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Research

PSYCHODYNAMIC PSYCHOTHERAPY OF A CHILD WITH INTERNALIZING SYMPTOMS: A STUDY OF OUTCOMES

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When psychopathology is considered as a developmental phenomenon, the data on child psychotherapy must be of interest to all therapists. The aim of this study was to assess the results of psychodynamic psychotherapy in a child with internalizing symptoms using data obtained from the patient, her mother, her teacher and her psychotherapist. A systematic single case study was performed. The data were obtained using the following tools: interviews, the Rorschach Method, the Child Behaviour Check List for Children and Adolescents, the Teachers Report Form and questionnaires completed by the patient's mother and therapist. The psychotherapeutic treatment lasted for 40 sessions and the patient was 8 years old at the start of therapy. She presented with head and stomach aches after the sudden death of her father, as well as difficulty adapting to her new school. The Rorschach results indicated improvement in cognitive triad variables, interpersonal relations and expressing affection. Data from the patient, mother and therapist converged to yield the clinical picture of a more spontaneous girl, dealing better with her feelings and more socially integrated. This points to the importance of using mixed methods to assess psychotherapies and of consulting multiple informants.

KEY WORDS: PSYCHODYNAMIC PSYCHOTHERAPY, CHILD, CASE STUDY, INTERNALIZING BEHAVIOUR, ADJUSTMENT DISORDER

INTRODUCTION

Epidemiological studies report that most mental disorders have their inception in childhood or adolescence (Kessler *et al*., 2007), with half of those cases having their onset at the age of 14 (Kessler *et al*., 2005). Considering that spontaneous remission is unlikely for this population (Ford *et al*., 2007), research into treatments for children and adolescents is urgent. Furthermore, when psychopathology is considered as a

developmental phenomenon (Caspi *et al*., 2014), the data on child psychotherapy must be of interest to all therapists.

Emotional and behavioural problems are understood as symptomatic patterns, classified into two types: internalizing and externalizing (Achenbach & Rescorla, 1991). Internalizing problems are emotional disorders internalized by the individual; that is, they operate more on the subject than on the environment and the people around the child. Depression, anxiety, obsessive–compulsive disorders, somatic complaints, withdrawal, fear and sadness are examples of internalizing symptoms in children (Achenbach & Howell, 1993; Wilkinson, 2009). There is increasing evidence that psychodynamic treatments can be effective for children with internalizing disorders and symptoms, from the perspective of clinicians, the children treated, parents and teachers (Göttken *et al*., 2014).

Psychodynamic psychotherapy with children is derived from psychoanalysis and can be conceptualized as a form of interpretive treatment based on psychoanalytic understanding. Its object is to resolve symptoms, modify behaviours, improve global functioning and enable the child's return to the normal developmental impulses (Sours, 1996).

Although psychodynamic or psychoanalytic psychotherapy occupies a significant space in clinical practice, for many years psychoanalytic and psychodynamic therapies have been considered to lack a credible evidence base (Midgley & Kennedy, 2011). Many psychodynamic psychotherapists believe it is impossible to operationalize the concepts in order to instrumentalize the research, claiming that attempts at objectification can turn highly complex processes into simplistic measures. There is no consensus on the criteria for the target audience of psychoanalytic treatment; in addition, treatments are typically non-manualized, which makes it difficult to conduct empirical studies (Gabbard, Gunderson & Fonagy, 2002; Eizirik, 2006).

The specificities of child treatment also contribute to the discrepancy between research and clinical practice. First, it is the parents who seek treatment, not the patient proper. The child is developing continuously and these normal changes can confound the effects of treatment for a specific disorder, especially if treatment is medium or long term (Target & Fonagy, 2005). Another obstacle is inconsistencies among informants, which means that an intervention cannot always be evaluated decisively. The range of informants who can characterize a child is wide, ranging from the therapist, the person who made the referral and the school, to the family and the child. The researcher must therefore choose the most appropriate source of data for the purposes of the study. The tools that allow using the child as a source of reliable information, in order to assess his psychological changes, are rare and difficult to apply (Maruish, 2011). The perception of the school is limited, since it allows only for data from a single context, in which only some of the symptoms are observed. Parents have privileged information about the emotional and behavioural problems of their children (Treutler & Epkins, 2003), as well as their evolution or involution during psychotherapy, since they live with the patient in different contexts for long periods of time and are more aware of subtle changes in their child's behaviour. Furthermore, the parents are already linked to the therapist, facilitating access for the research. Therefore, mental health professionals generally consider the reports of the

parents with regard to the improvement, worsening or stagnation of their child as the best source of information and the best means of operationalizing therapeutic outcomes in clinical research.

