Positive Child and Adolescent Psychotherapy

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Only seeds

A man had a dream, in which he went to the greengrocer. He was greeted by an elderly man standing behind the counter. The young man asked with a strong voice: "What can you offer me?" The shop assistant replied in a friendly way: "It depends on what you wish for". Hearing that the client started to enumerate with no further hesitation: "If so, I would like world peace and unity of the world, abolition of all the prejudice and poverty, unification of religions, equal rights for women and men." At that moment the old man interrupted and said: "Just a moment young man, most probably there has been some misunderstanding between us. I do not sell fruits here, only their seeds."

Citied in: Peseschkian [1]

Introduction: The Importance of the Family and Social Context

For a comprehensive understanding of child or adolescent issues it is of particular importance to know the environment in which they live, develop, and learn every day. A child rarely reports a problem of a psychological or psychosomatic nature of their own initiative. Their limited insight into the nature of their own experiences, in addition to subjective or objective obstacles, makes it difficult. Usually, it is the adult who recognizes specific symptoms that may manifest as psychological suffering in the child. Depending on developmental age and sense of safety, the young patient confirms or denies the perceptions of adults.

Presentations where the parents directly share their worries and observations about the child are more beneficial. This enables the therapist to gather the most important data from the caregivers, and at the same time allows the assessment of the dynamics of mutual relations in the family and build the initial alliance with the parents. The prognosis is much worse when the disturbances in the child's functioning are observed by persons from outside the family, such as tutors, counselors, or teachers. This may indicate neglect by the closest family members and presage difficulties in building a therapeutic relationship with the family.

The positive psychotherapist should obtain information about their juvenile patient from various potential sources. This creates an opportunity to compare the child's ways of reacting in a variety of social surroundings. It should be considered that symptoms presented by the child are strongly related to explicit and implicit family conflicts, in addition to the level of stress experienced by the family and their coping styles. The presence of family members, both at the stage of making a diagnosis and during the process of a child's treatment, seems to be a key to the success of further therapy.

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Key Definitions

Developmental Phases in the Life of the Child and Its Family

The individual therapy plan should be preceded by a thorough clinical diagnosis. To make such a diagnosis, it is essential to have extended knowledge in the field of children's psychomotor development and the stages of family development. For the first issue, the stages of psychosocial development described by Erikson and Erikson are particularly useful [2]. They define normative developmental crises, which, if solved properly, provides the child with new skills and at the same time starts a new stage in their life. On the other hand, unsolved crises cause inhibition and remaining fixed at that developmental stage. This leads to recurring conflicts later in life, e.g., basic mistrust, sense of inferiority, or the feeling of shame. The author of PPT also gives special meaning to ego development in a social context; however, he explains the nature of conflict connected with this process in a different way. This subject will be discussed in the next section.

The second important point of reference in the working out of the clinical diagnosis in PPT of children and adolescents are cycles of family development, as described by Duvall [3]. According to this author's observations, families grapple with specific tasks at particular stages of the child's life, which requires specific resources and adaptation skills. In the absence of those resources, the family system reacts with resistance to expected changes. Then it is the child who unconsciously develops symptoms of illness, which perform a homeostatic function for the whole family, e.g., separation anxiety at the stage of going to nursery school or juvenile depression at the stage of the empty nest.

Attachment and Basic Capacities

A lot of clinically useful knowledge on the subject of child development was brought about by the theory of bonding by Bowlby [4, 5], later broadened by Ainsworth [6, 7]. It emphasizes the fundamental importance of a bond between a child and a basic object of attachment, most commonly the mother. This bond is decisive for the proper emotional, cognitive, and social development of every human being. What guarantees optimal development is a secure bond, in which the mother is fully in tune with the physical and emotional needs of her child. Experiences of a safe relationship bear the fruit of trusting oneself and others. As stems from practice, there are also unsecure attachment styles, among which the anxiety-ambivalent and anxiety-avoidant styles can be mentioned. Prospective observations indicate that relational schemas from early childhood are being unconsciously reproduced at further stages of a person's life and that this may lead to numerous disturbances and dysfunctions (unsecure attachment styles).

