Intersubjectively oriented, time-limited psychotherapy with children: How does the therapist evaluate the therapeutic process and what are the therapist's tasks?

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Based on the therapist's evaluations of three therapies, this research aims to study the therapeutic process in intersubjectively oriented, time-limited psychotherapy with children. A primary objective is to further develop the therapy method. The study comprises therapies with children 6–11 years of age, who had experienced difficult family situations. Each child received 12 therapy sessions. The number of therapy sessions with children and parents was agreed upon beforehand, and the therapeutic objectives were approved by the parents. Each of the therapy processes were evaluated by the therapist by answering three questions and filling in three forms after each therapy session. The forms were: The Feeling Word Checklist; an alliance form for the child; and a process form. The therapeutic alliance and the behaviour of the therapist during the therapy sessions are discussed on the basis of the total material. The following main tasks for the child therapist emerged: structuring the therapy sessions; following the child's initiatives; participating and cooperating with the child; exploring the child's expressions; and understanding and regulating emotions.

Keywords: Time-limited psychotherapy; intersubjectivity; therapeutic alliance; mentalization; short term psychotherapy

Introduction

This article relates to intersubjectively oriented, time-limited psychotherapy with children (Haugvik and Johns 2006, 2008; Haugvik, 2013), a structured therapeutic method, where the objectives and the number of sessions are contracted with the child and parents. The parents take part in therapy parallel to their child.

The theme described and analysed in this paper is what the child therapist actually does during the therapy sessions. The qualitative analysis and conclusions in the study are based upon the child therapist's evaluations. This is the third article in a series that analyses the therapeutic process in three therapies, from the perspectives of the child, the parents and the child therapist.

In the previous two articles, the individual child therapy processes, along with parents' therapies, have been analysed (Haugvik and Johns, 2006, Haugvik, 2013).

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The focus formulation, the effect of the therapies, as well as the children's and parents' evaluations, were discussed.

The hypothesis in the first study (Haugvik and Johns, 2006) was that a shared focus in therapy might help the children to experience new or expanded feelings, and new experiences. We found that the children through the course of the therapy showed a deepening and enrichment of their feelings and experiences. The children also introduced hope and solutions to difficult issues. Parents reported that their children were more able to express and share their own needs and feelings. Symptom reduction was also reported. It seemed that joint attention, agreement upon goals, sharing and acknowledgment of expression of feelings and experiences facilitated a positive therapeutic outcome for these children.

In the second article (Haugvik, 2013), the parents expressed how coming to the therapy sessions was a positive experience for them, as well as for their children. The session evaluation form and journal notes supported this finding, which emerged from interviews with the parents. Certain guidelines were suggested for the parallel parent therapy, as described below. The parents gave written consent for participation in the study. The therapy project was approved by the Norwegian Data Inspectorate and the Regional Committee for Medical Research Ethics for Eastern Norway.

Central characteristics of time-limited psychotherapy with children
The therapeutic method is inspired by earlier literature on time-limited psychotherapy with children (Proskauer, 1969, 1971; Peterlin and Sloves, 1985; Sloves and Peterlin, 1986) and has been further developed into an intersubjectively oriented, time-limited therapy model (Hansen, 1991a, 2000, 2012; Haugvik and Johns, 2006, 2008; Haugvik, 2013; Svendsen *et al.,* 2012). The theoretical grounding takes developmental psychology as its foundation with an intersubjective perspective (Stern, 1985, 2004; Trevarthen and Aitken, 2001). By intersubjectivity, Stern (2010) means the sharing of another's experience. The intersubjective perspective in clinical psychology emphasises reciprocal dialogue, regulation, and negotiation (Hansen, 1991b).

Three mental states are central in *intersubjective relating* (Stern, 1985, 2010). These are sharing of joint attention, sharing of intentions and sharing of affective states. Sharing of affective states can be promoted by affect attunement (Stern, 1985, 2004). Affect attunement by the therapist is intended to support the child in being able to share his or her inner experiences with the therapist. Affect attunement means reading the child's affective condition on the basis of external behaviour, adjusting to the child's emotional state, and reflecting the child's affective expression without imitating the behaviour.

Therapy structure
The therapy method is structured. Within a pre-defined and mutually agreed framework, the therapy content is open, and it is created jointly by the child, the parents, and the therapist. The number of sessions and the objective is agreed upon with the parents and the child before therapy starts. The time frame is usually limited

to 10–12 therapy sessions. The parents have their own sessions in parallel with the child, and the framework for the parents' therapies is agreed upon before therapy starts.