Meanwhile, the way in which parents perceive the emotional health or disorder of their children is subject to their own personal conflicts, the couple's conflicts and their expectations about treatment. This perception does not necessarily represent the child's actual situation. It is also necessary to consider the discrepancy between answers provided by fathers and mothers about the behavioural problems of the same child (Borsa & Nunes, 2008).

Given the implications of the various sources of information on treatment, it is relevant to investigate the perceptions of multiple informers about the effects of psychotherapy. The research and systematic publication of these perceptions are vital to establishing evidence-based treatments, taking into account the growing academic and social demand for clinicians to conduct research that informs their practice (Hott *et al*., 2015).

It is also important to highlight the potential of studies based on single cases. Single case studies consider an individual entity (patient, therapist–patient dyad, group therapy or interaction between these) as a unit of analysis and interest (Eells, 2007). It serves as a naturalistic and flexible research strategy that uses multiple methods and varied sources of evidence and information to intensively and profoundly describe an individual case. In addition, it focuses on intra-subject variations over time in order to test the theoretical statements (cases) or generate explanations to be tested or confirmed in subsequent studies (Serralta, Nunes & Eizirik, 2011). Naturalistic studies occur in the usual clinical setting, and provide an opportunity to understand the processes that promote therapeutic change, which requires a closer and deeper analysis of therapist–patient interactions (Kennedy & Midgley, 2007). Furthermore, single case studies are relevant for testing clinical theoretical models (Jones, 2000). Though comparative results studies report on the effectiveness of the treatment, their value for testing the clinical constructs underlying treatment models are indirect and limited.

The objective of this study was to assess the results of psychodynamic psychotherapy of a child with internalizing symptoms, using data obtained from the patient herself, her mother, her teacher and her psychotherapist.

METHOD

Study Design

A mixed methods (quantitative and qualitative) study design was employed, based on the Systematic Case Study procedure (Edwards, 2007). Systematic Case Studies are characterized as idiographic, longitudinal and intensive. They are an extension of clinical practice, simultaneously advocating systematic data collection, repeated measures and independent judges (each judge scoring results individually, blind to the scores of other judges).

Participants

Patient: Alice (pseudonym) was 8 years old at the beginning of her psychotherapy and was referred for treatment by her neuropaediatric physician – the child presented with headaches and stomach aches. No organic cause was identified on clinical and imaging exams. The symptoms had begun immediately after the unexpected and sudden death of her father, five months before beginning psychotherapy. After the father's death, the family suffered a financial upset: the girl had to change to another school two months before the beginning of the therapy. The patient was unable to adapt to the new school. She had difficulty in making new friends, longed for her old friends, constantly criticized the lack of order of the state school, cried frequently and was reluctant to go to classes. The mother and the teacher described Alice as a rigid and perfectionist girl, but very affectionate. Her mother was also concerned about the girl's anguish regarding sexual matters: the girl expressed disgust at public expressions of affection, anger towards boys; she was ashamed and anxious when the television portrayed a couple holding hands or the adults talked about dating. The therapist confirmed these impressions. Alice was diagnosed with adjustment disorder [DSM-V; American Psychiatric Association (APA), 2013]. Alice was in her third year of elementary school and lived with her mother and her sister (two years younger).

Psychotherapist: the psychotherapist had 10 years of clinical experience, specialization, a Master's degree, PhD and post-PhD in child psychodynamic psychotherapy. Based on the tripod proposed by Freud (1919) for training analysts (and often also used for psychodynamic therapists), in addition to theoretical training, the therapist was in personal analysis at the time she was treating Alice. A more experienced therapist supervised the case. The psychotherapist fell pregnant during the course of Alice's psychotherapy.

Intervention

Alice's psychotherapy comprised 40 sessions with the girl, eight sessions with her mother and one session with the mother and the patient together, over a period of 14 months. Sessions were typically weekly. The therapist visited the school to talk to the teacher at the beginning of psychotherapy. The treatment was interrupted several times, owing to school holidays and the therapist's maternity leave. Between session 33 and 34, there was a break of almost three months. Before session 34, at resumption after maternity leave, a session was held with the mother and the patient together. During this session, the end of the therapy was decided. According to her mother, the symptoms that brought Alice to treatment had already resolved. During withdrawal from therapy, the family began facing new financial difficulties. Alice's grandmother, who took care of her, fell ill, so that payment of psychotherapy became impossible, as did transportation of the patient to the appointments. The girl wished to maintain the treatment but reported feeling better and understood the difficulties of continuing meetings with the therapist. The therapist noted several issues that still required work, but recognized the achievements of the patient thus far. At this session, the

price and frequency of the final sessions were renegotiated to allow the patient and therapist to say farewell and come to terms with the separation. The last seven sessions had this as their focus. The decision to end the psychotherapy coincided with the return of the therapist from maternity leave. It is possible that unconscious factors associated with the pregnancy and absence of the therapist might have influenced this decision, in addition to the elements consciously manifested by the mother.