Nossrat Peseschkian described attachment relationships with constructs, which he called basic capacities. Among them he mentioned trust, contact, time, patience, and others—see Chap. 2 for an introduction to the Positive Psychotherapy model. According to the model, basic capabilities, which are implicitly present in the child–caregiver relationship, constitute a kind of matrix that enables the child to satisfy their specific biological and psychological needs [8, 9]. Peseschkian especially emphasizes the role of modeling, that is, unconscious identification with the adult model. In his opinion, in the first 2 years of life, children embody some of basic capacities that in the future will determine their attachment style. What models the family environment and what dimensions of the relationship are being reinforced is dependent, among other things, on transgenerational transmissions and on the sociocultural context in which the family lives.

Social Education and Secondary Capacities

The older a child becomes, the more visible are the influences of the broader social environment and cultural context. The child starts to assimilate specific norms of behavior that are necessary in the process of social adaptation. Peseschkian defines

them as secondary capacities (conscientiousness, politeness, punctuality, diligence, and others) [8, 9] and stresses the fact that the child internalizes them throughout education, starting in nursery school. One may easily notice that from that moment, satisfying a child's emotional and relational needs will be conditioned by reinforcement or by suppressing selected secondary capabilities. It will promote individual unconscious compromises, according to the rule: if I am honest, then my parents will be proud of me, or if I am obedient, then my parents will show interest in me.

Conflicts

Above-mentioned unconscious compromises on one hand are decisive for survival, and on the other hand they shape a child's personality and limit their repertoire of resources for reaching happiness or self-actualization. It can be said that the unconditioned need of love is transformed into individual compromises between basic capacities (differentiated equivalents of love) and secondary capacities (differentiated norms of social behaviors). Peseschkian names these compromises *basic conflicts*. Stemming from previous chapters, when they are aroused in a child, then an internal conflict is developed that externalizes itself through the agency of mental or psychosomatic symptoms.

Estimation of Resources

In the case of the dysfunctions of a child, which have psychological or neurobiological bases, very often it is their limitations that remain the focus of attention of its family and the social environment. Adults, and sometimes also peers, openly express their disapproval toward the child's reprehensible conduct. As can easily be suspected, such negative marking disrupts the child's self-esteem and leads to social exclusion. To a great extent, this phenomenon applies to children diagnosed with attention deficit hyperactivity disorder (ADHD) or oppositional-defiant disorder (ODD).

In PPT, the therapist aims to reverse this process as early as possible. Particularly useful are meetings with parents, family members, tutors, and teachers. Every one of them may recall descriptions and images of the child that go beyond negative schemas. Recognition and naming hidden resources of the child promotes the establishment of secure and open relationship with them. It also seems useful to search for an answer to the question about the child's capacity that owing to reasons independent of them could not fully develop and thus how their development could be stimulated during the course of the therapy.

A useful way to engage the family is to reformulate the child's behaviors from those that are difficult to accept to those that serve the family and protect its values and principles. Owing to positive connotations, the child regains its previous position in the family system instead of being excluded. Moreover, mutual accusations and criticism are replaced by attempts to reach mutual understanding and to search for solutions.

Particularly good are positive reflections on the family as a whole and its individual members from an outside perspective, seen with eyes of friendly and attentive observers.

The process of discovering psychological resources, both from the individual and from the family, is included in the conception of *positum*, which has been described in previous chapters. This assumes that every person is good by nature and that to be able to realize their potential, they need optimal conditions. If some unfavorable circumstances have brought this process to a halt, it is the aim of the PPT to remove these obstacles and give the young patient an impulse to develop.