Great emphasis is laid on being clear with the child and the parents about what the therapy structure will be. It is about the focus of therapy, explained below, as well as the number of therapy sessions and how long the sessions will last. This is agreed upon before the start of therapy and reviewed with the child at the beginning phase of therapy. The therapist keeps to the agreements throughout the therapy and does his or her best to put right deviations that may occur. All sessions should be completed, even when some may need to be re-scheduled.

Before and after therapy there are joint sessions with the child and the parents in order to plan and to summarise the therapy. The theme or focus is proposed by the therapist in the first joint session. It is important that the parents understand and agree to the focus, and that they actively support this in the presence of the child. A visual overview of all the sessions is made with the child during the first therapy session in the form of a calendar. Time is allocated at the end of each therapy session for the child to draw something that has been important in the session, in the relevant square of the calendar.

The completion of therapy is planned and prepared in the second half of the therapy. In the final session, some time is set aside for communication about the therapy. The child chooses whether this takes place at the start or end of the session, and the therapist is responsible for ensuring that there is adequate time for it. The therapist gives the child a small object or story that symbolises the focus or something that has been important in the therapy. Therapy feedback to the parents is also planned with the child in the final session.

Therapy focus
The focus of therapy refers to the theme that we choose to work with in therapy. Focus serves to create joint attention to the experiences, thoughts and feelings presented by the child itself. This understanding is related to literature about intersubjectivity and theory about self-development. The focus is expressed by a metaphor suggested by the therapist and is a tentative interpretation of a part of the inner world of the child. Being a metaphor, the focus is a suggestion to the child about sharing something related to his or her inner world. The metaphor is a starting point for the child to share his or her inner world with the therapist. The goal for the therapy will therefore be to emphasise the importance of the child's own feelings and experiences and be able to open up new or expanded experiences, or alternative ways to cope. The objective of the therapy is not primarily symptom reduction, or that the child shall do more or less of something specific. The objective is rather to give the child greater possibilities for expressing his or her subjective experiences, thoughts and feelings, including not only positive but also negative feelings and experiences that the child has not been able to share so far. The parents' acknowledgement of the focus for the therapy is also emphasised. The focus for the child's therapy takes as a point of departure the child's experience, and is formulated in a positive fashion. A

joint focus ensures attention on what the child personally has presented as being difficult, while the focus simultaneously redefines the difficulty. There is thereby an emphasis on the child's resources (Madssen, 2005).

The therapist, the child and the parents agree on a metaphoric formulation of focus. The therapist is active in connecting the therapy's content to the agreed focus, and the child is invited to share his or her experiences. Some examples of metaphorical formulations of therapeutic focus would be acquaintance with all the child's different 'rooms', 'powers' or 'treasures', that is to explore the child's feelings, thoughts and experiences, or 'to become the captain of one's own ship', 'mastering one's own powers' and so on (with emphasis on affect regulation).

Parallel parent therapy
The parallel parent therapy should promote mentalizing or reflective function (Haugvik, 2013). Mentalizing implies the ability to attribute meaning to the actions and communications of others as well as oneself:

> Mentalizing is a form of imaginative mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, purposes, and reasons).
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> (Fonagy, 2010: 18).

Through the caregiver's emotional attunement and mentalizing, the child is supported in organising his or her inner state. This form of interaction is the foundation for connecting attachment, self-regulation, and mentalizing (Fonagy and Target, 1997; Hart and Schwartz, 2009). Mentalizing is seen as closely related to the child's personality development and affect regulation (Fonagy *et al*., 2002). Parallel involvement with the parents supports the therapy focus and the parents' ability to better understand themselves and their child (Svendsen *et al.,* 2012; Haugvik, 2013). The following guidelines are suggested for parent therapy (Haugvik, 2013): 1. As part of the initial phase of the therapy, there should be an assurance that the child's situation in the family is safe and sufficiently caring; 2. Efforts should be made to share and explore the parents' own experiences, feelings and thoughts regarding themselves, their child and the family situation; 3. Parallel parent therapy should reflect upon the child's possible subjective experiences, feelings, thoughts and needs; and 4. Focus should be on expanding and balancing these reflections in order to promote the mentalizing ability of the parents.