The psychotherapy took place at the psychotherapist's private office in the south of Brazil and followed the psychodynamic orientation. The psychotherapist defines her theoretical and technical approach as belonging to the object relations school. In the meetings with Alice, the psychotherapist describes having based her interventions on the theoretical assumptions of Bion and on Fonagy's mentalization theory.

During Alice's treatment, some strong elements of transference were noted and interpreted, especially during the period of the therapist's pregnancy (revealed in session 17). The patient's feelings regarding pregnancy facilitated working on family conflicts, separation experiences (from the father, the old classmates – the future separation from the therapist), obsessive anguish of control and childish sexual fantasies.

Psychotherapy was the only intervention the patient received during this period. Before seeking psychotherapy, the mother had decided to administer floral remedies to calm the patient. Florals are natural and highly diluted liquid extracts commonly used for emotional problems. In Brazil, they can be purchased in specialized stores and are not considered medicines, requiring no medical recommendation. A few months after the beginning of the psychotherapy, the patient decided not to take these florals drops anymore.

Instruments

Rorschach Method The Rorschach is a projective personality assessment. In its administration, 10 inkblots are presented to the examinee, who responds with what they look like or what they might represent. The respondent can provide one or more responses for each blot (Mihura *et al*., 2013). The inkblots are mottled and uneven, presenting the fantasy with stimuli and resulting in projections. In this study, the Rorschach was applied, coded and interpreted following the Exner Comprehensive System (1999, 2003). This system adopts an empirical approach, following rigorous psychometric standards. The Rorschach yields global, integrated data on psychological organization. In this way, it also involves attention, perception, decision-making and logical analysis. For Weiner (2000), the Rorschach describes the personality, at both a structural and dynamic level. The Rorschach was administered to Alice twice during the course of her psychotherapy.

Child Behaviour Check List for Children and Adolescents between 6 and 18 years of age (CBCL/6–18) and Teachers Report Form (TRF/6–18) The CBCL/6–18 and the TRF/6–18 are evidence-based instruments and were administered to the mother and teacher, respectively. The tools are part of the ASEBA Assessment System (Achenbach System of Empirically Based Assessment) (Achenbach & Rescorla,

1991). Their scales provide wide coverage of the psychopathological situations found in childhood and adolescence (Achenbach & Ruffle, 2000). The CBCL is the most efficient quantification instrument for parental concerns about children's behaviour (Carvalho *et al*., 2009; Wielewicki, Gallo & Grossi, 2011). The Brazilian version of the CBCL exhibited good sensitivity (87%), correctly identifying 75% of mild, 95% of moderate and 100% of serious cases (Bordin, Mari & Caeiro, 1995). The results indicate the patient's mean score on each scale and sub-scale, compared with the standardized sample. Respondents can be classified as 'clinical' (clear difficulties), 'non-clinical' (symptom levels similar to those in the same age group) or 'borderline' (scores on the cut-off point between these categories). The symptom scale is divided into three parts in the inventory: internalizing problems (anxious/depressed, withdrawn/depressed, somatic complaints), externalizing problems (rule-breaking behaviour, aggressive behaviour) and neutral (social problems, thought problems, attention problems) (Achenbach & Rescorla, 1991).

Questionnaire that Focalizes Important Issues and Changes Within and Outside Treatment – Version for the Therapist and Version for the Mother The therapist and the patient's mother were requested to write about the issue: what has been the most important change in the therapy thus far? They were asked to specify: when did the change take place (approximate date) and for them to describe it as carefully as possible, besides the circumstances and significant facts that might have been underlying the change. Calberg (2009) proposed this model.

Interview with the Patient, her Mother and her Therapist At the end of the psychotherapy, professionals in the research team interviewed the patient, her mother and her therapist. These were non-structured, open interviews. The starting point was an inquiry as to the respondent's impression of the psychotherapeutic process in question. The interviews with the patient, mother and therapist were approximately 30, 50 and 40 minutes, respectively. The researchers who conducted the interviews reported them.

Data Collection Procedure

The results of the psychotherapy were obtained from multiple perspectives: from the patient (Rorschach and interview), from the mother (CBCL, questionnaire and interview), from the teacher (TRF) and from the psychotherapist (questionnaire and interview). A psychologist trained in the use of the Rorschach conducted this test with Alice at the beginning (after four sessions) and end of treatment (between sessions 39 and 40). The CBCL (mother) and the TRF (teacher) were conducted at the beginning of treatment (after four sessions), after six months of treatment, and at the end of the process. The mother and therapist completed questionnaires at three months, six months and the end of treatment. The patient was interviewed between sessions 39 and 40, the mother was interviewed simultaneously at session 40 and the therapist was interviewed after the end of the psychotherapy.