The Process of Modeling in Positive Psychotherapy in the Development Period

Many contemporary scientific works and clinical observations indicate the fundamental role of the therapeutic relationship in the process of treatment [6]. This sort of relationship creates a secure model of attachment for the child and gives space

for corrective experiences, which in turn enable the development of a more mature and integrated ego. PPT, while systematizing the knowledge gained from direct observation of interactions in the family and from the interview (see Chap. 2 for the model and Chap. 26 for the first interview), defines these basic capacities, which are necessary for the child for the fulfillment of further development, making them directly accessible in the relationship, all the time consciously modeling this process. Depending on concrete needs, it can be authenticity, acceptance, patience, hope, and others. However, you should not forget that in the majority of cases, individual contact of the therapist with the young patient is like the sourdough in the process of healing. After the therapeutic session is ended, the child returns to their environment of everyday life and is subject to its various influences. Because of this, positive psychotherapists seek allies in the closest milieu of their patients. Their active participation in therapy enables them to directly activate the desirable capacities in their clients through identification with the selected therapist's attributes, and on the other hand, the patients can develop new and more healthy attachment styles in contact with the therapist. This way a child may use new relationship patterns that are given to her/him by the therapist and the primary support group.

Therapeutic Contract

In PPT, the arrangements concerning the therapeutic contract are arranged with the child's caregivers in the presence of the child. The discussion encompasses the location of the sessions, their frequency, the anticipated duration of the therapy, assumed therapeutic goals, and the plan of therapy. Moreover, the therapist, depending on the child's age, should negotiate the range of activity in the therapeutic process of the parents and other family members. The younger the child, the more advisable the presence of adults in the sessions. In the case of adolescents, it is recommended to separate individual sessions from consultation sessions, in which the patient's caregivers, other family members, or the whole family take part. This division corresponds with the natural process of individuation and separation occurring at this stage of family development. Furthermore, it enables at the same time the young person's needs for autonomy and dependence to be respected. In such situations, issues of confidentiality are discussed, which include information shared in the individual therapy with an exception for circumstances that are life-threatening the patient or others.

Forms of Psychotherapy in the Development Period

In the PPT of children and adolescents, the following forms of therapy can be applied, both independently and simultaneously:

- Individual psychotherapy
- Group psychotherapy
- Family psychotherapy

Group and family psychotherapy are described in Chaps. 22 and 20; thus, we shall now concentrate exclusively on individual therapy in the presence of the child's caregiver or caregivers, or with family consultations taking place from time to time.

In both cases, the individual therapy is in the foreground and the presence of adults in the sessions serves the achievement of therapeutic goals.

Therapeutic Techniques in the Development Period

Working with a child or an adolescent within the framework of PPT requires flexible adjustment of therapeutic tools and techniques, depending on the age and developmental stage of the child. This encompasses the method of work using:

(a) Imagination
(b) Tales and stories in the development period
(c) Expression in the form of art therapy
(d) Games and sports
(e) Dolls and puppets, etc.

Examples of techniques **in the development period** of such work are included in the next chapter and in the case description.

Therapeutic Process While Approaching Children and Adolescents

Positive psychotherapy is originally a strategic activity and the process itself has been described by its author of five subsequent steps [10, 11]. Each of these stages constitutes a clear frame of reference for all parties engaged in mutual interactions and serves to monitor the progress of the therapy.

Five stages of positive psychotherapy consist of:

1. Observation and distancing
2. Making an inventory
3. Situational encouragement
4. Verbalization
5. Broadening of goals

Stage 1: Observation and Distancing

This initial phase of therapy is aimed at gathering basic diagnostic information, in the clinical and descriptive sense of the word, expressed in the language of the child and their family. The reported problem is discussed from various perspectives of each of the persons taking part in the consultation.

