision. The training group is divided into three supervision groups based on previous clinical experience, with four participants in each group. The examination consists of active participation in seminars and supervision, approved written assignment as well as approved completion of short-term therapy including a written summary of the therapy process. As this is the first time the training is being held, the supervisors also meet once a week to discuss the processes in the supervision groups.

Discussion

An important topic for discussion concerned how to protect the MBT model from unserious therapists. MBT is an increasingly popular treatment model and many people are attending courses learning the therapy. Therapists delivering the therapy in an unserious or faulty way could result in a misrepresentation of the treatment model. One way of preventing this is requiring adherence checks and certification for MBT therapist, possibly with different levels of certification for therapists. There is also the possibility to offer ongoing supervision for MBT therapists, to help therapist to work correctly with the model. In practice, Ensink pointed out, therapists struggle to find the model that they work with and they need supervision. If this cannot be offered there will be lots of people saying that they work with mentalization when in fact they do not.

The discussion also concerned how mentalization work is best taught and learned. Muller’s model of considering attention regulation, emotion regulation and mentalization (Verheugt-Pleiter, Zevalkink & Schmeets, 2008) was considered an inspiring way of conceptualizing the ongoing assessment made in therapy. In the MBT courses at De Jutters, the aim is to create an atmosphere in the group so that people experience MBT themselves. This can be done for example by being personal when introducing oneself, underlining when other people mentalize, pointing to physical reactions in the here and now and trying to work with a mentalizing stand with the participants.
Practical ways of working in supervision are for example to let the participants transcribe ten minutes of therapy and comment on the transcription. Then the participant sends it to another person in the group and let them comment on it. Working like this is an effective way to bring in different perspectives. Muller also tries to use all senses in supervision, she said. One way to do that is to watch videotapes without sound, or with only sound, and then bring them together.

The use of video in training, research as well as supervision was also discussed several times during the workshop. There was an agreement that video can be a very powerful tool in training and supervision, and almost a must in research today. For psychotherapy trainees video material can be helpful in finding domains where the trainees can develop, that otherwise might not be known to the teacher or the trainee.

**Seminars in MBT-C training:**

1. Introduction and presentation of training  
2. Short Term Psychotherapy - for which children. Assessment.  
3. Half day seminar on mentalization theory and mentalization based therapy work with Nick Midgley, AFC  
4. Follow-up of the third seminar.  
5. Frames, settings, work with calendar  
6. Focus and focus formulation  
7. Assessment of parents. Parents and mentalizing ability  
8. Therapeutic stance and principles of treatment techniques in the child therapy  
9. Parent work  
10. Mentalization oriented interventions and therapy techniques in the child therapy  
11. Workshop on parental reflective functioning  
12. Psychotherapy from a broader perspective - What is psychotherapy? Curative factors  
13. Workshop on mentalizing oriented interventions in child therapy  
14. Seminar before examination task  
15. Termination of therapy and follow-up  
16. Short term psychotherapy, evaluation and research  
17. Workshop on team work  
18. Examination seminar  
19. Examination seminar  
20. Examination seminar
Summing up and moving forward

After two full days of talking about time-limited and mentalization-based work with children and parents, many new discussion topics had risen. The questions varied from practical and concrete to theoretical considerations. Some of the discussion points are summed up below.

Playroom material

It became clear that the clinicians had slightly different playroom setups and playroom material. All playrooms seem to have certain materials in common: a sitting group, drawing material, and access to a sand tray. But how much more should you keep in the playroom? At De Jutters, the therapists do not use their own rooms as playrooms, but have a larger playroom, making it possible to keep many more toys. However, for some children this becomes too stressful and the many possibilities and impressions of the playroom is not suitable for their therapies. Other clinicians also shared the experience that too many toys can promote fragmented play. From this view it can be preferable to only use a few toys, at least with children older than six. The clinics in Stockholm and Oslo keep relatively few things in the playroom. Muller and Tanum Johns, working also with music in their therapies, also has an assortment of music instruments in their playrooms.

Parental work and parallel sessions

There are also some differences between the clinics regarding how the parental work is conducted. In Holland, the parents have fewer sessions than the child, and the same therapist sees both parent and child. Most other clinics work with different therapists for parents and child. At the Erica Foundation they sometimes work with only one therapist, but the practical issue of the family having to attend at the clinic several times a week unless parents and child come at the same time is one reason for having parallel sessions with separate therapists. One can also argue that the confidentiality of the child is better protected when using two different therapists. Johns pointed out the usefulness of a co-therapist in keeping mentalization as therapists when working with some families. There are however also upsides with the same therapist working with both parents and child.