Data Analysis Procedures

The Rorschach protocols were codified by two independent judges and later compared. The inter-class correlation coefficients were 0.932 and 0.997 at the beginning and end of treatment, respectively. After independent codification, both judges discussed the concordances and generated a final protocol. The scores were compared with normative data (Ribeiro, Semer & Yazigi, 2012) obtained from the Brazilian population to interpret the results. Comparing the results with normative data for each age group (since the patient turned 9 years old between test administrations) allows us to visualize how the passing of time, in addition to the intervention, affects treatment with children, in which spontaneous improvement is expected in some domains, as a result of emotional maturation over the months.

CBCL and TRF were conducted using Assessment Data Manager (ADM), a software programme developed for this purpose. Interviews with the patient, her mother and therapist were reported based upon the guidelines for qualitative clinical research proposed by Turato (2003). Two researchers read each questionnaire and considered the changes reported by the mother and the therapist based on change categories described in the literature. These classifications were subsequently analysed and discussed for the formulation of the final categories of change, identified in the set of six questionnaires about the case.

Ethical Considerations

This study is part of a larger project entitled Interaction Structures in Child Psychodynamic Psychotherapy, approved by the Ethics Committee of the university with which the researchers are associated. The aim of this larger project is to measure the therapeutic results and processes of children in psychodynamic psychotherapy using mixed methods. Validated instruments are used to measure the outcomes (Rorschach and CBCL) and process (Child Process Q-Set, CPQ) from multiple perspectives. The outcomes of one case are presented here; the therapeutic process of the same case is described in Schimidt, Gastaud and Ramires (in press). Participants were consulted and signed a Term of Free and Clarified Informed Consent. They were informed that there would be no negative consequences if they withdrew from the study at any time and that this would not interrupt the psychotherapy in progress. The anonymity of the child and her family was guaranteed.

RESULTS

All results are presented; excerpts are discussed in detail. Hott *et al*. (2015) advocate that single cases studies should provide a multitude of information that allows the reader to draw his/her own interpretations about the treatment outcomes.

Data Obtained from the Patient

The Rorschach results are presented in Table 1. The scores of the patient in each domain are compared with the non-clinical population average for that age.

Table 1: *Rorschach's results*

	Beginning			*Final*		
	Score	*Expected scores for non-clinical children (age = 8 years old)*	*Patient's score status compared with expected non-clinical scores*	*Score*	*Expected scores for non-clinical children (age = 9 years old)*	*Patient's score status compared with expected non-clinical scores*
Performance						
Responses	16	16 (SD = 3.61)	–	54	16.11 (SD = 2.86)	↑
Lambda index	0.23	3.5 (SD = 2.20)	↓	2	3.49 (SD = 3.86)	–
Information processing						
W:D:Dd	6:7:3	–		8:28:18	–	
W:M	6:3	–		8:0	–	
Zd	−5	−0.02 (SD = 3.12)	↓	−2	−0.11 (SD = 2.68)	–
Zf	11	7.15 (SD = 3.02)	↑	12	6.45 (SD = 3.42)	↑
DQ+	7	2.74 (SD = 2.44)	↑	12	3.19 (SD = 2.71)	↑
DQo	8	13 (SD = 3.93)	↓	38	12.25 (SD = 3.65)	↑
DQv	1	0.75 (SD = 1.07)	–	4	0.53 (SD = 0.91)	↑
DQv/+	0	0.09 (SD = 0.30)	–	0	0.15 (SD = 0.41)	–
PSV	0	0.15 (SD = 0.36)	–	0	0.09 (SD = 0.30)	–
OBS	0	0.57 (SD = 0.60)	–	2	0.57 (SD = 0.64)	↑
HVI	1	1.60 (SD = 1.04)	–	2	1.85 (SD = 0.99)	–
Cognitive mediation						
X+%	0.5	0.39 (SD = 0.14)	–	0.27	0.43 (SD = 0.11)	↓
X–%	0.25	0.38 (SD = 0.15)	–	0.51	0.33 (SD = 0.13)	↑
Xu%	0.25	0.21 (SD = 0.13)	–	0.20	0.24 (SD = 0.11)	–
F+%	1	0.66 (SD = 0.69)	–	0.30	0.64 (SD = 0.20)	↓
P	5	2.98 (SD = 1.39)	↑	8	3.32 (SD = 1.49)	↑
S–%	0	0.72 (SD = 0.84)	–	0	0.53 (SD = 0.77)	–
FQ–	4	6.23 (SD = 2.47)	–	28	5.30 (SD = 2.28)	↑
Ideation						
EB	3:0	–		0:4	–	

