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Caught Between Two Maternal Generations: An Intergenerational Clinical Case Study of Narrative Psychotherapy

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Abstract

This article presents and analyzes a clinical case study of an 11-year-old child displaying disruptive behaviors, framed within a narrative-based therapeutic intervention. The case unfolds within a context of psychosocial risk characterized by early parental neglect, a history of parental substance abuse, and caregiving responsibilities assumed by the maternal grandparents. Psychological assessment combined formal and informal procedures, including the Semi-Structured Clinical Interview for Children and Adolescents (SCICA) and the Roberts Apperception Test for Children (RATC). Findings indicate a predominance of externalizing behavioral difficulties, accompanied by indicators of anxiety and limitations in the narrative organization of experience. The therapeutic process followed the principles of narrative psychotherapy, emphasizing problem externalization, the identification of unique outcomes, and the co-construction of alternative narratives. The contributions and limitations of the intervention are discussed, along with clinical implications for therapeutic work with children living in adverse family contexts.

Keywords: Narrative psychotherapy; Disruptive behavior; Childhood; Clinical case study; Psychosocial risk

Introduction

Narrative, as an organizing element of experience, has been the target of increasing clinical attention. In fact, the meaning we attribute to reality is neither random nor chaotic, but constructed, ordered, and transformed according to our psychological, biological, social, and cultural frameworks. Thus, it is not bizarre to understand psychopathology as a reflection of the disorder in one (or more) of the dimensions that make up the narrative [1]. Hence its relevance as an assessment tool.

Disruptive behaviors in childhood constitute one of the most frequent reasons for referral to mental health services, especially when associated with family contexts marked by instability, neglect, or psychosocial adversity. Literature has been emphasizing that these behavioral manifestations cannot be understood in isolation but rather must be framed within the child's relational history, the quality of the therapeutic alliance, and the meanings that the child constructs about themselves and the world [2-4].

Narrative psychotherapy, based on constructivism, proposes an understanding of psychopathology as a result of narratives saturated by the problem, which restrict the subject's identity and possibilities for action [5]. The co-construction of meanings in a therapeutic context, combined with the therapist's sensitivity to the client's style and their level of motivation for change, constitutes a central factor for the effectiveness of psychological intervention [6,7]. In clinical settings with children and adolescents, integrative approaches that combine narrative methods with strategies from other orientations, namely cognitive and psychoeducational ones, have shown a positive impact on emotional regulation, building hope for the future, and reorganizing subjective experience [8-10]. These interventions are particularly relevant in situations of psychosocial risk, where family support is limited or inconsistent.

This article aims to describe and analyze a clinical case study of a child with disruptive behaviors, followed up in narrative psychotherapy, highlighting the process of assessment, intervention, and critical reflection on the results obtained.

Method

Participant

Richie (fictitious name) is an 11-year-old male child who, at the time of the follow-up, lived with his maternal grandparents and an uncle in a socially disadvantaged urban context. He lived with his parents until he was two years old, a period marked by marital conflict, parental neglect, and active substance use by

both parents. After his parents' imprisonment, he permanently went into the care of his maternal grandparents. He maintains irregular contact with his parents, both of whom have a history of incarceration.

Richie's parents have a history of drug addiction and actively used drugs before Richie's birth and throughout the period he lived with them, that is, until he was two years old. At that time, his parents were arrested, and Richie permanently went into the care of his grandparents. Richie would go with his grandmother to visit his mother in prison, but with the irregularity imposed by economic difficulties.

When his father has a temporary release, he comes to visit Richie and takes him to spend the weekend with him at his paternal grandfather's house. According to the maternal grandmother, "the father is very affectionate with Richie... he always gets very excited when he's with him."

The mother was released about two years later and, since Richie was five years old, has lived with her boyfriend, his mother, and his sister in another house near his mother's house.

The mother continued to use drugs throughout the pregnancy. She mentions that Richie underwent "treatments" at the maternity ward, without being able to specify exactly what they consisted of. The mother and grandmother attribute Richie's disruptive behaviors to this situation.

The birth was normal and at term. Developmental milestones occurred as expected.

Both refer to Richie as a healthy child. The grandmother reports, however, that until he was 5-6 years old he had "problems with spasms, he would choke and even faint." During the first month of his life, he was hospitalized due to, according to the grandmother, a cardiorespiratory arrest; in the third month, the situation repeated itself, but less intensely, and hospitalization was not necessary. As he grew older, the spasms became less frequent until they disappeared around the age of five or six.

