Research Article

Received: 16 May 2024 / Accepted: 26 August 2024 / Published: 05 September 2024

Psychotherapy Process Influenced by Client's Age: Evidence from Professional Clinical Practice

Arbjola Halimi

Dr.
Department of General Psychology,
Albanian University,
Tirana, Albania

DOI: https://doi.org/10.36941/jesr-2024-0119

Abstract

Many attempts have been made to understand factors that contribute reclamation and recovery in psychotherapeutic process. Several studies focused their attention on specific inquiry identifying influences such as settings, environments, culture, approaches but further studies are essential to evolve investigating clients age impacting the psychotherapeutic process. This study focuses on client age, which is believed to be directly related to the outcomes of healing and recovery. The main purpose is identifying psychotherapeutic difficulties and challenges related to the age of the client. The presented data are collected from real psychotherapeutic practice. Methods used to collect data are evidence-based directly from therapeutic process and a thematic data analysis has been made together with behavioral analysis. Some of conclusions suggest that a lot of knowledge from therapist is needed related to psychological and human development, client's culture, client's actual activities and interactions outside session which are different in different age.

Keywords: *Client, Age, Psychotherapy, Difference, Success*

1. Introduction

Healing clinical psychological concerns and helping clients to improve their psychological well-being has never been easy. Mainly because the only instrument of cure and usually even for assessment and diagnosis process is the clinician/psychotherapist himself. Although some instruments are used during psychological assessment such as tests or questionnaires, the clinical judgement is always based on methodologies will the psychotherapist in the center such as clinical conversation and observation. Such methodologies are more important than the standardized instruments to collect accurate data about the client that help understand psycho-emotional statement and client psychological well-being to apply the appropriate psychotherapy techniques. Reliability of these data may vary from person to person and from one psychotherapist to another but their importance on

building a successful treatment plan[1] is unreplaceable. Beside the model of therapy or theoretical framework[2] used on treatment, approaches, and techniques, or even using integrative model, and beside a lot of other factors that influence the success of psychotherapy and treatment, age of client it is considered to have a great impact (since the conversation is prior to healing and the ability to communicate is depending on age among other factors). Different ages means different ability to understand, different language development and different level of conversation, different relationship with the therapist because psychotherapy is also a professional human relationship, different psychological needs, different clinical concern & different explanation of the concern, different roles in life, different level of autonomy from the others, different thinking capacity, different awareness about psychotherapeutic process, sufferance, different psychotherapy techniques, etc. A lot of psychological mechanisms depend on age and there are different psychological issues and needs. The purpose of this study is to identify some psychotherapeutic difficulties and challenges based on the age of the client within the therapeutic process and success of treatment. Although there exist an unlimited number of factors that influence psychotherapeutic processes which usually are treated and analyzed together, in this research the focus is the age of client, and all the dynamics created in relationship with that. Age is a crucial factor affecting early intervention, prognosis, recovery, healing, and change.

2. Methodology

Research is based on data gathered from real clinical cases directly from work practice in private settings. There are at least 90 cases analyzed from different ages. Specific selection criteria were age of clients, ongoing therapeutic treatment from 10 to 12 sessions and similar psychological concern (chronic anxiety). Specific data from the cases are not used for strongly ethical reasons and the analysis is based on psychotherapeutic experience with these cases in at least 3 years period. Qualitative content analysis is used for data discussion, results, and suggestions. Psychotherapeutic treatment was the prior and only purpose during the time (not scientific research) and data gathering it is based on direct treatment experience (evidence-based).

2.1 Sample characteristics

Sample size was divided in 18 cases between age 48-55 years old (10 women and 8 men), 20 cases between age 35-44 years old (12 women and 8 men), 20 cases between age 24-34 years old (10 women and 10 men), 20 cases between age 12-16 years old (12 girls and 8 boys) and 22 cases between age 6/7-9/10 years old (12 boys and 10 girls). All cases were from Albania living in different cities and villages (no living criteria was used) and with similar family income (average)

3. Psychotherapy Process

Norcross (1990), follows: Psychotherapy is "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal

[1] Treatment Plan it is based on specifics need of the client and techniques (Psychotherapy Treatment Planner)

[2] Techniques are based in a theoretical approach (cognitive-behavioral, humanistic, gestalt, psychoanalysis, etc.)

characteristics in directions that the participants deem desirable"[3]
APA definition of Psychotherapy: *n.* any psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns.
Kleinke (1994) described six fundamental therapeutic goals common to almost all psychotherapies: (1) overcoming demoralization and gaining hope, (2) enhancing mastery and self-efficacy, (3) overcoming avoidance, (4) becoming aware of one's misconceptions, (5) accepting life's realities, and (6) achieving insight. Common concerns that bring many to psychotherapy (e.g., anxiety, depression, loneliness, low self-esteem, problematic symptoms and/or relationships) often lead to the patient's feeling hopeless and demoralized. Psychotherapy usually seeks to return or develop a sense of hope or optimism. Insight into the intrapsychic, interpersonal, biological, and social factors that lead to symptoms and problems are likely to assist a person in coping more effectively with their concerns[4].

