Med. J. Malaysia Vol. XXX No. 4 June, 1976

Brief Psychotherapy with Children

by Dr. Diana Loh Pui Ying
M.B.B.S.(S'PORE) D.C.H.(LONDON) A.M.(STANFORD)
Child Guidance Clinic,
Assunta Hospital,
Petaling Jaya.

Introduction

SHORT-TERM THERAPY has been found effective in the treatment of behaviour disorders of children and adolescents.[2,4,5,8] Rosenthal[8] defines brief psychotherapy as limited to a maximum of ten calendar weeks. His technique involves a case formulation at the initial interview, the setting of realistic treatment goals and collaboration of the family as an essential part of the therapeutic process. In addition the therapist plays an active and often directive role. On account of the time constraint in brief psychotherapy, more planning and treatment strategy is involved and there is a constant focuss on the issue of termination. According to Barten[2], short-term therapy utilizes a health-oriented outlook emphasizing the assets and strengths of the child and parents. Hence with the family adopting more positive expectations, a change in other areas of behaviour would continue even after the therapeutic process has been concluded. The results of the above studies indicate that short-term treatment is as effective as traditional long-term treatment besides the economy of time and personnel. Philips[7] attributes the feasibility of short-term treatment in children to their natural forward surge – growing and changing, and the fact that parents respond better as parents than they do simply as adults seeking help.

Based on these findings, when the Child Guidance Clinic in Assunta Hospital commenced about two years ago, I decided that as far as possible, brief psychotherapy would be the treatment of choice. Thus all children with behaviour disorders who required therapy were given short-term treatment, hence excluding older children and adolescents with deep seated personality disorders and those who were psychotic. This paper reports my experience with the use of brief psychotherapy in a multiracial group of children.

Procedure

Child Guidance is a new concept in Malaysia and since I conducted the clinic alone, I planned a gradual approach to diagnosis and therapy, which would be more acceptable to the parents. Even among the Caucasian parents, only two had any knowledge of Child Guidance. Thus all parents were informed at the first interview that the diagnostic sessions would involve weekly visits for a total of three weeks. On each occasion, the mother was interviewed, a few of the fathers were also seen individually and the therapist had a play session or an interview with the patient, depending on the age. If psychological testing was indicated, it was done during this period. At the end of these sessions, a diagnostic formulation was made and the course of treatment planned. The parents were then informed of the child's problem, if psychotherapy was deemed necessary, the specified period not exceeding ten visits, preferably weekly sessions was then decided. In addition parents were counselled as to what role they play in the therapeutic process. I did not have the services of a psychiatric social worker to see the mother, at the same time, the child came for therapy. In order to maintain confidentiality of the patient so essential in the treatment process, mothers of children in therapy were seen every two weeks at a different time. This also enabled the therapist to keep track of behaviour at home and take appropriate steps.

The Patients

Of the 15 patients, 8 were Malaysians and 7 Caucasians. All were referred by Private Practitioners or were from the Paediatric and Medical wards of this hospital. The majority were from middle class homes and spoke either English, Chinese or Malay. Their ages ranged from 3 – 17 years. All were from intact families.

Diagnosis

After 3 weeks of initial evaluation, a diagnosis was arrived at together with predisposing causes or circumstances of the behaviour disorder. The classification of psychopathological disorders of childhood proposed by the group for Advancement of Psychiatry[3] was used. The patients fell into the following groups:–

Reactive disorders	10
Developmental deviations	1
Psychoneurotic disorders	3
Personality disorders	1

Table 1 sets out particulars of the patients together with their modes of presentation and symptoms.

Psychotherapy

The form of psychotherapy depended on the developmental level of the patient. Using non-directive play therapy, the younger children invari-