Interviews with parents as part of the short-term study at the Erica Foundation, as well as clinical experience, convey that a frustration for many parents is an experienced lack of transparency into the child’s therapy. Many parents express a wish to know more precisely what was helpful to the child in therapy, in order to understand their child better. This can be discussed from several perspectives. One thought is that this is an indication that the parents need more psycho-education. In some clinics it has been discussed whether they should use the last five minutes of each therapy session with the child and parent together, and let the child tell the parents what they did in therapy. However one could also argue that this would interfere with the protected room that is needed for the child’s therapy, making this a difficult dilemma. From a psychodynamic perspective, Herzmann pointed out, this can also be
understood in terms of couple’s function. One could ask how much of what is going on between the couple that is being held in the child. When the child is in treatment, the projections from the couple onto the child does not work anymore, making it difficult for the parents and leaving them without meaning. Another thought offered was that one reason for this worry in the parents comes from feelings of guilt, and the question if there was something that they could have done earlier. In the Norwegian model the parents meet the child’s therapist two or three times. The important part of this, Tanum Johns said, is not disclosing what is going on in the child’s therapy but for the parents to see the child’s therapist, thereby feeling more involved in the process.

Goals
After the presentations it is clear that there is agreement on the importance of a mutual focus when working with time-limited therapies. An important question is how we can work with mutual focus and goals to make the therapies even more effective. Ensink pointed out that CBT therapists’ skillfulness in working with goals probably is one reason for the large improvements made in CBT, making this an important task for psychodynamic psychotherapists as well.

One DSM-diagnose can mean many different things for different individuals. The crucial question is rather whether it is possible to share mutual attention.

Diagnostic groups
One question always relevant in any treatment model is the target population for the treatment. What diagnoses are suitable for the time limited perspective? Tanum Johns meant that it is not the DSM-diagnoses that decide. One DSM-diagnosis can mean many different things for different individuals. The crucial question is rather whether it is possible to share mutual attention. Is this true even for traumatized children? The answer is yes, according to Tanum Johns. Traumatized children need safety and continuity, making the time limit a safe and helpful frame in their treatment. It is sometimes necessary to do time-limited therapy in a series of repetitions, but where each new therapy calendar gives an opportunity to develop the therapy focus in line with therapeutic developments.

Measuring mentalization
After Ensink’s presentation, many thoughts about the measurement of mentalization were raised. What is a good measure to implement in a clinic, helpful in the clinical work as well as in the research? Ensink reflected that this must depend on the resources at hand. If the clinic has many students coming through, the Child Attachment Interview is definitely recommended. Students can be involved in administrating the measures, making it mutually enriching for both students and clinicians. In using the Parental Development Interview, Ensink has found that it can be helpful for clinicians to just read the interview even without rating it, as it gives a gut sense of the parent’s reflective functioning. In the Netherlands, the Attachment Story Completion Task is commonly used. However, as Ensink pointed out, this measure is demanding to rate since the task can get out of hand with some children. Externalizing children can give very bizarre answers, making it sometimes too much work for what you get out of it.

Treatment modules in MBT
In MBT the patient typically receives at least two treatment modules, such as family and children or group and individual, at the same time. A topic of discussion is whether double
modules are actually needed and if it enhances the effectiveness of the treatment. Bateman and Fonagy mean that using several treatment modules helps the mentalizing process. This fall De Jutters Clinic will experiment with a group format for children in the ages six to seven, since they are often isolated in school with big problems in relations with peers. It is commonly seen that the family problems improves from therapy but the school problems remain, begging the question whether a group module would be helpful for these children.

**MBT in the psychodynamic frame**

What is the relationship between MBT and classic psychodynamic therapy? The question was raised by Hertzmann, asking what it really is that we do when we say that we do MBT? Ensink pointed out that many of the MBT manuals have been written for patients with borderline personality disorder, who have very specific mentalization. Not as much is written about neurotic mentalization. We need to ask ourselves whether we add clarity or obscurity when reformulating processes into mentalization terms. When we think about processes that are central to therapeutic change, how much do we actually stretch the mentalization package? Mary Target has expressed that "Mentalization is not the goal of the therapy, it is the bonus". Ensink meant that this is a profound statement, meaning that we can free ourselves from reinstating everything in mentalizing words. We can still state psychotherapeutic processes the way they used to be stated.

How do we use interpretations, one of the basic interventions in psychodynamic psychotherapy, in MBT? Muller meant that a big difference in working with children is that a lot of things happen implicitly. "Sometimes", she said, "I want to put things in words, but the child does not. The thing to look for is when to and when not to." Tanum Johns agreed, saying that children express a lot through the affective therapeutic dialogue, and in doing so they experience that they are telling you something. However, when actually giving verbal interpretations, Tanum Johns meant, it is more clear in the MBT model that it is "me, with a mind" giving the interpretation, and that it comes from one perspective of many, and therefore also can be wrong.

**Stay mentalizing**

When working as an MBT therapist, one of the main challenges is to stay mentalizing yourself. Working with patients, and sometimes entire family systems, in distress, can easily throw you off. What are the keys to stay mentalizing as an MBT therapist? One of the main protecting factors seems to be the team. The clinicians agree that working in co-therapist pairs and/or having a safe reflecting team is important to keep your own reflection going. Muller said that she recognizes cuts in money being made at her clinic, creating higher pressure on the working floor. This pressure affects mentalizing capacities negatively. One take home message for me, Muller said, is that I need more inter-vision, and time to reflect, in order to stay on track. The time for team- and self-reflection is emphasized in the MBT model, and as MBT therapists this is an important treatment quality to protect.
Appendix

PARTICIPANTS

Julie Achim, MPs, PhD, Associate Professor at the Department of Psychology, Université De Sherbrooke, Canada. Among her professional interest are eating disorders, maternity and intergenerational transmission, psychopathology and psychodynamic treatment of child and adolescent, reflective function and mentalization-based psychotherapy.

