A Typology of Psychopathology and Treatment of Children and Adolescents

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Abstract

The purpose of this article is to present an overall transactional analysis model of psychopathology in children and adolescents and a framework for rapid treatment planning. A number of authors have presented a variety of transactional analysis treatment methods, but these techniques have not really been synthesized into a larger, encompassing framework. It is the aim of this article to do so.

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At age 3, Marie did not differentiate between people. She called no one by name and went to everyone indiscriminately. When thwarted, she went into rages that lasted for hours. During these periods she destroyed homes and injured herself and adults, hitting, kicking, punching, pulling hair, and urinating on people.

Her three-year life history was tragic. After removal from her schizophrenic mother's home because of neglect and abuse, she had been ejected from nine different foster homes, leaving a series of foster mothers partially bald. In some of these homes she had been sexually abused.

In the first year of inpatient and day-treatment therapy, she went through a number of stages. She began to distinguish one person from the others and then to call him by name. A little later, she started to carry around his photograph. This seemed to give her some comfort when he was not present. When she had a temper tantrum, however, she would threaten to tear it up. Gradually, she began actively to try to please him and two others, including her foster mother at the time. She asked us to send notes home to the latter when she behaved well for even part of a day. Then, she began to talk of absent people as nurturant and began to be helpful to other children. Three months later, she tried to get her foster mother to "get rid of this bad little girl" by raging almost constantly for two days, but the foster mother held firm. With each new stage, the intensity and frequency of her aggressive, destructive behaviors lessened.

As we interpreted this sequence, using the three ego states model, we believed we were witnessing the internalization of nurturant parenting figures, that is the development of a Nurturant Parent, the strengthening of her Adult, and the gradual development of Natural and healthier Adapted Child ego states. This process took over a year. Periodically she externalized internal conflicts between these ego states. Finally, she made an important redecision: that she could be loved and was lovable.

It is the aim of this article to delineate these processes more fully and to present a transactional analysis typology of child and adolescent psychopathologies and their treatment.

Child and Adolescent Psychopathology: A Typology

For heuristic purposes, the psychopathologies of childhood and adolescence can be subdivided into six basic types, although the different types may occur together. Each requires its own specific therapeutic interventions. These six types are:

1. lack of fit between a particular child and the environment
   a. problems in the child's environment
   b. special needs and sensitivities of the child
2. abnormalities in the formation of ego states
3. conflicts between ego states
4. conflicts within individual ego states

5. externalization of internal conflict
6. script (narrative) problems
   a. pathogenic decision
   b. other abnormalities in script formation and maintenance
      1) problems associated with severe stressors
      2) lack of or distortions in usual socialization experiences
      3) narrative modifications

These six classes of psychopathology will now be discussed separately.

Lack of Fit Between Child and Environment

Children come into the world with different sensitivities, needs, and temperaments. Some would probably do well with almost any parents, and some, because of special sensitivities and temperamental characteristics, would be a problem for almost any. Luckily, most parents can adapt to a wide range of different children. What is important is how well a particular child fits with his or her particular family. When they mesh well, the child is welcomed and validated; he or she develops a sense of security and trust and a sense of competence in influencing his or her world.

Unfortunately, this does not always happen. A particular child may get too much (for him or her) of something, not enough, or it may come at the wrong time. (Allen & Allen, 1979). He or she may get what would be appropriate for a different child, especially a child of a different age or temperament, but it does not fit for him or her. Often, this lack of fit is experienced as a lack of permission (Allen et al., 1996)—or so it can be conceptualized.

It is useful to break these problems down into two major types: in one group the major difficulty is in the environment; in the other, the major difficulty is in the child. Of course, there are often problems in both.