Table 1

Patients & Their Presenting Symptoms

Name	Nationality or Race	Sex	Age	Presenting Symptoms	Other Symptoms
1. Siti	Malay	F	3 yrs.	Oppositional behaviour	Regressive behaviour, aggression directed towards mother.
2. Ravi	Indian	M	4 yrs.	Night terrors	Temper tantrums, oppositional behaviour in school & at home, sibling rivalry.
3. Karen	Chinese	F	4 yrs.	Socially withdrawn	Temper tantrums, regressive behaviour, oppositional behaviour in school.
4. David	American	M	4 yrs.	Encopresis	Regressive behaviour.
5. James	British	M	6 yrs.	Urinary urgency & frequency	Irritability, provocative behaviour.
6. Paul	Aust.	M	6 yrs.	Marked aggressive behaviour in school	Nocturnal enuresis, difficult school adjustment, profane speech, destructive behaviour.
7. Charles	French	M	7 yrs.	Nocturnal enuresis	"too good" behaviour, hypersensitivity, social withdrawal.
8. Cara	Swedish	F	8 yrs.	Social withdrawal	Underachievement in school, temper tantrums, hypersensitivity.
9. Anne	British	F	8 yrs.	Frequent headaches	Difficult school adjustment, insomnia, overly dependent behaviour.
10. Mary	Aust.	F	9 yrs.	School failure	Temper tantrums, sibling rivalry overly dependent behaviour, low frustration tolerance.
11. WKY	Chinese	M	9 yrs.	Separation anxiety	Regressive behaviour, overly dependent behaviour, seductive behaviour.
12. Maniam	Indian	M	10 yrs.	Acute anxiety attacks	Confused and irrational, regressive behaviour, insomnia.
13. KEK	Chinese	M	15 yrs.	Acute anxiety attacks	School failure, nightmares, giddiness & palpitations.
14. WPC	Chinese	F	16 yrs.	School phobia	Freezing sensation in chest, distractibility, insomnia.
15. TSK	Chinese	F	17 yrs.	School phobia	Severe headaches, depression, forgetfulness, distractibility.

ably acted out their anxieties in doll play. The role of the therapist involved interpretation, reflection and reinforcement of more mature forms of behaviour. With the older children, anxiety problems were very pronounced, in fact 4 of them were hospitalised in acute panic states associated with multiple somatic complaints. They were placed on mild tranquilisers for a short duration, at the same time psychotherapy was commenced. During their stay in hospital, intensive psychotherapy was given every other day. The period of hospitalisation in all cases was short – less than one week. Upon discharge psychotherapeutic interviews were continued on a weekly basis. The time limit of brief psychotherapy still applied – not exceeding 10 visits. The older children tended to be more inhibited, hence more "therapeutic pressure" was involved. During the treatment sessions, the therapist focussed on the presenting symptoms, other problems that the patients or their parents brought forward and also dealt with any underlying psychopathology in the patient.

Increasing self-esteem was another treatment goal particularly for the older patients.

Duration of Treatment

Number of patients 15
Completed treatment 11
Definite to marked improvement 10
Relapse 1
Defaulted 4

The length of therapy ranged from 4 – 10 weeks with a mean duration of 6.6 weeks. If the diagnostic sessions were included, the total attendance at the Clinic came to an average of 9.6 weeks.

Termination

The duration of therapy, within the ten week limit, was specified before short term treatment commenced. This was stressed to both parents and patient initially, and as treatment progressed, the prospect of termination in the near future was brought up again as a reinforcement for further behaviour change. Then two weeks before termination, the question of adequacy of present functioning was discussed together with the information that there were only two more sessions left.

Follow-up

This was done through a follow-up interview with the mother or by telephone at 3, 6, and 12 month periods. Queries were made concerning the child's present social adjustment, school performance and any recurrence of the former behaviour problems. Parents were also asked to give an appraisal of psychotherapy – in what manner this was of help to their child. Relapse in the one patient occurred 4 months after the family left Malaysia.

The following case presentations show the type of problems encountered in brief psychotherapy:–

Case 1. School phobia

S. K. a 17 year old Chinese girl complained of severe occipital headaches for the past 3 months as a result of which she only attended school for 3 days in the whole of the previous term in Form 4. She had been admitted into the medical ward for investigation, EEG and skull x-rays were normal. She was then referred to the Child Guidance Clinic for management of school refusal.

S. K. was the only girl in the family with 4 brothers all of whom were high achievers. Her father was a clerk and mother a housewife. Both appeared detached and seldom visited her in hospital. S. K. came from a traditional extended family. The paternal married aunt dominated the family and S. K. was very attached to her. During hospitalization, this aunt was her constant companion.

S. K. completed primary school in Chinese medium and did extremely well. She was then placed in an English medium secondary school when she did not perform as well. However, she passed the L.C.E. examination and was placed in the Arts stream. While in Form 4, during the mid-year examinations, she passed in Maths., English and Bahasa Malaysia but failed all the other subjects.

Soon after that, her symptoms appeared – severe headaches, difficulty in concentrating on studies, forgetfulness and increasing anxiety as she felt progressively less capable of coping with her school work. When she felt better she would attempt to go to school, accompanied by her aunt, but would panic when the car approached the school and she would refuse to enter.