He attended preschool from two and a half to six years old, to which he adapted easily, forming affectionate bonds with the educators whom he still visits sporadically. He has attended the same school since the 1st grade and had the same teacher until the 4th grade. This year, as he was held back in the 4th grade, he changed teachers. His grandmother also mentions that the transition to the 1st grade went smoothly, with the behavioral problems intensifying from the 2nd and 3rd grades onwards.

Richie was referred, about two years ago, by his family doctor to a child psychiatry consultation where he was evaluated and where, according to his mother and grandmother, they concluded that he did not have any problems of that nature. He continues to take Atarax® as needed (when he is more agitated), prescribed by his family doctor.

Instruments

The chosen clinical assessment process included formal and informal assessment procedures. The formal instruments used were the Semi-Structured Clinical Interview for Children and Adolescents (SCICA) by McConaughy and Achenbach [11] and the Roberts Apperception Test for Children (RATC) [12,13]. Informal strategies included interviews with the child, mother, and grandmother, and direct observation of behavior during play activities in the sessions. For a broader and more comprehensive understanding of the case, data from the different assessment strategies were integrated, providing clues for diagnosis and intervention planning.

Procedures

The assessment process took place in the initial phases of follow-up and preceded the definition of the intervention plan. The therapeutic intervention was carried out weekly, over nine sessions, between February and May, and was mostly accompanied by the maternal grandmother.

Assessment Results

The SCICA results showed a predominance of more externalizing behavioral difficulties compared to internalizing ones, particularly regarding the aggressive behavior scale, which was positioned at clinically high values. Indicators of anxiety/depression were also observed, although to a lesser extent.

Semi-Structured Clinical Interview for Children and Adolescents (SCICA)

The SCICA is a standardized clinical interview that integrates the Achenbach Multiaxial Assessment System and is intended for individuals aged 6 to 18 years. This interview was administered to Richie in an initial follow-up phase, in order to assess, from his perspective, his difficulties and skills in different dimensions of life (e.g., school; extracurricular activities and interests; peer relationships; family relationships).

The results are presented in profiles that allow comparison of the scores obtained on 8 scales resulting from the interview protocol. Of these scales, 4 are categorized as internalizing (anxiety/depression; anxiety; family problems and isolation) and another 4 as externalizing (aggressive behavior; attention difficulties; strangeness and resistance). The interpretation of the results is done according to the age group in which the individual falls (6-12 or 12-18). The scores obtained on each scale are positioned in terms of clinical percentiles (based on a clinical sample of 381 children aged 6-12 years and 305 adolescents included in the 12-18 age range) and T-values (which also refer to clinical samples, therefore not providing cut-off points that allow differentiating scores with clinical significance from clinically insignificant scores). The authors propose T-values ≥ 55 as indicative of potentially serious problems. For example, Richie

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obtained a score of 14 on the scale corresponding to aggressive behavior, which places him at the 96th percentile, i.e., 96% of the sample obtained a score equal to or lower than Richie's. For that same scale, the T-value was 66, which indicates potentially severe problems in this area.

From the results, it is worth highlighting the fact that the total of the externalizing scales (T 54) is higher than that of the internalizing scales (T 50). Although the T values are below 55, and therefore cannot be considered clinically significant, there is a higher tendency for externalizing scales, which is somewhat consistent with the complaints made by Richie's mother and grandmother ("problematic behavior") and with the child's own reports (involvement in fights, threats to classmates, etc.).

Within the externalizing scales, the highest score was for the one referring to aggressive behavior (whose values have already been presented). The remaining scales were all below the T value of 55, so it is not possible to infer any clinical significance from them.

Regarding the internalizing scales, anxiety/depression was the most expressive (P 78 and T 58), thus indicating possible problems at this level. Interestingly, the score on the scale exclusively for anxiety was 0, which makes us think about the preponderance of depressive symptoms. The remaining scales fell short of the T55 value; however, the scale relating to family problems reached a T value close to clinical significance (T54), which is consistent with Richie's life history.

A more informal reading can add supplementary data for understanding the case. For example, when asked who the members of his family were, he did not include his mother or father, only in the following answer does he make the reservation "in my family, I should include my mother". In fact, his parents are absent from his daily life and probably even distant from his emotional experiences. Another curious piece of data emerged from the interview regarding potentially predisposing factors for Richie's disruptive behaviors: the tackles during soccer games and the names that other children usually call him.