Therapeutic alliance
The therapeutic alliance is dependent on three factors: goals, tasks, and the emotional bond (Bordin, 1994; Horvath and Bedi, 2002). In our therapy model the agreed focus is regarded as the *goal* of the therapy. *Tasks* denote what the therapist and the client carry out specifically, including the sharing of responsibility for who does what. Central tasks in this model are the therapist's responsibility for structuring the therapy and for giving the child an opportunity to choose activities freely within the agreed

framework. The common focus and tasks pertain to aspects of reciprocity (Haugvik and Johns, 2006). *Emotional bond* entails a positive relationship between the therapist and client, and this is shown through mutual trust, confidence, and acceptance. The emotional bond can be studied by asking children, parents, and the therapist about their experiences. It is explored in this study by the therapist registering what feelings are awakened when meeting with the child in the various therapy sessions, what experiences or feelings the child is understood to have in each therapy session, as well as how the therapeutic process is evaluated in each of the 12 sessions.

Research question
The purpose of the study is to uncover what the child therapist does during the therapy sessions in order to promote achievement of objectives in intersubjectively oriented time-limited psychotherapy. This has so far not been fully investigated or described for this therapy model. The therapy process is evaluated based on what the therapist highlights from the session in general, as well as the activity of child and therapist during the sessions.

We will discuss to what extent the therapist's evaluations confirm the importance of a good alliance for successful time-limited therapy, as previous findings (Haugvik and Johns, 2006, 2008; Haugvik, 2013) have indicated.

Method: design and analysis
In the processing of data we have applied elements from qualitative research methods such as *grounded theory methodology* (Strauss and Corbin, 1998), the *phenomenological approach* (Giorgi, 1985) and the *consensual qualitative method* (Hill *et al.* 1997). In addition, we have applied some quantitative measures.

The study encompasses therapies with three children. Twelve therapy sessions were carried out after three sessions of play observation with each child. Joint meetings were held with children and parents and their therapists before the start of therapy, immediately afterward, and three months after therapy. Separate sessions with the parents were held in parallel with play observation and therapy. The first author of this article was the child therapist.

In order to describe and better understand the therapist's activities during the child therapy sessions the therapist answered the following question: 'How would you describe the activity and how you and the child participated?' In the analysis the authors emphasised how the therapist's behaviour was described. The recordings were read and analysed individually and independently by each author. After repeated readings, exchanges, and revisions, a consensus on the descriptions was reached and five themes regarding the child therapist's behaviour during therapy were established.

After each therapy session with the children, the therapist in addition filled in three different forms containing questions of how the session progressed. The therapy sessions and rapport with the child is evaluated by the therapist on the basis of the therapist's feelings during the sessions and her assessment of what feelings and experiences the child expressed during the session. The forms are described below. A collective average score for the main areas appears in the article.

The discussion of the material is related to the alliance concept. First, we were looking for the therapist's expressions about 'Agreement on therapeutic tasks'. Second, we were searching for expressions about 'Agreement on goals'. Third, we were analysing the therapist's evaluation of the therapeutic bond. From this analysis a set of therapeutic tasks were inferred.

Evaluation forms
Process form
The form has been developed in order to capture important aspects of the therapy process from the therapist's point of view, and consists of different questions to the therapy session (Svendsen, 2007). In this study we will take a closer look at the following three questions: *What would you say first about this session? How would you describe the activity and how you and the child participated? How would you describe the contact between you and the child?*

Form for the therapist's feelings
Feeling Word Checklist, FWC (Holmquist and Armelius, 1994; Hoffart and Friis, 2000). The form comprises 36 different feeling words. The therapist should indicate which feelings are awakened with the child in each individual session. On a scale of 0–4, the therapist scores the extent to which the 36 feelings are recognised. The form is filled in by the therapist after each session. The feeling words can be grouped into three main areas (Hoffart and Friis, 2000): interest/boredom, insecurity/security, and anger. The reply categories were transposed onto a scale from 1 to 5, where 1 is the most negative and 5 the most positive in relation to the therapeutic alliance.

Alliance form for the child's presumed experiences / feelings
The alliance form, based on Therapeutic Alliance Scales for Children, TASC (Shirk and Saiz, 1992; Svendsen, 2007), concerns the therapist's evaluation and registration of the child's presumed experiences during every session. The form consists of 10 statements that are intended to describe therapeutic bonds and negativity. Negativity pertains to whether the child's experiences in the sessions or with the therapist are negative. Each statement is scored by the therapist on a scale from 1 to 4, with 1 the most negative and 4 the most positive in relation to therapeutic alliance for the child.

