HOW ABOUT YOU? BUILDING BLOCKS FOR A DIALOGICAL SELF THERAPY FOR CHILDREN

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ABSTRACT. In this contribution we will elaborate on child development, growing identity and dialogical self in therapy for children between 7 and 12 years of age. Therapy sessions using the Self-Confrontation Method with children are analyzed. The focus of the analysis is on the communicative attitude of the therapist. This leads to the formulation of communicative strategies for self investigation with children.

The Self-Confrontation Method is a narrative approach to identity; identity is constructed, justified and maintained through language (Kroger, 2007). The person structures experiences into narratives and reflects on feelings and emotions that are linked to those stories from different I-positions (Hermans & Hermans-Jansen, 2004). As a result of those reflections new beliefs and changing perspectives will be incorporated into their narratives. Eventually this process will lead to a macro-narrative or self-story (Angus & Mcleod, 2004). Such an organised repertoire of I-positions or explicit identity (Kunnen & Bosma, 2001) is not accomplished before adolescence. While children do reveal their thoughts about themselves in the stories they tell about their lives, these narratives are not yet organized around systematic cognitions about the self that can be made explicit and become the object of validation. They have yet to structure narratives from the past into an organized and conscious sense of identity. This article focuses on how to adapt the Self-Confrontation Method to working with children (ages 7 to 12) in this pre-adolescent phase.

Starting a dialogue with children (7-12) about narratives and the psychological self, poses all kinds of developmental limitations (Bruner, 1990; Fonagy, Gergely, Jurist & Target, 2004; McAdams & Janis, 2004). Because even children of the same age may still show significant developmental differences, there can be no hard and fast rules about at which age a child will be developmentally able to work with narrative techniques. Decisions about whether these techniques are useful to a child will have to be made on a case by case basis, and may involve some trial and error. Well-known developmental limitations when working with children in this age group are:

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- Inability to tell an organized narrative. The therapist must be able to compensate for that by constructing a narrative together with the child or by asking important others to bring along narratives;

- The incapability to distinguish between the primary experience of an affect (reliving the experience) and the reflection on that affect. Traumatic experiences can be especially difficult to deal with.

- Getting overwhelmed by the many negative emotions; the therapist must be able to limit those emotions.

- Dependence on the dialogue with adults in order to give words to its inner world. The child will be accustomed to directed internalization. The adult will have to create a new situation where the child will be guided into externalization of private knowledge (Valsiner, 2005).

- The important others in the life of the child may not have been able to recognize feelings and intentions and to find the proper words for those presumed feelings and intentions. The therapist will then face interpretations and cognitions of important others from outside the therapy room that determine the narratives of the child.

Therapists working with young children will complement their narrative approach to identity with other frames of reference. The Structural Stage approach and the interpersonal origin of identity are often used for this purpose. In the Structural Stage approach the focus is upon the internal structures of ego development from which children give meaning to life experiences. Each successive structure enables children to make sense of their life experiences in an increasingly complex way (Kroger, 2007).

The interpersonal theory of identity development focuses on the influence of important others in the development in identity. Vygotsky (1978) emphasized that in young children thoughts are preceded by social communication between the child and adults as they engage in joint activity. Adults help children form these thoughts and thereby help develop the child's identity. Only later does thought appear as an individual (and internal) capacity. Starting from these different theories the development of the verbalized self-concept may be described as follows.

Children as young as 18 months to 2 years begin to talk about the past, guided by adults who prompt them and expand on their fragmented recollections (Bruner, 1990; Berk, 2001). Dialogues that give words to a psychological self ("psychological self-talk") will occur frequently and spontaneously as adults and children spend their time together in every day situations such as household chores, meal times, walking home from school together etc. These daily conversations between child and adult about feelings and the reasons behind people's actions are linked to the achievement of

reflective functions in young children (Bertau, 2004). An implicit psychological self (a sense of continuity, of being a person, who despite changes in appearance or context, remains the same over time, Chandler, 2000) is firmly in place at the age of 3 or 4 in normal children

