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Collaborative Positive Intervention in an Inpatient Setting: A Case Study

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Abstract

This article entails a case study of integrating Positive Psychology theoretically framed interventions to a non-binary white adolescent with chronic suicidality in an inpatient setting. The article follows the clinicians first-hand experience of developing and implementing collaborative positive interventions as well as the learning process of both the clinician and patient on how effective treatment can present. The step by step incorporation of Martin Seligman's Positive Psychology concepts including PERMA to clinical treatment is highlighted throughout the case study. Patient feedback and shift in symptom presentation is included to note the likelihood of the treatment efficacy. Barriers to treatment due to setting is addressed and exploration into how future studies can explore these barriers as well as considerations for how to work around such limitations. The clinician's reflections regarding the implementation process as well as take away learning points are included to serve as an example of how strength's based relational interventions impact therapeutic relationships and result in shifts of patient autonomy, motivation, and engagement.

After approximately two years into the COVID-19 Pandemic as a Clinical Psychology Psy.D. student, it had become apparent through my clinical training that my priorities as a clinician had transitioned towards one of treating children and adolescents who were in chronic states of traumatic stress and presenting with increasing suicidal ideation. As a psychology extern at child and adolescent inpatient units in the Greater Boston Area for the past two years, I had grown accustomed to adolescents presenting with depression, suicidality, and self-harm that they reported were exacerbated by the pandemic through the real and perceived loss of hobbies, friends, and socialization with others. So when I was assigned by my professors during my Spring Semester of 2022 to select a patient in which I could create a treatment plan and implement a course of treatment utilizing a Positive Psychology theoretical framework and interventions, I was highly skeptical of the likelihood of meaningful outcomes.

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When the time came for me to select which of my individual patients I would create the treatment plan for, I gravitated towards the patient that I felt the most stuck with. I had spent a little more than 6 months treating this patient, dedicated the majority of my supervision time to discussing them, and still felt just as lost regarding treatment trajectory as I had the first day I met with them. For the purpose of this article and to maintain patient confidentiality, I will refer to my patient as M. M was an 18 year old non-binary (they/them) adolescent who had a longstanding history of frequent inpatient unit admittance since they were 13 years old. After the pandemic began, M was psychiatrically admitted in May 2020 and later transferred to a long term inpatient unit, where I worked together with them. M's presentation included chronic suicidal ideation and suicidal gestures including significant self-harm and multiple attempts of self-strangulation. Throughout the year long hospitalization prior to my work with M, their presentation had remained acutely suicidal and at high risk for suicidal behaviors, requiring one-to-one monitoring and multiple clothing and item restrictions for months at a time.

Upon starting our therapeutic relationship, my naïve confidence as a fourth year doctoral student who was envisioning a career of specializing in treating high-risk adolescents was quickly challenged. M presented highly treatment resistant for our first two months of meeting for individual sessions. I processed my failures endlessly through consultation and supervision, and found myself feeling helpless, unintelligent, and lost. My countertransference and perception that I could provide no help to M, and that they required clinical expertise far greater than I had acquired in my training, began to make me wonder how M must has perceived themselves, as possibly someone who was beyond helping and lost. Therefore, after six months of working individually with M, and still not yet having a clear picture of what intervention style fit their needs best, I jumped at the opportunity to incorporate Positive Psychology into our work together.

When I presented the possibility of integrating Positive Psychology Interventions into our individual sessions, M presented excited and engaged for the first time and expressed a strong desire to move away from processing their suicidality. M began to speak about how treatment had "always" focused on processing their self-harm and that treatment was often oriented towards chain analyses of past experiences of suicidal ideation and assessing current risk. I noticed that M's treatment thus far hadn't addressed ways to live a life above zero, a concept from Seligman's Theory of Well-Being that I incorporated throughout our intervention. (Seligman, 2011). I began the Positive Psychology intervention by asking C if they wanted to start focusing treatment on ways to live a life above zero. I used this wording as a way to describe the overarching theme of Positive Psychology and as an introduction to what our intervention will be focused on.

After I posed this question to M, they responded by saying that having something to look forward to would give them a break from having to constantly think about their depression and suicidal urges. M and I worked collaboratively to find out ways we can focus on the flourishing aspect of life and in a future oriented manner, instead of hyper focusing on decreasing their pain and suffering. I began by introducing Well-Being Theory and together we discussed what a

strengths-based intervention might entail. We discussed how often times treatment focuses on labeling and identifying problems or symptoms. We further explored how this labeling can overcome a client, and through this totalizing experience, they lose sight of where the label ends and the human self begins. I introduced the concept of positive labeling to M, explaining that it can serve as a motivator to shift how people perceive themselves (Niemiec, 2018). Together we practiced strength-spotting, by noticing and labeling character strengths in each other. I knew from their large pile of once used yet forgotten art supplies, M was creative and loved using their imagination to create art. M showed some discomfort when I strength spotted this skill of theirs because they perceived it as a compliment. However, despite the discomfort, they agreed with me. This response led me to incorporate the intervention to focus on the empirically supported elements of PERMA. I described to M that the construct of well-being required five measurable elements: positive emotion, engagement, relationships, meaning, and accomplishment (Niemiec, 2018).

