

ASSESSMENT OF CHILDREN FOR BRIEF PSYCHODYNAMIC
PSYCHOTHERAPY : TRAINING IMPLICATIONS

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ABSTRACT

The aim of this study is to develop a framework for the assessment of children for short-term psychodynamic psychotherapy, with a particular emphasis on the training of child therapists. For this purpose the literature on brief child psychotherapy is reviewed, and selection criteria mentioned in the literature are collated and summarized. These criteria are then applied to 5 cases seen by trainees or newly qualified clinicians in order to assess their usefulness in a training setting. Potential sources of difficulty for inexperienced clinicians in the assessment for and process of this specialized form of child psychotherapy are considered, and guidelines as to how this approach could be usefully employed in a training institute are suggested. On the basis of the literature and case discussions, a format for the assessment of children for brief psychotherapy is devised in order to assist the trainee.

PREFACE

The names, identifying data, and therapeutic material of all cases used in this thesis have been disguised in order to preserve confidentiality. Every attempt has been made to conceal the identities of the patient, the therapist and the supervisor. It is unlikely that the material could be identified, other than by those directly involved with the case.

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1. INTRODUCTION

While brief psychotherapy with adults has received much interest both in research and practice, relatively little work has been done in this treatment modality with children (Kazdin et Al, 1990 ; Peterlin and Sloves, 1985). As a result it appears that brief psychotherapy with children has not achieved the same acceptance as with adults (Rosenthal and Levine, 1971). However research has shown that time-limited therapy is effective with children (Hare, 1966 ; Koocher and Pedulla, 1977 ; Proskauer, 1969), and at least as effective as long-term work (Rosenthal and Levine, 1971).

The need for more studies in this area is pressing (Dulcan, 1984 ; Kazdin et Al, 1990 ; Miller, 1984). Kazdin et Al (1990), in a survey of the needs and practices of child psychologists and psychiatrists in the United States of America, report that studies of individual psychotherapy with children seem to be a high priority for clinicians, and Dulcan (1984) comments on the scarcity of prospective designs and sophisticated evaluation methods for brief child psychotherapy. She notes that widely differing patient populations, selection criteria and outcome measures make it virtually impossible to compare one study with another. Miller (1984) also comments that important issues like case selection, technique and termination have not been systematically examined.

These authors point to the need to know more about selection criteria regarding children being assessed for brief psychotherapy. Furthermore,

Kazdin et Al's (1990) respondents indicated a high priority for questions about child and family characteristics in relation to treatment outcome to be explored. This accords with the emphasis that is placed on assessment for brief psychotherapy with adults (Clarkin and Francis, 1982 ; Dickman, 1983 ; Malan, 1979 ; Marmor, 1979 ; Sifneos, 1984), and there is still a call for more research in this area. Clarkin and Francis (1982) state: "Clinicians must ... constantly make treatment decisions in the absence of definite evidence of what works best for which problems in which patients. We believe that tentative and relative selection criteria, based on whatever research and clinical evidence is available, are helpful to clarify the issues involved and to inform clinical judgement" (pp 176-7).

The importance of appropriate assessment for therapy follows from the existence of considerable evidence that under certain circumstances psychotherapy can be harmful (Dickman, 1983). Malan (1979) further emphasizes this, proposing that "in psychotherapy ... prescribing the wrong intervention on the basis of an inadequate initial assessment ... (can) have potential consequences that vary from unnecessary pain at one end to catastrophe at the other" (p. 209). Furthermore, assessment for psychotherapy is an area of crucial importance for positive outcome of therapy (Dickman,1983).

The aforementioned authors are all writing in a psychodynamic framework, and Marmor (1979) reports that the vast majority of American psychiatrists are still heavily committed to a one-to-one model of psychodynamic psychotherapy, highlighting the need to develop more time-

effective approaches in this area. This same interest in dynamic psychotherapy is evident in child psychotherapy. Kazdin et Al (1990) found individual psychodynamic therapeutic interventions to be commonly employed by their respondents. In a similar study, Koocher and Pedulla (1977) report that psychoanalytic theory is still a very powerful force in child psychotherapy, while McDermot (1984) quotes research indicating that individual psychotherapy remains the predominant mode of treatment in interventions with children. He also states that the average length of treatment is one year, with sessions once or twice weekly, and Kazdin et Al (1990) found the average length of treatment to be 7 months with sessions once a week. Thus it appears that there is a need for research in psychodynamic psychotherapy for children which is relatively short-term (less than one year), and that assessment of children to determine who would most benefit from such an intervention, and for whom it is contra-indicated, is critical.

2. A REVIEW OF THE LITERATURE

A review of the literature on time-limited child psychotherapy (play therapy) reveals that it is sparse and scattered.

The literature will be reviewed under sections pertaining to the description of short-term therapy with children, the rationale for such work, techniques employed, goals of therapy, and finally, indications and contra-indications for such work.

2.1 Description

The majority of therapists publishing in this area with children employ a psychodynamic orientation in therapy in which symbolic play is the medium employed, and selective interpretation is the main technique (Peterlin and Sloves, 1985; Proskauer, 1969; Rosenthal and Levine, 1971; Turecki, 1982). This technique has largely been drawn from the psychoanalytic writings of Anna Freud (1946) and Klein (1932), and the application of child analytic principles to child psychotherapy has been described by Sours (1978).

There is inconsistency in the literature as to the length of brief psychotherapy with children, with the result that studies cannot be rigorously compared or well-supported conclusions drawn from them. It is noteworthy that Rosenthal and Levine (1971) consider therapy of one year's duration to be long-term, whereas Drisko (1978) reviews studies of brief child therapy where the child is seen for approximately a year.

Hence it is essential that the duration of therapies reported in comparative studies be clearly specified. Drisko's (1978) review indicates that short-term psychotherapy with children ranges from approximately 3 to 50 sessions, once or twice weekly, with the total number of sessions being specified from the beginning. He reports that the majority of research in this area aims for a 3 month treatment period, but Dulcan (1984) emphasizes that the optimum duration of treatment depends on the number and severity of problems to be addressed, family and clinical resources, and the child's openness to change.

2.2 Rationale for the Use of Brief Child Psychotherapy

Rationales for the need to investigate further the use of brief psychotherapy with children have focused on economic, personnel and time restraints, in addition to the need to prevent as far as is possible the high rate of premature termination in play therapy. The increasing demand for mental health services for children and their families together with the limitations of professional and financial resources are resulting in large waiting lists for treatment and a limit to the number of children that can be seen (Parad and Parad, 1968). Furthermore, long-term, open-ended treatment places a big demand on the time investment of parents, children and therapists. The latter may be one of the reasons for premature termination of the therapy (Hare, 1966; Parad and Parad, 1968). Parad and Parad (1968) quote research indicating that explicit time limits reduce the likelihood of unplanned withdrawal from therapy.

However brief psychotherapy is an entity on its own, with its own techniques and advantages. It is not simply a shortened version of long-term therapy (Dulcan, 1984), and requires specific selection criteria and techniques.

Time limits are seen to be an intrinsic part of the therapeutic process. Sloves and Peterlin, (1986) report that children seem to engage in treatment more quickly and with greater intensity than in long-term work because they have to use more productively the limited time that is theirs. This increased motivation was found to be most marked for children experiencing poor self esteem, isolation, rejection and anxiety. Rosenthal and Levine (1971) speak of the "therapeutic pressure" that encourages patients to work. Parad and Parad (1968) report that many patients are pleased at being told of time limits, and this positive response was found to correlate positively with the successful treatment of the child's presenting problem, and with the parent's ability to cope with this problem.

Certain other advantages of short-term child therapy for specific cases have been outlined in the literature. These include the reinforcement of independence, self-directedness, security against loss of self-control, and autonomous ego functioning in latency-aged children (Peterlin and Sloves, 1985). In addition many theorists emphasize that time-limited psychotherapy arouses a sharply focused awareness of the finite quality of all relationships - thus loss, separation and sadness need to be confronted and worked through (Peterlin and Sloves, 1985; Proskauer,

1969; Turecki, 1982). This is especially useful in the bereaved child or one whose parents have recently been separated. Proskauer (1969) also suggests that children in time-limited work can come to see that limited care-givers are available and trustworthy.

2.3 Techniques

Techniques have largely been drawn from time-limited work with adults (Proskauer, 1969 ; Turecki, 1982), as exemplified by the writing of Malan (1979) and Mann (1973). In this discussion of technique, the focus of therapy, termination and necessary modifications for child therapy will be reviewed.

Focus

Treatment is planned from the outset to be brief and hence the therapy must be focused. Proskauer (1969) indicates that with insufficient time to explore all aspects of the child's pathology, the therapist needs to know what central issues demand attention and are suitable for at least partial working through in the time available. Hence the selection of an appropriate central theme is critical (Peterlin and Sloves, 1985), with this theme echoing both present conflict and past pain and being based on a psychodynamic understanding of the child's problem. Peterlin and Sloves (1985) suggest that the central theme should include a statement of the conflict being experienced and how the child's symptom represents a maladaptive solution to alleviate it. Some clinicians would then ask the child to think and speak about this mutually defined focus in

sessions (Turecki, 1982), however, while it is not explicitly stated, one would assume that the age of the child is an important factor in this approach. Other clinicians would rather tend to focus their interpretations of the child's play on the central theme. As Peterlin and Sloves (1985) suggest, the content and affect of play is interpreted such that feelings and cognitions are reframed to be made part of the therapeutic focus. They emphasize that this does not imply that all thoughts, feelings and behaviours not germane to the therapeutic process are ignored or suppressed. However, they attempt to limit the therapy from becoming too diffuse (Proskauer, 1969 ; Turecki, 1982), as the attempt to deal with too many areas of conflict or character problems implies the use of long-term work. In addition, therapeutic regression is guarded against, as opposed to its being actively encouraged in long-term work. As Peterlin and Sloves (1985) suggest, this may be avoided by exploring adaptive functioning and enhancing ego strengths, rather than addressing infantile feelings.

Termination

One of the most critical aspects of short-term work is the manner in which termination is approached and worked through. Depending on the length of treatment, interpretations regarding termination are frequently given from the beginning of the therapy (Dulcan, 1984 ; Drisko, 1978 ; Turecki, 1982) and this actually becomes the central theme. As Turecki (1982) indicates, brief psychotherapy, with its focus on termination, replicates in condensed form "the evolution of an important object relationship followed by the harsh reality of object

loss" (p. 402). Rosenthal and Levine (1971) report that for the majority of cases in their study, loss was a central dynamic feature of the presenting problem, thus making termination the prominent focus. In terminating a therapeutic relationship the child can begin to carry out in present reality the unfinished work of past separation and differentiation which must be accomplished for normal emotional growth to continue (Proskauer, 1969). Turecki (1982) notes that termination is the most difficult, but possibly the most beneficial aspect of brief psychotherapy.

Modifications

The above-mentioned techniques are very similar to those employed in short-term dynamic work with adults, including the focus on a central theme and termination, and the benefits of increased motivation and opportunity to work through loss. However with children certain modifications are required in order to accommodate their developmental level. These include the use of play, dealing with the time-limit, activity of the therapist, and the role of the parents.

Symbolic play was introduced by the psychoanalysts, specifically Klein (1932), as the equivalent form of the verbal free association employed in adult analysis. It has since become the most prevalent tool in child psychotherapy (Mishne, 1983), and play accommodates for the relatively poorly developed verbal skills of children. Psychotherapists who employ brief dynamic psychotherapy also work through the interpretation of the

child's symbolic play (as well as verbal material), as described by Peterlin and Sloves (1985), Proskauer (1969) and Turecki (1982).