The differentiation of perspectives enables the problem to be redefined and positive reformulation to be used, e.g., "Maggy, because you are unable to go to the kindergarten due to your anxiety, mother and father together are thinking about the ways to outwit it." In other words, we try to give another meaning to the reported problem and put it in the context of family relations and events. In PPT, we concentrate on careful observation of the socio-dynamics of the family system. Thanks to this observation, one can better understand both explicit and implicit norms of the family's functioning, as well as its structure, hierarchy, and patterns of communication, e.g., consent to express negative emotions by the child or lack of such consent. When the family consultation with a small child takes place, it is possible to describe the problem from the child's perspective by means of a story. Children create the stories willingly if they are instructed in simple wording, e.g., "Johnny, tell us the story of a little animal whose parents went off on a journey and they were left home alone…". Another useful form of making contact with a child and encouraging them to name their worries would be using role-play, when the therapist plays with a child with puppets, e.g., "*this puppet is Mary, who nobody likes in the class. Mary has just come back home from school and she doesn't want to talk to anybody." She doesn't know that a surprise awaits her and she will be visited by Aunt Lucy, who loves Mary very much. And that is her (Lucy), Mary can you act as Aunt Lucy for now and ask Mary how is she today and what has happened at school?"*

To sum up, during the stage of observation and distancing, the task of the positive therapist is to formulate the initial diagnosis concerning conflicts being experienced by the child and to discover the function of presented symptoms in the context of family relations.

Stage 2: Making an Inventory

At this stage, the therapist pays attention to the child's previous ways of dealing with difficult experiences or symptoms identified as problematic. The child's social skills, the capacity to articulate and to have insight are evaluated, in addition to both the availability and the range of support offered by the adult. In this way, the child's psychological resources are identified, in addition to their limitations and appropriate skills that need to be developed.

Detailed narrations of the child and their family concerning the genesis and the development of the symptoms enable the therapist to recognize the sources and conditions of their exposure. At this stage of therapeutic work, techniques such as discovering the patient's *line of life* and the *four dimensions of modeling* are useful.

In the first of above-mentioned techniques, the task of the child is to illustrate their line of life by means of a colored piece of rope and

place on it selected objects such as shells, stones, etc. These objects represent important life events of a child and their family. Discussing these episodes one by one may give valuable information and at the same time help the therapist to reconstruct the emotional climate that accompanied them, such as when we found that the stuttering of a 13-year-old boy was connected with a threat he had heard from an old man who was wearing a hat. That threat was: "If you do not listen to your father, the devil will come to you at night." As it turned out, this boy had been suffering from nightmares for several months and started to stutter after his mother had told him he was becoming rebellious toward his parents. The object that was associated with the man with a hat was a toy trumpet and the impulse to recall and share this experience with a therapist was evoked by the therapist's request to play on the trumpet.

The second technique is called *four dimensions of modeling*. They become the point of reference for the child's self-image in addition to their image of a partnership relationship, social relations, the view of the world, and the future. Adequate self-esteem, trusting close ones, hope, having the sense of agency toward forthcoming events, and their sense of meaning remain in close connection to basic models of interpersonal relationships that were internalized by the child. They influence the child's coping style in problematic situations and their ability to use their social support. The diagnostic and therapeutic repertoire in this field is broad, starting from the drawing of the family tree and going through the use of boards with figures and hand puppets. Special attention is given to reading and interpreting with a child fairy tales, stories or other works taken from various cultures, in which analogy to the current situation of the young patient can be found.

The second stage of PPT of children and adolescents presented above is helpful for a better understanding of both family and social sources of difficulties experienced by a child. In addition, during this stage, the patient's actual capacities can be recognized, which serve as their resources, but may also lead to psychological conflicts.

Stage 3: Situational Encouragement

During previous stages of therapy, the reported problem and its function have been defined and the genesis of conflicts, together with the actual capabilities involved, have been discovered. Now it seems important to recognize and strengthen the psychological resources of the child and their family environment in the context of formulated needs and therapeutic goals. Thus, the attention is intentionally directed at those life events that have been the source of strength for the family members and the role of the positive psychotherapist is to moderate the family communication style so that the unconscious resources of the family are more easily available. This is facilitated through various activities performed during the sessions, and in the form of homework, e.g., *"Mark, could you please finish at home a story that starts like this: Jack was a very impatient boy and would often speak at the wrong time. This caused him a lot of trouble until he spent vacations with his grandfather who helped him to find out many new things about himself…"*. By analogy, children are often interested to hear a story with an unexpected change of plot, when the main character, seemingly at a dead end, suddenly discovers new talents in himself or recognizes admirable qualities in other people.