Table 1: *Continued*

	Beginning			*Final*		
	Score	*Expected scores for non-clinical children (age = 8 years old)*	*Patient's score status compared with expected non-clinical scores*	*Score*	*Expected scores for non-clinical children (age = 9 years old)*	*Patient's score status compared with expected non-clinical scores*
EBPer	0	–		0	–	
FM	8	1.98 (SD = 1.67)	↑	8	1.98 (SD = 1.76)	↑
a:p	5:6	–		5:7	–	
Ma:Mp	2:1	–		0:0	–	
MOR	1	0.45 (SD = 1.07)	–	1	0.25 (SD = 0.55)	↑
2AB+(Art+Ay)	0	–		1	–	
Sum6	4	1.30 (SD = 1.28)	↑	0	1.02 (SD = 1.32)	–
WSum6	11	3.43 (SD = 4.00)	↑	33	2.98 (SD = 4.72)	↑
M–	0	0.25 (SD = 0.48)	–	0	0.4 (SD = 0.77)	–
Mu	2	0.21 (SD = 0.53)	↑	0	0.30 (SD = 0.75)	–
m	1	–		2	–	
Self-perception						
3r+(2)/R	0.5	0.25 (SD = 0.18)	↑	0.48	0.28 (SD = 0.21)	–
Fr+rF	0	0.06 (SD = 0.30)	–	0	0.06 (SD = 0.23)	–
FD	0	0.30 (SD = 0.67)	–	0	0.42 (SD = 0.72)	–
An+Xy	1	0.72 (SD = 1.25)	–	5	0.83 (SD = 1.16)	↑
MOR	1	0.45 (SD = 1.97)	–	1	0.25 (SD = 0.55)	↑
V	0	0 (SD = 0)	–	0	0 (SD = 0)	–
Pure H	1	1.11 (SD = 1.07)	–	3	1.55 (SD = 1.39)	↑
Hd	0	1.09 (SD = 1.70)	–	1	1.40 (SD = 1.62)	–
(H)	2	0.49 (SD = 0.67)	↑	0	0.64 (SD = 0.96)	–
(Hd)	0	0.15 (SD = 0.36)	–	1	0.30 (SD = 0.54)	↑
FQ–	4	6.23 (SD = 2.47)	–	28	5.30 (SD = 2.28)	↑
Interpersonal relationships						
CDI	4	3.72 (SD = 0.84)	–	4	3.60 (SD = 0.84)	–
Fd	0	0.25 (SD = 0.68)	–	2	0.13 (SD = 0.39)	↑

Table 1: *Continued*

	Beginning			*Final*		
	Score	*Expected scores for non-clinical children (age = 8 years old)*	*Patient's score status compared with expected non-clinical scores*	*Score*	*Expected scores for non-clinical children (age = 9 years old)*	*Patient's score status compared with expected non-clinical scores*
a:p	5:6	–		5:7	–	
Human content	3	2.85 (SD = 2.24)	–	9.2	2.89 (SD = 2.48)	↑
Pure H	1	1.11 (SD = 1.07)	–	3	1.55 (SD = 1.39)	↑
COP	1	0.19 (SD = 0.40)	↑	1	0.32 (SD = 0.70)	–
AG	0	0.28 (SD = 0.53)	–	0	0.19 (SD = 0.44)	–
Isolate/R	0.18	0.16 (SD = 0.16)	–	0.14	0.14 (SD = 0.15)	–
T	0	0 (SD = 0)	–	2	0 (SD = 0)	–
V	0	0 (SD = 0)	–	0	0 (SD = 0)	–
Y	0	0 (SD = 0)	–	0	0.06 (SD = 0.30)	–
Affect						
DEPI	2	3.40 (SD = 0.86)	↓	3	3.25 (SD = 0.94)	–
FC:CF+C	0:0	–		3:2	–	
Afr	0.33	0.59 (SD = 0.20)	↓	0.68	0.58 (SD = 0.24)	–
CP	0	0.02 (SD = 0.14)	–	0	0 (SD = 0)	–
Blends: R	0	0.09 (SD = 0.10)	–	0.05	0.06 (SD = 0.09)	–
Pure C	0	0.58 (SD = 0.89)	–	1	0.45 (SD = 0.77)	–
SumC':WSumC	1:0	–		2:4	–	
S	0	1.19 (SD = 1.26)	–	1	1.09 (SD = 1.08)	–
Control and stress tolerance						
CDI	4	3.72 (SD = 0.84)	–	4	3.60 (SD = 0.84)	–
EA	3	2.83 (SD = 2.21)	–	4	2.61 (SD = 2.35)	–
Es	10	4.09 (SD = 2.64)	↑	16	4.04 (SD = 2.92)	↑
Adj D	−2	−0.09 (SD = 0.56)	↓	−3	−0.11 (SD = 0.58)	↓

Please see note 1 at the end of the article for definitions.