The time-limit in brief psychotherapy is an important issue. Drisko (1978), in a study evaluating the impact of emotional disturbance on time understanding, found a markedly limited ability of emotionally disturbed pre-adolescents to conceptualize a future time interval. The implications of this finding for the child's ability to grasp the meaning in reality of a time limit for therapy cuts at the root of the positive attributes of brief child therapy mentioned earlier. Peterlin and Sloves (1985) also emphasize that one can expect the child to regard therapy as a timeless experience, even if informed at the outset of its limit. Thus they suggest various modifications to address this issue. Firstly, on a concrete level, a contract which includes dates of all appointments is drawn up, and the child ticks off the appropriate date after each session. They also emphasize the need to assist the child in bridging the gap between sessions by, for example, linking themes from the previous session or noting that a particular theme requires further discussion in the following session - thus conveying to the child that the work of therapy continues between sessions. Drisko (1978) suggests that the child may be able to understand and work with the time limit via the therapist who experiences its impact. Peterlin and Sloves (1985) take this further by suggesting that if the therapist remains neutral and non-directive in this regard, the child will see sessions as disconnected in both time and purpose.

This introduces a further modification - namely, activity of the therapist. Most authors in brief child psychotherapy emphasize an active approach on the part of the therapist, with much interaction and focused interpretation (Drisko, 1978; Dulcan, 1984 ; Peterlin and Sloves, 1969; Rosenthal and Levine, 1971; Turecki, 1982). This does not imply a directive approach, and can be understood as similar in technique to the therapist's role in brief psychotherapy for adults as described by Marmor (1979).

Finally, as the child is dependent on his or her parents, no treatment can be effective without including them (Reissman, 1973). The parents are always seen for the initial assessment, however questions regarding simultaneous interventions with the parents or family are not adequately addressed in the literature on short-term work. While authors do suggest some form of contact or feedback with the parents during the therapeutic process (Dulcan,1984 ; Proskauer,1971), the frequency of such meetings is not discussed and nor is the important factor of who sees the parents ie. the child's therapist or a colleague. Dulcan (1984) suggests that feedback meetings should include reports on the child's functioning outside of therapy in order to assess therapeutic effect and changes in the external environment, and may include clarification, explanation, direction and re-education for the parents.

2.4 Goals of Therapy

The goals of brief psychotherapy with children are usually limited and well-defined, being based on a psychodynamic formulation of the child's

problem (Dulcan, 1984 ; Turecki, 1982). This may be based on loss, separation- individuation or Oedipal issues, for example. As mentioned earlier, termination is made an explicit issue in order to work through unresolved separations and losses (Dulcan,1984). Turecki (1982) delineates the main goals as the acquisition of insight, lessening of superego pressures (if required), and the alleviation of symptoms. He emphasizes that brief psychotherapy can result not only in symptomatic improvement, but in persistent psychodynamic changes. This is especially true regarding the resolution of "ambivalent dependency" (in Turecki, 1982) as a result of adequately dealing with the child's ambivalent feelings about terminating. Proskauer (1969) sees the therapy as being a corrective emotional experience regarding relationships with adults, with it serving as a model for future relationships which enable the child to make use of limited caregivers, and which allow for the development of greater autonomy (Turecki,1982). Time-limited therapy does not necessarily aim for structural personality change, which is the goal of long-term work (Mishne,1983).

2.5 Indications and Contra-indications

However these goals may not be appropriate or attainable for many children, highlighting the need for assessment to determine which children might benefit from short-term work, and for whom it is contra-indicated. No comprehensive studies are available in this regard. However the majority of writers in child psychotherapy do refer to criteria for selection of patients who might benefit from brief work, indicating the importance of properly assessing the child and his or her

environment. What follows is an attempt to collate these findings or suggestions. It must be noted that these criteria refer specifically to brief psychodynamic psychotherapy, and may or may not apply to other forms of brief therapy with children.

Indications and contra-indications for brief psychotherapy with children can be subsumed under various interrelating categories, each of which must be rigorously assessed. These are the presenting problem (including diagnosis) ; the environment in which the child lives ; psychodynamic and aetiological factors in the child, and his or her response to the symptom and treatment offered.

Presenting Problem

Mishne (1983) outlines certain criteria which need to be considered in the assessment phase. These include the discrepancy between the child's chronological and behavioural ages ; the frequency and duration of symptoms ; the number of symptoms ; the intractability of the behaviour; and the child's personality and general adjustment. Bearing in mind the focal nature of brief work, children with acute, monosymptomatic and less severe presentations would be most appropriate. The most outstanding indication for brief psychodynamic play therapy is the existence of an identifiable central dynamic issue in a child with previously even and smoothly progressing development (Dulcan, 1984 ; Rosenthal and Levine, 1971 ; Turecki, 1982). This is especially so if the child can identify the issue themselves. It is most clearly indicated for children suffering reactive disorders, particularly object loss in

whatever form (Proskauer, 1969 ; Turecki, 1982), and for those with acute symptoms in response to stress (Turecki,1982).

Contra-indications include severe psychopathology in the child (Dulcan,1984). Children with mental retardation, psychoses and personality disorders are generally excluded from brief treatment (Peterlin and Sloves,1985). Severe symptoms such as extremely aggressive and destructive behaviour, suicidal attempts, isolation from social relationships and antisocial behaviour are correlated with failure of brief work (Rosenthal and Levine,1971).

Environment

As in brief psychotherapy for adults (Malan,1979) it is required that the child's environment be relatively stable and supportive such that the child's psychic energy can be directed inwards as opposed to needing to deal with ongoing external trauma. Hence severe marital discord, maternal deprivation and significant psychopathology in either parent is associated with failure in brief play therapy (Rosenthal and Levine,1971). Furthermore the environment must be sufficiently supportive and motivated in order to avoid undermining treatment (Dulcan,1984 ; Rosenthal and Levine, 1971). Reissman (1973) emphasizes the great importance of caregivers in the practice of psychotherapy with children, and suggests that it is one of the main determinants as to whether psychotherapy is employed. The child's dependence on adults may prevent some children from getting help even though it is wanted by the child and also indicated, or it may bring some children to therapy

despite their strong opposition to this help. Thus he emphasizes the importance of gaining an assessment of the child's disturbance from the therapist, the child and the parent. He states that the ideal parents in assessment are receptive, inquisitive and able to speculate and explore. Those who resist considering their influence on the child's actions or those who continually blame themselves, are problematic in treatment (Reissman,1973). Furthermore commitment to the therapy on the part of the parents is essential, and can be seen to be equivalent to the importance of the patient's motivation in adult work (Marmor,1979). Finally the family must be sufficiently flexible to accommodate changes in the child.

The Child

Intrapsychic factors in the child and his or her response to treatment plans apply both to brief and long-term psychotherapy. Marmor (1979), referring to adults, suggests that the same and more stringent criteria apply to short-term work. Traditional factors include that the child must be intelligent, exhibit psychological-mindedness, frustration tolerance and impulse control, and have intact reality testing (Mishne,1983). In children it is not possible to measure ego strength in the same manner as with adults, however it is critical that the child exhibit sufficient ego strength to be able to gain from dynamic treatment.

Moving to short-term therapy, factors including the child's ability to form a relationship easily, and the likelihood of being able to work

through termination are critical. Suitable candidates include children who are capable and willing to form a rapid relationship with the therapist during the diagnostic phase (Peterlin and Sloves,1985). For those children who cannot easily form a relationship, long-term therapy may be indicated. Hence extremely passive, schizoid and severely depressed children must be excluded (Peterlin and Sloves,1985).

Secondly it is important to evaluate whether or not the trauma of a preset termination date can be resolved (Peterlin and Sloves,1985). The child must have sufficient basic trust to avoid experiencing early termination as abandonment (Dulcan,1984). It is emphasized that children with a history of multiple losses should not be taken into brief psychotherapy as they cannot be engaged rapidly, and early termination will be perceived as another abandonment (Proskauer,1971 ; Turecki,1982). Dulcan (1984) supports this view and further suggests that the materially or emotionally deprived child will be likely to regard the persistent emphasis on a fixed ending as yet another loss, rather than an opportunity for resolution and progress. On the other hand, this opportunity is effective for well-adapted children who have not worked through single object losses (Proskauer,1971 ; Turecki,1982). Thus anticipated difficulty for the child in dealing with rapid termination is a contra-indication for brief work.

Also of importance is the child's motivation (Dulcan,1984 ; Hare,1966 ; Turecki,1982) and, linked to that, the child's internal distress or suffering and his or her ability to acknowledge it, plus relief at the thought of being rid of their symptomatology (Dulcan,1984 ; Peterlin and

Sloves,1985). As in adult work the latency child must be verbal (Dulcan,1984), be able to achieve insight (Hare,1966) and respond appropriately to trial interpretations (Miller,1984). The child's defences must not be too rigid or brittle in the area of the focal issue, and their personality structure should be able to permit rapid resolution of the issue (Proskauer,1971). The child must be able to accept some responsibility for their problems, and brief psychotherapy is contra-indicated for the child who firmly externalizes all responsibility (Dulcan,1984). Finally, Miller (1984) also indicates the importance of assessing the child's ability to remember and follow through from one session to the next. Children with marked impairment of object constancy should be excluded (Proskauer,1971).

Thus it is possible to summarize the indications for short-term dynamic psychotherapy with children, as indicated in the literature, into 8 criteria :

- 1) The existence of a focal presenting problem. This includes an assessment of the frequency, duration and severity of symptoms.
- 2) The child has been developing in a smooth manner and there have not been any significant developmental deviations. Object constancy would be assumed in a child over 3, and if this had not developed, it would constitute a developmental deviation which would require intervention and would contra-indicate brief work.

- 3) The child's environment is stable and supportive. This includes an assessment of the marital relationship, flexibility of the family to potential change in the child, and psychopathology of the parents.
- 4) Parents are motivated for treatment.
- 5) The child is able to form a rapid relationship with the therapist, and has sufficient basic trust.
- 6) The child is able to tolerate and work through a preset termination date.
- 7) The child's defences are not too rigid to allow rapid working through of the focal issue. This includes the child's ability to achieve insight and respond appropriately to trial interpretations, and that they have sufficient ego strength.
- 8) The child is motivated for treatment, and hence accepts partial responsibility for the problem.

3. TRAINING IN CHILD PSYCHOTHERAPY AND THE BRIEF THERAPY APPROACH

The importance of assessment in child psychotherapy highlights the need for adequate training and emphasis on this phase of therapy in trainee therapists. Dickman emphasizes that assessment for psychotherapy is an area of crucial importance for positive outcome of therapy, and hence that it should be an integral part of the training of intern psychologists. Furthermore, Malan (1979) suggests "the truth is that the assessment of a patient for psychotherapy is probably the most complex, subtle and highly skilled procedure in the whole field." (p. 210). It has also been proposed that treatment planning, including assessment, may become an intuitive process for many skillful clinicians (Looney, 1984), and this intuition is not developed in inexperienced clinicians. These factors, in addition to the dispersed literature on assessment of children for psychotherapy, point to the need to develop a strategy and provide guidelines for trainee therapists.