The children
The study encompasses therapy with three children aged 6, 9, and 11. Common to all the children was their difficult family situation. A difficult family situation is defined as considerable family conflicts that last for at least one year. Conflict could be between the parents, or between the child and parents, and might involve social care. The children are called Kim (6 years old), Karl (9 years old), and Nora (11 years old). We will briefly present the children's family situations, as well as the therapist's evaluations and approach concerning the therapy focus.

Kim, aged 6, had lived with several caregivers due to his parents' mental illness. He was living in a foster home during the time of therapy and was referred for

disturbed behaviour, confusion regarding where he belonged, and attention problems. The following can be seen from previous analyses of the child's therapy (Haugvik and Johns, 2006):

> *We judged that the best way to approach his experiences was to start with reflecting and confirming the inquisitive way he related to others and to his environment ... Given his changing care situation over a long period, the objective was to validate his feelings as relevant and legitimate ... It was suggested to Kim that work should continue with becoming familiar with all his 'treasures' (that is experiences, feelings, thoughts).*

At the end of the first therapy session, Kim was asked by the therapist to draw something important from the session in the square in the calendar. Kim answered that this was "difficult". He thought for a long while before he suggested drawing a house and a tree. The therapist said that he could draw just what he wanted. He drew a house, and during the conversation with the therapist said that his mother lived in a house like that. They then talked about how much he missed his mother. The therapist understood his statement about difficulty as an expression of exactly that. The therapist conveyed that this was understood by not forcing him to do something that was too difficult. This was meant as a form of affect attunement, which in turn led to exploring his feelings.

Karl was 9 years old and had experienced considerable parental conflict over a long period of time. He lived with his mother and for periods had no contact with his father. He had attention problems and psychosomatic ailments. There was a desire for him to be given an opportunity to work through the traumatic experiences he had suffered within the family. The following is taken from previous analyses of the child's therapy (Haugvik and Johns, 2006):

> *A goal for the individual therapy was to be able to clarify his feelings, so that he himself could experience his reactions as meaningful ... It was suggested to Karl that the focus should be on becoming aware of all his 'forces' (experiences, feelings, thoughts).*

During Karl's therapy, he played war and catastrophies in the sandbox. There was a lot of anger in his play. The therapist did not always understand who fought against whom, because this changed constantly. The therapist was active in trying to follow and understand what happened. The therapist was sometimes quite confused, and she had to ask and explore what happened during the play. It was assumed that these were feelings that Karl had experienced himself and that he was able to express some of this through his play in the therapy room.

Nora, aged 11, was seriously depressed, expressed a lot of anger, and had various psychosomatic afflictions. Her parents were divorced. She lived with her mother and had frequent contact with her father. The following is taken from the previous analyses of the child's therapy (Haugvik and Johns, 2006):

> *The focus was intended to symbolise an assumption that Nora struggled with many different experiences with regards to the family situation and her own role, and that it*

was important to be able to give space to all her feelings ... It was suggested to Nora that the sessions be used to become better acquainted with all the 'rooms' (experiences, feelings, thoughts) inside her.

A central task for the therapist was to promote an experience for Nora of being seen and accepted. During the therapy she sometimes demonstrated the need 'to get enough' in a somewhat childish way. By talking about what happened during their play, the therapist and Nora could nuance her wishes, dreams and expressions.

In the change interview with the parents at the halfway point and after termination of the therapy they were asked about positive and negative changes. The parents reported only changes that they perceived as being positive and the impression was confirmed through change scales and journal notes. For example, the parents reported that the children spoke up with greater clarity about their own experiences and communicated different emotions, also difficult emotions and they experienced this as a positive development. Further, it was pointed out that the children were perceived as being more open and self-confident and that they demonstrated fewer symptoms. Although the objective of the therapy was not primarily symptom reduction, the children in the study demonstrated both fewer symptoms and improved psychosocial functioning after the therapy (Haugvik and Johns 2006, 2008).

Findings
The therapist's activity during the therapy sessions
The data material was read several times by both authors separately, and after several revisions we arrived at the following consensus descriptions. The following themes were present throughout the therapist's evaluations of her own activity:

1. The therapist structured the framework of the sessions.
2. The therapist followed the child in his or her play.
3. The therapist participated and cooperated in the activities.
4. The therapist implicitly or explicitly inquired about and explored the child's experiences.
5. The therapist made efforts to understand and regulate the child's and her own emotions.