Problems in the child's environment. An only son of his widowed mother may need to be freed from being his mother's confidant and "the little man of the house." Then he may need actively to be discouraged when he attempts to reassume the role and encouraged to develop more appropriate interests. This may entail a sense of loss for both him and his mother. Such a therapeutic process can be conceptualized as reestablishing appropriate boundaries and a more appropriate power hierarchy in the family or as reducing the strength of injunctions—such as Don't Be You, Don't Be A Child, and/or Don't Belong To Your Peer Group—and as giving permission for other behaviors.

"Born thief," "congenital liar," and other such descriptions may serve as a guidebook for a child as to what is expected of him or her. Double but contradictory descriptions such as "pretty but dumb" often represent the differing views of two important people, such as mother and father or mother and grandmother. Often such appellations result from a lack of understanding of normal development. For example, a child cannot really be considered to be stealing until he or she understands the difference between what is his or hers and what is not. A child cannot lie until he or she understands what is real and what is fantasy. Most two year olds are oppositional: It is a manifestation of a growing sense of identity and autonomy and the troublesome realization that they are not the center of the universe. It makes a great difference, however, whether the parents see this oppositional behavior as a necessary developmental stage or as evidence of pathology or willfulness. In the former case, they are more likely to give the child permission to be himself or herself, to experience his or her own feelings, to think his or her own thoughts, and to be close, yet separate. In the latter, they likely will see only sickness or badness.

Sometimes a child is actively trained to be the kind of person his or her parent's Child finds exciting or familiar. Bill, for example, was actively rewarded when he behaved aggressively. His mother's obvious excitement and laughter manifested the delight of her Child. In reality, Bill resembled both his father, who was in prison for murder, and Bill's mother's own abusive father.

Special needs and sensitivities of the child. Some children are born with perceptual, attentional, cognitive, or motor problems secondary to neurophysiologic dysfunctions

(Greenspan, 1989). Jesse, for example, was the cause of much parental distress by the time he was a month old. He found light touch painful. When his parents recognized this and began to carry him on a pillow, his screaming, which had seemed endless, abated.

Pete, age one month, cried whenever held by his mother or grandfather but not when held by his father or the father's mother. This was the cause of considerable maternal self-recrimination and potential marital tension—until it was noticed that when the father and grandmother held him, Pete was able to look over their shoulders and see the world, but when his mother and grandfather held him his view was blocked by their shoulders—and Pete objected. This problem was easily corrected by holding Pete six inches higher. Uncorrected, it could have led to a series of secondary psychological difficulties.

Early in life, both these groups of problems respond to changes in the environment, that is, to environmental manipulation (Allen & Allen, 1979). The parent does something differently and the child changes. Consequently, parental coaching and education are very effective. Unfortunately, sometimes even at an early stage, simple environmental manipulation does not work because the child's deficits cannot fully be remediated. In other cases, someone may need the child to be ill. In these circumstances the only effective environmental manipulation is the treatment of the parent or family—if the child is to remain with them.

Sara and her mother are an example of this. Five-year-old Sara's mother was convinced Sara suffered from infantile autism. A scientist, Sara's mother kept a meticulous log of all of Sara's symptoms, even videotaping what she considered rituals and stereopathies. These videotapes actually showed a normal child: Sara's reported pathology was largely due to her mother's idiosyncratic interpretations of the child's behavior and her taking Sara's behaviors out of context. The mother was not at all happy with this good news and continued to devote several hours a day to exploring the biology of autism. Her one source of comfort was a user's group of parents of autistic children, which she had discovered on the Internet.

In reality, Sara's mother was fearful that she herself and the child's father had serious autistic characteristics. She had left her job as a researcher when she became pregnant, and because of the nature of her field, it was unlikely she would ever be able to return to it. Becoming the mother of an autistic child allowed her to deal with her own fears about herself and her husband. It also provided a new identity and a new career.

Unremediated, problems that arise out of the lack of fit between a child and his or her environment lead to deficits in ego state development or become internalized and manifest as interstructural or intrastructural conflict or pathogenic script decisions.