The number of answers and the Lambda index are evidence of two valid protocols for interpretation. In the first protocol, the diminished Lambda indicates a child with a perceptive maladjustment and difficulty discriminating between important and peripheral information, as well as one who allows herself to be easily invaded by emotional stimulation. At the end of the treatment, this index increased to the average for her age. The significant increase in the number of replies reveals a patient more open to experience, but with obsessive functioning and the need to please.

When Alice began psychotherapy, she demonstrated an optimal level of intellectual development (DQ+) and sophisticated and complex cognitive work (Zf), according to the Cognitive Triad. She also presented with perfectionist characteristics (Zf) and a high degree of conventionality (P). She paid great attention to environmental expectations and demonstrated excessive self-exigency, great discomfort and inner tension (FM). She also exhibited difficulty processing and regulating emotions, and a limited ability to identify and deal with affection (FC:CF+C; Afr; SumC':WsumC). The high egocentrism index revealed reduced interest in the outside world.

In interpersonal relations, Alice used to be passive, although not necessarily submissive, and without much interest in making contact with others (a:p; Human Content, Pure H). In relation to controlling and tolerating stress(es), she formerly presented with a high level of internal tension triggers – a state of emotional overcharge – which is plausible, given her psychosomatic complaints.

Post treatment, changes were observed in her ability to delay answers, by pausing to consider more environmental stimuli before responding to them (Zd), indicating that the emotion has been better processed or cognized (Zd; EB). The FQ–, X+%, X–% and F+% indices, however, indicate an increase in the style of answers: these became more individual, unusual and difficult for others to understand. Since this trait co-occurred with the need to please and exaggerated conventionality (FM; P), it possibly reflects the presentation, post treatment, of two parts of the patient: one still wishing to please and to belong to the environment; the other seeking greater authenticity.

Alice began showing more interest in others, as well as a more realistic perception of the other and herself, and an increased capacity for identification and empathy (Human Content; Pure H). These were possibly associated with her increased capacity to identify and express her emotions. Importantly, though, the indexes still indicate a child with elements of hypermaturity, even at the end of the treatment (FC>CF+C; Afr; SumC'<WsumC).

According to the self-perception measure, her tendency typically to centre in herself remained, associated with elements of deficient self-esteem (MOR) and distorted self-image (An+Xy). This last index is associated with somatic concerns and psychosomatic defences.

The Rorschach results indicate that, after treatment, Alice still presented with internal discomfort, emotional overload, self-demanding features, and as perfectionist, conventional and hypermature, consistent with an obsessive character. However, the results also illustrate an important change in her ability to express and deal with emotion, integrating them more effectively into her cognition; for example, making

Table 2: *CBCL/6–18 – syndrome scale scores*

	Beginning		*6 months*		*Final*	
	Score	*Classification*	*Score*	*Classification*	*Score*	*Classification*
Internalizing						
Anxious/depressed	14	Clinical	14	Clinical	14	Clinical
Withdrawn/depressed	7	Clinical	3	Normal	6	Borderline
Somatic complaints	8	Clinical	7	Clinical	7	Clinical
Externalizing						
Rule-breaking behaviour	2	Normal	0	Normal	2	Normal
Aggressive behaviour	6	Normal	2	Normal	2	Normal
Neutral						
Social problems	7	Normal	3	Normal	2	Normal
Thought problems	7	Normal	3	Normal	2	Normal
Attention problems	3	Normal	3	Normal	5	Normal

Classifications for girls aged 6–11 scored using T scores for ASEBA standard.

decisions. Psychotherapy thus enabled her to better realize her internal, ideational and affective potential.

During the interview, the patient reported feeling better over the course of the therapeutic treatment. By the end of the treatment, she was able to talk more about her problems and painful feelings. She used the metaphor of a bird that was caged and finally freed itself to describe the changes she experienced during therapy. The interview data are thus consistent with the Rorschach results.

Data Obtained from the Mother

The results of the three CBCLs completed by the mother are described in Table 2. According to her mother, Alice did not exhibit significant alterations in behaviour. Depressive symptoms showed improvement after six months of treatment, but regressed to the initial scores at the end of the therapy.

The results of the questionnaires completed by the mother are presented in Table 3. During the interview, the mother reported that the patient had improved throughout the therapy. She perceived that her daughter was, by the end of the treatment, able to express herself with greater ease and had acquired the strength to contradict her mother and teacher when she disagreed with something. She described her daughter as always liking going to the sessions and seeking to increase the frequency of the sessions at the beginning of the process (which was not possible owing to financial difficulties). Regarding the therapist's pregnancy, the mother believed that this event was well explored in the psychotherapy and that the therapist prepared Alice adequately for her leave. She saw advantages herself in the therapist's pregnancy, in that 'she (the therapist) could better understand the anguishes a mother feels'. The mother

Table 3: *Mother's answers to the questionnaire*

3 months	*6 months*	*Final*
Reduction of headaches	Disappearance of headaches	More confidence and joy
Better integration with new colleagues	Greater peace of mind about the school	Better handling of situations
Development of new somatic symptoms – itching in the body	Greater capacity to express discontent	Increase in the capacity to talk about fears and worries
	More sociable	More imposing of her own will

expected to be able to resume the treatment in the future with the same therapist, in the case of perceiving new difficulties in her daughter or a worsening of previous symptoms.