The child's communication took place implicitly and symbolically through playing, non-verbally as well as more explicitly and verbally. Both direct and indirect ways of communicating were important to the intersubjective dialogue. Play was regarded as the most important communication channel for the child. The interventions took place throughout the entire course of therapy. The interaction and relationship between therapist and child seemed to develop and deepen during the course of the therapy. This was in line with the somewhat higher alliance scores, along with the absence of diversions or avoidance behaviours, in the completion phase of the therapy.

The therapy process
On the basis of the therapist's descriptions of the therapy process for each session, the following is a more in-depth examination of the start, middle, and final phases for the

three children. For each phase a common summary of the therapist's answers regarding all the three therapies is included.

The start phase

In the description of the therapy process, the therapist emphasised how she, in the start phase, structured the situation by talking explicitly about the framework for the therapy. For example, in the first session the therapist noted: *I structured a lot around time, calendar, focus. He participated actively in making a calendar (...) I also led the finalisation / drawing on the calendar (...).* The child led, and the therapist followed the child in play, activity, and conversation. For example, in the first session one child played alone, and the therapist showed interest and followed what he produced. Another child took the initiative to different activities, and suggested playing Monopoly in the third and fourth session. From the first session it seemed as though the children accepted the therapist's proposed session structure, which included the use of a calendar, a plan for how to end the sessions, as well as openness for the child to choose the activity.

The activities first and foremost entailed different types of games and conversations, where the therapist participated in mutual exchange during the play. The therapist asked about the child's feelings and talked with the child about his or her experiences. The child was open about his or her feelings when asked. During the first four sessions, the therapist found that all the children shared their feelings with the therapist during conversation and play. In addition, the therapist found that the children themselves regulated the sharing of difficult feelings. The therapist noted that the children shared and communicated strong feelings and were sometimes reticent when the theme in question was difficult. The evaluations showed that rapport was good and reciprocal.

The middle phase

The central theme in the middle phase focused on the therapy structure, as for example when children asked how many sessions remained; repetition of the play themes or same play theme with variations, reciprocity in play, changing between leading and receiving help, and meta-communicating about difficult feelings or experiences as a way to express mental states. The children planned what they would do during the session and commented on the structure by talking about the number of sessions.

All children repeated different play themes from session to session. The children communicated first and foremost through play. One child mentioned a dislike of talking about sad and negative feelings and took 'control' of the game by making her own rule for taking the lead in a game. This was accepted as a part of the child's communication.

For most sessions, rapport in this phase was evaluated as good and reciprocal. The children themselves were described as contributing actively to contact with the therapist. The children initiated, maintained, and regulated the contact. For example, one child made phone contact as part of the play, asked for help while playing,

repeated the therapist's words and corrected the therapist. The children shared feelings in conversation and could show uneasiness when asked about difficult feelings. Contact in one of the sessions was evaluated as 'fairly good', that is to say, not as good as otherwise. In this session the therapist took up the theme connected to feedback to the parents, and the child did not show very great interest.

The completion phase

In the completion phase the therapist followed the child's initiative and participated in different activities. The children were found to be secure and honest with their feelings. Calm, confidence, and sadness were described. The therapy completion was prepared and took place in a way where the children expressed and were open about their own feelings in relation to the completion. The last session was described as fine, confident, good / very good, and calm.

Contact in this phase was described as 'good'. For two of the children, 'very good' and 'excellent' were used to describe the last and next to last sessions, respectively. The rapport was characterised by reciprocity, and the therapist became involved to make sure that there was sufficient time in relation to what the child wanted to do when the therapy was nearing its completion. The therapist structured the last session so that there was time to commemorate the ending.

Alliance

All twelve planned sessions with the three children were completed, and all forms were filled in, except for one session for one of the children. In the process form, the therapist described the contact with the child as very good in most of the sessions. Where this was not the description, the therapist answered 'fairly good' for one session, or the therapist described a specific episode from the session.

Replies to the alliance forms indicated that the therapist evaluated the therapy relationship as very good throughout the entire therapy process for the three children. The therapy process was divided into the start phase (sessions 1–4), the middle phase (sessions 5–8), and completion phase (sessions 9–12). To the question regarding the degree to which the therapist experienced an alliance, the therapist's responses gave an average score of 4.2 (4.3; 4.1; 4.2) on a scale of 1–5 for the three children across all 12 sessions (see Table 1). Regarding the three children's presumed experiences of a therapeutic alliance for all 12 sessions, the therapist's responses gave an average score of 3.4 (3.4; 3.5; 3.4) on a scale of 1–4 (see Table 2). Note that the average scores in table 1 and table 2 were at the same level (approx. 85 percent of maximum score) when correcting for different scales.