3.1 Factors influencing Psychotherapy Process

Professional therapeutic relationship, client's expectations of success, coping and confronting ability, client and therapist availability, providing the experience of mastery or control over the problem, and an attribution of success or failure are some important factors influencing Psychotherapy[5]. Other factors include:

1. Settings
2. Clinical Concern
3. Professional person!
4. Age of Client! (Psychological Development)
5. Age of Therapist
6. Etc.

3.2 Psychotherapeutic Relationship

Establishing the professional relationship in different ages requires different abilities and is related with a level of trust that the client should have with the therapist, professional perception (client must feel that the therapist is a good professional), a level of understanding about the process and being collaborative with the process. The professional relationship of psychotherapy is limited on time, frequency of contact, content of discussions, and level of intimacy in which a person may talk over problems or interaction (children) with a professional, etc.

3.3 Settings

Professional types of settings where psychotherapy is applied have a lot of influence (Private, Hospital and Health, School, Clinical, Forensic, or Involuntary commitment, Educational, etc.). In a study done by T. B. Karasu, S. P. Stein, E. S Charles[6] focused on the effects of therapist and patient age as factors in the evaluation and treatment of adult psychiatric outpatients, resident and not resident, data suggest that older patients are perceived as sicker, but less treatable than younger patients or patients of the same age group as therapist. Residents express a strong preference for treating younger patients, but more readily develop treatment relationships with same age patients. Both older and younger patients were significantly less likely to remain in treatment.

[3] *Contemporary Clinical Psychology, pg. 265*
[4] *Contemporary Clinical Psychology, pg. 267-268*
[5] *Contemporary Clinical Psychology, pg. 285*
[6] *Age factors in patient-therapist relationship T B Karasu, S P Stein, E S Charles*

3.4 Professional person

Before it was believed that only physicians could provide psychotherapy efficiently, thus preventing clinical psychologists and other non-physicians from conducting psychotherapy services. In fact, it wasn't until a major lawsuit in the late 1980s that psychologists won the right to be admitted as full members of American psychoanalytic institutes, resulting in their current ability to conduct psychoanalysis with patients (De Angelis, 1989)[7].

3.5 Psychological/Clinical Concerns

Psychopathology is a broad term used to describe theoretical and scientific understanding of mental disorders such anxiety disorders, humor disorders, personality disorders, neurosis, psychosis, developmental disorders, and other psychological disorders. It is believed that psychotherapy works better and is more efficient in treating those disorders since the cause is often psychogenic. Other issues that may need clinical attention as described in diagnostical manuals[8] may impact enormously the success of psychotherapy such as relational problems, quality of the parent-child relationship or when the quality of the parent-child relationship is affecting the course, prognosis, or treatment of a mental disorder; Behavioral problems that include conflict resolution difficulty, withdrawal, and over involvement; Disruption of family by separation or divorce; High expressed emotion level within family hostility, emotional over involvement. Uncomplicated Bereavement and loss (some grieving individuals present with symptoms characteristic of a major depressive episode), Abuse and Neglect; Maltreatment by a family member (e.g., caregiver, intimate adult partner) or by a nonrelative; Legal implications of abuse and neglect, (care should be used in assessing these conditions and assigning these codes). Having a history of abuse or neglect in the past (can influence diagnosis and treatment response in several mental disorders and may also be noted along with the diagnosis). Child's parent or other caregiver that deprives the child of basic age-appropriate needs and thereby results, or has reasonable potential to result, in physical or psychological harm to the child; Adult maltreatment and neglect problems; Spouse or Partner violence and abuse; Psychological adult abuse by others; Educational & Occupational problems; Housing Problems; Homelessness; Discord with Neighbor; Lodger, or Landlord, Problem Related to Living in a Residential Institution, Economic Problems[9]. Clinicians should consider the developmental needs of the client and the cultural context.