If it turns out that it is the parents or the whole family that require therapy (marital conflicts, domestic violence prevention, addiction treatment, etc.), such a recommendation must be clearly expressed at this stage and their realization becomes decisive for the therapist's decision regarding individual therapy in a child. An extended and often suggested form of treatment might be group psychotherapy carried out in a peer group, in addition to socio-therapeutic activities.

Summing up, it must be pointed out that at this stage of therapy both the patient and the whole family system are being prepared to accept permanent psychological change, which often requires personal engagement, determination, and courage.

Stage 4: Verbalization

Revision of therapeutic goals in the context of the child's individual needs and the whole family

system takes place during the stage of verbalization. Such goals are accomplished both in the sessions and in the social context of life. As was previously mentioned, the older the child, the more probable it is that family consultations are separated from the individual therapy sessions. Then it is of particular importance for the family to support the contracted goals of the individual therapy and respect the needs of autonomy and privacy of the adolescent. It should also be stressed that the family system is an important source of support, not only for the child but for the positive therapist as well.

The patient's self-knowledge, enriched at this stage, helps to discover the nature of individual conflicts and opening oneself up to new experiences, facilitating psychological development. Interventions of the therapist enable the excessively rigid beliefs to be relativized and help to change the child's tenacious patterns of reaction. In PPT, the process of discovering what internal and interpersonal conflicts contain is called differentiation analysis. Because of this analysis, it becomes more understandable to the child that, for example, the need for love and acceptance she or he solely satisfies through obedience toward the parents comes at the cost of not completely fulfilling their own desires. In other situations, the child can realize that to advocate the implicit family norms, she or he concentrates excessively on the need for achievement, which takes the form of obsessive behaviors. In other examples, the adolescent's need to experiment with drugs or alcohol turns out to be their only way of inducing their parents to openly talk about closeness or intimacy in their mutual relationships. Identifying the key elements of internal conflicts and contradictory values, attitudes, and tendencies that are connected with them makes it possible to externalize them, better understand the nature of their dynamics, and finally work out their positive resolution.

Case Example

One of my patients started therapy at the age of 14 because of his self-injuries. His autoaggressive behaviors evoked a lot of tension in himself, his family, and in his school environment. After some time, during one of the sessions, he realized that for many years he felt unfairly treated by his parents and grandparents, who in the boy's opinion preferred his two older siblings. When the patient was separated from his best friend who had moved with his family to another country, he started to injure himself with a sharp instrument. His parents were concerned about this and tried to establish some contact with him, but his deep-rooted grudging feeling made it very difficult for them. On the one hand, he longed for their appreciation and emotional support, but on the other hand, he was unable to take it. As he was unable to tolerate the tension evoked by this situation, he resorted to acts of self-harm.

When the patient discovered during the therapy that his desire for love was in opposition to his sense of justice, then he could better recognize his denied needs and finally expose them. He invented "Mr. Justice," whom he employed as his advocate to restore equity at home. During the session, he imagined how "Mr. Justice" would convince the family members to eventually recompense him for his long-lasting sense of grievance. Another character, who was the patient's deceased grandmother appeared in a session. She supported his parents and helped her grandson to realize that there are many languages of love and ways of showing it. This continued in the family consultation, when once more the patient's grandmother was recalled and she became recognized as a good spirit of the family, particularly attentive to the patient's needs. After this session, his self-inflicted aggression stopped.

To recapitulate, during the stage of verbalization, the unconscious and contradictory feelings, desires, thoughts, values, and motives are eventually named and are manifested through symptoms or dysfunctional behaviors. During the previous stages of therapy, the aim was to recognize the context in which they had been developed and their genesis, in addition to the initial analysis of their content. Currently, deepened differential analysis leads to their externalization. Under the conditions of the safe therapeutic environment, it becomes possible to experience an insight, reveal suppressed emotions, and undertake behavioral

experiments outside the sessions. The child, eventually strengthened by the therapist and their family, finds their way to positive resolution of their conflicts and acquires a healthy lifestyle.