Data Obtained from the Teacher

The results of the two TRFs completed by the teacher are presented in Table 4. The same teacher accompanied the patient during the first six months of treatment. At the end of the psychotherapy, another teacher accompanied the patient, who completed the TRF at this point. However, this teacher was pregnant and left on maternity leave during the period in which the patient was ending treatment, not completing the questionnaire. The teacher who replaced her had been working for two days with the patient and thus was too unfamiliar with Alice to complete the questionnaire. The information collected from the school about the patient thus refers only to the first six months of psychotherapy. According to the perceptions of the teacher, Alice had not undergone significant alterations in her behaviour. According to the teacher

Table 4: *TRF/6–18 – syndrome scale scores*

	Beginning		*6 months*	
	Score	*Classification*	*Score*	*Classification*
Internalizing				
Anxious/depressed	3	Normal	1	Normal
Withdrawn/depressed	4	Normal	4	Normal
Somatic complaints	1	Normal	3	Borderline
Externalizing				
Rule-breaking behaviour	0	Normal	0	Normal
Aggressive behaviour	0	Normal	0	Normal
Neutral				
Social problems	3	Normal	0	Normal
Thought problems	1	Normal	0	Normal
Attention problems	0	Normal	2	Normal

Classifications for girls aged 6–11 scored using T scores for ASEBA Standard.

Table 5: *Therapist's answers to the questionnaire*

3 months	*6 months*	*Final*
Decrease of the somatic symptoms Suspension of the use of floral drops, asked for by the patient, since she thought she was not anxious any longer Greater expression of anger and discontent in the sessions Insight on the need for control and on the fear of disappointing people	Increase of obsessive defences – development of cleaning and bedtime rituals Increase of somatic defences – renewed headaches during the fifth month, which disappeared again at the sixth month Patient more bold and confident Patient more relaxed to talk about her feelings, better mentalization capacity Strengthening of the therapeutic alliance with the patient Fickleness in the therapeutic alliance with the mother	Patient more 'sassy' (words of the patient) More reflection and expression of feelings/thoughts Less worry around pleasing (greater authenticity) Improvement of the somatic symptoms Disappearance of the obsessive rituals Improvement in the relationships at school Work on separation anxiety (related to the father's death, the change of school, the therapist's and the teacher's maternity leaves, the mother's job, etc.) – improvement in the way the patient faces farewells Internalization of the therapeutic function

questionnaires, Alice achieved normal (non-clinical) scores on all scales at all time points. The teacher noticed an increase in somatic problems over the six months.

Data Obtained from the Therapist

The results of the questionnaires completed by the therapist are presented in Table 5. In addition to the data in the table, the therapist reported that, when visiting the school during the second month of treatment, the teacher believed Alice was more integrated in the school, with increased interaction with both pupils and teachers. The teacher highlighted, however, that Alice still feared making mistakes in her schoolwork, and was excessively perfectionist. At the end of the treatment, the therapist believed the somatic symptoms had improved significantly, but not resolved completely. When the patient had pains, she demonstrated more *insight* into them, understanding their meaning. Even with these improvements, the therapist perceived the girl as highly defensive during the final sessions, which might indicate unresolved issues.

During the interview, the therapist reported improvements in the patient in terms of the main complaints that brought her to therapy: she adapted better to her new school and her headaches and stomach aches became less frequent, intense and disabling. The therapist perceived a shift in the defensive style of the patient: the neurotic defences (both obsessive and hysterical) were superseded by mature defences and the patient exhibited better access to her feelings, less repression and less

intellectualization. The therapist believes the issues related to the grief owing to the death of her father will accompany the patient throughout her life, as part of her history. The role of the therapy was to offer a space in which the patient could reflect on and mentalize these experiences, diminishing the displacement of that suffering to other spheres of her life. The therapist believes the patient still has unresolved issues, including guilt for sexual thoughts, her identification with the feminine, and the role her good behaviour and perfectionism play in the family dynamics.

DISCUSSION

The study documents the results of psychodynamic psychotherapy with a child with adjustment disorder. There are many indicators of improvement, consistent with the literature on psychoanalytic treatment. In Alice's psychotherapy, elements from different theoretical schools can be identified: the reduction of persecutory and depressive anxieties (consistent with Melanie Klein's proposal), the resumption of development (Anna Freud), the expression of the true self (Donald Winnicott, it is perceived when the patient describes herself as a bird, finally free to fly), developing the apparatus to think the thoughts (Wilfred Bion). The case presented here illustrates that the plurality of criteria with which to assess the results of psychodynamic psychotherapies can be complementary.