Deficits in Ego State Development

When first hospitalized at age three, Marie (described at the beginning of this article) seemed to distinguish no one and had no apparent desire to please anyone. In time she developed some kind of internal models based on the nurturant ward staff; that is, she developed some Nurturing Parent ego states and corresponding Adapted Child ego states. Only then did she begin to want to please anyone—and to change her wild, unregulated behavior.

In a young child, the forces of normal growth and development favor the processes of internalization and ego state development. This is enhanced if the child lives in a "good enough" nurturant, supportive environment. As a person grows older, however, this seems more difficult, although it still can be done, as Muriel James's (1974) work on self-reparenting shows. People can do a great deal through Adult decision and clear planning. Just being in an appropriate environment, people, and especially children and adolescents, have new experiences and can develop new internal models of the themselves and others. That is, they develop new Child and Parent ego states. Despite its name, "reparenting"—as it relates to much of the work of Schiff et al. (1975)—might better be considered "childing." This was basically the work done with Marie.

Conflicts Between Ego States (Interstructural Conflicts)

At the culmination of much severe internal self-harassment from his very punitive Critical Parent, eight-year-old Peter set his gasoline soaked arm on fire. His sadistic, physically abusive father had recently moved out of the house, ostensibly because of the children's "bad behavior" and his wife's inability to control it. Peter's self-immolation was a way of giving himself the punishment his Critical Parent said he deserved. It was a peace offering both to his Critical Parent and to its origin, his real-life father.

Conflict between ego states is usually between Parent and Child ego states, as Peter illustrated. Goulding and Goulding (1976) labeled this a Type I impasse, and Perls (1969) called it the "topdog—underdog impasse." It is the typical neurotic conflict.

The goal of treatment for this problem is some sort of resolution between the ego states. Often this involves reducing the punitive nature of the Critical Parent or helping the child develop more Nurturing Parent ego states and protection of Child ego states. This can be done in a number of ways: modeling; permission-giving transactions; active discussion with the child's Adult; and playing out of themes using art, puppets, and toys or in storytelling between the therapist and the child. Not infrequently the child actually puts the Critical Parent or its manifestation in some sort of jail until it can be reformed and transformed. The therapist needs to be experienced by the child as protective, as capable of standing up against the Critical Parent, and as strong enough to create an atmosphere of safety.

Conflicts Between Different Aspects of One Ego State (Intrastructural Conflicts)

Peter was able to describe another type of conflict, this one between "good Peter" and "bad Peter." It was "bad Peter" he had punished. He was able to dialogue between the two parts of himself using puppets and toys, to support and nurture "good Peter," and to forgive the "bad Peter," whom he finally decided was not really all that bad. He locked up the angry father (projected Critical Parent) in a toy jail.

Joanne, at 14, was able clearly to distinguish between a part of herself that wanted to be dead (Adapted Child) and a part that did not (Natural Child) and between one Parent ego state that said she should die and another that said she should live because suicide would bring shame on the family. She was able to do traditional two-chair work between Adapted and Natural Child ego states, between different Parent ego states, and between Parent and Child ego states. It became evident that the part that wanted her dead was an internalization of her mother (P_1), who actually had tried to abort Joanne during pregnancy.

Externalized Conflicts

Any of us can project an internal conflict onto the environment and fight it there. This is what happens in play—with puppets, dolls, or art. However, it also occurs in the real world. When it occurs there, it may easily be confused with a lack of fit between the child or adolescent and his or her environment.

Marie raged for a whole weekend, tearing down drapes, pulling out large chunks of her foster mother's hair, and destroying the home. "You want to get rid of this bad little girl," she screamed over and over. The foster mother held firm, with only a few hours sleep during 48 hours, resolutely repeating, "You cannot leave. This is your home and your family now and you have to stay here no matter what you do." This prolonged turmoil was, in part, the externalization of the internal conflict between Marie's Critical Parent and a much earlier rejecting mother (P_1) and Adapted Child.