Training in brief psychotherapy would appear to be particularly important in the internship because of the time limit the latter places on all therapy contracts. In this country intern psychologists have at most a 10 month placement in child psychology, and psychiatric registrars spend 6 months in a child and family unit. Thus for these trainees, if psychotherapy with children is to be undertaken it has of necessity to be brief. As Notman and Zinberg (1969) suggest, the stimulus for the development of a short-term therapy programme may have arisen for economic reasons, but coincidental with this is the possibility of offering better training as well. Time-limited therapy

also offers an early opportunity for trainees to confront some basic problems of all psychotherapy which may not emerge as quickly or dramatically in open-ended treatment (Proskauer, 1971).

Thus the development of a time-limited model in psychotherapy would allow both for the necessary training of psychiatric professionals in child therapy, while also providing appropriate intervention for highly selected cases. It would alleviate to some extent the conflict frequently experienced by trainees and their supervisors between service and training objectives. An example of such a conflict would be the trainee who requires experience in individual child psychotherapy and hence takes a child into therapy inappropriately in order to satisfy training requirements.

The importance of psychodynamic training is highlighted by Dickman (1983) in an examination of brief psychotherapy with adults. She indicates the tendency among interns to value highly the acquisition of psychodynamic skills and to aim to practise psychodynamic psychotherapy after the internship. This seems likely to be true for interns wanting to work with children.

4. AIMS AND RATIONALE

It has been mentioned earlier that brief dynamic psychotherapy with children is not, and cannot be, a fragment of long-term therapy. The "fragment" approach would constitute employing the open-ended techniques of long-term work, in which there is no clearly defined focus for the session, the goal is structural personality change, and termination occurs at the end of the trainee's placement and is often premature. In brief child psychotherapy definite modifications, selection procedures, goals and techniques are required.

However, much of the literature available to interns refers to long-term psychoanalytic child psychotherapy. For example, the frame of reference used at the University of Cape Town's Child Guidance Clinic has predominantly been the "fragment of long-term therapy" approach. The author's training in child psychotherapy included lectures on psychoanalytic play therapy by a therapist who only employed long-term therapy, and group supervision of cases by a psychoanalyst who also only employed long-term work. Suggested reading referred interns to psychoanalytic or long-term therapy techniques. No mention was made of time-limited therapy, although therapy was of necessity brief.

This study aims to draw together the literature on short-term child psychotherapy in a manner that will inform and have practical utility for a training programme. The main focus of this paper will be on selection of children for brief dynamic psychotherapy with trainees once individual psychotherapy has been indicated as the treatment of choice.

Five cases seen by interns or recently qualified clinicians for time-limited child psychotherapy will be presented as illustrations, particularly with regard to factors that would influence selection. The criteria listed earlier will be applied to these cases in order to assess their utility in a training setting. Potential sources of difficulty for inexperienced clinicians in this specialized form of child psychotherapy will be considered, also in relation to case material, and guidelines as to how this approach could be usefully employed in a training institute will be suggested.

The terms "brief", "short-term" and "time-limited" psychotherapy as employed in this study refer to the use of symbolic play in a therapeutic relationship, in which sessions occur once or twice weekly for a maximum period of one year. As trainees placements range from approximately 3 to 10 months with the average period of time available to see a child being 6 months, this was felt to be appropriate. Furthermore, studies have indicated the limitations of seeing children under the age of 4 (Lebo, 1956), and it would be more appropriate to work on a verbal level with adolescents. Hence the term "children" in this study refers to children from the ages of 4 to 12.

Thus it is hoped that by providing guidelines for trainees and their supervisors regarding the assessment of children for brief psychodynamic psychotherapy, and outlining suggestions and possible pitfalls in the process of the therapy, a possible gap in present training opportunities will be addressed. This will also enable appropriate services to be provided for those children who require it.

5. ANALYSIS OF CASE MATERIAL

In this section 5 cases seen by trainees or inexperienced clinicians will be presented and discussed with respect to selection criteria and difficulties experienced by beginning therapists. The cases were intervened with using the "fragment of long-term therapy" approach, and trainees were required to leave the unit 6 to 10 months after first meeting the child. They were chosen for discussion as a result of their usefulness as illustrative material. Data was obtained from case files, and where files were insufficiently informative, an interview with the therapist was conducted.

All cases were seen at one of two training clinics for psychologists, psychiatrists, and clinical social workers in Cape Town. Both these clinics see the whole family for the initial interview, and a full family and personal history of the child is obtained. Thereafter a decision as to the most appropriate intervention is made. Furthermore, all trainees received individual supervision with practising clinicians. In one of these units, few supervisors were experienced child therapists.

The following cases will be presented with the focus on presenting problem, family assessment, and personal history and mental state examination of the child. Thereafter an analysis of the case will be discussed.

5.1 The Case of Mike

The first case to be presented is that of Mike, a 10-year-old boy, who was referred to the clinic by his mother. The presenting problem concerned head-twitching and nervous pulling of his mouth and eyebrows which occurred approximately every 2 seconds and began 5 years prior to admission under stressful circumstances. However in the past 3 years this behaviour had become associated with Mike's annual month-long visit to his father, who was divorced from his mother and lived in another city. The head-twitching began 2 weeks before a visit and continued for a further 2 months following his return. This twitching also occurred when he was in a punitive situation at school. Associated with this behaviour was a marked and uncharacteristic self-depreciatory attitude.

Mike was the middle of 3 boys. An elder brother was 11 and his half-brother was 5 months old. His parents were divorced when he was 4 after a conflict-free, yet distant marriage. Both remarried shortly thereafter. Mike had an ambivalent relationship with his mother and showed evidence of anxious attachment through his desire to be near her, but the anger he expressed when he was. After the birth of his half-brother he felt that his mother had less time for him, and verbalized that he feared his stepfather would love his own child more than him. The home situation and marriage were reportedly stable and happy. Both mother and stepfather appeared to be invested in the treatment.

Mike was a planned child, but his mother was disappointed as she had hoped for a daughter. He progressed normally and with no major

difficulties. At the time of referral he was in std.2 at a respected boys' school where he was an average student. He tended to befriend younger children and to fear any violence in play. He preferred imaginative play, and enjoyed ballet which he did at his own request. His father strongly disapproved of his interest in ballet.

Mike presented as an attractive, slightly overweight boy who separated easily from his mother. He spoke easily about his feelings and showed appropriate emotional responsiveness. He related well and made good eye contact, however he fidgeted and avoided eye contact when talking about sensitive areas, notably his head-shaking, the relationship with his father, the school environment and his enjoyment of ballet. He defocused from sensitive topics by changing the subject. Mike expressed concern about his head-twitching and about being a "baby" as he cried a lot. He reported being anxious about school where he was beaten for misdemeanors, and about nightmares in which his parents were killed.

The clinician understood Mike's twitching to follow from his fear of his aggressive impulses, and anxiety evoked by the failure of his defence-mechanisms of denial (through which his aggression was not recognized) and introjection (through which his anger was internalized and emerged as a self-depreciatory attitude). Reaction formation, by which aggression was transformed into passivity, was used to deal with the anger he felt towards his father and symbols of male authoritarianism such as the school environment.

Three assessment sessions for play therapy were undertaken, and revealed that Mike had a good capacity for symbolic play and responded appropriately to interpretations. He related spontaneously to the therapist, immediately involving her in his play and engaging in long dialogues about the play and the transference in relation to his problem. The therapist concluded that play therapy was the treatment of choice, and a few sessions of parental counselling were also offered.

Analysis

It is evident from the history that Mike was symptom-free until the age of 5, and was progressing normally in all respects. Thereafter it became apparent that his symptom of head-twitching was clearly associated with stressful events. The therapist understood his symptom to follow from fear of his own anger, needing to suppress it and maintain a non-violent persona through reaction-formation. Hence Mike presented with a single symptom which had a clearly defined precipitant, and a clear dynamic focus existed. While he had had stressors in his life, his development had progressed relatively smoothly and his symptoms had not interfered with his general functioning, which indicated good ego strength.

Mike was clearly eager to work on his problems, as evidenced by his internal distress and requests for help, plus his ability to speak spontaneously both verbally and non-verbally through symbolic play about his fears and conflicts. He easily formed a positive relationship with the therapist and was able to use her as a transference object, and respond to interpretations about this, in early sessions. He responded

to trial interpretations by taking the material further and showing appropriate affect. It was likely that Mike would have been able to negotiate termination successively - he had not had repeated major losses and, through his relationship ability clearly evidenced the ability to trust. Furthermore he would be returning to a supportive family system. Termination would be likely to allow for the working through of the loss of his father.

Finally, the parents (M & SF) were clearly motivated for treatment. They had tried other ways of helping Mike which had failed, and now were open to intervention. They readily agreed to parental counselling sessions.

Thus in this case, all the criteria listed earlier as regards selection of children for brief psychotherapy had been met. The therapist, a recently qualified psychologist, felt that Mike would benefit from psychotherapy and suggested that he be seen on a once-weekly basis. No termination date was set. The focal issue was that of exploring Mike's underlying aggression and his need to maintain a good appearance. This was not discussed with Mike, but interpretations were focused on this issue. Mike was seen for 7 months. His mother and stepfather were seen by an intern psychologist for 5 counselling sessions in which they were able to reach an understanding of how their attitude towards Mike's father may have been hindering his coming to terms with the situation. Therapy was terminated when it was felt that Mike had worked through his focal conflict, and termination was repeatedly addressed and adequately worked through. By the end of therapy Mike had grown in self-confidence and his tics were reportedly no longer in evidence. Communication with

his father was reestablished, and an amicable compromise regarding Mike's visits was established. The prognosis for Mike was felt to be good.

Mike was appropriately assessed for play therapy, and furthermore the importance of environmental influence was acknowledged and Mike's parents were seen. However the success of this case can also be seen to follow from the therapist's having formed a good working relationship, focused on a central issue, and dealt adequately with termination.

5.2 The Case of Ann

The potentially disastrous consequences of not properly assessing a child for psychotherapy can be seen in the following case presentation.

Ann, a 7-year-old girl, was seen by an intern psychologist who had 7 months left of her placement at a child guidance clinic. Her mother, who had referred Ann at the suggestion of her teachers at a girls-only school, was the sole informant at the initial interview. She identified 4 major problems. Firstly Ann's school progress was poor, even though an intellectual assessment performed the previous year indicated that she was of above average ability. Her schoolwork deteriorated after the family moved to Cape Town 18 months prior to presentation. Since that time she had had no friends and yet craved company. The third problem was that Ann was "obsessionally" tidy at home, packing and repacking her cupboard and suitcase, and becoming extremely distressed if the precise order in her room was disturbed. Finally, her mother reported that Ann

had always been "disturbed", exhibiting very labile emotions. However in the past term she had been especially unhappy, withdrawing to her room and crying. Further symptoms became apparent during the interview, but they will be presented as they unfolded in her history.

Ann was described as a difficult and tense baby who would not settle into a routine. She did not sleep through the night until the age of 3, and thereafter had always had difficulty falling asleep. Since Ann was 3 she had also refused to eat and this had worsened in the 5 months prior to referral. Her mother described it as "a battle to get her to eat anything". Ann was also described as generally being fearful, and she would bite her nails badly. Her school difficulties were exacerbated by reportedly very poor concentration. Ann was described as being very short tempered and when angry would scream and go white in the face. She would retire to her room when upset, and apparently once threatened suicide during a particularly heated parental quarrel.

