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Parents’ and psychotherapists’ goals prior to psychodynamic child psychotherapy

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In order to explore goals of parents and psychotherapists prior to child psychotherapy, the following questions were asked: (1) How are goals for psychotherapy formulated? (2) How can similarities and differences between parents’ and psychotherapists’ goals be understood? Questionnaires regarding psychodynamic child psychotherapies (n = 33) with parallel parental work were analysed using qualitative methodology. The child psychotherapists’ goals were often connected to the intrapsychic and relational development of the child. The parental therapists formulated goals focused on providing support to parents. The parents’ goals, on the other hand, concerned to a great extent giving the child help and to a lesser degree receiving help for themselves. They expressed their expectations concerning the child’s psychological development with a more everyday use of language, often with an emphasis on general psychological well-being. The study also indicated that parents had limited knowledge about the therapy’s implementation and framework. Some clinical conclusions could be made. Negotiating goals prior to parental and child psychotherapy can help create realistic expectations and promote a beneficial therapy situation.

Keywords: child psychotherapy; parental work; goals; negotiation; psychodynamic

Introduction

Psychodynamic child psychotherapy can be an effective treatment for children with different disorders (Midgley & Kennedy, 2011; Palmer, Nascimento, & Fonagy, 2013). Positive treatment results are maintained at follow-up (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003; Trowell et al., 2007). However, the treatment method needs to be developed further and factors that contribute to a positive treatment outcome must be examined (Fonagy, 2002). The treatment goals of child and parental psychotherapists, parents and children are considered important; however, to date they have not been sufficiently
examined (Weinberger & Eig, 1999). For many families, the first step in psychotherapy is to identify their goals of therapy. Formulating explicit goals enables the child, parents and therapists to create a common platform and a therapeutic alliance (DiGiuseppi, Lincsott & Jilton, 1996) prior to starting. Creating a therapeutic alliance with parents in the form of parallel sessions has also been described as an important part of child psychotherapy (Fonagy & Target, 1996; Kennedy, 2010). By conveying an understanding of the child’s and the parents’ view of the aim of therapy, the therapist may reinforce motivation in the family (Hawley & Weisz, 2003). The degree of motivation prior to psychotherapy contributes to a readiness to participate actively in both the planning phase and the psychotherapy itself (Constantino, 2012). Urwin (2009) emphasised the importance of the parents feeling as though the psychotherapy professionals have understood their expectations and view of the child’s problems. A framework, the Hopes and Expectations for Treatment Approach, was created by Urwin in order to address these aspects as well as to facilitate an assessment of whether expectations were fulfilled.

Children seldom initiate psychotherapy themselves. The child’s motivation towards forthcoming psychotherapy might be influenced by the attitude of their parents and other important persons in the child’s life since it can be hard for a child to imagine various alternatives and consequences (Kazdin, 1996). It is essential that parents are well informed prior to their child’s psychotherapy, especially as parental involvement affects the child’s expectations to a high degree (Shuman & Shapiro, 2002). Svendsen and Hansen (2008) emphasise the importance of involving the child in formulating comprehensible goals. The child’s expectations and understanding of such goals may be the main factor that creates a basis for continued cooperation. How well the child is prepared for change has been thought to be significant for the therapeutic process to evolve (Llewelyn & Hardy, 2001).

An interview study connected to this study showed that even young children had expectations regarding their forthcoming therapy (Carlberg, Thorén, Billström, & Odhammar, 2009). A majority of the children mentioned difficulties in relationships with others or expressed that they wanted help with a psychological problem. It was easier for the children to identify their problems than to know how they could be resolved. Many had a diffuse picture of how therapy would be conducted. Despite this, several of the children were very positive, curious and expectant prior to starting psychotherapy. Bradley, Murphy, Fugarrd, Nolas, and Law (2013) who also studied goal formulations of children and adolescents before treatment found that objectives such as psychological growth, functioning in everyday life, and coping with specific symptoms and problems were expressed as important.

Consensus about goals in therapy has been discussed as a fundamental prerequisite for a successful outcome (Hawley & Weisz, 2003). Garcia and Weisz (2002) described a connection between a lack of general agreement regarding goals and the frequency of interrupted therapies. Explicit formulation of goals can facilitate evaluation of the outcome for a family in an easily
understandable way. Law (2013) used an aim-based measurement scale, the Goal-Based Outcome Measure (GBOM), to evaluate progress in clinical work. This measures how far the child and parents feel the child has moved towards reaching a goal after an intervention. Emanuel, Catty, Anscombe, Cantle, and Muller (2014) stated that using the GBOM provides an additional source of valuable information. The GBOM also ‘gives a different perspective to clinical outcome measures and can measure different sorts of change that might not always be captured using only behavioural or symptom based outcome measures’ (Law, 2013, p. 12). It may also enhance psychotherapeutic work through collaborative process between the patient and the parents.