It is important for the therapist to distinguish projected conflict from a lack of fit between child and environment. Many children are moved from home to home or school to school only for the same problem to emerge in the new setting. Geographic moves work only when there is a true lack of fit between the child and the environment. They will not cure an externalized conflict.

Script Problems

Pathogenic script decisions. When our son, Michael, was in kindergarten, it was quite apparent he could read. However, he adamantly insisted he could not. One day while driving to school he told us that he had decided that since we were old(er) parents, we might soon die and leave him, but if he did not grow up (learn to read) he could keep this from happening. With assurance, protection, and new information, he could decide it was safe to let people know he could read—all this in an apparently casual conversation during the ride to school!

As in work with adults, a child needs help to look at his or her decision, then to be given new information or a new emotional experience as well as permission and protection so that he or she can make some new decision. This can be done formally using art, puppets, dolls, or sometimes, as in Michael's case, quite casually in conversation. Adolescents can usually do more formal chair work.

After some debate about whether they were true, Marie came to accept her foster mother's statements. With the ongoing provision of safety and protection, she was able to decide she was lovable and worthy of love. With this redecision, there was a major improvement in her behavior.

Redecision work with adults has traditionally been divided into three stages: (1) contract, (2) reliving of a key scene, and (3) a Child redecision. In working with children and adolescents, however, we have found it useful to use Prochaska and DiClemente's (Prochaska, Norcross, & DiClemente, 1994) work on readiness for change. Modifying their work, we (Allen & Allen, 1997) suggest seven stages. Not infrequently, children and adolescents and their parents are at very different stages at any given time. Unlike in work with adults, we may not always make these stages explicit.

1. *Precontemplation.* People in this stage are unaware of any need for change. Most children are at this stage when their parents bring them in for treatment. Being in a group and listening to others helps adults move from this state to the state of redecision.

2. *Contemplation.* At this stage people are aware that they have a problem, but they have not yet decided to do anything about it. They may be helped by encouraging them to look explicitly at the pros and cons of their behavior and its effects and the pros and cons of change.

3. *Preparation.* At this point, people intend to take some action in the near future—but not just yet. This stage ends with a specific therapeutic contract, something that children often do not do explicitly.

4. *Redecision.* This involves reliving a key scene, the introduction of some new information or feeling, and a Child redecision. This needs to be done in an atmosphere of permission and protection.

5. *Action.* At this point people modify their behavior and do something new. Planning new behaviors and arranging reinforcements (strokes) (Allen & Allen, 1989) are important therapeutic steps. For children and younger adolescents, adults usually have to arrange this.

6. *Maintenance.* This stage is marked by consolidating gains and working to prevent relapse—again work usually done by the adults for children and younger adolescents.

7. *Termination.* Finally, the new behaviors are integrated into the person's daily life and no longer require constant attention.

Other abnormalities in script (narrative) formation and maintenance.

1. *Script problems associated with severe stressors.* Berne (1972) described the problem of the open-ended script, which refers to when people have outlived their original script plan. Superficially similar problems can be found in children and adolescents (and adults) who have suffered severe trauma or who have been deprived of socializing experiences.

For example, Joe, age 9, was left emotionally numb after a fire that killed most of his family. He had nightmares, repeatedly set fires, and had other symptoms of post-traumatic stress disorder. As a part of this picture he had a foreshortened sense of the future. Indeed, he did not expect to live until he was ten. He had no plans or hopes for the future and could not even consider the possibility of having any.

Recent studies (Yehuda & McFarlane, 1995) suggest that there is a physiological basis—at least in part—for such problems. The surge of hormones at the time of a severe stressor, especially adrenal hormones, may actually destroy part of the hippocampus, a part of the brain involved in memory. It is often difficult for people suffering from such traumatic experiences to deal with resulting problems because even minimal cues that remind them of it precipitate sudden uncomfortable physiological changes. These interfere with attention, problem solving, and processing the trauma. In fact, one of the symptoms of the disorder is avoidance. This makes it difficult to integrate the trauma into one's life and to develop a life plan. Who knows how many aimless inner city youth fit into this category. For them, the ephemeral excitement of drugs or gang behavior may offer what little comfort and direction they have.