During the diagnostic sessions, S. K. appeared depressed and apprehensive, somatic complaints dominated the interviews. Since hospitalization, she was placed on small doses of Diazepam. She communicated almost entirely in Cantonese which she spoke very well. It was obvious that she had a very poor command of English and hardly up to Form 4 level. By the 3rd visit, S. K. expressed a desire to return to school when she was fully recovered.

In the diagnostic formulation, her aunt was told that S. K. had a strong attachment to her and ambivalent feelings towards her parents. She attempted to resolve this by moving into their room since her illness but still they did not alter their attitude toward her. School phobia was related to separation anxiety from her aunt together with an impending fear of failure in school and a complete loss of face at home. It was further explained that S. K. would require psychotherapy over an eight to ten week period. The focus of therapy would be to help S. K. work through her ambivalent feelings towards her parents, to enable her to accept her illness as having an emotional basis, to help her return to school as soon as possible and to improve her self-esteem. The role of the family, particularly her parents, was to be supportive of her efforts to resume studying and to obtain for her the services of an English tutor. As therapy progressed, there was a perceptible improvement in affect, at the same time, somatic complaints decreased. By the 5th visit, S. K. was well enough to contemplate returning to school after the Chinese New Year holiday. I arranged with her headmistress to permit her to return to school on a gradual basis, initially confining herself to a few classes – Bahasa Malaysia, English Language, Maths and Art, the latter two being her best subjects. Her social relations had also improved. Together with some classmates, she visited a local orphanage to distribute toys and sweets to the children.

The following week, S. K. reported that she was attending school daily and could easily cope with the four subjects specified. In fact she was coping so well that she started to sit in on all the other classes. She looked very attractive in a new long dress and her headaches had largely gone. Her aunt reported that at home she was completely changed. She was now assertive, verbally aggressive to her younger brothers, and often pestered her aunt to go shopping for new dresses for herself. She was happily attending school daily. Her family was pleased with the change. On that note therapy was terminated after 10 weeks.

At the follow-up interview, one year later, S. K. had completed the Form 5 examinations and obtained four distinctions but failed in Bahasa Malaysia. She intended to repeat the examination and possibly go for further studies. There was no recurrence of school refusal.

Case 2. Urinary urgency and frequency

James W, a 6 year old English boy, was referred by the paediatrician because of frequency and urgency of micturition for which no physical cause could be found. For the past year he had 3 attacks of frequency each lasting only a few days. Sometimes he received treatment from the family doctor, at other times symptoms would spontaneously subside. On this occasion however frequency had lasted 3 weeks, urinanalysis was normal and medications were of no avail. Mrs. W reported that James went to the toilet every few minutes even while he was enthralled in play or watching T.V., he awoke 2 – 3 times at night for this purpose and lately was more irritable and provocative towards his elder brother.

James was the younger of two boys in the family, his father was a mining engineer and mother a housewife. Both parents had a close and warm relationship with the children. Mrs. W had been unwell for the past few years and had had several operations but was now fully recovered. Mr. W. spent a lot of time with the boys and rarely punished them.

James was a very intelligent, verbal and imaginative child. In the first play session, the repeated bashing together of the heads of the parent dolls and later interlocking of the boy and father dolls was very suggestive of the primal scene. No comment was made at that juncture as I was unsure of the significance of this play. James also played a game of hide and seek in the adjoining bathroom but managed to withhold micturition throughout the entire 45 min. session.

The following week Mrs. W confirmed that about 10 months ago on a Sunday afternoon, the boys were found peeping through the keyhole of their parents' room, while they had intercourse. The boys giggled a lot, acted sheepishly and subdued for the rest of the day. They were told off but no other punishment was meted out. The key hole was then sealed! Soon after this incident James' attacks of frequency began, the present attack being the longest. Mrs. W reported that since the previous visit, James had made a lot of progress and day-time frequency was much less.

During the second play session, James was seen tugging at his penis on several occasions. He made a doll using plasticine then fiercely smashed it very flat with a rolling pin saying "my father says some people have to be squashed." When queried by the therapist, he replied "because they are bad." He then proceeded to describe how some people were squashed and full of blood. I felt this was related to his witnessing the primal scene and fear of punishment. When asked what would make

him scared, James replied with a lot of bravado that he was not scared of anything except some crocodiles he saw in the zoo.

In the diagnostic formulation, Mrs. W was informed that James' problem specifically castration anxiety was aroused by the primal scene. This is particularly traumatic in a child during the period of oedipal conflicts, and in this case, the added anxiety connected with his mother's several operations. Anger and at the same time fear of the father's power was very real. Treatment would entail play sessions for 5 more weeks to enable James to work through his anxieties and fears with respect to his father and so prevent further recurrences of this problem.