At the interview Ann presented as a petite and attractive child in loose-fitting school clothes. She appeared anxious and depressed. She related well to the clinician and seemed anxious to please, but at times was withdrawn.

Ann's home environment was chaotic and unpredictable. Both parents had been married previously and there was one half-sister of 10. Her father had had an unhappy childhood and had violent temper outbursts at home. He was reportedly unpredictable and continually attempted to sabotage his wife's arrangements. Ann's mother had been seriously depressed in

the previous 18 months, was hospitalized 3 times and was still on medication at the time of the interview. She had seen numerous psychologists and terminated all treatments prematurely. The marriage was described as traumatic, with little communication and much fighting. There were constant threats of divorce.

The intern understood Ann's symptoms as arising from a lack of security leading to anxiety, which she attempted to allay by fastidiously ordering her room. Furthermore it was felt that Ann had identified with the inappropriate methods used by her parents to cope with stress, this leading to her depression, withdrawal from peers, inability to concentrate, and violent outbursts if she did not get her own way.

The reasons why Ann was taken into play therapy by the intern, who was going to leave the unit after 7 months, are unclear. It is possible that training needs were paramount. However Ann was seen for play therapy and her mother for counselling by another intern. Mother's counsellor, concerned at the extent of family difficulties after having seen her for two sessions, suggested that the family be seen for family therapy. However the parents refused.

Analysis

If this case is considered with the suggested indications for brief child psychotherapy in mind, it can be seen that not many of these requirements were satisfied. Firstly there were numerous presenting problems, with a long history of neurotic problems, apparent since

before Ann was 3. These symptoms affected most areas of her functioning, and while they could be understood dynamically, there was no focal issue that could be addressed in short-term therapy that would alleviate the source of her difficulties. In fact her symptomatology and developmental history constituted what Anna Freud termed an Infantile Neurosis, which she suggests requires long-term intensive psychoanalysis for its resolution. Psychiatrically her symptoms indicated a Major Depression (DSM III-R), which is a severe diagnosis in a child. As Rosenthal and Levine (1971) have reported, children with severe symptomatology should not be seen for brief work. They mention suicidal ideation, which Ann exhibited, as a contra-indication.

Considering environmental factors, it is clear that Ann's family were neither stable nor supportive. The constant threats of divorce and family disintegration, Father's unpredictable outbursts, Mother's depression, and general chaos constitute difficult circumstances for a child and require that their psychic energy be reserved to deal with numerous external stressors. Clearly they cannot be available to looking inwards and dealing with dynamic anxieties. The lack of support from Ann's family could be seen in that her father did not attend the initial interview, and he and her mother were extremely resistant to family therapy. Furthermore there was a history of Mother approaching therapists, devaluing them and then leaving. This did not auger well for Ann's therapy, as it could be predicted that she would withdraw Ann from therapy prematurely. In addition, both of Ann's parents had a psychiatric history, with ongoing difficulties. The selection criteria for brief therapy stated earlier emphasize contra-indications

to be severe marital discord, significant psychopathology in either parent and the lack of a stable, supportive and motivated environment. Clearly Ann's environment alone would serve as a contra-indication for brief therapy.

Ann appeared to be able to form a superficially good relationship with the therapist. However her very rigid defences, including obsessional defences, would not allow her to respond to interpretations in any other than a defensive way. In fact these defences were probably necessary in her chaotic environment and should not be challenged. Furthermore, it has been suggested earlier (Peterlin and Sloves, 1985) that severely depressed children should not be seen in brief therapy as they cannot easily form a relationship.

The possibility of Ann being able to work through an early termination is unclear. It may be that the structure and stability provided by such an intervention would be containing for her considering her unpredictable home life over which she had no control. However the loss of stability would also be very threatening for her at the time of termination. Her depression, and its psychodynamic aetiology of loss, would make it difficult for her to deal with yet another loss.

Thus it appears that, for the majority of criteria, Ann was not appropriate for short-term therapy. In fact therapy was counter-productive, actually increasing her symptomatology.

Ann was seen 6 times in play therapy, and in the sessions her obsessional defences were marked. After the sixth session she did not return, and the intern received a letter from Mother saying that she had moved to another city with the children as a result of marital difficulties. The intern mentioned some therapeutic difficulties in her case summary: "Ann entered therapy under false pretences from her mother that she was doing so to help with her schoolwork. During the few sessions we had, her confusion as to what was expected of her added to her history of seeing people as unpredictable and untrustworthy and made her very defensive. Her mother's ambivalent feelings about Ann relating specially to another woman exacerbated Ann's distrust. It was significant that after the session in which she was able to express some anger and respond to interpretations about this for the first time, her mother terminated therapy." Thus it is highly possible that Ann perceived the termination of therapy as a punishment for expressing anger, thus turning it inwards again in the form of depression.

Another personal difficulty mentioned by the intern was that she found herself interpreting excessively and "being too attacking in getting through her defences". The reason she gave for this was that the symbolic play was so clear to her on a dynamic level that she wanted to interpret it immediately. It is also possible that the intern felt overwhelmed by the complexities of a case that she had to deal with in a limited period. The resultant anxiety might have prompted her to try and resolve as much as she could, and as quickly as possible, in the time that she had.

The case did not end at that point. Ann's mother contacted the intern a few weeks later to say she was back in Cape Town and wanted Ann to resume therapy. She had approached another therapist for family therapy. At this point the intern had a chance to reassess the situation and decided that the case should be referred to a unit where long-term therapy was undertaken, as she was leaving the clinic in less than 4 months. She explained this to Ann and her mother. The mother was extremely angry at Ann's being abandoned, and requested that she be seen for a further 2 months until family therapy started. The intern held her position and finally the mother agreed to contact the recommended unit. It is quite possible that Ann did feel abandoned and rejected by her therapist, but at this point there was no alternative. Unfortunately the intern did not see Ann for a termination session. Case management terminated with a follow-up phone call to Ann's mother in which the feedback indicated that Ann had become increasingly unhappy and tearful, and was threatening suicide.

This case indicates the potential dangers of not assessing a child properly for short-term therapy. The difficulties experienced could have been predicted on the basis of selection criteria. It can be seen that the therapy in fact constituted a repetition of traumatic experiences in Ann's life - namely the lack of security and consistency from which Ann's anxiety was hypothesized to have arisen ; the rejection and lack of holding that she would previously have experienced from a depressed mother and threatening father ; and the consequences of expressing anger being rejection. While increased family problems may account for the exacerbation of Ann's symptoms, it is also likely that the repetition of

negative experiences outside of the family by someone who claimed to want to help her, namely the therapist, was a contributory factor.

5.3 The Case of Eric

Not all cases are as clear or defined regarding their suitability for short-term work as the previous two. The following case serves to illustrate the process of reasoning when the case is not clear-cut.

Eric was an 11-year-old boy who was referred to the clinic 6 months following the suicide of his father in the bathroom of the family home. His mother referred him because of his fears of illness and death. These fears dated back to the death of his grandfather when Eric was 7. From that time he would become tearful when ill, fearing that he was going to die, and would become anxious when exposed to people or the media referring to illness or death. Eric reported that he could not sleep at night and would read until he felt tired, as otherwise he had recurring thoughts that he was going to die. During the day, if he experienced these thoughts, he would go and play to rid himself of them. Furthermore, in the 3 months prior to referral, Eric had experienced episodes of "palpitations", during which his heart rate would increase, he felt cold and scared, and verbalized his fear of dying. These would subside when he was comforted by his mother.

Eric's history revealed that he had suffered numerous major losses. His paternal grandfather was killed in an accident 5 years prior to admission, his maternal grandfather died of a heart attack one year

later, with his grandmother dying the following year. During this time Eric's close cousin of 28 had a heart attack.

As mentioned earlier, his father committed suicide by hanging himself in the family bathroom. He was described as a good and caring father when sober. However he was alcohol dependent, and when intoxicated would become violent and threatening. Two years prior to his death he was institutionalized as a result of his alcoholism, was fired from his job as a plumber, and remained unemployed until his death. Eric had an ambivalent relationship with his father. He reported having many happy and enjoyable times alone with his father, but resented and became fearful of him when he was drunk as, since infancy his father had shaken him and threatened to hit him. When his father died, Eric had wanted to shout, but his mother had quietened him. He was ill with a fever on the day of the funeral. Eric's 17-year-old sister, and only sibling, also appeared to have had an ambivalent relationship with her father, and also had clearly not mourned him. However she refused to return after the initial interview.

The marital relationship had been difficult for a long time as a result of Father's alcoholism, violence and threats of physical abuse. The parents were divorced 6 weeks prior to his death. However he remained in the house. His suicide occurred on the day by which Mother had told him to leave the house. Three years prior to this, when Eric was 8, Mother refused Father permission to sleep with her, and Eric moved into Mother's room where he was still sleeping at the time of admission.

Eric's mother, a nursing sister, was described as nervous, lonely, dependent and sometimes depressed. She shared a room with Eric as she feared sleeping alone. Mother presented as a well-dressed, quietly-spoken woman who showed emotion in brief tearfulness when discussing her husband's death and her feeling of being unsupported. She was clearly asking for support.

Eric was a planned child who was not breast-fed as Mother was "sick". She returned to work after 2 months, and Eric was cared for by the family maid until mid-afternoon. His early development was unproblematic, however he was enuretic (nocturnal) until the age of 9. His eating was normal, and sleep was unproblematic until his father's death. Eric had always bitten his nails, and got headaches when emotional. When upset he would hang on to his mother in a childlike manner. His play was also childlike, and Eric was described as being very immature. He was very dependent on his mother and did not like playing out of her sight. However at school he was a high-achieving student and had good friends.

Eric presented as a healthy, neatly dressed boy in school uniform. He did not speak unless addressed directly, but responded quietly and comprehensively. He looked down when conversation centred around his father, and when questioned he could speak of the good and the bad experiences he had had with him. Eric responded reservedly to the clinician, not dropping his guard or allowing him to get close.

Eric's difficulties were understood by the clinician to follow from unresolved grief following numerous family deaths, particularly his father's, with the interrelated theme of Oedipal guilt as a result of his replacing his father in the bedroom. Eric's main defences were seen to be hypochondriasis, repression and regression. Furthermore it was felt that his mother's enmeshed relationship with him should be addressed. Thus Eric was taken into play therapy in order to work through his unresolved grief. An initial termination after 8 sessions was suggested, but this was later extended to 16. Mother was seen simultaneously in individual therapy. Both Eric and his mother were seen by intern psychologists.

Analysis

On the surface Eric's presenting problem, his fear of death, appears to be quite focused. It was the only symptom presented, there was a clear precipitant in his grandfather's death, and a precipitant to his anxiety attacks in his father's suicide. The central issue seems to be one of unresolved grief, with the psychodynamic focus being Oedipal guilt and ambivalence. Furthermore Eric's symptom had not interfered with his functioning at school or with peers, which is a good sign. Thus, in terms of the presenting problem, Eric seems to be appropriate for brief work - a clear psychiatric and psychodynamic focus existed, and Eric recognized the problem. Other problematic areas in his life situation would be dealt with in his mother's therapy as they largely stemmed from her difficulties.

Two factors suggest possible complicating variables in understanding the presenting problem, namely Eric's enuresis which continued until he was 9, and the possible indication that he was regressed as suggested by his general immaturity and dependency, his relationship with his mother, and his immature play. This regression could be related to his unresolved grief and the role in which his mother placed him for her needs, or it could suggest earlier psychological damage. The enuresis could support this hypothesis, or it could also have followed from ongoing family stress. However these two factors must be born in mind as potential "danger signals".