There is a need for more knowledge on how the initial contact, including formulating goals takes shape in psychodynamic child psychotherapy. It is important to examine parents’ and psychotherapists’ goals prior to psychotherapy and to come to an understanding about how these may differ (Bradley et al., 2013).

**Aim and research questions**

The aim of this study was to explore the explicit formulated goals of parents and psychotherapists before the start of psychodynamic child psychotherapy with parallel parental sessions. The following questions were formulated:

(1) How are goals for psychotherapy formulated by parents and psychotherapists?

(2) How can similarities and differences between parents’ and psychotherapists’ goals be understood?

**Method**

The study is part of the Erica Process and Outcome Study at the Erica Foundation in Stockholm (Carlberg et al., 2009; Odhammar, Sundin, Jonson, & Carlberg, 2011). To explore parents’ and psychotherapists’ goals prior to child psychotherapy, an analysis of case material was carried out. To attain a high degree of external validity, a naturalistic approach was used with a close connection to clinical context with children found in everyday clinical practice. Child and adolescent psychiatric units were contacted to recruit participants to the study. Altogether parents and psychotherapists in 38 cases agreed to participate. All cases fulfilled the following inclusion criteria:

(1) The psychotherapies were conducted on a psychodynamic basis.

(2) The psychotherapy was time-limited to between 1 and 2 years and had a frequency of once to twice a week.

(3) The children were between 5 and 10 years of age at the start of therapy.

(4) Therapy goals could be formulated at the start of therapy.

(5) The parents met a parent therapist at least every 14 days.
Five cases were not included in the final analysis; one because the family chose to end therapy and four because of lack of data sent to the research team. Dropout analysis showed no special features that distinguished these therapies from those included in the study.

**The children**

The 33 children represented a wide range of ages and mental health problems and can be considered as representative of children in contact with child psychiatric units (Table 1). The children often manifested several symptoms, and the psychological problems were multifaceted (Arcelus & Vostanis, 2005).

**The psychotherapists**

A total of 32 child psychotherapists delivered treatment (6 = men, 26 = women). One psychotherapist had two children in treatment. All therapists were health care professionals such as psychologists or social workers, and most of them had specialised training in child psychotherapy. The psychotherapists with only basic therapy training received regular supervision from an experienced child psychotherapist. All child psychotherapists had a psychodynamic orientation. In total, 35 parental psychotherapists (29 women and 6 men) participated. All were experienced health care professionals.

**The treatment model**

Psychodynamic child psychotherapy often involves treatment of difficulties that have emerged after repeated experiences that have formed dysfunctional ‘inner working models’. The focus in the therapy is on how the child experiences him/herself and others. This in turn affects the child’s mentalisation ability, their psychological well-being and their relationships. The relation between the child and the therapist is the basis for working through the child’s difficulties.

<table>
<thead>
<tr>
<th>Table 1. The children included in the study.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Comorbidity</td>
</tr>
<tr>
<td>Main diagnosis</td>
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<td></td>
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</table>
**Material**

Data collected from questionnaires completed by child psychotherapists, parental psychotherapists and parents were analysed. Each participant answered the questions independently after assessment but prior to therapy. Questions were formulated in the following way: ‘Describe the three most important goals of this therapy. The first goal is … The second goal is … The third goal is …’. These three goals were treated as equal without reference to any internal order of preference.

Questionnaires to the parents were distributed by the therapists, completed at home and thereafter sent to the researchers without any identification except the case code, ensuring parents confidentiality. For research purposes, the questionnaires were gathered separately. The aim of this procedure was to capture the informants’ individual thoughts prior to psychotherapy.

**Data analysis**

A comparative analysis of data across all 33 cases was carried out using qualitative content analysis according to Graneheim and Lundman (2004). Primarily, the first author carried out the analysis. After repeatedly reading through the questionnaires, meaning units were created. These were abstracted and condensed (Coffey & Atkinson, 1996). The formulation of goals were coded and grouped into categories at a higher level of abstraction. When the preliminary categories had been made, other possible categories were tested. When the categories had been established, these were checked to ensure that all meaning units could be referred to a category and that none of the meaning units could belong to more than one category. The data were also analysed case by case within the same child therapy with regard to the various aspects of the research questions. The authors discussed the categories that had emerged in depth in order to increase the trustworthiness of the interpretations (Williams & Morrow, 2009).

