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## Accentuate the Positive: Strengths-Based Therapy for Adolescents

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### Abstract

**Purpose:** The field of psychiatry has conventionally employed a medical model in which mental health disorders are diagnosed and treated. However, the evidence is amassing that using a strengths-based approach that promotes wellness by engaging the patient's assets and interests may work in synergy with the medical model to promote recovery. This harmonizes with the patient-centered care model that has been promoted by the Institute of Medicine.

**Methods:** The article uses a clinical case to highlight the attributes of a strength-based model in the psychiatric treatment of adolescents.

**Results:** Outcome metrics from a number of studies have demonstrated enhanced youth and parent satisfaction and decreased use of hospital level of care with the implementation of strengths-based therapeutic modalities.

**Implications:** Incorporating strengths-based interventions into conventional psychiatric practice provides a multi-faceted treatment approach that promotes recovery in children and adolescents with psychiatric disorders.

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#### CONFLICT OF INTEREST

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## Keywords

Strengths-based; adolescent psychiatry; positive psychology; patient-centered care; health promotion

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## 1. CASE

Zoe is an 18-year-old college freshman who presents to your clinic. Zoe describes excessive worry about a variety of life challenges. She becomes easily overwhelmed by her academic performance and social situations. In the face of perceived failure or criticism, Zoe frequently resorts to cutting her forearm with a razor for emotional relief. She begins to panic and worry whenever she walks into a lecture. Zoe calls home to cry every night and eventually decides to move out of the dormitory and move back home with her parents, where she is able to commute to college. Despite moving home, her anxiety symptoms persist and her grades continue to fall as she cannot focus in class. Eventually, Zoe requests medical leave from college for a year.

Prior to college, Zoe excelled in environments with structure and clear expectations. She was bright, goal-oriented and organized. Zoe was one of the popular girls in high school, with many friends, but she was vulnerable to sadness and anxiety when facing separation and transitions. In the 6<sup>th</sup> grade, Zoe's best friend left town to attend a different middle school. Losing her friend while transitioning into puberty was difficult. Zoe experienced crying spells, had little interest in her favorite activities and did not feel like making new friends or hanging out with siblings. Zoe did not know how to explain her situation to family and friends, and began to avoid going to school entirely. Her mother initially arranged home-bound tutors, but later decided to quit her full-time job to focus her full attention on Zoe's homeschooling. Gradually, Zoe began to see and spend more time with friends and eventually slowly transitioned back to public school.

In high school, Zoe performed extremely well while juggling school work, extracurricular activities, and part-time jobs. Zoe's volleyball coach was particularly impressed by her leadership and dedication to the team. With a competitive SAT score and high school volleyball championship in her resume, she received a full-ride volleyball scholarship offered by an out-of-state university. Before the semester started, Zoe's mother began to voice her concerns that Zoe would not be able to adjust or thrive being so far from home. This led to a strained mother-daughter relationship. Eventually, Zoe agreed with her mother, declined the scholarship, and chose to attend a college near home.

## 2. DISCUSSION

Using a conventional medical treatment model, we would start with a diagnostic formulation based on symptom presentation. Zoe met the criteria for major depressive disorder in middle school and evolving generalized and social anxiety disorder in the context of separation and

transition to college. The treatments of choice may include a selective serotonin reuptake inhibitor (SSRI) with or without psychotherapy. Cognitive behavioral therapy (CBT), which would be clinically indicated in Zoe's case, would focus on improving Zoe's mood and anxiety by addressing cognitive distortions and problematic behaviors. Zoe's recovery, as reflected by a reduction in psychiatric symptoms, may be tracked by commonly used assessment scales, such as the Beck Depression Inventory (BDI) and Hamilton Anxiety Rating Scale (HAM-A).

The conventional medical model in psychiatry arose with pharmacological discovery and the introduction of DSM-III in the 1980s. In contrast to psychoanalytical theories, the medical approach emphasizes a systematic process of gathering data, identifying symptoms, creating a differential diagnosis and a working diagnostic formulation based on Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 2013) criteria, and then implementing treatment modalities that target the disorders and/or symptoms (Mayes & Horwitz, 2005). The treatment usually utilizes the clinician's clinical acumen and expertise and external treatment resources. However, some have suggested that medicalization of the field has diminished the conceptual richness of the inner life of patients, including aspirations, ego strengths, and complex family dynamics (Sedler, 2016). The conventional medical model often focuses on rectifying deficits and challenges and does not always consider the child's existing strengths and abilities or environmental resources that may be leveraged towards treatment progress.