3.6 Age of Client and Development

3.6.1 Questions and Dilemmas

Many questions may arrive:

How do we apply psychotherapeutic techniques in children? Adolescence? Young adulthood? Adult? Persons in the middle-age? Are psychological and psycho-emotional concerns the same for different ages? etc. Role and Self in different ages. Cognitive ability to understand, attention (to follow therapeutic session), psychotherapeutic collaboration, family issues in children and adults (family presence on therapy), development and rapid change on children and adolescence, transition period and assessment mistakes during adolescence, development, and life transitions in adults. Psychotherapeutic goals based on age; Symptoms and reactions, level of motivation, insight, progression and prognosis, disposition to treatment and drop-out, same age group as the therapist,

[7] *Contemporary Clinical Psychology, p. 46-47*
[8] *DSM-V-RV*
[9] *DSM-V-RV*

residents, age of therapist, abandonment of therapy, setting goals and expectations for the process in different ages, relapse (more likely in children and slightly less in adolescents). Is change difficult at some ages? Motivation, Insight, disposition. How are assessment data collected in different ages?

Carr (2009) emphasizes clinical concerns that are typical for certain group ages therefore psychotherapeutic interventions that are required are specific according to the nature and psychoemotional concern that affect each age group. He also gives importance to family involvement on treatment (family therapy) specially for chidlren, adolescents and young adults.

Mackey (2009) emphase that human are in a process of development of Self which is a different process from childhood to aduthood meaning that the damaged self on Adulthood is different from previews stages of life and consenquently the Psychotherapy Process. (Pg. 66-75)

During treatment of early traumas where painful experiences are inevitable as much as the need to stabilize a relationship with the therapist the last one can be threatened from attachment experiences or from the need that clients have (with ealrly traumas) to learn a new kind or form of attachment (Mqueen at all, 2009; William, 2004. Pg 77). In different age group the possibility for this new way of attachment and the increase of capacity for reflection on the internal emotional state (Mqueen, 2009; Solms & Turnbull, 2002. Pg. 77) it is also different.

Refering American Psychological Association website (2003), Glicken (2009) wrote that the most common emotional problems experienced by older adults are different from the other ages such as dementia from 5% (between the ages of 65 and 85) to 30 % (over the age of 85), an irreversible deterioration of cognitive abilities accompained by emotional problems including depression, anxiety, paranoia and serious problems in social functioning, sleep problems, health issues and feelings of sadness and helplessness.

Children and adolescents bring different motivation for treatment from the involuntary nature of client and lack of understanding the therapeutic process and objectives. There is also a different child perception about therapist (Thompson & Fedewa, 2015. Pg 7-8)

4. Collected Data, Analysis and Discussion

4.1 Empirical data from clinical practice, usual concerns, and discussion

Child (he is only a *Child*): Communication, Application of techniques, Information (who is explaining?), Level of understanding, Dependence, and guidance (from the system, parts of the systems directly or indirectly)

1. Psychological suffering in children is differently expressed compared with adults. It is important to understand a child's behavior as their prior endeavor of expressing their feelings *(all children in therapy didn't express complains but they expressed agitation and chaotic movements or fear physical reactions*)
2. Therapeutic Relationship. It is important at the beginning of psychotherapeutic treatment to not connect with caregiver but with the child, although it is important to have a safe and "friendship" communication with the caregiver present. This will help a child understand that you respect, accept, and encourage his level of autonomy and will help him feel safe in front of a stranger (therapist) and with the process of psychotherapy (to follow and collaborate). Start with a positive phrase or with a smile. Put some toys in visual area for him/her to see them from the beginning. Make him/her feel free to touch/play with them from the beginning and then start talking with him and the caregiver. Start to observe also. You do not need to waste time. *At least 18 cases of children were touching the toys in first session and in all of them the therapeutic relationship was established. In 4 other cases when toys were not available it took 2-3 sessions to establish therapeutic relationship*. These results show important differences in the process from children to adults where it required a considerable number of sessions (at least 3 to 4 sessions in all the adults' clients).
3. Communication. It is necessary to be careful with communication and language of the child,

adolescent, and their culture (phrases used in the family, school, or community). Use simple phrases and ask not directly (for example you are discussing some situation, and you are asking his/her opinion about that. How it happens/What happen). Make him feel that he/she is saying, not that you are asking. Conversation must include the fantasy of the child. Almost half of children engaged positively to the request of sharing opinions and techniques stimulating fantasy of the child was extremely helpful in collecting data from child sufferance and misinterpretation. *All the children (22 of them) responded positively to the technique facilitating psychotherapeutic process*. Differently in adulthood therapist is very limited to use fantasy techniques as contents could be manipulated by clients.