**Ethical considerations**

The study was approved by local ethics committees. Parents gave their informed written consent. The therapies included were rendered anonymously and certain details were changed in order to make it impossible to identify the families. This was done without changing the character and core of the contents.

**Results**

The formulation of goals clarified what the parents wanted the child to receive help with, as well as the therapist’s and the parents’ view of the potential of child psychotherapy. The analysis also showed, from a broader perspective,
how parents and psychotherapists in the study perceived and described psychological problems and the various participants’ general view of the psychotherapeutic treatment.

Categories of goals formulated in the questionnaires by parents and psychotherapists are reported below in order of their observed rate of occurrence (Table 2).

**Child psychotherapists’ formulated goals**

The child psychotherapists’ goals concerned to a very high degree the child’s psychological development, highly reflecting the therapists’ theoretical frame of reference.

**Intrapsychic development**

The child therapists wished to help the child to be able to feel, regulate and reduce affects as well as to gain increased impulse control. The goals concerning affects mostly addressed understanding and reducing the child’s own negative affects as well as gaining access to, and being able to express, positive affects. Another recurring goal focused on enhanced ability to use negative affects, such as anger and sadness, in a constructive way. Increasing the child’s self-esteem and self-confidence were often mentioned. This could include reducing the child’s omnipotence and developing a more realistic self-image. Developing or working through inner generalised pictures of others was another area mentioned. These formulations were often linked to perceived insecure attachment patterns in the children. Another goal suggested by the child therapists was improved mentalisation ability, e.g. to be able to reflect on one’s own and others’ feelings, thoughts and beliefs. Developing the child’s use of play and fantasy were also mentioned.

**Relationships with others**

This category included enhancing contact ability, sharing and reciprocity as well as the ability to create trusting relationships. Another goal was for the child to be more caring about her/himself in relationships with others as well to be able to genuinely relate to others without being dependent on external affirmation. This included an enhanced ability to take initiative and to verbalise thoughts and feelings in relation with others.

**Relationship with parents**

One recurring goal formulated by the child psychotherapists was for the child to achieve an improved and more trusting relationship with the parents, including more age-adequate emotional bonding. Some goals were influenced by ideas about a lack of secure attachment, such as helping the child to be less self-sufficient or overly dependent.
Table 2. Categories of goals formulated by child psychotherapists, parents and parental psychotherapists.

<table>
<thead>
<tr>
<th>Child psychotherapists</th>
<th>Parents</th>
<th>Parental psychotherapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intrapsychic</td>
<td>1. Child’s psychological development</td>
<td>1. Providing support for the parents in their role as parents</td>
</tr>
<tr>
<td>development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Relationships with</td>
<td>2. Symptom reduction</td>
<td>2. Parental cooperation about the child and parents’ own relationship</td>
</tr>
<tr>
<td>others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Relations between</td>
<td>3. Relationships with others</td>
<td>3. Relations between child and parents</td>
</tr>
<tr>
<td>child and parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The therapist as a</td>
<td>4. Help for parents with their own well-being or giving parental advice</td>
<td>4. Help parents understand their feelings about the child</td>
</tr>
<tr>
<td>new trusted person or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the therapy as a safe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Symptom reduction</td>
<td>5. Relations between child and parents</td>
<td>5. Focus upon the child’s problems</td>
</tr>
<tr>
<td>traumatic experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The therapist as a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>new trusted person or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the therapy as a safe</td>
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<tr>
<td>place</td>
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</tbody>
</table>
The therapist as a new trusted person or the therapy as a safe place

The child therapists expressed thoughts about the encounter between the therapist and the child functioning as a corrective emotional experience, in other words, for the child to feel valuable and understood, thereby promoting development in the area of relationships in general.

Symptom reduction

The child therapists’ goals regarding symptom reduction were connected with the child’s intrapsychic development or relationship skills. Examples could be to learn to sit still or be able to manage aggressive actions. Reduced compulsiveness was often mentioned.

Working through traumatic experiences

Attachment trauma or trauma in connection with adoption and other separations were mentioned. These goals were combined with other areas, for example, increasing the child’s self-confidence or developing psychological bonds with others.