Eric's home environment was previously disruptive and unpredictable, but at the time of referral appeared to be stable. Whether or not his mother was supportive needed clarification. It may be that, being so needy and dependent herself, she could not really be available to support Eric. Her overinvolvement would not really allow Eric a place to work through his own feelings. But of crucial importance is the question of whether his mother would allow someone else, namely the therapist, to form a close bond with her son without sabotaging the treatment if he attempted to separate from her. On a surface level Mother was supportive of the treatment plan offered, and was relieved at the thought of individual therapy for herself.

Considering factors internal to Eric, the strong points that stand in favour of therapy were his intact ego strength, as evidenced by his good school performance and peer relationships, and his internal distress and wish to rid himself of his symptom. Furthermore, although 11, his

history of immature play suggested that he might be able to use symbolic play. This however was not assessed. Of concern was his guarded relationship with the therapist. His smiling polite facade would not allow him to get close to him or engage with him properly. This inability to engage rapidly, which is a contra-indication for brief work, is noticeable in children who have experienced many losses (Proskauer,1969). It might be that, since Eric's losses occurred in later childhood and he had always had a stable and nurturant relationship with his mother, he would be able to work through them in a time-limited therapy. However his inability to engage with the therapist indicates that these losses might have affected him severely, and suggests that he would have difficulties in being able to use and work through an early termination. In fact he might need to keep up his defences in the therapy in the face of yet another loss.

Thus, in summary, while Eric's presenting problem, and to an extent his environment, might fulfill most of the conditions for short-term therapy, factors including his history of numerous losses, relationship ability with the clinician, and the envisaged manner in which he would deal with termination are major contra-indications for brief work. In addition there were queries raised about aspects of both his presenting problem and environment. On the basis of these factors it is felt that this case is not appropriate for brief work, especially with an inexperienced therapist without intensive supervision.

Eric was seen for play therapy. Initially an 8 session contract was made, and after 7 sessions it was extended for a further 8 sessions which would begin after a holiday break.

During sessions Eric remained polite and distant from his therapist. His play revolved around the bathroom in a doll's house and bathroom rituals, however he denied any interpretations linking it to his father's death. The therapist tended to back off as a result of these "rejections", and remained largely an observer for most of the sessions.

Eric obviously became attached to his sessions, and was reluctant to leave them. This was never interpreted. The termination issues were further avoided by not dealing with the proposed ending and instead offering more sessions. Nor was the holiday break addressed. At the end of the 16 sessions the intern attempted to address termination, but when Eric denied any feelings he "decided to respect his space and not speak about it if he did not want to". They said goodbye as two acquaintances. Not dealing with termination in a child where loss is a central factor, is a major intervention omission. Eric's pattern of not resolving and working through separations and losses was thus repeated.

A further problem was that, as predicted earlier, Eric's mother felt excluded from his treatment, became angry with the therapist and began cancelling sessions.

Eric was never able to engage directly with the therapist and remained defended. While he may have worked through some of his difficulties

through his symbolic play, the focal issue was not addressed in a meaningful way by the therapist and, most probably was not properly resolved.

It is debatable whether Eric experienced termination as another loss - it may be that he, quite appropriately, protected himself through his distance and lack of contact. However by so doing the opportunity for working through his difficulties was largely lost. It is possible that, had termination been worked at throughout the therapy, Eric might have benefitted.

5.4 The Case of Tony

Clearly the appropriate selection of a child for short-term therapy is not enough to ensure the success of the therapy - the need to maintain a focus and be directed by one's psychodynamic understanding is critical. The following case provides such an illustration, and is also a further example of the selection criteria for brief work.

Tony, aged 8, was referred to the clinic by his mother following what she described as his "negative reaction" to his parents' divorce 4 months previously. He was tense and easily upset, and would burst into tears at the slightest provocation. He was frequently tearful and reported that he was unhappy. Tony was also very aggressive towards his mother's boyfriend, continually challenging him and seeing "how far he could push him". His mother thought that Tony might feel rejected by her, as the children lived with their father, and hence was jealous of

her boyfriend. Both parents felt that Tony's loyalties to them had been split and they were unsure as to how to deal with this.

At the time of referral Tony and his two older sisters (aged 10 and 12) were living with their father in the family home. Their maternal grandmother had taken on an active caretaking role. She was not well-liked and was described as strict and authoritarian. Father was described as a conservative and peace-loving man who would get upset if things did not work according to plan. According to Mother, he had not yet let go of her and accepted the divorce. Tony had a good relationship with his father and had become protective of him following the divorce.

Mother had high achievement needs and was never happy as a housewife. As a result of feeling restricted, she found a part-time job, began studying, and extending her social life. This resulted in increasing parental conflict and much fighting. Mother left the family 3 months prior to the divorce. By this time she was involved with another man, her boyfriend at the time of referral, and reported that she wanted "some space to sort herself out". While she was given custody of the children she felt unready to take them with her at that point, but hoped to in the future. It appeared that she had been a relatively stable and nurturant parent. However, since the separation, she had not seen the children on a regular basis reportedly because of her long working hours. Relations between the children and their mother varied according to her moods - if she was in a good mood, they spent a lot of enjoyable time together, but if not, she would send them to bed early.

The relationship between the parents was friendly at the time of referral, and Tony's sisters appeared to be well-adjusted.

Tony was an unplanned child, and his statements such as "I was not meant to be" indicated that he perceived this as a rejection. Both parents were very happy about the pregnancy. His mother was his primary caretaker, and he started creche at 3. His milestones were slightly delayed and he had motor coordination problems which required intervention. These had been resolved to the point that he was a first team soccer player. Tony had always been a healthy child, and his eating patterns were good. Following the divorce there was evidence of sleep disturbance which had not been a problem previously.

Tony was an average student at school and was good at sport. He did not have many friends, but this had improved in the few months prior to referral after he had changed schools. He still reported that he was lonely. His relationships with adults were reportedly good and he was a friendly child. Tony enjoyed physical, outdoor games, which occupied his afternoons. He was described as a sensitive boy who over-reacted to criticism. He did not show his feelings easily.

Tony presented as a casually-dressed, small blond boy who listened attentively in the family interview. He happily remained alone with the clinician and, although apprehensive at first, was able to relax with time. He related very well to the clinician, chatting freely. He appeared to be unhappy, and expressed a wish that his parents would be reunited.

The clinician, an intern psychologist, understood Tony's unhappiness to have followed from a messy divorce and the consequent insecurity he felt as a result of the major changes in his environment. The intern felt that he had not accepted the divorce, still hoping that his parents would reunite, and hence had not worked through this loss. Furthermore it was felt that Tony had experienced his mother as rejecting him, and this had reevoked his feelings of being unwanted. His aggressive relationship with Mother's boyfriend was understood to follow from Tony's anger at his mother's being taken away from him and for the hurt his father had experienced. The intern decided to see Tony in play therapy in order to work through his feelings of being rejected and to come to terms with the divorce. The two family units were also to be seen so that the divorce situation could be clarified, the feelings allowed to emerge and so be processed, and practical arrangements negotiated.

Analysis

Tony's presenting problem was clearly defined and understood as a reaction to the divorce. Confounding his ability to work it through were his parents' difficulties in separating (which needed to be dealt with), and his perception of being rejected by his mother. While the latter issue could have been resolved in part by maternal counselling, it was felt that this had reevoked his feeling of being unwanted, which would explain his strong reaction to criticism, and that this was an important issue which Tony had to resolve. Thus the central themes would be

mourning and dealing with perceived rejection. It appeared that Tony had had adequate mothering and, other than his motor coordination problems, his development had been smooth. Certainly there was no evidence of distorted psychological development or symptoms prior to the divorce. Thus a focal issue existed in a child who had developed normally, and who was able to identify this issue himself.

Both parents appeared to be committed to Tony's therapy and to family therapy. In part it seemed they were motivated through their own guilt and unresolved feelings, which would also be addressed. Another positive sign was that one of their daughters had attended the clinic for problems in peer relationships, which had been resolved, and both parents had remained committed to her therapy. Mother's attempt to find reasons for Tony's reaction showed insight and psychological mindedness, and she was able to look at both her role and other factors in its aetiology.

Tony's home environment was stable on a day-to-day basis. However in the long-term it was unclear how long he would remain with his father. The other destabilizing factor was his mother's erratic interactions with the children, which would need to be addressed early on in family therapy so that a compromise could be reached. It seemed, however, that Tony's environment was supportive and stable enough to allow him to work through his issues in therapy. This would be assisted by the family work, which would address the maintaining factors.

Tony was able to interact easily with the therapist, who was male. Furthermore, he had had no major previous losses and he was never emotionally deprived - his mother was involved in what seemed to be a nurturant manner for much of his childhood before the separation. Thus her leaving him was a major loss which termination could assist in resolving. A factor which needs to be born in mind is that Tony had issues concerning abandonment and rejection. It might be that termination could be perceived as another rejection. However there was no actual early rejection or deprivation, and hence it is possible that this complex could be worked through within a carefully considered therapeutic frame. Tony is one of those children who would benefit from a concrete outline of session dates in a contract signed before the first session, and by repeated interpretations focusing on perceived rejection in the play, termination of sessions or the therapy, and other factors in the transference. In this way it seems that Tony would have been able to use the termination and work through it appropriately. The therapist and supervisor would have to be extremely careful that these factors were not neglected, or termination may have been experienced as another abandonment.

Tony was able to acknowledge his distress and verbalize his fears. The fact that he was able to talk about his feelings, and show the appropriate affect, is a good sign. It indicates that his defences concerning the focal issue are not too rigid so as to inhibit the work, and also indicates, in conjunction with his interaction with the clinician, that he is motivated for treatment.

Hence, in summary, Tony does satisfy most of the criteria for brief work. Two possibly problematic areas, namely environmental inconsistency and the possibility that Tony may perceive termination as a rejection, are possible to address in the therapy (individual or family) itself. The reason for this is that there is no indication that Tony has suffered primitive damage, as evidenced by his unproblematic defence structure and good ego strengths. However it would be crucial that these areas of the therapy were adequately addressed.

Unfortunately the intern did not keep either the focal issue or the above-mentioned warnings in mind. Tony was seen in play therapy with no mention of a termination date, even though the intern was leaving in 6 months. Altogether he had 16 therapy sessions which were terminated at Mother's request as she felt that he was making no further progress.

The reasons why can be seen in the content of the sessions. The majority of sessions were spent playing competitive games, which were not interpreted or commented on. It was apparent how this could have been linked to Tony's fear of being rejected if he lost, or to the divorce and his need to challenge his mother's boyfriend. Furthermore, while Tony repeatedly made reference to the divorce verbally, this was not followed through by the intern. As an example Tony drew a picture of a boat and commented on how the owner had gone to have a key cut for his house because his wife had locked him out. Here, as on many other occasions, an opportunity was lost to address the focal issue. This intern felt that Tony would work through his difficulties himself in the relationship. Clearly this is not possible in a time-limited therapy. It

is possible that the intern felt that interpretations would intrude on their relationship, as he appeared to indicate in his therapy notes, and this could have been addressed in supervision.