4. Understanding the normal developmental anxiety of a child is an important assessment process.
5. Technique applications are different. Psychotherapy as a game and role play in children. Creativity from psychotherapist is needed as it is asked to perform different interaction with child. The level of interactivity should not influence the ability to observe and collect data and the focus on healing. Data gathering is difficult because a lot of attention is focused on interaction. Observation and interaction are important. The application of techniques is not equally possible. *In children 16 cases interacted with the therapist by playing or touching the therapist creating more confidence in the process and progression as the improvement was rapid and qualitative (differently from adult where the process was slow and sluggish)*
6. Scheduling the time of session without destructing child activities (sometimes it is difficult to understand because parents will not explain to therapist (they are focused to schedule the time according to adults' activities)) so is better to ask/explain them before or to discuss this with the child if he/she is at least 6 years old). This will help a lot in the therapeutic relationship.
7. Information (Who is giving information or explaining child concern? Who is referring? The ability of the referring person to understand a child's psychological needs. Efforts to understand psychologically the referring person and to make a rapid evaluation of him/her are needed.
8. Psychotherapists must be attentive/careful with silent psychological concerns.
9. Dependence. A child and even an adolescent is always part of other systems and guidance and that brings a lot of confusion in therapeutic relationship because parents always ask children what happened during the session and sometime what they discussed. Sometimes if there are things, they do not like they end-up sessions (the deciding for the child) or make the child/adolescent even more confused (specially the child). Parents' judgement for psychotherapy process is not a professional judgement but an emotional one. Psychotherapists must not feel overcharged by parents' complaints about process or interruptions.
10. Children will behave as adults want or have asked them to behave sometimes and you must make him/her feel that this is a free environment to behave as they want. This will help establish the relationship and start the healing process. Parents may feel shame from children's behavior although many times it is a normal one and they will tend to control them by asking "not to move or play like this" Assure children to behave as they feel and to be free.
11. Learn how to face/resolve problems of confidentiality (if the child is referred by school, parents discuss the process of therapy with teachers breaking the confidentiality). Problems with confidentiality (if a child sees you in the street, he will talk to you).
12. Who is referring to the case and why? A child will never come alone or take a decision for therapy. There is usually a reference from parents, school, or other caregivers.
13. Problems with more than one caregiver, family constellation, family transition, story, events, evaluation. Usually with children it is needed to evaluate the entire family (even more). Assessment of the Caregivers together with child's living environment or other systems

(especially school and community near home) is important.

14. Ask about child living/lifestyle (Adults)
15. Child alone? Child alone is never enough in the process of therapy. Firstly, there is always fear from the stranger (therapist). Secondly information it is needed about child behavior (observation outside the sessions) and parents or caregivers are a strong source of that information although it is better to be careful on the accuracy of information they are sharing for the child and their abilities to understand child reaction and sufferance/psychological concern. Adults' evaluation is also needed.
16. Adult-child relationships need to be evaluated and difficulties (if there are) accepting parental/adults' behaviors that may have caused the problem.
17. Who accompanies the child to therapy requires analysis.
18. Therapeutic environment and contact. Therapeutic environment must be pleasant and the meetings not formal. It is even better if you smile or start with a play.
19. In families with more than one child, invite and observe them all in relationship together.
20. Understanding the culture of the family and other adults, transgenerational implication, and relationships adult-adult not only with the partners/parents but others as well (cousins, affiliated persons in child's life).
21. Health issues of adults that affect children need to be identified. Health issues of adults may create/cause a lot of fears and other psychological concerns in children.
22. In the assessment and intervention process analysis about the way school or teachers refer the case must be accomplished. Sometime problems with teachers are present in parents and children. They use an accusation style on parents, and parents behave like victims or use self-accusation believing everything teachers says (inferiority of adult and inferiority of the child). Often the focus of treatment should not be the child or adolescent but the adult.
23. In children it is important to work hard with the symbolism and natural imagination of the child, without harming it. Understanding symbols, characters, and fantasy stories is extremely helpful in understanding child's sufferance or distress and making the assessment. This also helps understand protection strategies that the child may have built up mentally to protect themselves from anxiety or emotional pain. Evaluate the child's storytelling, emotion, preference of characters and interpretation.
24. Understanding a child's fears requires advanced knowledge on cognitive development (level of comprehension and reasoning). Although children's express words that he/she is not afraid of true/untrue figures or animated, this often does not turn out to be true. Children need guidance, explanation rather than exploration (they may be involved in a completely harmful and aggressive play without realizing it and this can cause them fear, anxiety, and nightmares).
25. Children do not understand the cause, nor do they explain suffering. Observation and interaction are extremely important.
26. The problems in children are clearer. Although they find it difficult to express themselves because of language development but also the inability to understand their suffering, the use of appropriate comprehension techniques helps a lot in clarifying the problems, while the adults can hide the problem (through conversation)
27. Psychotherapists must be aware of adult jealousies. Parents or other adults who bring their children or teens in therapy along the way may show "jealousy" or feelings of discomfort to the therapist about parenting ("the therapist may not know better than me what my child needs!")
28. Be aware of adults not taking responsibilities or disconnecting themselves from psychotherapeutic process ("you fix him")
29. Consider where the child is going after session (what about his/her living environment)
30. Psychotherapists must combine when it is possible child individual sessions interspersed with family therapy sessions.