Stage 5: Broadening of Goals

Broadening of the goals is the last phase of therapy. During this stage, the summing up of the individual changes that have occurred in the patient and their family environment up to now takes place. Once more those skills and resources are named that have proven helpful for the child and appear to be for him or her an object of identification in the future. Therapeutic effects are strengthened by techniques using imagination, e.g., "*John, if you travelled in the near future with your time machine, tell me which of your abilities would you take with you. To each of them you can assign one of the objects you find in the box next to you. Tell me exactly why you take this and not the other object and what it means to you. Tell me also under which circumstances do you think each of your skills may be particularly useful.*"

During that final stage, what also appears to be useful is to define together with the child potential difficulties and unwanted events, in addition to strategies that can be developed to maintain the sense of efficacy. The patient's family members should be included in that process to enhance their ability to consciously sustain previously achieved psychological changes in the system. A case example with diagnosis and therapeutic interventions is shown in Fig. 16.1.

Case Example with Diagnosis and Therapeutic Interventions

Circumstances Under Which the Therapy Started

A mother with her 12-year-old son came to a therapy session. The general practitioner that directed her noted in the referral that for several months the boy had been suffering from gastroesophageal reflux disease (GERD) and the standard treatment was applied, but there was no improvement in the boy's state of health.

Stressors (Actual Conflict)

In the interview, the mother confessed that the psychosomatic symptoms of her son are probably related to the incident that took place during the school dance a year before. At the time, the boy dedicated to his homeroom teacher a piece of

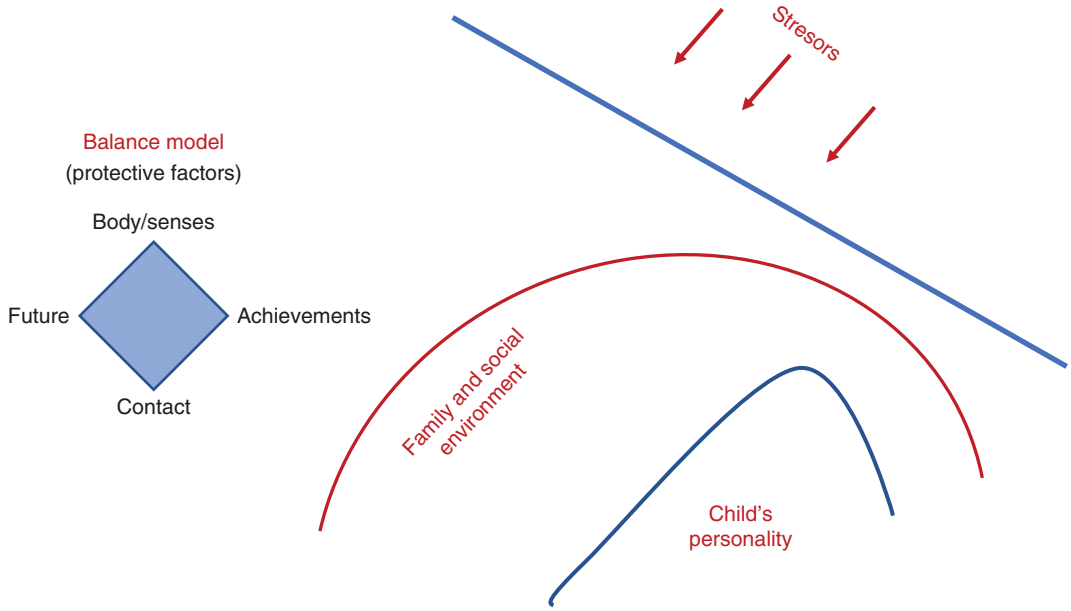

Fig. 16.1 Model of therapeutic diagnosis and intervention

music from the charts, in its original English version. It turned out that the song contained obscene words. The teacher took the behavior of her student as an act of hooliganism. She started to discipline him in front of the class and deprive him of previous privileges (class president, top of his class). The boy consistently refused to talk about the motives for his behavior at the school dance and subsequently avoided going to school. Interventions of the mother with the school partially improved the situation.