Table 1.
The alliance experienced by the therapist for all three children, scale of 1–5:

Average	C1	C2	C3	C123
Session 1–4	4.2	4.2	4.0	4.1
Session 5–8	4.3	4.1	4.2	4.2
Session 9–12	4.4	4.3	4.2	4.3
Session 1–12	4.3	4.2	4.1	4.2

Table 2.
The children's presumed experiences of a therapeutic alliance, scale of 1–4:

Average	C1	C2	C3	C123
Session 1–4	3.2	3.5	3.5	3.4
Session 5–8	3.3	3.2	3.3	3.3
Session 9–12	3.7	3.5	3.7	3.6
Session 1–12	3.4	3.4	3.5	3.4

Discussion

We will discuss our findings in relation to the three main elements in Bordin's (1994) definition of the therapeutic alliance; agreement regarding tasks and goals, and emotional bonds. We will further consider how these elements manifest in the three therapy phases. Based on the therapist evaluations, the conclusion will give some proposals for the therapist's approach to the content of the sessions. The content and themes of the therapy are intended to be individualised for each child, and are created jointly in the 'here and now' of the therapy room. Some specific approaches and activities on the part of the therapist seem to enhance the therapeutic alliance and change.

Agreement on goals

The children in the research project seemed to accept specific therapy goals: to become aware of, recognise, and expand feelings, thoughts, and experiences connected to a difficult family situation. The therapist found that the children quickly communicated subjective experiences and they could be honest and open about their experiences. The therapist related to the children's play and activities as meaningful in themselves. The therapist also talked to the children about their feelings and experiences. They continued this communication through the entire therapy. The therapist found that the children first and foremost communicated implicitly through play and play-related activity, but also through conversations where they partially meta-communicated about the play and the play-related activity.

The therapy method emphasises intersubjective sharing and affect attunement for the purpose of relating to and understanding the children's play and activities as meaningful. This is in line with the concept of *mentalizing*, which entails implicitly

and explicitly interpreting one's own and other's behaviour as meaningful expressions of inner life (for example needs, wishes, feelings, and common sense) (Fonagy and Target, 1997; Fonagy *et al*., 2002). Having parent therapy parallel to time-limited therapy with children is also intended to promote mentalizing abilities among parents, that is their ability to understand their own and the child's mental states (Fonagy *et al.,* 1991), with significance for the child's secure attachment (Haugvik, 2013). The two therapy arenas for children and parents will thereby be able to support the child's development in a mutual and supplementary manner.

Agreement on therapeutic tasks
The therapist was active and leading in implementing the therapy structure, especially during the first phase. The session activities included various types of play and conversation, where the children led in the choice of activity and play. The therapist followed the children and participated actively in the interaction with the children. The children could steer how much they would tell, and there was room for the children to avoid or postpone themes that appeared to be difficult for them. In some cases, in the start and middle phases, the therapist found the child avoiding the theme, diverting, stopping, taking control of the situation, or showing unease. For example, during the middle phase one child took control by spontaneously making his/her own rule for the activity in question.

   The therapy method has a clear framework (Haugvik and Johns, 2006, 2008; Haugvik, 2013; Svendsen *et al*., 2012), and there is reason to assume that the therapy format itself, which is delineated, clear, and plain, creates predictability and security, both for the child and for the parents. From the beginning of all three therapies, it appears that the children related to and accepted this framework. The children communicated through play and through direct communication. The agreed framework functions as a 'secure base' for further investigation and development of the child, together with the therapist. Security is a precondition for children to be able to express and explore feelings and experiences in an open manner (Bowlby, 1982, 1988; Fonagy and Target, 1998).