Pre-school children will talk of themselves in terms of physical characteristics or focus on physical activities when describing themselves (DeHart, Sroufe & Cooper, 2004). It is only when children make the transition from pre-operational to concrete operational thinking (Inhelder & Piaget, 1955) that they can distinguish between external words and actions on the one hand, and inner psychological experiences on the other. Selman (1980) describes this as an emergence of a child's sense of an inner private self and a growing awareness that all people have inner thoughts and feelings. The child becomes an individual with introspection on a psychological self.[1] Reflection on and differentiation of the self from others, resulting in a verbalized sense of psychological self, are situated in this period of concrete operational thinking (7-12). This psychological self is a hard-won developmental acquisition, developing in verbal interactions with primary care takers (Fonagy, Gergely, Jurist & Target, 2004). In most children this foundation of a dialectic personality model is present at the end of primary school age (Fonagy et al, 2001; Greenspan, 1997; Verhofstadt-Deneve et al, 2004). Therapists working with children in this stage of development have to reckon with this emerging sense of self rather than prelude to their future formal cognitive abilities.

Self –Confrontation Method for Children

The Self Confrontation Method for children is the children's version of the Self Confrontation Method (Hermans & Hermans, 1995). It was intended for short-term interventions with children in the 7 to 12 age-range with mild emotional or behavioral problems (Van Doorn & Louwe, 2005, 2006).

The self-investigation begins with the presentation of a pool of 36 emotions, written on colored cards. There are feelings of self-enhancement (S-feelings), feelings of contact and union with others (O-feelings); positive (P-) feelings and negative (N-) feelings (Hermans, 1995). Each emotion is printed on a card, the color of which links to the category the feeling belongs to. The differentiation in four kinds of feelings is not explained to the child. The child is asked to sort out four cards of each color that seem to fit in his or her life. The therapist then asks about the meaning and importance of the selected emotions for the child. The feelings are written down on a personal list. These activities lead to affective exploration of the child, while the therapist learns about the way the child verbalizes and signifies.

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[1]. The psychological self then becomes a concept of the self that is made out of psychological constructs such as mental characteristics, cognitive abilities and customary ways of feeling.

The therapist then presents pictures of everyday situations. The child is invited to formulate narratives about his or her own experiences, associated with the pictures. Children are also allowed to bring pictures or drawings to talk about. The therapist writes down what the child verbalizes. After having formulated a narrative, the child scores his or her affects with the help of the personal list of emotions that was created earlier using the cards. In the adult version of the Self Confrontation Method, after completing a series of narratives and systematically evaluating these narratives the person is invited to formulate a meta theory about the psychological self. It was concluded that this last phase of the process (the formulation of a meta theory) was too complicated for most of the children (Van Doorn & Louwe, 2005, 2006).

This version of the Self Confrontation Method for Children was developed for short-term interventions with children in the 7 to 12 age-range with mild emotional or behavioral problems. Working with long-term therapies with children with severe emotional and behavioral problems it became increasingly clear that the systematic use of the standard elements of the Child Confrontation Method was not always possible because of the developmental limitations that were described in the introduction. The exploration of narratives from the outside world, followed by a systematic affective exploration of 12 different feelings proved too difficult in series of sessions with several children. Yet the children seemed to benefit from the sessions and developed new reflective skills.

In this study we wanted to explicitly describe the adaptations to the Child Confrontation Method needed to overcome developmental problems. These adaptations were formulated after close observation of the interactions between therapist and child, with a focus on both verbal and non-verbal expressions, and information about the therapist's intentions. Therapy sessions of two boys who were in therapy for more than a year were recorded and transcripts of the sessions were made. After analyzing the recordings and transcripts of the sessions, we tried to formulate what aspects of the therapist's behavior were helpful in supporting the child to explore and organize his emotions and cognitions. This led to a sharper understanding of the focus of the therapeutic conversations. In this article we will try to make this process transparent using excerpts from several sessions as illustrations.

Method

For this study, two different case studies were used. These cases were selected for analysis and reflection because of their complexity and the therapist's need for feedback on her approach. The analyses of the case studies made use of the notes that were kept by the therapist both during and after the therapeutic session, video recordings of the encounters, and transcripts of the recordings according to conversational analysis conventions (Jefferson, 2004). The analyses were carried out on the original Dutch data and relevant fragments were translated into English for this

article. Both parents and children consented to the use of these tapes and transcripts for scientific research. The excerpts in this article were chosen because they highlight the theoretical considerations. The focus is on the supportive quality of the therapist's actions. We paid special attention to the therapist presenting alternatives, keeping silent to enable the child to make a choice, verbalizing children's descriptions of differentiation and preference, and reinforcing the child's positive qualities.