In the 1990s, Martin Seligman, then president of the American Psychological Association, advocated for the shift within the field of psychology to "positive psychology," emphasizing human strengths, virtues and well-being (Rettew, 2019; Seligman, Steen, Park, & Peterson, 2005). Subsequently, the term "positive psychiatry" was coined by Dr. Dilip Jeste in 2012 when he was the President of the American Psychiatric Association. Positive psychiatry is defined as "the science and practice of psychiatry that seeks to understand and promote well-being through assessments and interventions aimed at enhancing positive psychosocial factors among people who have or are at high risk for developing mental and physical illness" (Boxorgnia, 2018).

Donald O. Clifton, known as "the father of strengths-based therapy," (Buckingham & Clifton, 2001) proposed that individuals can achieve far more when efforts are spent on reinforcing their greatest strengths, rather than on highlighting their weaknesses. Helping adolescents understand and utilize their strengths can assist in building hope and confidence about their ability to overcome challenges. How can we utilize this approach to enhance Zoe's treatment, to inspire her own sense of agency, and to improve treatment adherence?

If we were to utilize a strengths-based approach, where would we start? Let's conceptualize Zoe's situation through the lens of a brand-new college student caught in the transition of leaving home. Complications include a parent whose significant scaffolding and accommodation have contributed to Zoe's doubts in her ability to individuate, contributing to Zoe's current anxiety and depression. The following are important issues to consider when deciding on a treatment plan. How has the experience been for Zoe to leave her social comfort zone from a high school where she was popular and surrounded with friends, and

how has this experience been similar to her previous childhood experience of separation from her best friend? How has it been for her to have a strained relationship with her mother, who had formerly been both a protective and authoritative figure? How does Zoe's mother handle the separation from Zoe and how does her mother's response make her feel? How does Zoe perceive herself when adjusting to a new environment? Whom can she identify at college that can provide support in addition to her mother? How do we introduce medication, such as a selective serotonergic reuptake inhibitor (SSRI), while considering Zoe's assets and her own goals?

Partnering with Zoe and her family, five immediate goals, strengths and target plans are identified. (1) Zoe is a very self-disciplined person who works well with consistency. Recognizing this strength, we co-construct a structured daily routine that helps her manage college life, such as setting a scheduled bedtime, emphasizing behaviors that promote a healthy sleep/wake cycle, maintaining regular exercise and a healthy diet, scheduled study time and personal time. (2) Zoe's parents are warm, nurturing and supportive. We encourage Zoe to schedule a set time to communicate with her parents, and for them to reflect on and share their mutual thoughts and feelings around adjusting to college life. (3) Zoe is able to engage in meaningful relationships. She joins an extracurricular group of interest on campus where she can make friends. (4) Zoe is skilled at sports and finds exercise to be a source of coping and stress relief. She decides to continue her athletic interest by joining college intramural volleyball. (5) During high school, Zoe had a tremendous relationship with her volleyball coach, who inspired her to work hard and be a leader. Zoe's hope is to be a future coach to motivate other children and adolescents to strive their best in volleyball and in life. We continue to support Zoe's passion to inspire others.

Throughout the therapeutic work, the clinician guides reflection, reassurance and encouragement of Zoe's competencies. This becomes critical as Zoe learns to trust her own abilities and transitions to independence in college. In addition, working with her mother promotes her mother's confidence in both her daughter's ability to succeed independently and her ability as a mother to continue to provide support and stay connected with her daughter. The strengths-based approach can also be implemented in combination with pharmacological intervention. A clinician can discuss the probable benefits of medication in improving Zoe's quality of life by reducing her symptoms to a more manageable level. Potential adverse reactions of medication for the treatment of anxiety and depression should also be carefully specified and openly discussed. While communicating to Zoe that you believe in her competence to assume agency around decisions regarding her care, she begins to gain self-confidence. In the maintenance stage, Zoe's individual strengths and desired goals guide ongoing treatment and recovery. Open-ended inquiry into Zoe's understanding of the components of healing helps Zoe clarify her goals and priorities. Sensitivity to her values regarding spiritual, cultural, and lifestyle identity and choices is fundamental to strengths-based and patient-centered care.