After reviewing aspects of PERMA together, M expressed that creating art brought about Positive Emotion. At the time, M was only able to draw a connection between positive emotion and art and we were willing to explore together how our art activities may foster more connections to the other elements of PERMA. I gave M the opportunity to choose an activity and they described wanting to create their own sneakers, by drawing designs on white Vans that they had. During the first week of practicing the intervention, there became an apparent behavioral shift in M, yet I felt our discussions in session were still lacking content. M began to wake up early for school every day of the week, perform their ADLS, attend school, and return to the unit asking to meet with me so that we can continue to work on the sneakers. They gradually began to eat more consistently throughout the day and treatment members noted that this shift was strongly correlated to their engagement in our art activity. Most specifically, a clinical social worker stated that M had shared their intentions to eat in order to increase their energy so that they may be awake and able to engage in our art sessions in the late afternoon. M also connected that their increased eating came with greater ease than in the past because they were socializing with others about art or interests during meal times which shifted their mind form perseverating on calories and the amount of food they were consuming.

However, during our sessions, M would often remain quiet and focus on the art without connecting their experience verbally to PERMA or Positive Psychology and I wasn't getting much feedback around how the intervention was working from their perspective. To address this unknowing, I gave M an open ended question of what they would like to do after the sneakers are finished. They described a recent reconnection with an old friend and a desire to create 4 portraits of their friend to give as a gift. This prompted our discussion around the relationships element of PERMA and further rooted our intervention in an empirically supported practice that doing a kindness to others produces the single most reliable momentary increase in well-being than any exercise tested (Seligman, 2011). Throughout approximately 9 consistent sessions, M and I continued to create art and discuss how the intervention impacted M's well-being. At this point,

M's restrictions on the unit lessened and they reached a great accomplishment of being safe enough to be allowed to go on walks with family members off the unit and outside of the hospitalgrounds. Through supervision, I was able to process how the relational nature of our work and the collaborative standpoint that I took fostered self-confidence that M might not have experienced before. I further understood that this relational experience did not always contain verbal discussion in sessions. M's ability to utilize their strength by connecting to peers on the unit through their art was a strong example of how the process of our sessions promoted their confidence to connect with others outside of session.

However, there are notable drawbacks to implementing such interventions in an inpatient setting. The systemic barriers of a highly restrictive hospital setting were apparent in each session. For example, requirements ranged from which type of paintbrushes were used to ensure that no "sharp" object was admitted to only having 30 minutes or sometimes less to meet for session due to the highly structured nature of the unit's schedule. Specifically for high-risk cases such as M, it was difficult to shift to a strength-based mind set when they have experienced years of inpatient level of care, and consistent messages from clinicians that they were not safe enough to return home. To me, a large part of the positive intervention focused on the shared experience of collaborating on a strength and giving the patient a voice to express their thoughts and contribute as an equal part to that collaboration. Therefore, it was a conflicting message to encourage autonomy yet simultaneously have to deny M multiple different art modalities that they were interested in because of the hospital safety precautions. For future implementations, I find it necessary to compensate for aspects of the intervention that cannot be designed to the patient's desires by validating those frustrations and seeking alternative ways that the patient's voice can be heard.

Overall, M and I learned a lot about Positive Psychology together. I learned that giving M's decision making freedom over our activity allowed them to embrace their autonomy and further bolstered their confidence to design something they were passionate about. I also learned of the distinction between this personal autonomy and collaboration, and how being figuratively and literally side by side with M highlighted the importance of their role in treatment. M and I explored the efficacy of this approach and how the positive interventions took away their perceived pressures of being "tested" on the application of intervention skills, a stress they often felt with Dialectical Behavioral Therapy.

M learned of the different PERMA elements and further connected how PERMA can be translated into other activities they engage with. I think this new experience for M and myself taught us both that interventions aren't required to follow a scripted manual and we were able to witness over time how consistent application of a strengths-based intervention gradually impacted one's presentation. Also, M and I appreciated that using the activity as a sort of time keeper allowed us to look back after an activity was finished and see how much they have accomplished since the beginning of the project. While M and I continued to work individually together through

my training year, we incorporated art into all of our sessions, and created a list of individuals to whom M plans to gift their art. During our termination sessions, and as I transitioned out of the training year, M and I were able to reflect on their flourishing process and how both our perceptions of treatment modality efficacy drastically shifted towards one of a collaborative and relational nature.

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