31. It should not be forgotten that children are developing quickly (changing), and the focus of psychotherapy should be on improving factors that help a healthy psychological development and reduce anxiety or others psychological clinical concerns. Whereas in the case of adults, more than encouraging external factors (although they are not excluded), work is done/focused by stimulating internal psychological mechanisms that make them more powerful. Internal psychological mechanisms are considered important also in children but always in combination with external factors.
32. See outside (what is happening in different settings). School, Neighborhood, Family,
33. Consider evaluating parent behavior, caregivers' behavior, siblings' interactions, time the child is spending with them, parents' life, etc.
34. Adult diseases can affect children, family conflict can affect a child and the continuing of psychotherapy process.
35. Exploring "early traumas" in children is an elaborator process different from adults.
36. The information psychotherapist needs about cartoons, animated movies, virtual friends, etc.
37. Initial Consultation, Assessment, Development of Treatment Goals, Implementation of Treatment, Evaluation of Treatment, Termination, Follow-Up are all different in

Adolescent (is a Child in the past by life experience and Adolescent in the present)

1. Psychological sufferance in children is expressed by actions inside and outside the process of therapy. Otherwise in adolescence sufferance is expressed by words and actions usually not inside the process of therapy. For that reason, in children, we focus a lot on behavior also because resistance is almost totally absent in them (except at the beginning because of the fear from therapist). Psychotherapists need to be aware of adolescent resistance (everything looks "old", therapist as well). Adolescents are very selective at what kind of information will share with therapist and that requires more sessions to understand adolescent psychological emotional concern and intervention (adolescents' resistance is different from children resistance partially because they are careful with their self-esteem). They want to look good in the therapy. They will hide at the beginning their bad reactions/behaviors outside therapy. It takes time to build therapy confidence/trust with adolescents. Consider that adolescents are aware of family issues/conflict, etc.
2. Therapeutic Relationship. How to start and how to make him/her believe in you? Who is referring? There are moments when adolescents are coming to therapy by parent/adult/others' request. This may cause serious problems to establish therapeutic relationship if they are "forced" to do so. Prior for therapist at this moment is to ask adolescents if they want or not to come. They may be dysphoric/ repulsive with the therapist, also because they may have lack of information about therapist, process, and their destructive behavior (not to be aware about the consequences of their destructive acts). Other times adolescent can be acceptable with the therapy, collaborative (especially when they ask therapy by them self), but therapist must be careful with the information is sharing with adults (only by adolescent permission or after discussing firstly with him). In the first steps is good to explain to adolescents that no one can be forced to come to therapy for him to feel free and not repressed. Other times therapy is impossible (adolescents will refuse) and the only thing you can do is to give professional advice to adults after having and securing to have the right information from them (*behavioral observation analysis)* Another important issue is to consider the surroundings of adolescent life (factors affecting directly/indirectly the child. For example, conflict in the family, neighborhood). Sometimes their problems may not look serious to you but please consider that they may be extremely serious in their age (romantic relationship, image concerns about how they look, problems of understanding the difficulties or risks- ***central themes from cases***). Some other times when adults understand that some of their issues relate with the child concern, they start to change behavior (sometime not for real) to look good to the therapist or to the child

(adolescents always have an inner conflict in front of their parents (feelings) (*behavioral observation analysis*). Adolescents may change their opinion about their parents through sessions (parents start to change their behavior to have a positive opinion from their children during session (what he/she is saying to therapist?)). In this point it is important to overlap the risk at therapy because adolescents may think their parents are changing for real (by not coming any more to therapy) and not only from the fear of child discussion inside the therapy with the therapist (*it was a riks in 4 cases*). Some other times, even one session is fully enough to change. Parents feel tired with adolescents. Psychotherapists must work with parents/adults to help them be aware about their role and impact on therapy. Psychotherapists need to consider parent-adolescent-therapist relationship and the autonomy of the child. Ask what happens after sessions. Some adolescent emotional issues are related to parent/adults' maladaptive behavior or habits *(in 8 cases parent didn't understand autonomy concept directing all adolescent behavior also in therapeutic intervention).* Be aware you are the therapist not the caregivers as sometimes adolescents tend to have a more approximate relationship with therapist since he/she feels you understand him/her better. Be careful with therapy addiction/dependence.