Six months later, Zoe has successfully transitioned back to college and moved back into dormitory with classmates. Her grades are back to As and Bs. Zoe's college success also alleviates her mother's anxiety and tendency towards overprotective parenting. They maintain a close relationship, and her mother is proud of her daughter for having a healthy

college life. Zoe continues to enjoy playing volleyball in college, and plans to apply for a summer internship as an assistant volleyball coach in a summer enrichment program for elementary-aged youth.

### 3. IMPLICATIONS

Strengths-based intervention focuses on the patient's attributes that promote wellness and can work synergistically with the conventional medical model of treating disease. The strengths-based approach is predicated on the assumption that each individual has a unique set of goals and possesses internal strengths and external resources that can help them achieve these goals. It also aims to activate a patient's hopefulness through a strengthened relationship with him/herself, family, therapeutic supports, community, and culture. Empathic parental guidance to Zoe's mother helped her gain confidence in her daughter's resilience, which activated hope for Zoe's prognosis for both Zoe and her mother. Restoring a stable family relationship provides a long-term resilient foundation for the child, which should be one of the key elements in the strengths-based intervention, especially in child and adolescent patients. The strengths-based model is patient-centered (Institute of Medicine, 2001), and provides the patient with the greater agency in the recovery process, while the clinician collaborates with the patient to identify and bolster their strengths to progress towards recovery. It not only guides our psychotherapy direction but also enhances engagement in psychopharmacological intervention, since the outcome directly ties to the patient's recovery goals. One strengths-based therapy, solution-focused brief therapy (SFBT) has demonstrated efficacy with patients from diverse racial and ethnic groups, with those that are resistant to change, and in school, specialty mental health outpatient treatment and medical settings (Zhang, Franklin, Currin-McCulloch, Park, & Kim, 2018). SFBT has demonstrated enhanced patient-doctor communication, medication adherence, and the promotion of health-related behaviors (Zhang *et al.*, 2018). Strengths-based cognitive-behavior therapy (CBT) promotes resilience by incorporating strengths-based elements such as focusing on the development and utilization of resilient beliefs and behaviors instead of identifying and challenging cognitive distortions (Padesky & Mooney, 2012). Evidence has shown that strengths-based interventions that promote wellness generate positive outcomes in children with psychiatric disorders and disadvantaged backgrounds. For example, physical exercise has been shown to be beneficial for children with Attention-deficit Hyperactivity Disorder (ADHD) (Vysniauske, Verburgh, Oosterlaan, & Molendijk, 2016), whereas mindfulness practices help teens to cope with anxiety and low self-esteem (Biegel, Brown, Shapiro, & Schubert, 2009). Similar treatment models also extend to the entire family's wellness with the understanding that "positive parenting promotes children's health" (Hudziak & Ivanova, 2016). Furthermore, a strength-based approach has been shown to improve hospitalization rates, self-efficacy and a sense of hope (Tse *et al.*, 2016), as well as parent satisfaction and appointment adherence in the outpatient setting (Cox, 2006). Yet, there are limitations to the strengths-based intervention. Patients who are unable to engage in therapy, such as those with an acute psychotic or manic episode, may not respond to strengths-based therapy as an initial intervention, and will likely require stabilization of symptoms through use of medication and other intensive treatments. Solution-focused brief therapy has been shown to be effective in patients with internalizing disorders such as

anxiety or depression, but less so in those with externalizing disorders (Zhang *et al.*, 2018). High functioning patients may have acquired greater resilience than more severely psychosocially challenged patients and families, and thus may respond more effortlessly to a strengths-based approach. In many cases, the strengths-based intervention can be used in conjunction with the conventional medical approach, rather than as a monotherapy. This will require clinical discretion to determine which elements of each modality are best suited to the clinical presentation. In addition, there can be instances in which a trait that is adaptive in certain settings proves to be maladaptive in other settings. For example, Zoe's tendency to thrive within structured environments served as a strength in high school, but this soon became maladaptive in college when life was less structured. Clinicians may need to re-define strengths and goals as patients transition to different settings and situations. Although strengths-based approaches have demonstrated efficacy in a number of studies, further research into the benefits and limitations of this approach is needed.

In closing, incorporating strengths-based intervention into our conventional practice provides a multi-faceted treatment approach that promotes optimism for recovery in children and adolescents with psychiatric disorders.

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