The child psychotherapists seem to have looked at children’s problems from a broad perspective, and almost without exception, formulated goals were categorised to various categories in each child’s psychotherapy. Below is an example from child psychotherapy with a 10-year-old girl diagnosed with disruptive behaviour disorder. She was considered to be depressed, anxious and greatly lacking in feelings of security and self-esteem:

(1) ‘The girl will gain better self-esteem and dare to be able to recognise her own desire to play’. (Intrapsychic development)
(2) ‘Her need to control the mother will decrease’. (Relationship with parents)
(3) ‘She will learn to behave more age-appropriately and to seek out her peers’. (Relationships with others)

The parents’ formulated goals

The parents’ goal formulations were generally shorter compared to the therapists’ and could be divided into the following categories (Table 2):

Child’s psychological development

Parents mentioned helping the child to become more secure and harmonious, seeing possibilities in life rather than only problems, or making the child happy and regaining self-confidence.
Symptom reduction

This category predominantly contained reducing externalising behaviour symptoms such as fighting, overactivity or tantrums. Formulation of internalising symptoms goals could be, for example, helping the child to reduce anxiety or to decrease his/her need for compulsive control.

Relationships with others

The parents mentioned supporting the child in having a well-functioning relationship with others. This included teaching the child to socialise and engage in mutually satisfactory play with peers or helping the child begin to have trust in others.

Help for parents

Some parents stated that they would like to be helped with their own well-being in order to be able to manage the child’s problems. Only in exceptional cases did parents express expectations of help for their own psychological problems.

Relationship between parents and child

This category included many different aspects: getting the child to accept boundaries, helping the child to have trust in his/her parents, creating a harmonious situation between parents and children and helping parents to meet the child in a psychological sense.

Help for the family

One difference from the child psychotherapists’ formulation of goals, which seldom concerned a family perspective, is that some of the parents had expectations that the psychotherapy would be able to improve the atmosphere in the family.

The child therapist as a new trusted person or the therapy as a safe place

This category contained the parents’ feelings about the child as being insecure or maltreated in the daily social environment, at home or in school and their hopes for the child to relate to the therapist in a more trusting manner.

The parental psychotherapists’ formulated goals

The parental psychotherapists’ goals could be divided into the following categories (Table 2):
Focusing on providing support for the parents in their role as parents

This category included discussing how parents’ actions have an impact on the child’s behaviour and helping parents to act more consistently towards their children. One key goal mentioned was helping parents to recognise when they are competing with the child instead of maintaining a trusting child–parent relationship.

Parental cooperation about the child and the parents’ own relationship

The parental psychotherapist mentioned discussing couple relationships, as they negatively affect the child’s problems. This could include encouraging the parents to listen, collaborate and develop confidence in one another.

Improving relations between child and parents

This category concerned reducing over-dependence between parent and child. One goal mentioned was helping the parents to encourage their child to express thoughts and experiences towards them and responding to the child with confirmation. Parental psychotherapists mentioned helping parents to manage, rather than act out, their feelings of anger towards the child.

Helping parents understand their feelings about the child

Goals in this category could include helping the parents gain an understanding of feelings of shame regarding the child’s behaviour, and instead discover positive attributes in the child. Parental psychotherapists mentioned working through and gaining a better understanding of the anxiety the parents feel around the child or managing the ambivalent feelings that the child awakens.

Focusing upon the child’s problems

Goals in this category focused primarily on helping parents to gain a better understanding of their child’s problems and psychological needs and gain a more realistic picture of the child’s difficulties and resources. Doing so can help parents in identifying what help and support the child needs and creating space for the child to test various approaches and strategies for him/herself.

Individual therapeutic goals

The goals that emerged could originate from the parents’ personal history, e.g. helping them to develop their understanding of the emotions and mechanisms that govern problematic interactions within the family. Helping parents to raise their anxiety tolerance may result in enabling them to become more available to the child. This category also includes supporting parents to distinguish their own problems from those of the child.
Analysis case by case

Case by case comparison of goals showed a great degree of similarities between the child psychotherapists and the parents. In half of the therapies, the goals were in explicit agreement. In approximately one-quarter of the therapies, the goals were not exactly at odds with one another, but parents’ goals were less developed in that they were more general, using everyday language about psychological well-being rather than using specific psychiatric symptoms or developmental psychology terms. Parents formulate goals more in terms of symptom reduction. In these cases, the goals showed a complementarity, as goals from parents and psychotherapists described different aspects of the child’s problems. Only in a few therapies were goals prior to psychotherapy in conflict. Some parents did however state they wanted the child’s problem to be assessed, to get a diagnosis and receive information regarding an expected prognosis indicating that they were not yet focused on formulating goals for the child psychotherapy at that time.