The first session concerns a 7-year-old boy (Dennis), who came into therapy because of serious communication problems and emotion regulation problems. Before the therapy started he was diagnosed with PDD-NOS by a child psychiatrist. (PDD-NOS - pervasive developmental disorder, not otherwise specified - is a disorder in the autistic spectrum with communication problems, limited social reciprocity and restricted repetitive behaviors) An analysis of part of the first session will be presented. The session was selected because it is illustrative of the way different I-positions can be presented to a child who is not used to reflect about himself. The analysis is based on the therapist's notes of the first session.

The second session concerns a 9-year-old boy (Maarten), who was referred for therapy because of serious aggressive outbursts at school. He was diagnosed with ADHD and ODD by a child psychiatrist. (ADHD is a disorder characterized by attention deficit, hyperactivity and impulsive behavior. ODD - oppositional defiant disorder - implies a recurrent pattern of negativistic, defiant, disobedient behavior towards authority figures) The boy frequented therapy sessions on a weekly basis for over a year. During that time Maarten changed schools and made a new start without aggressive outbursts. A transcript of the start of a session in the second year of therapy is selected, because it is illustrative of the way children can talk about different positions of the self after practising that ability in therapy for a period of time.

Interactions about everyday routines in therapy

As underlined in the introduction, an external dialogue with adults precedes inner speech and an internal dialogue in the child. One of the first guiding questions while analyzing the tapes and transcripts was where to find questions by the therapist and pieces of conversation between therapist and child that would focus on the child's I-positions. That redirected our attention from interactions about the problems the child was referred for and thoughts and feelings underlying those problems to interactions about everyday therapy routines.

Verbal interactions about everyday therapy routines start when the child enters the therapy room and talks with the therapist about what, where and when in therapy. The therapist does not present a planned set of activities, but suggests several possible activities. *"We can play with the animals on the floor or we could sit at the table where you can make a drawing. If you prefer to play a board game we can sit over there. It is*

up to you to decide." When talking about the choices, the therapist will comment on the time needed for each activity and which materials may be used.

By introducing diverse activities to the child in this way, the therapist mentions several possible I-positions, defining them in terms of activities, space, materials and possible outcomes. The therapist will add some comments about what the child did in former appointments or plans that the child made earlier. There will be a map with drawings made or forms filled in to remind the child of those earlier events. At the end of the meeting the therapist will talk about the next appointment *"Do you already have plans for our next meeting? Maybe you would like to bring some materials with you from home? Or is there something I need to organize for you for the next time?"*

The child is made aware that there are choices to be made; the choices can be pointed out, and they are linked to physical realities. For example, a set of pencils and paper can offer a physical representation for drawing. The child is addressed as someone with personal preferences (different I-positions), which may change. The therapist makes it clear that the child can only consult itself to discover what his or her favorite activity is. Awareness of different I-positions becomes a lived experience.

Talking about activities will gradually turn over to talking about the self that is experiencing all of that. The therapist puts a vest on because she feels cold and comments on that. That can naturally lead to the question whether the child feels cold too and the explanation that the therapist does not know that and has to be told. Making an agenda for the meeting leads to comments about not knowing what the child will decide. *"I know that you liked to play with the sand and water table last time, because you told me so. I don't know what you would like to do this time."*

Using a therapy room leads to all other kinds of explanations about self and others. There are other children using the same therapy room. They come for different reasons and they will choose different activities. Talking about that and stressing the fact that every child will make unique choices is a regular aspect of therapy. Each child is given a private drawer to save his or her own products and materials. *"You don't know what happens here when you are gone. You do know that your things will be kept safe in this drawer, waiting for you when you come in next time."* Sometimes a child has to learn this the hard way. One of the children had to be confronted with a sand and water table that was not the same as when he left it several times, before he understood that there were other children playing with it when he was not present.