Roberts Thematic Apperception Test (RATC)

The RATC is a projective technique intended for children and adolescents aged 6 to 15 years. It consists of presenting 16 cards containing images relating to everyday situations of interpersonal relationships. The child is asked to tell a story about each of the images.

The results are presented considering two types of profiles, one referring to eight adaptive scales (trust in others; support-others; support-child; setting limits; identifying problems; resolution 1; resolution 2 and, resolution 3) and another relating to five clinical scales (anxiety; aggression; depression; rejection and, unresolved) and three clinical indicators (atypical responses; poorly resolved and, refusal). We can also develop an interpersonal matrix that allows us to summarize the relationships between the scales, the indicators and the figures identified by the child. There are also three supplementary measures (ego functioning index; aggression index and, projection levels scale) that we chose not to use, as they are more consistent with a psychodynamic reading of the case, which was not chosen for this situation.

Regarding the interpretation of the results, the number of responses for each scale is transformed into a T-value, with all values between 40 and 60 considered within the average. The standard deviation unit corresponds to 10 T-values, so from this value onwards, the result is understood as clinically significant.

In the adaptive scales, the item "trust in others" stood out with a score 28 T-scores above the upper limit of the average (T 88), and the item "support-others" positioned 11 T-scores above the upper limit of the average (T 71). The presence of positive peaks in the adaptive scales may suggest compensatory resources to which we should pay special attention. However, although higher scores generally mean more adaptive functioning, extremely high scores may have pathological significance. In Richie's case, the high score for trust in others may suggest high dependence and difficulties in decision-making. The other scales are within the average, even though resolution 1 and resolution 2 scales are above average (T 68) and below average (T 36) respectively, the values are not sufficient to be considered significant. No resolution-3 was used, although, considering their age range, this was to be expected.

Regarding the clinical scales, anxiety stood out, scoring 11 t-scores above the average (T71), thus assuming clinical significance. The scale relating to depression was only slightly above the average (T42). Conversely, aggressiveness was slightly below the norm (T38), being the lowest of all clinical scales, which contradicts the symptomatic complaint (aggressive behavior). The remaining scales are within the average, although very close to or even at its upper limit (rejection T60; unresolved T58).

The elaboration of the interpersonal matrix allows us to verify that the items trust in others and support-others are mostly distributed among parental figures and peers, while the items problem, anxiety and resolution-1 are mostly concentrated in the child, as well as the totality of unresolved issues. The interpretation of the interpersonal matrix prioritizes the interpersonal relationship process, while the scales and indicators are more related to the content of the stories. If we connect this data with Richie's life history, we realize that Richie seeks support and help from his reference figures, but that his expectations of response or resolution go little beyond himself. Moreover, the high number of resolution-1 even suggests the persistence of a belief in instantaneous and unrealistic resolutions. This is a child who, probably, at least in the first years of life, felt his requests for help and attention were frustrated and therefore became accustomed to responding, albeit magically and out of touch with reality, to his internal needs. The focus of problems and anxiety is also centered

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on the child, possibly reflecting feelings of guilt that he may have developed in response to his experiences of neglect (for example, feeling that he was not up to the attention and availability of his parents).

High elevations in the adaptive scales of trust in others and support from others stand out, interpreted as possible indicators of relational dependence. The clinical anxiety scale showed clinical significance, while aggressiveness was below the normative average, suggesting a discrepancy between the behavioral complaint and the underlying emotional experience. The analysis of the interpersonal matrix indicated a concentration of problems and anxiety in the child figure, with expectations of resolution poorly supported by the relational context.

Narrative Analysis of Richie's Stories

From the analysis of Richie's narratives (news of the week and RATC stories), the following results stood out: regarding the narrative structure, Richie presents a reasonable sense of coherence in his stories; however, some difficulties are observed in the temporal and sequential organization of events and their integration into a whole, i.e., the organization of the different elements of the discourse is somewhat confusing and does not culminate in a global meaning. As for the narrative process, for the age group in which Richie is included, high levels of narrative complexity are not yet expected. However, it is worth highlighting a lower development in the sub-dimension associated with the construction of meanings from experience. This aspect even seems to be related to the previous one, since the difficulty in organizing experience and attributing meaning to it will certainly constitute an obstacle to the construction of meanings from experience.