3. Relationship with peers, adults, family members, first attractions, self-esteem, self-image, self-identity are some ***central themes*** to investigate, evaluate and discuss with adolescents.
4. One of the most typical challenges of psychotherapeutic process in adolescents is to understand the typical transition and dependence/independence relationship with adults. Confidentiality, type of information you can discuss with adults, culture of group of peers (***central theme***), education, and communication problems of adults (***central theme***) (*you have become a cow, stop eating*)
5. It is important to focus on the teen as he or she begins the conversation or even if they don't start a conversation and not on the adults who are accompanying him or her.
6. It is also important to discuss with adolescent first all kinds of information that you will share with the adults and after you get adolescent approval you explain why you need to do so by sharing some information with adults). *Almost half of the cases show resistance to share information with adults (parents or caregivers)*
7. Investigating cases of abuse and guilt which are more difficult to identify in the adolescent as he or she tries to hide them. Adolescent may feel shame or weak to talk about and they may be concerned about "what the therapist is thinking of me." (*observed in 4 cases*)
8. Adults often work with children and adolescents to distance themselves "by knocking on the door."
9. In the case of children and adolescents, the physical appearance of the therapist is also important. With teenagers and their dress. *Six adolescents made comments on how therapist was dressed up.*
10. Beware of parental behavior. Do not position yourself with the parent. You are often an adult, so adolescents and children realize that not all adults are the same. *Parents took the position of guiding the adolescent "together" with therapist in 9 cases.*
11. The decision to continue or discontinue is not up to the child or adolescent sometimes as well as the decision to come (who pays?)
12. Adolescents, even though they are either silent or very intense in their expression, usually have a clearer picture of the causes of their suffering (they are mostly obstacles encountered by others internalized). *Internalization of others' opinions as a **central theme** influencing insecurity in clarifying self-image and self-esteem (although they may have a clear image of self, they feel insecure if it is the "right image" "I don't now…they say I am like…. I don't do things for that…. I don't think I am like that…but maybe they are right)*
13. The discussion of physical appearance in adolescence takes an extraordinary proportion. They worry too much about things in their body appearance *(central theme)* that we as adults may not consider important about, but it takes a deep and longtime distress to them.

Belly, height, weight or misconception about weight, nose, face, "circles around the eyes", etc. Strange explanations about appearance even though it can be extremely beautiful. The adolescent, constructing the image of himself, can never be understood without others (self-image is the way the individual thinks that others see him or how he thinks that others perceive him, is built in relation to others)

14. Sometimes the suffering of a child or adolescent comes from the extreme demands of adults who want to "fix the child" while violating his naturalness (there is nothing to correct). In these cases, everything is ok with the child and often the question arises what to do with psychotherapy (change)? *In 2 cases parents brought adolescents in therapy but there was no need for therapeutic intervention in adolescent.*
15. Remember that a large part of psychological problems generating later in live or other ages originate in adolescence. All adolescents' life experiences matter. This does not happen to an adult who selects, excludes, or ignores some experiences that he or she has learned are not as important (*differences related with age in treatment from analysis of central themes between adolescents and adults)*
16. Beware of giving advice. It happens that caregivers of children or adolescents consider psychotherapy a process of giving advice, so it is important to be careful and investigate the intentions of the visit as well as to clarify that the advice is professional and completely different from the therapy process.
17. In a Child or Adolescent, psychotherapists can observe and evaluate some relationships with others since they never come alone.
18. Consider the normal transition of adolescents and do not confuse that with clinical/diagnostic issues!
19. Teenagers tend to hide problems with parents because they may still be afraid of them.
20. Follow adolescent need and avoid diagnostic language (there is a risk that the adults will use that with him/her later)
21. Early traumas need to be elaborated with an extreme precaution and professional attention.
22. Information you need about social media, internet, models images, virtual models ***(central themes)*** of interaction in adolescents, etc. Psychotherapists need information about adolescents' activities, trends, models, etc., how they feel they look in front of their peers (***prior central theme***) (self-esteem, self-image, identity)
23. Initial Consultation, Assessment, Development of Treatment Goals, Implementation of Treatment, Evaluation of Treatment, Termination, Follow-Up are all different in adolescence.