The issue of termination and rejection was also avoided, even though Tony made frequent reference to it. It was important for him that his therapist did not see other children, kept the room the same and was there precisely on time for sessions. Tony was obviously concerned about the holiday break, but this was not spoken about. Finally, when 2 sessions were set aside for termination, Tony arrived late and the competitive games continued as before. The intern tried to speak about termination at this point, but Tony ignored him.

Another point of interest is that this same intern saw the families for family therapy after Tony's therapy had been terminated. This will be discussed later in the paper.

In conclusion it seems that Tony's presenting issue was not really worked through. In fact it seems to have been avoided as the intern did not respond to Tony's attempt to address it and instead interacted with him more through the games. Tony's symptoms did not remit, although practical details were arranged, and the consistency of his mother's visits agreed upon in family therapy. This case points to the importance of supervision in keeping the trainee focussed on the central issue, and in working through any blockages the intern might have. It also indicates the usefulness of the outlined selection criteria in pointing

to potential problems in the therapy, and to ways of dealing with such problems.

5.5 The Case of Jess

The question now arises as to whether cases exist that fulfill the selection criteria for brief therapy but are nonetheless inappropriate. Jess was one of those children who seemed appropriate for short-term psychotherapy, but in fact required long-term work. This case will be presented and discussed with regard to selection criteria, and an attempt will be made to see whether hidden confounding factors to short-term therapy, or pointers towards them, could have been found in the assessment period. This case was seen by a intern in a unit where short-term psychotherapy with children is rarely employed.

Jess, aged 4 , was referred to the unit with her 5-year-old sister on the advice of their preschool teacher. The presenting problem, as reported by their mother who was the sole informant, was that both children showed extreme anxiety and insecurity following the divorce of their parents 9 months previously. Jess had been depressed, clingy and unsettled at school, whereas at home she had terrible tantrums and there was strong sibling rivalry. She also exhibited obsessive-compulsive traits - she could not tolerate disorganization, would spend much time packing and repacking her cupboards, would change her clothes 6 to 7 times a day, and washed her hands repeatedly. The time of onset of these obsessional behaviours was not elicited. Jess had also been masturbating, and her mother felt that she was copying her sister.

Jess' sister presented with far more disturbing symptoms which indicated the strong possibility of sexual abuse from her father. This was later confirmed. Because of the seriousness of the sister's symptoms, Jess' presentation was relatively neglected. It was initially felt that Jess would have been exposed to the sexual abuse of her sister, but that she was not directly involved other than in sexualized games with her father. However it was later confirmed that she had also been sexually abused, although the duration of this was unknown at the time.

Jess was an unplanned child. Her father was extremely angry about the pregnancy as he reportedly knew that he could not love more than one child. As a result of Father's unrelenting reaction, which lasted throughout the pregnancy, Mother was very distressed, and there was postpartum depression. Jess' father showed no interest in her and never approached her until she was 2. Jess only began to speak at the age of 2, but otherwise she developed normally. Her sleeping and eating patterns had always been normal. Jess had been attending a preschool for a year prior to referral, and her difficulties there have been noted above. She also became tearful and clingy when leaving her mother. Jess was described as a strong-willed and difficult child who had a bad temper. She was brave and would stand her ground with other children. Her peer relationships were reportedly good.

At the initial interview, Jess presented as an immaculately dressed, very attractive child of above average intelligence. She seemed to be confident, have a good self esteem, and was an outgoing child. Jess

showed no apprehension at being interviewed alone and engaged well with the clinician. She showed no signs of depression, anxiety or fear. Her play was spontaneous and self-initiated, although obsessional. She reported that she did not like her father.

Jess' father was described by her mother as a psychopath. She reported that he did not feel for anything, and had no conscience or regrets. He was dishonest in business and reportedly had no sense of responsibility. He "adored" his older daughter, and had her sleep between the parents from when she was 2. Mother reported that she has mood swings, and poor tolerance and patience for her children, with whom she did not like to remain for long. The father was the more nurturant parent and was more involved with the children, whereas Mother was more detached.

The marriage had deteriorated after Mother had informed Father of her second pregnancy. However they avoided problems by largely functioning independently of each other. They attended 6 sessions of marital counselling, but this was terminated by Father. It was Jess' mother who filed for divorce, which her husband would initially not grant. Thereafter he wanted custody of the children. At the time of referral the parental relationship was tense.

The intern understood Jess' symptoms to have resulted in part by a traumatic divorce, ongoing parental conflict, and the move to a new house. Sexual contact with her father had not been confirmed at this stage, but it was felt that an inappropriate relationship with her father could be an important factor in her presentation. On a

psychodynamic level , the intern hypothesized poor bonding with her cold, distant and uninvolved mother. Her initially rejecting father was unavailable as an object for her until she was 2. It appears that both parents had had disturbed childhoods and that neither had the capacity to parent properly. Thus, psychodynamically, the intern was suggesting that Jess had been deprived on a primitive level, and hence that there was very early damage. Psychiatrically she was diagnosed as having an Adjustment Disorder, with obsessive-compulsive traits (DSM III-R).

At this point the intern felt that, while Jess' sister required long-term psychotherapy, Jess herself appeared to have been more resilient to the traumas she had experienced, possibly because she had a better relationship with her mother than her sister did. She was felt to be both less disturbed and disrupted. The sexual abuse of Jess by her father was confirmed before she was taken into therapy. However it was still felt that Jess could benefit from short-term therapy. This was a team decision, and it was felt that she did appear resilient and would just need an opportunity of 6 to 12 months to work through the traumas of the sexual abuse and divorce.

Jess was seen in psychotherapy by another intern, also a woman. However it became apparent very early on in the therapy, through her symbolic play, that the sexual abuse had evoked earlier primitive damage in Jess which had to do with her mother - she had associated the abuse with infantile conflicts that needed to be worked through. The intern realized that Jess was more disturbed than was first thought, that it was not possible to work through the sexual abuse in isolation, and that

clearly defined focal issues, namely working through her loss (of her father and security), and dealing with her feelings and coming to some resolution about the sexual abuse. It is possible to deal with both these issues in time-limited work, especially if her symptoms were understood as constituting an adjustment disorder. Furthermore, although it was hypothesized that there was early psychological damage, it was felt that Jess had the resources to work through the divorce and abuse without the need to address those early issues in therapy. The apparently reactive nature of Jess' symptoms, her previously normal development, her confident and outgoing persona, and the lack of any evidence for depressive or longstanding anxiety symptomatology, suggest that, in terms of her presenting problem, she is a good candidate for short-term therapy.

However two factors have been neglected. Firstly, severe obsessive-compulsive symptoms which, although this was not investigated, probably predated the divorce. If they did not, the severity of them is of concern, and should point the clinician to the possibility that they were a defence against an earlier trauma which was being reevoked. This very strong and, it seems, time-consuming defence may have been the means by which Jess was able to portray such a confident persona. Hence this symptom/defence might have pointed to confounding factors that would contra-indicate the use of brief work. Secondly, Jess' delayed speech development could have pointed to early severe conflicts, if other factors were excluded.

Jess' mother was committed to the therapy of both her children as she was obviously distressed about their experiences. While it was unlikely that she had the personality reserves to be supportive or nurturant towards the children, it was unlikely that she would try to undermine the treatment. With the intervention of Child Welfare, the external ongoing stressor of the abuse would end, and it was likely that their environment would be stable. Furthermore Jess seemed to have a nurturant and supportive teacher. Both parents were psychiatrically disturbed, however it was unlikely that Mother's disturbance would significantly hamper Jess' ability to work in therapy as she could provide for her instrumental needs. Thus, while a more nurturant mother might have enhanced this variable, Jess' environment does fulfill the criteria for brief work.

Jess' relationship ability appeared to be good and she engaged well with the clinician. She was verbal and able to articulate her concerns, while she could also use symbolic play spontaneously and non-defensively, as a trial play session indicated. Furthermore, there were no major losses prior to the divorce. Hence it is possible that she could use termination in order to work through the loss of her father, their home, and the stability she had known.

However Jess was an emotionally deprived child, as indicated by her history and the way in which the case was understood. In the first 2 years of her life she had to contend with an emotionally cold and distant mother, and a father who wanted nothing to do with her. The earlier discussion of selection criteria indicated a reservation about

taking emotionally deprived children into short-term psychotherapy (Dulcan, 1984), as it was indicated that they would be likely to regard the emphasis on termination as another loss rather than an opportunity for resolution. In the case of Jess, this may have been a contra-indication for brief work.

Jess was able to verbalize her unhappiness, thus acknowledging her problem and indicating her internal distress. Of concern as regards brief work, was her strong defensive structure, most notably her obsessional defences. This obsessionalism was also evident in her play. The question to be answered, before brief therapy was embarked upon, is whether these defences would severely inhibit or block her working through her focal issues. But more importantly, it must be considered whether short-term work could contain and work with the anxieties and impulses that were being defended against. This cannot be guaranteed if one considers the type and extent of the defence that she had employed, and the early deprivation that Jess experienced.

Thus on the basis of an analysis of this case employing the selection criteria outlined, it can be seen that there were indicators that long-term work was required. These included her obsessive-compulsive behaviour, the associated rigid defence structure, and her early, and ongoing, emotional deprivation. These factors, together with the severity of her stressors, interact to caution the therapist against brief work. If the time-limits placed on trainees are taken into account, any indicators that brief therapy might be contra-indicated must be taken seriously.

6. SELECTION CRITERIA AND PROCEDURES : A FORMAT AND DISCUSSION

A review of the literature of time-limited psychodynamic psychotherapy with children indicated various possible criteria for selection of children appropriate for this form of intervention. These criteria were collated and summarized, and then applied to 5 cases who were seen by inexperienced therapists in order to illustrate the extent of their usefulness and importance in training situations. Furthermore, potential difficulties for trainees in both assessment and therapeutic process were noted as they occurred in case material.

By applying the criteria to the cases, it was found that they could discriminate between those children who were appropriate for brief work, and those who were not. It was also apparent that each criterion was important in reaching a decision, and that none were redundant. Furthermore they were found to be useful in pointing to potential difficulties in the therapy which would need careful consideration.

These selection criteria will now be discussed with particular reference to beginning therapists. Guidelines regarding the assessment procedure, and the manner in which these criteria can be elicited will be discussed. The importance of using the assessment procedure to inform the therapeutic process has been indicated, and hence guidelines for the latter will also be suggested. Finally, concluding comments and recommendations will be made.

6.1 SELECTION CRITERIA

On the basis of the summary of criteria obtained from the literature and their usefulness as applied to the cases discussed earlier, a format for the assessment of children for brief psychodynamic psychotherapy has been constructed with the aim of assisting trainees in the selection of appropriate cases for this work (Appendix A). This format ensures systematic coverage of all important areas to be assessed, and provides a summarized means of recording the information. The accumulation of "yes" and "no" responses will assist in rapid decision-making. What follows is a discussion of this format, the criteria, the assessment procedure and the manner of eliciting informative responses to such criteria from the child and family. Any modifications from the original literature will be discussed, and guidelines for trainees and their supervisors will be suggested.

The division of the selection criteria into 3 categories - namely Presenting Problem, Environment, and Factors within the Child - appears to be a useful one. This is especially so as they correlate with the Maudsley Interview Schedule for Children, which, with minor modifications, is the basic framework employed by both training institutes in Cape Town. The sections of the Maudsley consider the presenting problem, the family and environment, and the personal history and mental state examination of the child. Thus, if a good initial assessment of the child and family has been performed, it is possible to employ this information in order to assess further whether the child could benefit from time-limited psychotherapy. Hence the assessment

format, and the ensuing discussion of selection criteria, will be presented under the aforementioned 3 headings.