Family Context (Basic Conflict)

The young man had grown up in a single-parent family. The patient's father had left his mother for another woman when he was 6 years old. The father remarried a year after and had a new family. The boy met up with his father regularly, but wasn't keen to share with his mother what he was experiencing during those meetings.

In the situation of the breakdown of the family, the patient tried to maintain a good image of both the mother and the father, struggling with a conflict of loyalties. He was brought up with respect for the authorities and a sense of politeness, at the same time he suffered from the injustice that he had experienced in his early childhood. He gained his parents' recognition and appreciation with ambition, diligence in school, and being responsible.

Personality Traits of the Boy Enhancing Development of GERD

- Excessive tendency to suppress and control emotions for fear of rejection of his environment
- Tendency to experience strong emotions such as anger or irritation
- High level of anxiety

Child's Resources

- Ambitious, conscientious, independent, resourceful, responsible

Internal Conflict

The boy was accustomed to showing respect to adults whom he was attached to and he never questioned their decisions. During the memorable school dance, he dedicated his favorite piece of music to his homeroom teacher, not fully understanding the content of the original version of the song. The reaction of his teacher surprised him and evoked a sense of injustice. For fear or rejection and loss of relation that was important to him, he was unable to consciously experience or openly express his grudge. Confronted with his teacher's disapproval, he tried to earn her appreciation with even more diligence in studying and distinguishing oneself with politeness. This strategy was not helpful in the resolution of his internal conflict. He suppressed negative feelings, which resulted in the development of GERD.

Balance Model

- Body—physical symptoms indicate the existence of internal conflict, but the patient is incapable of interpreting them
- Achievements—the boy is trying to resolve the conflict by fulfilling his school obligations even more conscientiously, but that is not evoking the appreciation of his homeroom teacher
- Contact—on the one hand the boy is afraid of losing the relationship with his favorite teacher, but on the other hand, he does not use social support, struggling to resolve his conflict on his own
- Future—the boy's experiences are dominated by a sense of injustice and the lack of hope of regaining it

Interventions Applied and Therapeutic Change

Identifying stressors and discovering the boy's personality traits (his resources and limitations), in addition to the broader family context, enabled the therapist to define the nature of the patient's conflicts and plan therapeutic actions. Therapeutic interventions aimed at the development of those capabilities of the patient that would bring balance to his life (four dimensions of life model) and in this way initiate psychological change and strengthen his mental resilience.

During the first stage of therapy, the boy became aware of his suppressed emotions (grudge, anger, loneliness) and was provided with tools (role-play, change of roles, externalization of emotions) to express them more openly. During the next stage, he named the strategies that he applied in situations of growing psychological tension, which only exacerbated his problem (being diligent, hardworking, polite, and only apparently independent). After that, he was confronted with the choice of new and more useful strategies, in the context of the balance model. These assumed greater body awareness (dialogs with the stomach and reading the signals sent by the body), in addition to turning to adults for help (assertiveness training). During trials of adopting new behaviors, his internal conflicts concerning the loyalty and politeness to adults and the related disappointment became more intensive. The boy gradually became engaged in the role-play with his parents, his homeroom teacher, and his peers. Then his realized how much he feared rejection and loneliness. At this difficult moment, the therapeutic relationship became particularly important. At this stage, the boy revealed a strong need to tell imaginary stories about children who were forced to take care of adults. But the next sessions involving his mother helped him to confront his fears and once again to be found in the role of a child who can feel dependent on his parents. Planned interventions of the mother at school and discussions with the teacher and the boy's father helped him to restore the sense of justice. At that time, psychosomatic symptoms that initiated when starting a therapy gradually disappeared.

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