   An actively participating therapist within an agreed framework where the child is able to steer activities and conversation themes has been described above as a central ingredient in this particular therapy method. The therapist links the content to the agreed upon focus (Haugvik and Johns, 2008; Haugvik, 2013). During the therapeutic process the children emerged as individuals becoming more conscious about their own actions in the play and interaction with the therapist. The framework for therapy seems to give the child opportunities to relate to and talk about his or her own mental states (Meins *et al.,* 2006), to participate actively, and to emerge as individuals with their own agency (Sharp and Fonagy, 2008). The term *agency* is used by Stern (1985) to describe the child's feeling of being able to influence and make something happen (or not happen) in the parent–child interaction, and this is regarded as the most central point in self-development. It seems that the form of therapy under evaluation here, albeit time-limited, can indeed give the child an experience of agency. The therapist emphasises affect attunement in the meeting with the child, and a mutual and

interactive regulation process can be developed (Beebe and Lachmann, 2002). In line with this we see that the tendency for children to avoid difficult themes is not reported in the completion phase, indicating a feeling of being heard and understood and an openness to and tolerance for a wider scope of feelings. These findings indicate that the agreed framework helps to facilitate the therapeutic process.

In this intersubjective situation established between the therapist and the child, the sharing of affective conditions and experiences is a kind of doing-together which is related to therapeutic change:

> It is the doing-together that enriches experience and brings about change in ways-of-being-with-others through the implicit processes discussed. Complementary to this, verbal meaning making and narrativizing as forms of explicating can be viewed as also bringing about therapeutic change.
>
> (Stern, 2004: 227)

> With an emphasis on implicit experience rather on explicit content, therapeutic aims shift more to the deepening and enriching of experience and less to the understanding its meaning.
>
> (Stern 2004: 222)

According to Stern the implicit is simply nonconscious, whereas repressed material on the other hand is unconscious. In line with this intersubjective approach, transference is seen as subordinate to the more overreaching regulation of the therapeutic relationship (Stern, 2004). The point of departure in intersubjective time-limted psychotherapy is the child's present subjective experiences, and the therapist's main task is to facilitate expansion of the child's experiences through common focus and exploration (Hansen, 2012). A clinical task for the child therapist, then, is to selectively apply treatment tools or techniques as a function of developmental, psychopathological and contextual factors (Shirk and Russell, 1996).

Bond
Our findings show that the therapist had a good and mutual connection with the children, which indicates a robust therapeutic alliance. This is consistent with children's and parents' positive experiences of the relationship (Haugvik and Johns, 2006, 2008; Haugvik, 2013). The alliance forms show the highest scores in the final phase, which can indicate a positive process. The emotional bond can be strengthened when the child is given room to express him/herself through thoughts, feelings, and behaviour, and when the therapist validates them (Fonagy and Target, 1998). The children are invited to think about and meta-communicate their own feelings and experiences (Sharp and Fonagy, 2008). Our findings indicate that the children used this opportunity.

In one of the sessions the rapport with the child was evaluated as 'fairly good'. In this session the therapist prepared feedback for the parents, trying to engage the child in discussing this but the child did not appear to be interested. In preparing feedback to the parents the therapist left the 'here and now' mode. This can be an important

therapeutic move for maintaining the structure, but it can nevertheless be regarded as an *interactive failure*. This probably contributed to a type of break in the ongoing interaction. However, the break was followed by repair when the therapist and child returned to the 'here and now' mode. The contact in the sessions that followed was again evaluated as good. Communicating with the child about feedback to the parents is important in this model, and we see that this was given priority by the therapist. It is important to underline that this of course does not exclude the possibility that the therapist still mentalizes the child's emotional experience. According to Tronick and Gianino,1986), Tronick, (1989), being able to alternate between interactive failures and repairs is significant for positive connection and is regarded as a precondition for being able to see the child and contribute to regulation, both in a development-related context and a therapeutic context. Tronick (1998) describes how the mutual regulation of affect may create dyadically expanded states of consciousness in therapy. The hypothesis of Dyadic Consciousness states that each individual is a self-organising system that creates its own states of consciousness – states of brain organisation – which can be expanded into more coherent and complex states in collaboration with another self-organising system.

The three different types of measurements used in this study indicate a good connection between the child and the therapist. A clear frame with a focus on investigating, understanding, and expanding the child's own experiences (Fonagy, *et al*. 2002, Fonagy and Target, 1998) can be important preconditions for this. Predictability and recognition promotes security and can form the basis for developing mutual trust, acceptance, and confidence. Within a predictable frame characterised by security and confidence, the child can use his or her resources and experience a greater level of intersubjective sharing, with a feeling of agency. Research in developmental psychology reveals that this alone can promote development (Slade *et al.,* 2005). Three mental states are accentuated as central in intersubjective relating: Sharing joint attention, sharing intentions and sharing affective states (Stern, 1985). The guidelines and focus for therapy contribute to ensuring the first two conditions: having common awareness about the therapy's focus, which is about sharing the child's feelings, thoughts, and experiences, and having common aims regarding the therapy. A secure relation is a precondition for sharing affective conditions (Fonagy, 2002; Fonagy *et al.*, 2008).