A. Presenting Problem

The presenting problem can be subdivided into the existence of a focal problem, and a consideration of the previous developmental history of the child.

The Existence of a Focal Problem

The single most important requirement for brief therapy is the existence of a focal problem (a psychodynamic issue or conflict that is seen to underlie all symptoms) which can be addressed and worked through in a limited time period (Peterlin and Sloves, 1985; Proskauer, 1969; Turecki, 1982). Factors which affect the possibility of rapid resolution include the number, duration, frequency, severity and intractability of the symptoms, and the child's level of general functioning (Mishne, 1983).

Thus a thorough assessment of the presenting problem is necessary from the time it was first noticed. Questions should aim to determine whether there were any precipitating events, and possible time, place or person specificity of the problem. The extent to which symptoms interfere with general functioning will give some indication of the severity of the problem. Any further symptoms that may be elicited by the history interview should be evaluated as to whether they can be understood as further manifestations of the focal issue or not. As object constancy

should be well-developed by the age of 4, the lower age-limit considered in this study, any irregularities in this regard would constitute another, severe, problem and hence would contra-indicate the use of brief work.

In summary, the most appropriate cases would present with acute, monosymptomatic, less severe problems for which there is a clear psychodynamic and/or aetiological precipitant. Thus Mike's presentation of a tic with associated self-depreciation, which had clear precipitating events and a psychodynamic aetiology that could be operationalized in therapy, can be seen to fulfill this criterion well. However Ann's multi-symptom presentation in which most areas of her functioning were affected, would indicate that brief psychotherapy should not be considered. The severity and duration of her symptoms point to the need for long-term intervention.

Previous Developmental History

A history of smoothly progressing development in the child would serve to ensure that the presenting problem is an isolated reactive disorder, such that the therapy would not be contaminated, and hence extended, by unresolved earlier conflicts and primitive damage in the child (Turecki, 1982). By evaluating this factor, hidden pathology may be detected, as in the case of Jess. A full personal history conducted in the Maudsley manner would indicate any developmental irregularities and/or neurotic symptoms.

The clinician must consider whether previous symptoms, if they occurred, were isolated stress-related manifestations which have remitted. These would be assessed in the same way as the present problem, as indicated above. If so, the child would probably be appropriate for short-term work, but this factor would be born in mind in relation to any other contra-indications. Eric's enuresis, which may have been an anxiety-related response to ongoing family conflict, would be such an example.

If there were any irregularities of longstanding or of marked severity, the therapist would consider their aetiology and determine whether these issues needed to be addressed (in which case long-term therapy may be indicated), or whether the present focal issue can be addressed separately to the aetiology of the earlier problems. However for trainees, who are confronted with many novel experiences and who can only see children in therapy for a limited period, it is suggested that the fewest possible risks are taken, and that caution be exercised in cases where early damage is suspected.

B. The Environment

In order to assess the child's family as fully as possible, it is suggested that the whole family be seen at the initial intake interview. Not only will this indicate whether the primary intervention should involve the family or any subunits thereof, but, if child psychotherapy is to be undertaken, the family interview will point to additional family or parental factors that might be exacerbating the problem and hence would need to be addressed. These factors will be considered

later in this paper. Furthermore, in a family interview, the therapist can enhance verbal explanations of environmental factors through direct observation and intuitive understanding. Selection criteria which pertain to the environment can be subsumed under 3 headings - the stability, supportiveness and motivation of the family.

Family Stability

As has been mentioned earlier, it is critical that the home atmosphere be stable so that the child's attention can be focused inwards to deal with dynamic conflicts as opposed to having to confront ongoing external major stressors (Rosenthal and Levine, 1971). These stressors would serve to exacerbate the child's difficulties. Factors concerning family and marital relationships, the mental states and psychiatric histories of the parents, parenting and disciplining, and any other potential sources of stress, are necessary to consider.

Excessive parental conflict would be likely to interfere with the child's ability to use the therapy, and would preferably need to be addressed in marital therapy. Inconsistent parenting could improve following parental counselling. External stressors (eg. if the child is being bullied at school and this is exacerbating his or her distress) must be systematically dealt with where possible. An example of this can be seen in the case of Jess, where the therapeutic work would have been severely compromised had the sexual abuse by her father not been stopped.

It is also important to obtain a psychiatric history of the parents and to assess their current mental state. Psychopathology in either parent is likely to be a major stressor for the child, as the parent may be emotionally unavailable or inconsistent in their parenting. If it is possible to assist the parent through referral for intervention, this should be arranged. However, severe parental psychopathology is a contra-indication for brief work (Rosenthal and Levine, 1971).

The case of Ann is a useful example to indicate the potential problems of seeing a child in therapy when there is family instability. Her situation was particularly chaotic, and required that she maintain obsessional defences in order to deal with this instability. These, in turn, would inhibit her using the therapy. The parental conflict and instability, together with both parents psychopathology, in fact resulted in Ann's therapy being interrupted and subsequently terminated, and previous traumatic experiences being repeated for her. Conversely, the stability in Mike's home was a major factor in allowing him to work with his anger in therapy and have it accepted.

Family Support

The therapist should assess the degree to which the child will be contained by the family outside of therapy, and also the degree to which they would be supportive of changes that take place in the child.

A child who feels unsupported might need to maintain a persona that is acceptable to the parents, and hence would find it difficult to drop

this facade for the brief therapeutic hour. Furthermore, if the child is distressed as a result of therapeutic material, it is important to know that the family can be caring and containing. Parents who are neglectful or over-involved point to complications for the child and the therapy (Reissman,1973).

The family who are either openly or covertly ambivalent about changes that may occur in the child are likely to undermine treatment by terminating prematurely, or by disallowing the child to change through subtle means. Thus it is important to assess the role of the child's symptoms in family functioning so that potential hindering factors in the family can also receive intervention. Eric's mother's resistance to allowing him to separate from her, which would inevitably start to occur as therapy progressed, can be seen as an illustration of this point. Her anger at the therapist and her cancelling of sessions would be the expression of her fear of losing Eric. This issue would have needed to be worked through in Mother's therapy in order for Eric to mature, and for the therapy to progress.

Parental Motivation

Without parental motivation, the possibility of premature termination and irregularly attended sessions is high (Dulcan,1984 ; Rosenthal and Levine,1971). Furthermore, lack of parental commitment is likely to be transmitted to the child and hence undermine the therapy. Parental motivation in child therapy is equivalent in importance to the patient's motivation in adult work, as described by Marmor (1979). Poor motivation

and commitment on the part of the parents is a contra-indication for brief therapy.

Parental motivation can be assessed by evaluating their feelings about their child being in treatment and their attitude towards psychotherapy, payment, and the possibility of their own direct involvement in individual, parental, marital or family therapy. The latter point would indicate to what extent they are able to acknowledge their part in the presenting problem, and their willingness to change. Useful indicators of commitment are the parents' history of therapeutic commitment (if applicable), and an assessment of parental responsibility and commitment to the child. Parental psychopathology might again be an important factor in this regard. Practical considerations such as whether the child can be brought for therapy regularly must be discussed.

Ann's parents' history of terminating therapies prematurely and their unwillingness to confront their own difficulties in family therapy would indicate poor motivation and commitment. The ultimate outcome was lack of commitment to Ann's therapy, and the resultant premature termination. This case points to the need to consider, in the assessment phase, any parent-child patterns that may be acted out in relation to the therapy, and whether these could seriously compromise the therapy or result in a repetition of a traumatic experience for the child. As was discussed in the previous section, Eric's mother's need to keep him by her side had resulted in her sabotaging attempts he had made to separate from her, and thus it could be predicted that she might also sabotage his therapy. Whether the mother's needs could be addressed and worked with in her

therapy or not would be critical. In fact premature termination for Eric, as a result of his mother's needs, would constitute the repetition of a previous traumatic experience for him, namely another sudden loss of a person to whom he was close. The repetition of unhappy experiences in Ann's treatment has already been discussed.

One way in which to keep the parents involved and motivated is to discuss clearly with them the length and goals of their child's therapy so that they can be part of the decision-making process. Regular feedback sessions would also be helpful in this regard, as will be discussed later.

C. Factors Within the Child

In order to assess fully the child for brief psychotherapy, it is suggested that 3 formats are employed. Firstly a full personal history must be elicited from the parents, then the traditional mental state examination of the child performed, and, thirdly, a diagnostic play session would assist the clinician in his or her evaluation. The manner in which each session would inform decision-making will be considered as each selection criterion is elaborated. These selection criteria will be addressed under 4 headings - namely relationship ability ; ability to negotiate termination successfully ; the child's motivation; and his/her defence structure.

Relationship ability

The child who cannot rapidly form a positive relationship with the clinician in the diagnostic phase will be resistant to accepting their input, and hence a long period in which the relationship is worked on would be required before the focal issue could be addressed (Peterlin and Sloves, 1985). Hence children who are extremely shy, reserved, distant or hidden behind a facade (as was the case with Eric), would not be appropriate for brief work (Peterlin and Sloves, 1985). Nor would children who have an initially hostile or negative transference reaction to the clinician, unless it is felt that this could be worked through quickly in order for the focal issue to be addressed, or if this transference reaction is a manifestation of the focal issue, in which case it could be gainfully employed.

The manner in which the child relates would be assessed largely in the mental state examination and diagnostic play session. Factors such as their involvement with the therapist in play or dialogue, eye contact, and their responses to the therapist's attempts at forming a relationship would be considered.

Eric's inability to drop his facade and relate freely to his therapist was seen to be a limitation of his therapy. However, Mike's easy verbal and symbolic (play) dialogues with his therapist in a diagnostic play session were a strong indication that he could benefit from short-term therapy.

The child could relate through play or directly with the therapist, and both should be considered. The literature speaks of the need for the child to be verbal (Dulcan,1984). However it is also critical that the child have the ability to use symbolic play. It cannot be assumed that all children can employ this means of communication, and it is even less likely that they, especially young children, could maintain a purely verbal interaction. Hence the need for a diagnostic play session, in which toys are available as in a therapy session and the child can use the time as they like. This unstructured session would provide some insight as to how the child would respond in therapy, and how they would engage with the therapist and the materials.

Thus, in summary, the child must be able to relate easily and be able to communicate through symbolic play or verbal interaction about their conflicts in order for brief therapy to be indicated.

Resolution of Termination

The clinician must consider whether a preset termination date could be worked through and utilized by the child without it being experienced as a rejection or abandonment (Proskauer,1971 ; Turecki,1982). This criterion cannot be unequivocally assessed, but some guidelines will be provided. Any query about the child's capability to successfully negotiate termination, serves as a strong contra-indication for brief therapy (Dulcan,1984; Proskauer,1971 ; Turecki,1982), especially in the case of trainees for whom the duration of therapy is limited.

The literature has suggested that children with a history of multiple losses or emotional deprivation, or those with insufficient basic trust, would be likely to experience the repeated emphasis on termination as rejecting (Dulcan,1984; Proskauer,1971 ; Turecki,1982). Furthermore, it is possible that children who are severely depressed may experience termination negatively, as the dynamic aetiology of depression is loss and termination would constitute a further loss. The case illustrations of Eric (numerous losses) and Ann (depression) provide two examples of contra-indications for brief work which stem from envisaged termination difficulties in part.