By the 4th week, Mrs. W stated that James was fine and micturition back to normal. In play he was still preoccupied with killing all the fierce animals and protecting the good ones. During the subsequent sessions, father doll continued to receive rough treatment. Snakes were twined round his head and neck "so he can't see because he is bad." On another occasion, father doll was so bent and distorted in the legs "so he can't walk." When reflections were made of the boy's anger toward the father, James' answer was to bash the heads of the parent dolls together and throw them in the basket.

By the 5th session, James seemed to have worked out his anger on the father doll and play was back to normal. Mrs. W reported that he was much happier in school and at home. The entire duration of treatment was 8 weeks. At the 3 month follow up, there was no recurrence of frequency of micturition, he was performing very well in school and given the leading role in the annual school concert.

Conclusion

Case 1 illustrates how a common problem like school phobia can be helped through brief psychotherapy. The emphasis is on initial case formulation, realistic treatment goals and participation of the family in the therapeutic process. For the adolescent, Kerns[5] is of the opinion that "the time limit mitigates some of the fears of his own normal functioning, that he is not so badly off, and frees him to work on his problem." The therapist too working within this time constraint has to plan before hand the treatment focus for each session, with the ultimate aim of helping the adolescent adapt to his internal needs and to reality.

Case 2 is an example of the use of non-directive play therapy within the brief psychotherapy set. Within the span of 8 weeks, the patient expressed his anxiety, hostility and aggression in spontaneous doll play and was able to resolve his conflicts. In all cases, the duration of therapy is always specified and reemphasised in the course of treatment. The therapist attempts observations, reflections and interpretations for the child. According to Axline[1] "it is not necessary for the child to be aware that he has a problem before he can benefit by the therapy session." Further Woltman[9] states that "free play of itself has decided cathartic value."

In the treatment of behaviour disorders of children it is a debatable point where diagnosis ends and therapy begins. According to Masterson[6] even with the first phone call for appointment the therapeutic process has begun. Hence the separation of diagnostic and therapeutic sessions is a mere convenience for explaining to parents. With many of the children in this study improvement was shown after the first session. Technically the duration of therapy should be reckoned from the initial visit. Even then in this study, the average length of treatment is still less than 10 weeks.

The results of this study indicate that brief psychotherapy is suitable for the treatment of a variety of behaviour disorders in children. Hopefully there will be a greater awareness of behaviour problems in paediatric practice. The child's developing personality is more flexible and responsive to therapy. Brief psychotherapy with the economy of time and personnel would extend help to a greater number of children.

Summary

Child Guidance is a new development in Malaysia. This paper records my experience of brief psychotherapy with a multiracial group of children. Though the numbers are small, results are encouraging. In Malaysia with the acute shortage of personnel in this field, greater use of brief psychotherapy is advocated.

Acknowledgement

I wish to thank Dr. F. R. Bhupalan, Medical Superintendent of Assunta Hospital, Petaling Jaya, for permission to publish this paper.

References

1. Axline, V.M. Non-directive Therapy. In Mary R. Haworth (Ed.) *Child Psychotherapy*. New York: Basic Books Inc. 1964.

2. Barten, H.H. & Barten, S.S. *Children & Their Parents in Brief Therapy*. New York: Behavioral Publications. 1973.

3. Group for Advancement of Psychiatry Report No. 62. *Psychopathological Disorders in Childhood: Theoretical Considerations & a proposed Classification,* group for the Advancement of Psychiatry. New York 1966.

4. Hare, M.K. Shortened Treatment in a Child Guidance Clinic: The results of 119 cases. *Br. J. Psychiat.*, 112, 613 – 616, 1966.

5. Kerns, E. Planned short-term Treatment, a New Service to Adolescents. *Social Casework,* 51, 340 –346, 1970.

6. Masterson, J.F. Psychiatric Treatment of Adolescents. In A.M. Freedman & H.I. Kaplan (Eds.) *The Child: His Psychological & Cultural Development*. Vol. II. New York: Atheneum. 1972.

7. Philips, E.L. & Johnston, M.S.H. Theoretical & Clinical Aspects of Short-term Parent-Child Psychotherapy. *Psychiatry*. 17, 265 – 275, 1954.

8. Rosenthal, A.J. & Levine, S.V. Brief Psychotherapy with Children: Process of Therapy. *Am. J. Psychiat.*, 128, 141 – 146, 1971.

9. Woltman, A.G. Concepts of Play Therapy Techniques. In Mary R. Haworth (Ed.) *Child Psychotherapy*. New York: Basic Book Inc. 1964.