Finally, the narrative content is diversified, denoting some variety in the themes, characters, settings, and actions he chooses for his stories.

Clues for Intervention Arising from the Assessment

Differential diagnosis

Richie presents problematic behaviors that could be compatible with some of the criteria [14] for attention deficit hyperactivity disorder, oppositional hyperactivity disorder, and conduct disorder, but we consider that they do not fit into these diagnostic categories, as they do not have the persistence or severity required to be included there.

Disruptive behavior disorder not otherwise specified seems to us to be the one that best fits the symptomatology described by Richie and family members, since it "applies to disorders characterized by oppositional conduct or behaviors that do not meet the criteria for Conduct Disorder or Oppositional Disorder. It includes, for example, clinical pictures that do not fully meet all the criteria for Oppositional Disorder or Conduct Disorder, but that present significant clinical disability" (DSM-V).

Therapeutic Intervention

The intervention was based on the assumptions of narrative psychotherapy, integrating a constructivist and relational perspective of the therapeutic process [5]. The clinical framework prioritized the construction of a collaborative therapeutic alliance, understood as a co-constructed process between therapist and client, sensitive to the child's relational styles and developmental needs [2,3].

The process began with the collaborative definition of the problem, identified as "bad behavior," and with the systematic introduction of externalizing language. This strategy aimed to promote differentiation between the child's identity and the problem, favoring the emergence of positions of greater agency and personal responsibility. The identification of unique outcomes and the construction of alternative narratives were worked on through structured activities, such as the "news of the week," widely described in the literature as facilitating narrative reorganization and motivation for change [3,6].

In parallel, strategies for emotional self-regulation and symbolic expression, inspired by narrative and creative approaches, with evidence of effectiveness in reducing anxiety and promoting emotional skills in children, were integrated [8,15]. The grandmother was involved at specific moments in the process in order to favor the social validation of the observed changes, recognizing the central role of significant figures in the consolidation of alternative narratives.

The therapeutic process was interrupted after the ninth session due to abandonment of the follow-up.

Therapeutic Process/Intervention

In planning and executing this intervention, we were inspired by the therapeutic roadmap proposed by Henriques and Gonçalves [16] for applying narrative psychotherapy to children, which is governed by the constructivist assumptions of the re-authoring model of White and Epston [5]. Thus, we started from the premise that the worldview the client shares with the therapist should be used, not to correct or challenge it, but to co-construct more adaptive and functional alternatives for their life, so that the problem is weakened [16]. The therapeutic process will tend to assume a collaborative character, rather than a more didactic approach, whose central objective will be to expand the client's skills in the dimensions they perceive as problematic.

In the first session, Richie, his mother, and his grandmother were present. The family was expected to sit down spontaneously: Richie, somewhat shy and hidden under his hat pulled up to his ears, was the first, followed by his grandmother, a heavy lady in her sixties, who sat to his left, and finally his mother, thin, with a weathered or tired face, but with an easy smile, who sat to his mother's left. The two remaining chairs were occupied by the therapists. In the room, the grandmother assumed the central

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position, which made us imagine that this also happens in the family.

The mother was only present at the first session; in subsequent sessions it was always the grandmother who accompanied Richie. The follow-up, which was proposed as weekly, was often interrupted by the client's unjustified absences. The therapeutic process took place between February and May, with 9 sessions held.

After gathering information regarding his personal and family history, we realized that it was a situation with a relatively structured symptomatic pattern, a problematic family situation, and precarious socio-economic conditions. We then began by defining with Richie and his family what problem they wanted to address. While for his mother and grandmother the problem was unequivocal: Richie's "bad behavior" (aggression towards other children, disobedience to adults, poor school results), for Richie the difficulties were not so clear: "the others also hit me and insult me" (sic). In Barkley's opinion [17], children with behavioral disorders have little awareness of the destructiveness of their actions, therefore not perceiving their behavior as problematic. From Richie's perspective, what could become a problem was being held back in the 4th grade again and "going to boarding school" (a threat from the teacher). The decision was then made to explore which situations or events in his life could contribute to this happening. Richie began by revealing that it was "quite difficult to study," as he couldn't stay focused on the task and that the fights at recess ended up interfering in the classroom, "outside we fight and then in the classroom we call names and throw papers, we're always talking in class and not paying attention" (sic), which also didn't facilitate learning. And he ended up concluding that he would like to "change his bad behavior" (sic) to obtain better school results. An agreement was then made: we would form a team against bad behavior, with Richie as the coach and us as his assistants.