Table 3 presents an example from a single case with a nine-year-old boy diagnosed with reactive attachment disorder with temper tantrums. In this case, the parents’ goals are less developed, more general and they use a language that is more everyday in nature. The parental therapist formulation of goals focuses on parental cooperation and thus is quite different from the parent’s and the child therapist’s child-centred goals.

Table 4 presents another example of how the parent therapists’ formulation of goals differs from those of the parents in a therapy with a ten-year-old

Table 3. Example of formulation of goals in one individual case.

<table>
<thead>
<tr>
<th>The child therapist’s formulation of goals</th>
<th>The parents’ formulation of goals</th>
<th>The parental therapist’s formulation of goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attain a more realistic and less omnipotent view of himself and his role in the interplay with his parents and other adults, which in turn would pave the way for establishing relationships with other qualities (intrapsychic development/relationship with others)</td>
<td>Getting better self-esteem (child’s psychological development)</td>
<td>Get the parents to listen to each other (parental cooperation about the child and parents’ own relationship)</td>
</tr>
<tr>
<td>To be able to manage his aggression and to use it in a more healthy and constructive way, with regard to expressing and conveying wishes and needs (intrapsychic development)</td>
<td>More respect/consideration for other people and their needs (relationship with others)</td>
<td>Get the parents to talk to each other (parental cooperation about the child and parents’ own relationship)</td>
</tr>
<tr>
<td>Develop a truer self, which does not only depend upon external affirmation and appreciation of competitive performance (intrapsychic development)</td>
<td>One does not need to be able to do everything from the beginning. It is not a competition where it is a question of being first (child’s psychological development)</td>
<td>Get the parents to see their child and relate in a reasonably adequate way. Allowing one parent and child to interact, without the other parent stepping in and acting (relations between child and parents)</td>
</tr>
</tbody>
</table>
A girl who had been sexually abused and was having cooperation problems in the family. The parents formulated goals focused on the girl’s problems whilst the parental therapist mentioned involving parental collaboration, their ability to understand the girl and taking parental responsibility. These goals may be in conflict since the focus is different.

**Discussion**

The results showed the child psychotherapists’ goals were more elaborate and often connected to the intrapsychic and relational development of the child. The parental therapists formulated goals that focused on providing support to the parents, often related to their role as parents. The parents’ goals, on the other hand, concerned giving the child help and to a lesser degree concerned receiving help for themselves. As expected, the parents in this study expressed their expectations concerning the child’s psychological development with a more everyday use of language, often with an emphasis on psychological well-being and not on specific symptoms. This study also indicates that parents had limited knowledge about the therapy’s implementation and framework.

Parents, child psychotherapists and parental psychotherapists expressed their goals differently before starting therapy. However, the study also shows a high level of content agreement between the child psychotherapist’s and the parents’ goals. This differs from an earlier study where consensus about goals was not reached in half of the therapies (Hawley & Weisz, 2003). Parents, often using general expressions from an everyday perspective for what they want help with, may be more vulnerable to the psychotherapists’ descriptions when delivered in a professional language. Baldwin (2014) describes how parents meet the therapists with a wide array of emotions and usually concrete expectations:

> On the surface are presenting complaints, typically in the form of disruptions or problems at home or school. For many reasons, often including a loving desire to see their child do well and be spared pain, parents wish for immediate relief or a fantasised quick fix of their child. Often, though, harsh and overwhelming intense feelings of guilt, shame, and self-blame for the child’s problems lie beneath … (p. 4)
The initial contact between the therapists and the parents may then be an important point of departure for both the conducting of psychotherapy and for outcomes in terms of successful cooperation, mutual understanding and developing expectations. Explicit formulation of goals could, as Shuman and Shapiro (2002) pointed out, contribute to parents obtaining a more positive, accurate and pronounced perception of their child’s psychotherapy. It could also strengthen motivation and better conditions for consensus regarding the ways in which psychotherapy could be helpful (Urwin, 2009). This seems especially important as parents’ attitudes towards the child psychotherapy may greatly affect the child’s expectations (Kazdin, 1996). Support from parents is considered to be a fundamental condition for the child to be able to participate in, and make use of, the psychotherapy.