In work with preschool survivors of the Oklahoma City bombing, it became apparent that putting together a book of photos of their lives and their friends before and after the bomb has been useful in helping them "get things together." Some stopped their repetitive play and nightmares after a reunion with other survivors at McDonalds or at a Barney concert. Returning to an orderly, predictable routine in an atmosphere of safety seemed especially beneficial in recreating a sense of continued and continuing life.

2. *Lack of or distortion in usual socialization experiences.* Martin, age 22, began using drugs heavily when he was about eleven. Shortly after, he dropped out of school. His father left money for Martin on the kitchen counter every day but made no effort to control him or keep him in school. Indeed, he was grateful not to have him at home exerting a bad influence on his younger brother. By age 16 Martin had joined a cult in which he lived for five years, cut off from most of the usual experiences of adolescence. At age 22 he left the cult but had no idea who he was or how to live without the cult's rules, supports, and restrictive but predictable expectations.

We can conceptualize Joe and Martin as having problems both in ego state development and in script formation and maintenance quite apart from any specific pathogenic script decisions they may have made. People who have been in cults have the compounded problems of having to learn all the skills they did not learn while dealing with the sudden loss of time—identity—and cognitive structuring, as well as the loss of the social and financial support the cult offered. Usually, they also fear retribution.

3. *Narrative modification.* In 1995 Williams reported on a group of women who, as children, had been brought to hospital emergency rooms because they had been abused sexually. As adults they reported the event but said it had occurred to a sister, cousin, or some other person. It seems that the frontal lobes are important for establishing the temporal and spatial context of memories, and it appears that they do not attain their full adult state until the twenties or thirties. Consequently, for physiologic reasons, the life story some young victims elaborate may be quite different from what actually happened.

Not all narrative modifications are this dramatic, however. In telling our stories or (in the case of children) hearing our stories told by others, we consolidate our memories and our identities—and also change them. A story does not tell everything that happened. Some events are highlighted while others are neglected, and in the telling, the story may be modified.

John, age 9, was convinced he was a total failure. His mother died shortly after his birth, and his father left, leaving John with his grandparents. He had no friends. He wore braces and therefore believed he "looked stupid." Having been removed from his mathematics class because of his poor performance, he obviously was "stupid."

All these "facts" were correct—as far as they went. However, they did not tell the whole story. His mother had died shortly after his birth—but in a car accident. Only recently had his father left—not because he was deserting John, but to work temporarily in Alaska so he could earn enough money to make a down

payment on their own home. John had few friends because in moving in with his grandparents he had moved to a new neighborhood and had only been there a few weeks. The move also caused him mistakenly to be placed in a mathematics class for which he did not have the prerequisites. From the same events, a very different story could emerge.

Complex Pictures

In real life, many children and adolescents present with a mixture of these six classes of problems. Not every child needs redecision therapy or environmental change, as we hope is abundantly clear. Each level of problem must be treated in its own right, and some need interventions at several levels. Here are some typical examples of more complex situations.

Paul: Age 17, Paul was severely depressed. He was receiving Cs and Ds in school, even though his parents devoted five or six hours a night to helping him with homework. He had no time for social activities or friends. His thinking was slowed, and he awakened early, about 3 a.m. He felt stupid, worthless, and helpless. He took some comfort in eating even when not hungry and was 100 pounds overweight. He thought seriously of suicide and had secreted a revolver.

First, a no-suicide contract was obtained and the gun removed. This was clear permission to be. Then work was done on the conflict between the part of him that wanted to be dead and a part that wanted to stay alive (intrastructural conflict). He decided to live.