The Child's Motivation

Clearly, conscious resistance to the therapy or to change on the part of the child will block any attempt at therapeutic intervention in the short term (Dulcan,1984 ; Hare,1966; Turecki,1982). While some children will actively refuse therapy, others may come because they have to.

Inability or resistance to use the diagnostic play session may indicate poor motivation. In addition, children who do not accept some accountability for their problems and firmly externalize all responsibility, are unlikely to remain motivated (Dulcan,1984). It is likely that children who are distressed by their symptom and respond to the prospect of it being alleviated with relief, will be motivated to work in therapy and see some reason for having to work with painful feelings (Turecki,1982). The latter augers well for a brief therapy intervention, as in the case of Mike. ^u sp.

The Child's Defence Structure

As in brief psychotherapy with adults, the child's defences must not be too rigid so as to block his or her ability to work with the focal dynamic issue (Proskauer, 1971). Not only will these defences render therapy ineffective, but they also point to the possibility of strong anxieties, conflicts or impulses in the child which he or she is vigorously attempting to keep hidden. These issues might then need to be addressed if defences crumble, and long-term work would be required.

Thus an assessment of the child's defences serves as another safeguard against the trainee being confronted with deep pathology in the child which could not be separated from the focal issue. For example, Jess' rigid and severe obsessional defences were seen to be protective mechanisms of the ego against infantile conflicts and traumas which ultimately were seen to be interacting with the focal problems, necessitating long-term therapy.

The child's defence structure can be assessed with the aid of a personality description by family members, a full personal history, direct questioning about the child's response to stressful events, and observation of the child's play and mode of relating. The diagnostic play session can be employed to assess the child's response to trial interpretations. Children who respond verbally or through symbolic play by carrying the material further or showing insight, or who exhibit increased rapport with the clinician, indicate defences which are flexible enough to allow for therapeutic work. Children whose history

suggests rigid defences and who ignore or continually deny trial interpretations and attempts to focus on the central issue, would not be appropriate for brief work.

A full assessment of the child's defences and their purpose would follow from a psychodynamic formulation of the focal issue and other noteworthy behaviours that he or she exhibits. Thus Mike's need to maintain a non-aggressive persona was understood as a defence (reaction formation) against his underlying anger. As a further example, Ann's obsessional tidying and the distress she showed when her room was disturbed, was understood as an obsessional defence against anxiety arising from a lack of security. These defences were also evident in her play, and constituted a contra-indication for brief therapy.

D. Making the decision

On the basis of the above criteria, the decision as to whether the child is appropriate for short-term therapy can be made. If all the criteria are not met, it is the interaction of complicating variables that would serve to contra-indicate brief therapy, rather than a single criterion not being met. However, for reasons detailed earlier, criteria referring to the existence of a focal issue and the envisaged ability of the child to negotiate termination successfully, stand on their own as contra-indications if they are not met. Furthermore, a particular criterion may be critical if the dynamics of the child interact with it, or major problems for the therapy are envisaged.

Informed supervision would be essential in assisting the trainee in reaching a final decision and drawing the selection criteria together. As has been emphasized, caution must be taken and any doubts about the appropriateness of the child for brief therapy should not be ignored. This follows both from the time restrictions, and potential difficulties that may be experienced by trainees in the process of therapy that could be exacerbated by unmet criteria.

A further use of supervision in the assessment phase lies in the fact that often it is not the questions asked, but rather the observations and applications of the therapist's understanding (especially as regards possible patterns being repeated) that will elicit the response to the criterion in question. Hence supervision can assist in pointing to these observations. The case of Eric provides an illustrative example. While on the surface Eric's mother was motivated and committed to his therapy, an understanding of Mother's dynamics indicated that if Eric attempted to separate from her as a result of the therapy, she might sabotage the process. Thus supervision could assist the trainee in constantly thinking dynamically, and by emphasizing the importance of observation and counter-transference responses in the assessment phase.

Finally, it is important to consider whether any complicating variables elicited in the assessment phase can be addressed in the child's therapy, or in other forms of family, parental or environmental intervention so that they do not compromise the child's ability to work with the focal issue. Examples of such interventions include Eric's

mother's individual therapy, Tony's family therapy, Mike's parents' counselling, and the intervention of Child Welfare for Jess.

6.2 GUIDELINES FOR TRAINEES REGARDING THERAPEUTIC PROCESS

Certain areas in the process of brief psychotherapy with children have been highlighted as potentially difficult for trainees. These will be considered briefly, with guidelines for the therapist and supervisor. They will be discussed under the headings of Preparation, Process, Termination, and Parental contact.

Preparation

When deciding about the appropriateness of brief therapy, the need to define a focal dynamic issue arises. This would follow from a succinct formulation of the child's difficulties in a manner that would inform treatment. Clearly the wrong choice of focus would render the therapy largely ineffective (Proskauer, 1971). Hence the supervisor could stand as a safeguard against such an occurrence, assisting with insight and suggested reading.

On this basis, the proposed duration and frequency of therapy would be decided. The number of sessions decided upon would depend on the number and severity of problems to be addressed, family and clinical resources, and the child's openness to change (Dulcan, 1984). The experience of the supervisor would be the main factor in aiding this decision. It is,

however, recommended that the child be seen at least once-weekly in order that the therapeutic pressure be maintained.

The Therapeutic Process

The main emphasis in this phase of therapy is the therapist's constant focus on the central issue. This implies the trainee knowing what material should be interpreted, and how, and what material should be left untouched - a difficult task, especially so if there is early damage in the child that must be avoided. In depth supervision, using detailed therapy notes, would serve to keep the trainee constantly focused on the central issue, and provide suggestions in anticipation for the following session. Guidelines as to what kinds of material should be left uninterpreted would assist the intern.

Finally any anxieties or other , possibly unconscious, counter-transference issues could be usefully addressed by the supervisor. For example, Ann's therapist's over-interpreting, which might have followed from her anxiety at having limited time to address many problems, could have been pointed out to her in order to assist her with her underlying difficulty which might have contaminated the therapy. It might also provide a useful indication of the child's anxieties that have been transferred to the therapist. Any particular anxieties of the therapist regarding brief work and their fear, following their own insecurities as trainees, that they cannot solve all the child's problems must be addressed. Rosenthal and Levine (1971) indicate that therapist skepticism regarding the efficacy of brief work was correlated with poor

therapeutic outcome. In training, the supervisor's skepticism, the intern's insecurity regarding their ability to be effective, and their feeling that they must solve all the child's problems, could be confounding factors which must be addressed.

Termination

The reality of a preset termination date makes termination an ever-present issue. Proskauer (1971) speaks of the tendency of many therapists to underestimate, avoid, postpone or repress the approaching termination as a result of pain at separation or loss, thus being unhelpful to the child in working through this pain. This would be especially true for trainees. Kranz and Lund (1979) provide research which indicated that 80 percent of the student therapists in their study became overly concerned and protective or possessive of their child clients as termination approached. Difficulties arose for these trainees in objectively viewing the therapeutic dyad. Furthermore trainees may, as a result of feeling inadequate, not believe in their importance to the child and hence underplay the working through of termination. It is also possible that the therapist may avoid dealing with termination as they get defocused by the child's defences against separation and loss.

Thus the supervisor could assist in constantly pointing to termination, and dealing with the trainee's avoidance, if applicable. The supervisor could help the therapist identify the child's defences against ambivalent feelings, and see possible relationships between the focal issue and the child's reactions to termination. The case of Eric, for

whom termination could have been linked with previous losses in his life, is such an example. Where loss is a factor in the child's presentation, the proper working through of the termination is critical.

Parental Contact

If no form of family intervention is indicated in conjunction with the child's therapy, it is suggested that regular (monthly) contact is maintained with the parent(s). It is important that the parents have some insight into the therapeutic process, within the bounds of confidentiality, and that the therapist receive information as regards the child's progress outside of therapy. In this manner, parental motivation can also be maintained, and any resistances they may have towards the therapy can be detected and addressed. It is suggested that the therapist him or herself feed back to the parents in order both to reduce time-commitments of clinicians, and so that the parents do not feel excluded by their child's therapist. However it is important that the child be aware of meetings between therapist and parents, and is assured of the confidentiality of the material.

7. CONCLUDING COMMENTS

While brief dynamic psychotherapy is being suggested as useful in a training setting as a result of time restrictions of trainees, it is in fact a more demanding and difficult form of therapy than long-term work. This follows from the need to choose a clearly defined and appropriate focus, and thereafter to rigorously maintain this focus. The trainee would have to make constant, and instant decisions as to what material to interpret and what to leave, and interpretations would be made with far less information informing them than is the case when the child has been seen over a long period. Furthermore, the difficulties in working with a preset termination date have been noted.

The value of the trainee having an experience of child psychotherapy, with the skills in interpreting, goal-directed therapy, dealing with the transference, and working through termination, must be weighed up against the potential difficulties inherent in brief child psychotherapy for the inexperienced clinician. However it is felt that an appropriate assessment of the child in combination with good supervision could redress the balance.

Proskauer (1971) reports that individuals with no previous experience in child therapy have conducted effective time-limited therapy under the supervision of an experienced clinician. Thus trainees would require in-depth, detailed supervision from supervisors experienced in working with children.

However more research is required as regards the process and outcome of brief psychotherapy, and this may follow from the implementation of such interventions in training institutes. The assessment criteria suggested in this study would need to be evaluated and modified further on the basis of the experiences of interns. A question that needs to be addressed is whether children who have experienced early psychological damage should ever be seen in brief therapy. It is perhaps impossible to maintain work on a focal issue with these children - as it was in the case of Jess. However, if children with early damage are to be seen by trainees, provision must be made by the institute for the trainee to be able to continue seeing the child in long-term work (perhaps even after they leave their placement) for cases in which the focal issue is later found to interact with early pathology, or hidden pathology exists.

It is hoped that by employing brief psychodynamic psychotherapy with children in a training institute, this mode of intervention could be further refined and developed, and hence become accepted as a valid and effective form of therapy for selected cases.

APPENDIX A

ASSESSMENT OF CHILDREN FOR BRIEF PSYCHODYNAMIC PSYCHOTHERAPY

1. PRESENTING PROBLEM

a) Does a focal problem exist ? Y / N

Psychodynamic statement of the problem :

b) Has previous development been smooth ? Y / N

List deviations if applicable :

2. THE ENVIRONMENT

a) Is the family stable ?

Y / N

Comments:

Can any source of instability be
addressed in treatment ? Y / N

b) Are the family supportive of the child ?

Y / N

Comments:

c) Are the parents motivated for therapy ?

Y / N

Comments:

3. FACTORS IN THE CHILD

a) Does the child relate easily ? Y / N

Description:

Can the child:

converse verbally ? Y / N

use symbolic play ? Y / N

b) Can termination be successfully resolved ? Y / N

Reasons:

c) Is the child motivated for therapy ? Y / N

Does he/she want relief from symptoms ? Y / N

Does he/she take some responsibility
for symptoms ? Y / N

d) Are the child's defences sufficiently
flexible to allow rapid resolution
of the focal issue ? Y / N

List defences:

Does he/she respond appropriately to
trial interpretations ? Y / N

CONCLUSIONS

A. Is this child appropriate for brief therapy ? Y / N

Comment:

B. Are there any complicating factors ? Y / N

List:

Can these be addressed in treatment ? Y / N

Procedure (if appropriate) :

C. Do any other family units require intervention ? Y / N

Comment:

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