This is how externalizing language was introduced into the therapeutic process. This type of discourse allows focusing the problem outside the child, facilitating the organization of resources and strategies to fight against this difficulty, which ceases to be intertwined with the child himself. The fundamental objective of externalization is the deconstruction of the problem, in order to facilitate and promote the emergence of more adaptive alternatives for the child. The possibility of decentering oneself from the point of view of the problem opens the way to other perspectives, possibly more in line with the subject's desires and expectations.

To favor and facilitate the use of this language, the problem was characterized as a personified entity, with its own desires, objectives, strategies, allies, and fears, which negatively interferes in Richie's life. The "bad behavior" was present almost every day at school, I often visited him at home, and, less frequently, it even appeared at the scouts. Its strategy was to make him think that fighting or disobeying was the best way to resolve situations. Its allies were the "fight" (when they insulted him or said something he didn't like), "some boys at school," and the teacher (who was "very annoying," sic). The desire and objective of the bad behavior was to make Richie fail the year again. It was more difficult to find the weak points of the bad behavior, but he concluded that when he does things he enjoys, the bad behavior becomes less active (going camping with the scouts, shopping with his grandmother, going out with his uncle).

At this point in the therapeutic process, after mapping the influences of the problem on the individual's life and relationships with others, a new stage begins: promoting and strengthening the emergence of alternative narratives, not saturated by the problem, i.e., mapping the influence of oneself and relationships with others on the "life" of the problem [5]. Although the predominance of the problem may seem to absolutely dominate the individual's life, there are details and exceptions (unique outcomes) that are usually relegated to the background, often not even being recognized. Identifying and amplifying unique outcomes is a strategy for detailing alternative narratives [16]. By identifying unique outcomes, it becomes possible to anticipate what the person's life would be like without the presence of the problem.

One of the strategies used with Richie to promote the expansion and consolidation of unique outcomes consisted of a written report of "the week's news" (already used to identify problems and seek/build solutions). This activity consisted of creating a kind of weekly newspaper to which Richie assigned a title and where he reported at least two situations that had occurred to him during the week, one positive and one negative. Even in the negative situation, the aim was for Richie to identify exceptional aspects of the problem and assign meanings related to an alternative narrative. Here too, similarly to what was done to better understand "bad behavior," the impact of unique outcomes at the bodily, emotional, cognitive, and interpersonal levels will be detailed, also contributing to complicating the procedural dimension of the narrative.

The new narratives must be experienced by the subject and validated socially, otherwise they risk remaining mere temporary exceptions [18]. Change must always be supported in extra-therapeutic contexts [19]. In the case of children, because they are dependent on their parents or other significant people, it is essential to involve them in the change process, as they play a fundamental role in its validation or invalidation.

Richie's grandmother remained very closed off from the perspective of the problem, minimizing her grandson's progress. Therefore, she was invited to participate at the end of some sessions, with the aim of encouraging sharing and recognition of exceptions and changes in Richie's behavior. The part of the session with just Richie was usually concluded with a game chosen by Richie from two or three options previously defined by us. The intention of this strategy was twofold: on the one hand,

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it aimed to end the session in a playful way to dilute any internal tensions that occurred during the session and to strengthen the complicity of the therapeutic relationship; and on the other hand, it aimed to promote cognitive (e.g., concentration and strategy planning), emotional (e.g., frustration tolerance and decision-making ability), and social (e.g., rule compliance) skills.

In parallel, Richie's self-regulation of anger and frustration responses was worked on. The strategies to avoid being dominated by "anger" consisted of practicing and training at home what we call "creative relaxation" (running and jumping with punches in the air, in order to provide a physical release) whenever he was called names or felt like hitting a classmate. This was a proposal that Richie embraced very well; in almost every consultation, he reported episodes (unique results) in which it was possible to resist bad behavior using this strategy.

Richie abandoned the therapeutic process after the 9th session. He missed the following appointment, and we waited for him to reschedule, which didn't happen for two weeks. We then contacted him to inquire about the situation, and his grandmother complained about her lack of availability to attend appointments. However, a new appointment was scheduled, but he missed it again, and there was no further contact (Table 1).

Table 1: Summary of the objectives and strategies outlined for the therapeutic process.