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Kristina Berglund Fries, MSW, licenced psychotherapist at the Erica Foundation, Stockholm, Sweden. Her main professional interests concern parallel parental work, short-term adolescent psychotherapy and change processes in family relations. Early influenced by Stern’s developmental psychology theory, she now has a special interest in modern psychodynamic concepts such as attachment theory and mentalization. She also works as a lecturer and clinical supervisor at advanced level.

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Gunnar Carlberg, PhD, Professor at the Department of Education, Stockholm University, Director of the Erica Foundation, Stockholm, Sweden. Licensed psychologist and psychotherapist with various publications within psychodynamic developmental psychology and child psychotherapy research. His PhD work was on psychotherapists’ experiences of change processes and turning points in child psychotherapy. Current research interests are outcome and process research including qualitative methods. He is the project leader of the Erica Process and Outcome Study (EPOS).

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Karin Ensink, PhD, Associate Professor at Université Laval, Québec, Canada. Her professional interests concern clinical child psychology and psychotherapy, Asperger syndrome, mentalization and attachment. She is currently engaged in research on childhood trauma and sexual assault and it’s impact of on attachment, mentalization and clinical symptomatology.

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Leezah Hertzmann, MA, licensed adult and couple psychoanalytic psychotherapist at the Tavistock Clinic, London, England. She is head of the Parenting Together Service at the Tavistock Centre for Couple Relationships, and has co-authored several papers in the area of interventions for parents with mental health problems, and their children. She is one of the principal investigators of a randomized controlled trial investigating the Parenting Together model of intervention which is currently being undertaken in collaboration with the Anna Freud Centre.

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Karin Lindqvist, MSc, psychologist in clinical supervised practice (PTP) at the Erica Foundation, Stockholm, Sweden. She has a special interest in mentalization based psychodynamic psychotherapy. She runs the website www.psykodynamiskt.nu aiming at presenting new research on psychodynamic psychotherapy. 

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Nicole Muller, licensed psychotherapist and family therapist at De Jutters Centre for Child and Youth Mental Health, Hague, Netherlands. She has a special professional interest in mentalization based treatment programs for children, adolescents and parents. She is a lecturer at advanced level in the areas of attachment theory, child and adolescent psychopathology and mentalization.

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Anders Schiöler, MSc, licensed psychologist and psychotherapist at the Erica Foundation, Stockholm, Sweden. His main professional interests concern mentalization based short-term child psychotherapy, attachment theory and assessment methods in the field. He also works as a lecturer and clinical supervisor at advanced level.

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Unni Tanum Johns, MSc, licensed psychologist, music therapist and lecturer at the University of Oslo, Norway. Her professional interests concern traumatized children and adolescents, therapeutic relationship, developmentally informed child psychotherapy, play, communication and micro processes in child therapy. She is conducting research as well as developmental work on time-limited psychotherapy with children, partly in collaboration with PhD Birgit Svendsen in Trondheim, Norway.

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Agneta Thorén, PhD, licensed psychologist and psychotherapist at the Erica Foundation, Stockholm, Sweden. Her PhD work at the Department of Psychology, University of Stockholm was on early parental-child communication and the development of language, self and mentalization in blind children. Current research interests concerns process and outcome of psychodynamic child and adolescent psychotherapy. She is the project leader of the Erica Short-Term Psychotherapy Research Project. Main clinical interests are parent-child psychotherapy and developmentally informed psychotherapy for young children with mentalization deficits.

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PROGRAM

Friday, 26 April
09.00 – 09.45 Gunnar Carlberg: Opening
09.45 – 11.00 Karin Ensink: Assessment of mentalization
11.00 – 11.15 Coffee
11.15 – 12.30 Nicole Muller: A model for time-limited child psychotherapy in Holland
  – Case presentation and discussion
12.30 – 13.30 Lunch
  – Case presentation and discussion
14.45 – 15.15 Coffee
15.15 – 16.30 Jan-Olov Karlsson and Anders Schiöler: A model for work with children and
  parents in time-limited psychotherapy at the Erica Foundation
  Kristina Berglund Fries and Helena Vesterlund: Case presentation and
discussion
16.30 – 17.30 Summing up
  Dinner

Saturday, 27 April
09.00 – 10.15 Leezah Hertzmann: Work with parents in entrenched conflict
10.15 – 10.30 Coffee
10.30 – 11.30 Research
  Agneta Thorén: Short-term psychotherapy for children and their parents:
  Presentation of a clinically based research project at the Erica Foundation
  Discussion
11.30 – 12.30 Training
  Anders Schiöler: Training in mentalization based psychotherapy for children
  and parents
  Discussion
12.30 – 13.00 Lunch
13.00 – 14.00 Summing up. Next step?
REFERENCES AND FURTHER READING