The fact that the therapist is not present in the everyday life of the child may need the same kind of explanation. This will be part of the start of therapy: *"I don't know what your house looks like, so can you make me a drawing? Or maybe you can bring me a picture next time? I don't know who belongs to your family. Can you make me a drawing or shall we make a list of all the people that live in your house?"* Together with creative products and forms like session rating scales, the drawing and

the list will have prominent places in the file of the child. *"This is what I know about you and I know it because you told me."*

We concluded that talking about everyday routines in therapy leads to differentiations in terms of time, space and preferences. Conversations about everyday routines in therapy can be seen as practicing dialogues with an important other person about the existence of and organization in different positions. Working along this line differs from working with protocol-based treatment books, used in cognitive behavioral therapy. It takes professional training to learn to offer the child choices, to wait for his or her decisions and to reinforce those decisions in term of "Oh, that is how you are feeling/who you are. OK."

Talking about every day routines is reassuring and predictable. The child can get accustomed to the role of the therapist: inviting the child to look inside without directing the content of the child's thoughts. It also gives the child an opportunity to practice the ability to talk about inner psychological experiences with an adult. Dialogues about the problems that the child is referred for will be more difficult because of the negative emotions that will be associated with those problems and the child's possible fear of rejection by the adult. It is tempting to put forward the hypothesis that this kind of verbal interactions about everyday routines needs to precede dialogues about different I-positions related to the problems that the child is referred for.

Interactions about I-positions related to the problems of the child

The next guiding question while analyzing the tapes and transcripts was how the therapist supported the child in thinking about different I-positions when talking about the emotional problems that were the reason for referral. Would the same elements (presenting alternatives, awaiting choices and verbalizing and reinforcing individual aspects of the child) be recognizable in those more loaded interactions? Considerations about this will be illustrated with parts of the therapy sessions with Dennis and Maarten.

Dennis' case

Summary of session with Dennis, boy, 7 years old)

(Recollection from notes made right after the session)

Dennis has made a picture of two terrible monsters. Talking about the monsters and making a visual representation has made him very anxious. He is overactive and cannot stop associating about monsters. His stories grow more frightening with every new idea that comes to his mind. When asked how it feels to think about monsters, he says he likes it. It is his favorite subject and he does not want to stop talking about them.

The therapist puts a box of Lego in front of Dennis and mentions that they could

build a house together. That would be fun, but you can't build a Lego house when you're all excited about monsters and unable to think about something else.

Dennis agrees that it would be nice to play with Lego together, but he does not know how to stop thinking about monsters.

The therapist offers him several options: "You could give the drawing to me to put away in the drawer. Or you could tear it apart and throw it in the dust can. Maybe putting the drawing face down would be enough. I don't know what would be the best solution for you. Can you tell me what suits you the most? "

Dennis decides that it will be best if the drawing were put away in the drawer. Then he can look at it next time. Maybe he will even make another drawing about monsters then.

When the drawing is out of sight he relaxes and works with the therapist on a Lego house for fifteen minutes.

Analysis

In this session the therapist has to assist the child in regulating his fear. There are several ways for an adult to help a child to cope with anxiety. The two most common options for parents are the affective way (kissing it away) or the educational way (explaining to the child that those monsters are not real, so you don't have to be afraid: "They can't hurt you"). A behavioral therapist could take the picture away and replace it with a nice activity like building with Lego. A therapist with a cognitive behavioral education would teach the child helpful thoughts: "If you tell yourself that it is only a drawing and a drawing can't hurt you, you will feel better than if tell yourself "look how terrible this monster is, look at his big teeth!"."

Supporting a growing sense of identity asks for different kind of structuring. The therapist refrains from giving answers to immediate momentary difficulties. She encourages the child to step back from the immediate situation and consider his options. This example illustrates several successive steps to invite the child to do take such a reflective position.

The therapist is confronted with a child that is absorbed by the experience of thinking about monsters and he is not motivated to leave the position of "Dennis with the monsters". So she offers him a concrete example of another position: "Dennis building a house with Lego". The box with Lego, representing the alternative I-position, is on the table, visual and tangible. That makes it possible to verbalize those positions while pointing them out.