General objectives and strategies	• To provide space and facilitating situations for the emergence of an alternative behavior to "bad behavior"	
	• To maintain the consultation space with very explicit rules, so that he can perceive that he is complying with them (favoring the construction of a different image of himself, of a boy who follows the rules)	
	• Structured sessions: plan with him the activities for the next session and summarize the current one (to favor the predictability of the space)	
	• Always focus (at least) part of the session on what he identified as a problem (so that he feels that his request and his opinion were valued)	
	• Clearly show the limits between "good" and "bad", for example, asking for the "News of the Week" related to school, home, alternating good and bad news, presenting the issues in a balanced and contrasting way.	
1st	• Information gathering • Problem definition • Establishing/solidifying a relationship	• Unstructured interview. Start with neutral topics: activities they enjoy, friends, family, routines, and history of the problem • Focus attention on the child, giving them a leading role.
2nd	• Establish/solidify relationship • Complementary information gathering	• SCICA administration
3rd	• Assessment of the perception of interpersonal relationship dynamics	• RATC administration
4th	• Involve family members (particularly the mother) • Inform family members about the assessment process and intervention plan	• Interview only with the grandmother (spontaneously brings a photo album) – the mother cannot attend
5th	• Externalização do problema • Caracterizar o problema e identificar estratégias para lutar contra ele	• Introdução de linguagem externalizadora • Relaxamento criativo
6th	• externalizing the problem	• Characterize the problem and identify strategies to combat it • Introduction of externalizing language Creative relaxation)
7th	• Identify problems and build solutions (externalizing training) • Promotion and training of strategies to deal with negative emotions • Co-constructed narratives (dilemmas, news of the week)	• Co-constructed narratives (news of the week) • arguments of the problems • Creative relaxation
8th	• Externalizing process • Identification of unique results	• Encourage the recounting of experiences and their decomposition in emotional terms • Co-constructed narratives (dilemmas, news of the week)
9th	• Externalizing process • Identification and expansion of unique results	• Co-constructed narratives (dilemmas, news of the week)

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Discussion

This case illustrates narrative psychotherapy in intervention with children in contexts of psychosocial adversity, highlighting the relevance of the therapeutic alliance, motivation for change, and the co-construction of meanings a central factor in the clinical process [6,7]. The externalization of the problem and the valorization of unique results allowed the emergence of alternative narratives, albeit in an incipient form.

The integration of narrative strategies with components of emotional self-regulation and the involvement of significant figures is close to integrative models widely described in the literature, which advocate the therapist's technical flexibility as a condition for responding to the complexity of clinical cases in childhood [9,10]. In this sense, the intervention could have been enriched with a more systematic articulation with the school context, similar to what has been proposed in studies on psychological intervention in educational contexts [20].

Among the limitations of the process, the short duration of the follow-up, the early interruption of therapy, and the difficulty in consistently involving parental figures stand out. Complementary ecological or behavioral approaches could have contributed to a greater generalization of changes, particularly in cases where behavioral symptoms coexist with significant emotional and contextual difficulties [21].

For a more effective intervention, the teacher's participation could have been requested in strategies to improve behavior and academic performance and validation of unique results. Similarly, their participation in scouting should have been valued, since the family may not be a sufficiently structuring support, and other support could be valued. In the process of validating unique results, the resources of the school and the scouting group could have been used.

Externalizing language can quickly provide results, changes that, being still incipient, are not properly consolidated. This perception of change can lead the client to prematurely perceive the problem as resolved and disinvest in consultations and the change process itself, considering it complete, resulting in early abandonment of therapy. Although this is a possibility, it does not seem to us that this is the reason for Richie's abandonment, as the grandmother was not very confident in her grandson's changes. There was a lack of solidification, through intense elaboration with Richie and social validation of the unique results in order to bring forth a new identity, establishing the client's sense of control.

We were careful not to set overly ambitious goals for this intervention (for example, proposing family therapy because it was a complicated situation at that level) that would frustrate Richie, his grandmother, and the therapists. However obvious it seemed to us that Richie's difficulties were related to his distant relationship with his mother (despite the physical proximity), it would not be realistic to propose working with the mother if that was not the request and if, in practice, that availability does not exist.