Young Adult (*Child, Adolescent in the past and Young Adult in the present*), relationship with peers, partner, colleges, other adults, self-realization, social self (***central themes***)

1. Therapeutic Relationship. Establishing a therapeutic relationship with a young adult is easier compared with previews ages mentioned above since the request for help is coming by themselves (not by others or sometimes by others but with their approval) (*in all cases*). Meanwhile with young adults is a risk to stop the process of therapy early before the ending because they may think "that they can continue by themselves now" (after feeling good in the first sessions) (*in 6 cases*). Sometimes arriving at this point in the process of psychotherapy is a good improvement for next and continues steps that an young adult may need to do to recover from anxiety and other emotional clinical issues (they may say "I want to try be myself now") but other time this can be a very harmful and premature decision leading beliefs that even psychotherapy does not help them and there is no hope for them (***central theme***) (not seeing that they interrupted the process earlier and without psychotherapist approvement) (*all the 6 cases return to therapy after 3-6 months having that thought*)
2. In young adults it is observed that injustices in the work environment or physical distances from work play an important role along with conflicts of an economic nature (***central***

themes). Evaluating real and proactive causes, existing, and during the process of psychotherapeutic change is a focus of attention in psychotherapy at this age. *(differences in here is that is difficult for therapist to manage all outside influences in clients)*

3. In adults and adolescents marked problems with online reading and self-diagnosis, exposure to information (should be investigated). Lack or confusion of information as well as exposure to events (they analyze similar cases).
4. Relapse. Factors that can cause relapse must be elaborated before therapy ends.
5. In Young Adults and Adults, psychotherapists do not have the possibility to observe relationships with others and usually the only source he has is the client himself (*differently from children and adolescents).*
6. Avoid Diagnostic Language (they may come to therapy only to confirm their doubts/hypothesis/diagnosis redden in internet and fears which is extremely large activity clients (adults and young adults) are involved during these days. Language they use in therapy is usually related with their internet readings (*I feel emptiness. I have depression and I am scared I will go made because of "my depression": self-diagnosis*)
7. Direct questioning (Leave the client to talk but you formulate some questions). Clients will direct you to the things they consider important and not for the real cause. (*all adult clients did that at the beginning of sessions differently from adolescents who tried to hide less or to be less superficial than adults in telling their stories giving therapist a deeper insight of their psycho-emotional wellbeing compared with adulthood)*
8. Wait for the client to be ready to talk and share some delicate content.
9. Ask always if they used info sources, especially internet, media, etc. (*by behavioral analysis 42 cases adults & young adults used internet for information and a lot of effort it was needed for therapist to identify and understand quantity, quality, frequency, impact that is usually negative of such experiences together with clients' beliefs for "the right sources" differently from children and adolescent)*
10. Ask if they have other psychotherapeutic experiences or "alternative" forms of treatments and beliefs they may have related with those experiences and the actual psychotherapeutic experience.
11. Adults tend to make their own decision to discontinue the therapeutic process even when it is not over and for this reason may experience relapse.
12. Information you need about social, legal, economical, health environment.
13. The simulation is to be investigated in adults while in children it is less possible.
14. Initial Consultation, Assessment, Development of Treatment Goals, Implementation of Treatment, Evaluation of Treatment, Termination, Follow-Up is different in young adults.

Adult (Child, Adolescent, Young Adult in the past and Adult in the present).

1. Therapeutic Relationship. They may establish a relationship, but the professional authority of psychotherapist may be at risk depending on how client and therapist shape their power during process. *A lot of resistance was present in 36 adult cases differently from children, adolescents and young adults' cases.*
2. Psychotherapeutic Approach may influence the layer of psychotherapeutic dynamics.
3. The suffering in adults is related with various roles (***central theme***) they may have, and psychotherapist must explore all influential dynamics because a lot of actual interpretations are related with those experiences or perceptions in life/role change).
4. Roles- Parent, Partner, Worker, Coworker, Adult in the family and responsibilities, Guidance, Model, etc. (***Central themes***)
5. Adults require a higher number of sessions than children and adolescents to whom change comes faster but this depends on the severity of the problem. The reason for this is that adults experience their fears more extensively and are often more ashamed of them.
6. It is also necessary for adults to investigate if there is a history of drug use. This is because adults tend to avoid psychotherapy thinking that they can solve the problem on their own

and start treatment / self-medication with sedatives. Adult clients may seek for psychotherapeutic help after lack of improvement from using medicines and once they become aware concerns are psychological in nature and not physical. Therapists need to be aware of the substance effects in clients' cognitive processes as they impact their brain. *Differently from other ages the cases were more complicated clinically by medical use.*