The therapist then states that she is confident that the child can make up his own mind and waits. The child can take time to make up his or her mind, and experiences

that the therapist finds it worthwhile waiting for that decision. After the child made his choice the therapist verbalizes this decision (modeling inner speech) and that it is something that suits the child (reinforcing a sense of self). The child now becomes an expert about the experience and the therapist acknowledges that the child is the only one who can tell whether the reactions of the therapist fit his developing frame of reference. The therapist's expertise is to capture the experience in symbols and words that are noteworthy to the child and in reflecting upon the complex intentions and feelings behind that experience.

Maarten's case

Transcript of a second year session with Maarten, 9 years old.

39.M   I am 9 years old now. Yesterday was my birthday.

40.T   *(puts out her hand)* OK. *(talks with a formal voice)* Congratulations. So you are 9 years old now?

41.M   Yes.

42.T   How does it feel to be 9?

43.M   *(enthusiastic)* Nice!

44.T   Yes?

45.M   Yes.

46.T   Does it feel different from being 8?

47.M   Eeeeeeeeeeh. YYYes, a little.

48.T   What is the difference, tell me what feels different?

49.M   Wellllll, You are getting older and that means that … you can…see more things and do new things.

50.T   *(nods confirmingly)* Older and wiser my father used to say.

51.M   Yes.

52.T   When you get older, you get wiser.

53.M   Yes. And … you are allowed to visit different attractions in the park.

54.T   Yes, of course, that is important.

55.M   And.. Yes. I am allowed to watch different movies and I can do different things than before. For example eh ..ehm…I was allowed ….hmmmmmmm….Yes. Look later on when I visit high school, then my father will buy me my own computer and I can use it in my own room.

56.T	Another new thing added, because you will be older then.
57.M	[Yes .
58.T	Could you draw me the difference between Maarten when he was still very small, but already going to school
59.M	[a baby?
60.	*(M looks to T, a smile on his face)*
61.M	OK.
62.T	and Maarten as you are now. Could you draw them both for me?
63.M	Hm hm. *(takes up the pencilbox)*
64.T	Oh, I see you are going to use the new pencil box. Does it contain pencils or felt pens?
65.M	pencils. *(M does not look up to T while preparing paper and pencils)*
66.T	OK.. What will be your first drawing? The old Maarten or the new one?
67.M	[The old. *(laughing)*
68.T	The old Maarten. Okay. (pausing) Meanwhile what can you tell me about the old Maarten?
...	
82.T	Yes. *(laughing)* Hey, How did it happen? Why did it take that old Maarten so long to finish his sandwich?
83.M	Because he did not want to drink his milk. *(looks at T)*
84.T	Aha!
85.M	But nowadays I drink chocolate milk
86.T	*(nods)* That's a fine solution.
87.M	Yes, *(plays with his leg)* and now I am allowed to choose my own favorite sandwich.
88.T	[So that suits you.
89.M	yes.
90.T	Well I am anxious to know what you will make the old Maarten look like. Was he a happy boy …
91.M	[Yes
92.T	..sitting on the carpet?
93.M	*(plays with his leg, talks without looking at T)* Eeeehm, that boy was grumpy most of the time (looks at T)

94.T	(bends forward) Well , how can you put that on paper. Must be… (points to the pencil box) Hey, I see your name is on the box. That is nice!
95.M	Yes, because mine is the same as my sisters.
96.T	Aha. Well. And does it contain pencils or felt pens? Let me see.
97.M	They are ball points. (Shows the points to T)
98.T	ball points Oooooh, they do look nice.
99.	*(M begins drawing)*
100.T	*(talks softly, bends over to watch the drawing)* Well that sure is a grumpy Maarten.
101.	*(about 10 seconds of pause)*
102.T	it is a fine drawing
103.	*(about 8 seconds of pause)*
104.M	Hmmm.
105.	*(about 15 seconds of pause)*
106.M	I make him say "I hate this" Do you see that? (draws a balloon with the words written in it)
107.T	[oh ho ho ho ho ho ho *(laughs)* Yes indeed! Everybody can see that now.
108.M	Now I am going to make a completely different drawing of myself.
109.T	The old Maarten or the new Maarten?
110.M	The new Maarten.
111.T	Here he comes: the new Maarten. A boy that is already 9 years old!
112.M	He is much bigger.
113.T	Yes, yes. *(smiles)*
114.	*(about 30 seconds of pause)*
115.M	*(laughs softly)*
116.T	Why are you laughing?
117.M	Oh, ehm. I just laugh because I am happy.
118.T	So you are not a grumpy Maarten anymore?
119.M	*(makes soft noises 'la')* No, not anymore most of the time. *(makes more soft noises,'la la')*
120.	*(pause about 8 seconds)*
121.M	*(laughs)*