Final Considerations

Despite its limitations, this case study highlights the relevance of narrative psychotherapy as an approach sensitive to the relational and identity complexity of children with disruptive behaviors. Narrative intervention constitutes a promising way to promote significant changes, particularly when integrated into broader support networks. The integration of narrative strategies with components of emotional self-regulation and the involvement of significant figures is similar to integrative models widely described in the literature, which advocate the therapist's technical flexibility as a condition for responding to the complexity of clinical cases in childhood [9,10]. In this sense, the intervention could have been enriched with a more systematic articulation with the school context, similar to what has been proposed in studies on psychological intervention in educational contexts [20].

References

1. Gonçalves O (2000) Living Narratively: Psychotherapy as an Adjective of Experience. Coimbra: Quarteto.. Coimbra: Quarteto.
2. Soares L, Botella L, Corbella S (2010) The co-constructed therapy alliance and the technical and tactical quality of the therapist interventions in psychotherapy. European Journal of Psychotherapy and Counselling 12(2): 173-187.
3. Soares L, Botella L, Corbella S, Lemos MS, Fernandez M (2013) Different Styles of Clients and the Construction of Therapeutic Alliance with a Therapist. Revista Argentina de Clinica Psicologica 22(1): 27-36.
4. Soares L (2024) Theoretical contributions in clinical psychology. Diversitas Journal 9(4).
5. White M, Epston D (1990) Narrative means to therapeutic ends. In: New York, NY: Norton.
6. Soares L, Oliveira F, Lemos MS, Lucas CV, Botella L, et al. (2012) Motivation for therapy: an important ingredient to change? Revista de Psicologia da IMED 4(1): 640-648.
7. Soares L (2025) Self-knowledge of health professional: Therapist styles. J Clinical Research and Reports 18(3).
8. Lucas CV, Soares L (2014) Being a teen and learning how to surf anxiety: Integrating narrative methods with cognitive–behavioral therapy. Journal of Poetry Therapy 27(2): 69-82.
9. Oliveira F, Soares L (2014) Changing the clinical narratives patients live by: a cognitive behavioral approach of a clinical case of paruresis. Journal of Poetry Therapy 27(4): 193-203.
10. Lucas CV, Teixeira D, Soares L, Oliveira F (2019) Bibliotherapy as a hope-building tool in educational settings. Journal of Poetry Therapy 32(4): 199-213.
11. McConaughy SH, Achenbach TM (2001) Manual for the Semistructured Clinical Interview for Children and Adolescents. In: (2nd edn.), Burlington, VT: Achenbach System of Empirically Based Assessment (ASEBA).
12. Roberts GE, McArthur DS (1982) Roberts Apperception Test for Children (RATC): Manual. Western Psychological Services.

How to cite this article: Monteiro, A., Soares, L.. Caught Between Two Maternal Generations: An Intergenerational Clinical Case Study of Narrative Psychotherapy. OAJ Gerontol & Geriatric Med. 2026; 9(4): 555768. DOI: 10.19080/OAJGGM.2026.09.555768

13. Roberts GE (2005) Roberts Apperception Test for Children: 2 (Roberts 2). In: Western Psychological Services.
14. American Psychiatric Association (2022) Diagnostic and statistical manual of mental disorders. In: (5th edn.), text rev. Washington, DC, USA.
15. Pereira C, Soares L, Alves D, Cruz O, Fernandez M (2014) Conhecer as emoções: A aplicação e avaliação de um programa de intervenção. Estudos de Psicologia (Natal), 19(2).
16. Henriques MR, Gonçalves M (2001) Narrative Psychotherapy with Children: Putting Fear to Flight. In: Gonçalves M, Gonçalves O (Eds.), Psychotherapy, Discourse, and Narrative: The Conversational Construction of Change. Coimbra: Quarteto, p. 20.
17. Gelfand DJ, Jensen W, Drew C (1988) Understanding child behavior disorders: An introduction to child psychopathology. In: Holt, Rinehart, Winston, (2nd edn.), Chicago, IL, USA.
18. Gonçalves M (1999) Narrative therapy with children and adolescents: what are problems made of? Revista de Psicoterapia 11(44): 59-82.
19. Gonçalves M, Henriques MR (2000) Narrative therapy for anxiety: a therapeutic manual for children and adolescents. In: Coimbra: Quarteto.
20. Lucas CV, Soares L (2013) Bibliotherapy and child development: The collaboration between psychologists and educators. Journal of Poetry Therapy 26(3): 137-147.
21. Lucas VC, Soares L (2025) The Impact of Tics Disorder in The Development of a Child. Journal of Clinical and Laboratory Research (JCLR) 8(6).

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