7. The thoughts / worries and dynamics that accompany adults are more confusing as are the fears that follow one another. This is mainly due to their increased life roles and responsibilities, consequently they think that they will have more consequences ***(central theme)*** (e.g. if someone is suddenly scared of going crazy. Other fears developing are such as losing the parental role, work, etc.)
8. In adults, more than with external factors (although they are not excluded) psychotherapy is focused in stimulating internal psychological mechanisms that make them more powerful.
9. Health info/knowledge it is needed be therapist with adults because a lot of adults' fears are related with their physical and mental health (***central theme***).
10. Defense mechanisms in adults are stronger and as a result more difficult to treat.
11. Adults understand better psychotherapeutic process, but they may have an overprotected attitude toward therapy and will chose with more resistance the type of information want to share (therapist must explain sometime why is doing such question "Why are doing me that question? How is this related to what I have?"). Adult defensive interactions are stronger, more difficult and can even become protective (why are you asking me about this?) by selecting to the maximum the information they share (*observed in 12 cases*)
12. Some types of behaviors are transformed into habits and the change is difficult because the client is scared/frightened to take that risk (life equilibrium that he/she has although unhealthy gives him a little sense of stability). Psychotherapeutic change if it is not well-defined with the client can bring improvement in one direction but aggravation in one other.
13. There are moments when you must make predictions about client behaviors.
14. Adults have more fears related to others. For example: "*-I am afraid of fainting. If I faint and where I can be? How do others react? It is a shame*". Adults that during childhood were told shame about this behavior shame that behavior. In adults the relationship with others in general causes fear while in children the fears are generally related to those who caused the harm or perceived harm.
15. The mentality, culture and internalized traditions ***(central themes)*** have a pivotal influence that determine therapeutic relationship, process, continuity and success, feeds, family support, etc.
16. Adults make more interpretations and generate more fears after the initial fears (more confusion, more analysis). In adults, if they are not clinical situations, there are generally embarrassing situations which are experienced with extreme fears and feelings of shame ***(central theme).*** It usually starts with a health problem or thought as such (panic attacks) which generate immediate symptoms such as fainting, diarrhea, drop in blood pressure, numbness or shaking of hands, sweating, cramping, difficulty in breathing, foot cooling, etc.
17. The focus on therapy in adults is comprehensive.
18. The presence of other adults in the process (and / or adolescents) is partly helpful or even non-helpful (depends on the level of understanding of the process and the relationship / relationship they have with each other)
19. It is more difficult to change experiences and mental distortions towards these experiences in adults. Lifestyle is more influential in adults (family care, responsibilities, life constraints, etc.). *In all the adults' cases the number of sessions was greater compared with children, adolescents or young adults.*
20. Some behaviors have already become a habit and have created a kind of life stability although not healthy making change difficult. Therapeutic change can bring improvement

in one direction but deterioration in another. *In one client for example there was a lifestyle established (type of cooking, time of eating, type of food, use of apparatus measurements for heart, blood pressure, temperature) which was difficult to change. In adolescents and children (although in some cases they created some habits as well, those habits were not as complicated as in adult client and with a lot of more difficulty to change them (as there were related on maintaining the problem) in adult client.*

21. In adults the therapeutic process is experienced more painfully as the experiences, events or feeds in question are long out of place or preserved.
22. Exposure to information in adults
23. Interpretations on previous experiences (I do not go for anything, something will always happen, I failed (***central theme***)
24. Life experiences in adults are numerous (positive and negative)
25. Early traumas need to be elaborated.
26. Information psychotherapist is needed in social, health environment.
27. Initial Consultation, Assessment, Development of Treatment Goals, Implementation of Treatment, Evaluation of Treatment, Termination, Follow-Up is different in adults.

5. Conclusions

Some conclusions suggest that the most influential factor in psychotherapy is clients age and that a lot of knowledge it is needed from therapist for human development, trauma processing in different ages, approaches and techniques applications, client's culture, client's actual activities and interactions outside session which are different in different age. To conclude psychotherapists must be aware about continuous changing in clients age as they interpret differently life experiences.

A practical implication following this study is related to an encrease of professional awarwenes among therapists that before to ask for the right model of psychotherapeutic intervention and before to start evaluating clinical concerns and intervention age is a dominating influencing factor.

Recommendations relate with future studies to be performed collecting data from other psychotherapists experiences working with cases and to compare or create further understanding how client's age influence psychotherapeutic process.

This study has several limitations but the most important is analysis of the cases from one single perspective (psychotherapist/researcher itself treating the cases) opening opportunities for many biases by pychotherapist beeing directly involved with client psychotherapeutic issues and impact.

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