The importance of creating a culture of collaboration with the family entering health services for children has been addressed in earlier research (Brewer, Pollock, & Wright, 2014; Troupp, 2013). This culture has to permeate the entire organisation to support collaborative goal setting in a systematic way. This study in line with Emanuel et al. (2014) indicates it is also important that the formulation of aims is done in collaboration between therapists, parents and children: ‘Both patient and parents may benefit from a sense of ownership of the treatment aims’ (p. 11). Law (2013) advocates that, ‘the most important measure of change is that which children, young people and their families have chosen to make themselves’ (p. 11).

The child psychotherapists’ goals are deeply influenced by their theoretical orientation and professional language. Svendsen and Hansen (2008) emphasised the importance of formulating comprehensible goals as a way of involving the child. An in-depth discussion of goals could be crucial, as agreement on means and goals seem to be one of the critical aspects of strengthening the therapeutic alliance (DiGiuseppe et al., 1996). Findings from Carlberg et al. (2009) support this where only one-third of the children showed they understood that the planned psychotherapy was connected with their problems. The goals can be used to show and remind the child what they are aiming for during the psychotherapy. It can also be a satisfying motivator to see progress in relation to the goals as the therapy progresses.

The study indicates that when goals are formulated regarding both the parental contact and the child psychotherapy, they may differ in focus. The child psychotherapists’ formulation of goals in this study seldom involved a family or parental perspective. Comparisons between formulation of goals from the parents and the parent therapist showed that the latter generally focused upon support for the parents, including how they can cooperate with each other, whilst the parents have goals mainly related to their child. However, divergent or complementary perspectives from different participants could be a major asset in child psychotherapy if discussed openly and thus could provide a more comprehensive picture of the family’s needs.
Limitations of the study
There are benefits as well as difficulties in integrating research in a naturalistic setting. This study attempts to capture expectations for psychotherapies as they portray themselves in everyday child psychiatry services. Subsequently, the children in the study had different kinds of psychological problems and often comorbidity reflecting those attending child guidance clinics. Due to the parents’ positive attitudes towards participation in the study and the study’s design of the selection by the therapists of appropriate therapies, the generally positive expectations of parents and psychotherapists may reflect this selection process and therefore be less representative. A study based on questionnaires has inherent limitations. Further explorations of goals and goal setting might benefit from using interviews as method for data collection.

Clinical implications
Some clinical implications can be drawn from this study and the literature, which are as follows:

Carefully raising questions prior to psychotherapy concerning expectations related to content, framework and goals might increase the likelihood that the treatment is adapted to the specific family. A rigid use of formulated goals might restrict the psychotherapeutic process. If goals are allowed to change and new goals can be added during the course of psychotherapy, this could be prevented.

Therapeutic goals should in a collaborative culture, as far as possible, be formulated according to the family’s frame of reference and life experiences. By explicitly discussing goals of psychotherapy, differences in expectations can be discovered and discussed with parents and between child and parental psychotherapists before the child psychotherapy starts. These negotiations may also contribute positively to the therapeutic process.

It is important to listen carefully and in detail to the parents’ use of language when goals are formulated concerning child psychotherapy and parental contact. Parents’ more everyday descriptions of goals for therapy must be weighed against the more professional psychotherapist descriptions.

It may be of value to help the child to express difficulties by adapting the formulation of goals to the child’s age and developmental level. This might communicate that the psychotherapy is a place where one can receive help.

Formulating clear goals facilitates the evaluation of the effectiveness of therapy, where outcome can be seen in the light of previous explicitly formulated goals.

Further studies
Interviews in contrast to questionnaires could probably provide more detailed knowledge of parents and psychotherapists subjective experiences of
formulating goals prior to child psychotherapy. It is desirable that future studies also capture the process of negotiation of goals.

The goals and expectations of children in psychotherapy have been investigated previously (Bradley et al., 2013; Carlberg et al., 2009). Further studies could differentiate and deepen the understanding of the child’s own thoughts and experiences.

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Notes on contributors
Fredrik Odhammar, MSc, is a licensed psychologist and psychotherapist. He is a teacher, supervisor and Director of studies at the Erica Foundation in Stockholm, Sweden, an institute providing psychotherapy for children and adolescents, and professional training at university level and research. He is also a PhD candidate at the University of Stockholm. In his research, he has a special interest in relational aspects in psychotherapy, therapist variables and therapeutic alliance related to clinical process and outcome in child psychotherapy.

Gunnar Carlberg, PhD, professor at the Department of Education, Stockholm University and former Director of the Erica Foundation in Stockholm. He is a licensed psychologist and psychotherapist with various publications within psychodynamic developmental psychology and child psychotherapy research.

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