It was discovered that he had major deficits in auditory processing and auditory memory. These problems made it difficult for him to understand and remember what his teachers said. He also had major problems in visual-motor coordination. This resulted in his being unable to catch or bat a ball—problems that led to his being rejected by peers when he was younger. No one wanted him on their team, and the other boys called him "faggot." As a result, he withdrew and missed both socializing experiences and peer support.

An antidepressant relieved some of the vegetative signs of depression such as his early morning awakening and psychomotor retardation. Physical, occupational, and educational therapy were helpful in his coming to understand his visual-motor coordination problems—and that he was not just "stupid"—and in his learning better to deal with his deficits. He learned to audiotape lectures, and a special device was found that allowed him to comprehend better what he heard. Despite his poor fine-motor coordination he could run, swim, and lift weights. In these activities, he made some peer friends. (These are all environmental manipulations.)

With new Adult information, Paul was able to interrupt his internal Critical Parent self-harassment that he was stupid, incompetent, and ugly (interruption of Parent-Child interstructural conflict).

With new information and these new experiences, Paul could make some new decisions. He was able to go back to early scenes in which he had decided he was stupid and worthless and to rework them. He then went on a diet and began an exercise program.

In summary, Paul's treatment involved environmental manipulation (gun removal, audiotaping lectures, audio device, occupational and educational interventions, medication, and developing a social support system). It also involved resolution of an impasse (Critical Parent-Adapted Child interstructural conflict) and two redecisions. The first and most important of these was the redecision to live, which he could make after work between the part of him that wanted to live (Natural Child) and the part that wanted to die (Adapted Child). This involved the resolution of an intrastructural conflict. The second redecision was that he was not stupid and worthless and that he could do more than live in the sense of breathe and occupy space. He was entitled to live with some zest!

Success fed on itself. A year later Paul had lost about 100 pounds, and a few months later he placed well in a state teen body-building contest. His grades had improved—with less work. With more time and a better self-image he found a girlfriend. His parents, relieved of having to spend several hours a night on his

homework, found new interest in each other and their own lives.

Conroy, age 18, handcuffed himself to his bed every night so that he would not be able to get up and kill his parents in his sleep. He was convinced he was "crazy" at the least and possibly "Satan-possessed."

Conroy had been a model son and student, winning a prestigious scholarship to study in Europe. There he had become progressively more disturbed. He complained that something was wrong with his thinking and that he could not remember. He also developed panic attacks. He was tortured with bizarre, wild dreams, often of killing his parents. At times he did not know who he was or where he was. His mother rescued him, bringing him home to a series of psychiatric hospitalizations and depressing diagnoses.

It gradually became apparent that he was worse in certain enclosed environments. One night he went to a local movie theater that was then popular with adolescents. In addition to a light show, it had a smoke machine in the lobby. He became so disoriented he could not find his way home. He lost the girl he was with and ran his car over the median of a freeway, narrowly avoiding being killed.

Conroy had special sensitivity to certain hydrocarbons. If he avoided them his thinking was clear and easier and his memory better. The wild dreams abated and he no longer became disoriented in space and time. When he was not able to avoid such exposure, he developed signs of organicity: disorientation in time and place and, at times, even in person, as well as problems in immediate and recent memory and thinking and disturbing nightmares.

With this new information, Conroy could make new decisions: namely, that he was not "crazy" and not "the son of Satan." He learned to avoid exposure to certain chemicals. Indeed, he improved so much that he graduated magna cum laude from college and was a runner-up for a prestigious international scholarship.

Summary

It is possible to break down psychopathology in children and adolescents into six basic categories. With some modifications, this classification can also be used in work with adults. It allows for rapid assessment and rational treatment planning. People need not sit down before a full banquet when they need and can use only the salad—an important consideration in the United States in this era of managed health care with its fiscal restrictions and forced treatment justifications.

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