We have highlighted the importance of agreement on therapy focus before therapy starts, as well as agreement on tasks for the therapist, the child and the parents for the therapy in general. More specific therapist tasks during the therapy sessions with the child are described and discussed. Therapeutic bond was examined, and in this study the therapist evaluated the bond as overall good. There is room for both positive and negative affect for the child and the therapist in this therapy method. According to developmental psychology, affective mutual regulation and the experience of interactive failure and repairs between the therapist and the patient is seen as an important factor for therapeutic change (Tronick, 1998). Play is the main arena for children to express themselves. Through offering the child an opportunity for 'playing with reality' and the scaffolding provided by the therapist, it is suggested that

development of reflection and mentalization is promoted (Fonagy *et. al,* 2002). Let us now turn to the clinical implications from our findings.

Conclusions

On the background of the analysis of the three therapies, it seems that some active interventions and reflections on the part of the therapist contributed positively in the therapy process. This includes therapeutic interventions that can contribute to establishing a secure relation and a good alliance as the foundation for achieving therapeutic objectives.

Our analysis highlights some main themes concerning the role and behaviour of the child therapist in intersubjectively oriented, time-limited psychotherapy with children. The following five main themes are emerging as central tasks for the child therapist as facilitators for regulating the child's behaviour, feelings and thoughts.

1. *Structuring the framework of the therapy sessions*

The therapist is active in structuring the therapy sessions during the therapy regarding time, therapy focus and the use of a visual calendar. The therapy room is presented to the child as a secure base for further exploration.

2. *Following the child's initiatives*

The therapist follows the child in his or her activity and conversation. The therapist shares attention, shows interest, tunes in to what the child communicates, and comments on and asks about what the child is playing or producing. These actions on the part of the therapist can be designated 'affect attunement'.

3. *Participating and cooperating with the child*

The therapist participates in mutual exchanges or other activities. The child can invite the therapist to join in the play, or the therapist can invite him or herself to join in where it is natural to do so. In this way the therapist is an active interacting partner through tuning in, intersubjective sharing, and exchange.

4. *Exploring the child's expressions*

The therapist actively explores and inquires about the child's situation, expressions, feelings, thoughts, and experiences, and in that way links the activity to the agreed upon focus. This takes place first and foremost through play and the child's 'here and now' activities. What happens in play is connected in an implicit way to the agreed upon focus. There is no assumption that what takes place in the session is explicitly linked to the child's current situation, but if this link is made, it is done in a careful and inquisitive way. The therapist's questions and reflections in relation to the child communicate a mentalizing stance, which would include tentative questions, curiosity and checking, and eschew framing interpretations with unwarranted certainty.

5. Understanding and regulating emotions

The therapist notes and seeks to understand the child's behaviour when the child feels unease or seems insecure in the situation (for example by avoidance of a theme, diversion, idealisation, excessive control, disturbance, ambivalence). The therapist provides for increased security and agency for the child to influence the interaction and regulate feelings and activity. The therapist is also aware of her own reactions, feelings, and thoughts during the therapy session, in line with an intersubjective approach.

Possible limitations

This material can be regarded as limited when it comes to deriving specific therapeutic conclusions. Previous research from the same three children's individual therapy progress, as well as parents' and teachers' evaluations, however, are together intended as an almost 360 degree evaluation of the therapy process. The previous studies are compatible with the findings that emerged in this study and support the proposed therapist tasks (Haugvik and Johns, 2006, 2008; Haugvik, 2013). The forms used were systematically filled in after each of the 36 therapy sessions (with the exception of one session), and thereby include the therapy processes in their entirety. In this way we intended to study the therapy method and the therapy process from different angles and in depth. The fact that these therapies were part of a research project could have biased the therapist's evaluations, in the direction that her scores were more positive than they would have been otherwise. The therapist was also aware that both the children and the parents were asked to fill in several forms covering 'alliance' during and after therapy, and this could have influenced the answers. One limitation is that we did not have reliable scores of the alliance from the perspective of the children (Haugvik and Johns, 2008).

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