Analysis

In this fragment the statement of the child about his birthday leads to the introduction of different positions of Maarten: the one who is 8 years old and the one who is 9 years old (lines 46-49). The two positions are explored in terms of activities like the attractions you can visit in a park. That leads Maarten to explore the position of an even older Maarten in the future that will be allowed to undertake new activities (lines 53-56).

In line 58 the therapist makes two interventions. She expands the two positions to the old Maarten (narrowing that position to the period of serious trouble at school) and the new Maarten (who is doing much better). The old Maarten and the new Maarten can be seen as two different I-positions. This is combined with a request to make a drawing of those two positions. Making a drawing is a way to elicit an observer's position in Maarten. He is the Me literally looking at the two positions, thinking about differences between the two. Talking about the drawings leads to formulating differences in activities (line 69), preferences (lines 83-85), intentions (line 83), feelings (lines 100-106) and physical appearance (line 112).

In line 64 and in line 94-98, talking about the pencil box, we see examples of everyday talk in therapy that was discussed in the first section, with elaboration on the kind of pencils and the difference with his sister's pencil box.

In the videotape it is clear that Maarten is very relaxed during this session. He knows the routine of exploring different I-positions, accepts the expansions of I-positions and is accustomed to drawing pictures of those different positions. He knows that the dialogue with the therapist will be helpful and enjoyable. In a later session he stated: "It is nice to be here, but I don't want to talk about problems at home or at school anymore. I can do that with my mother or my teacher. I just want to play games and to contemplate upon that. That makes me feel nice and quiet inside".

Conclusion

In this presentation we summarized our reflections upon the Self-Confrontation Method for children with severe emotional problems in long-term therapy. It was demonstrated how the therapist can structure experiences in the therapy session to reinforce a firm and explicitly verbalized sense of self in the child. In this structuring, different positions of the child are made visible and tangible. The therapist verbalizes those positions and explains that the child can make choices. When the child makes a choice the therapist reinforces that choice and labels it as a chosen position, placed in time and place. ("This is who you are here and now"). The position will be placed on record so that therapist and child can look back on it and discuss the child's ongoing differentiation in positions in the course of time.

We came to formulate some building blocks for such a supportive strategy for children that fit with the principles of the Dialogical Self theory (Hermans, 1996a; 1996b). When comparing our interactions with the children in long-term treatment with interactions in the original Child Confrontation Method the focus of conversations changed from telling and valuating narratives to supporting the child to make comments on the psychological self and differentiate between I-positions. The dialogical child therapy does not focus upon the child's problematic narratives and how to solve the problems. It rather circles around the child's self and identity by using "psychological self-talk". In doing that the dialogical child therapist compensates for the child's not fully developed capacities to reflect on an organized repertoire of I-positions of the self. The therapy aims at facing Me rather than at facing problems. In adult therapy this would have meant the exploration of an organized repertoire of positions; in child therapy, it will concern the differentiation of all kinds of emotions and evaluations linked to immediate experiences. The child is encouraged to step back from the immediate situation and to consider alternatives - in essence to explore and think about the psychological self. The dialogical therapist is able to structure experiences in a way that gives the child a growing sense of identity. That leads to an external dialogue about I-positions to prepare the child for the development of an internal dialogical self at a later age.

This study is based upon therapy sessions of one therapist. The analysis of the material was meant to gather information about the conceptual framework about the dialogical self in child therapy. As Hermans stated: "The prevailing concept that a theory should first be developed and later applied in practice, is not a very productive one for counseling and therapy" (Hermans & Hermans, 1995). We need systematic descriptions of practice as part of the dialogue between scientists and practitioners. The description of the focus of the described therapy sessions and explication of the procedures worked with are meant as a contribution to this ongoing discussion with other professionals in this field. This work in progress, a growing consensual conceptual framework, can eventually lead to the purposeful application and evaluation of different strategies, directed at specific areas of change and consensus about treatment integrity.

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