Changes in Rorschach scores were identified in the affective and interpersonal sphere, as well as in some elements of the cognitive triad. Self-perception, control and tolerance to stress did not change significantly. At the end of the treatment, data from the patient, her mother and her therapist consistently present the picture of a more spontaneous girl, dealing better with her feelings and more socially integrated.

There were changes towards greater associative production, greater openness to experience and greater manifestation of internal resources. It is inherent to the therapeutic process that the mobilization of affective, emotional and ideational aspects of the therapy allowed Alice to express emotional discomfort, anguish, anxiety, fears, and to acknowledge and elaborate painful internal experiences in an inter-relational context. However, some peculiarities of this treatment, such as the break owing to the therapist's pregnancy, the grandmother's illness, the mother's excessive workload and the financial difficulties, might have hindered improvement of control and tolerance of stress, since Alice continued undergoing a period of significant emotional tension. Besides this, questions of Alice's self-perception and her rigid manner and self-demanding information processing style possibly needed more time to change significantly. Gronnerod (2004) suggests that problems with the expression and management of affection are more accessible to therapeutic intervention, in the initial phases of the treatments, than problems related to self-perception.

In this context, it is evident that the changes were marked by evolutions and setbacks. The mother's answers to the CBCL, for example, demonstrate oscillation regarding the dimension withdrawal/depression – the mother noticed improvement after six months of treatment, but this improvement was not maintained at the end of the psychotherapy. This movement is characteristic of psychodynamic

psychotherapy, in which the emphasis is on engaging the patient in self-reflection and the postponement of action until reaching an understanding, which results in gradual rather than linear change (Luyten, Blatt & Mayes, 2012). Further, it is well established that symptoms may worsen before they improve (Tang, Luborsky & Andrusyna, 2002). As exemplified in a case study described by Schneider, Midgley and Duncan (2010), the psychodynamic therapeutic process weakens the defences used, which can illuminate previously veiled anxieties.

The participants in the current study reported an overall improvement in the global functioning of the patient throughout the therapeutic process, consistent with Lewin *et al*. (2012), who analysed the concordance of improvement perception among therapists, parents, patients and independent evaluators in the treatment of obsessive–compulsive children. They found that children and parents are capable of providing accurate measures of improvement after the treatment, not only therapists and independent evaluators. In Alice's case, the therapist was perceived as less benevolent and more critical than the mother and the patient when noting the limitations of the treatment. Lewin *et al*. (2012) reported similar findings, concluding that therapists are slower to perceive improvement in child patients than are the children themselves and their parents. It is necessary that therapists remain attentive to the perceptions and needs of their patients and their families, to avoid introducing to the therapeutic process requirements and demands not derived from the patient proper, but rather from their high degree of personal and professional exigency. On the other hand, it is important to consider that the issues raised by the therapist to justify the continuation of the treatment (the patient's difficulties breaking away from the desire of the other, her obsessive defences) are coincident with the results obtained by Rorschach at the end of the treatment, which indicate elements of hypermaturity in Alice, a need to please and an exaggerated conventionality. It is possible that sleeper effects will help the girl overcome these issues, since an ongoing improvement can occur with children treated with psychodynamic psychotherapy (Trowell *et al*., 2007).

A central point in Alice's treatment was her father's death, including how this unfolded in the internal and external reality of the patient. Children have greater difficulty ending the mourning process. On the other hand, part of a healthy mourning is the child's capacity to reconsider the relationship with the parent at different stages of development, in the light of new emotional and cognitive acquisitions (Biank & Werner-Lin, 2011). In that context, when assessing psychological aspects of children who have lost one of their parents, Cerel *et al*. (2006) verified an association between the death of a parent and an increase in psychiatric problems. Considering the relevance of the theme, Alice's therapeutic process was proposed to be consistent with that proposed by Szymanowska (2014): working on expressing her feelings, and reflecting on her father and her feelings of guilt related to his death.

Alice's treatment was characterized by elements of death (mourning her father, the loss of her school) and of life (the therapist's pregnancy, overcoming the family). The therapeutic repercussions of the pregnancy of the therapist on psychodynamic treatment are well known (Korenis & Billick, 2014; Tonon, Romani & Grossi, 2012). Some studies (Simonis-Gayed & Levin, 1994; Tonon *et al*., 2012; Wolfe, 2013)

report that such a pregnancy catalyses and facilitates aspects of the process; others describe difficulties that arise (Ashway, 1984; Bassen, 1988; Hacham-Lynch, 2014; Korenis & Billick, 2014), such as the tendency not to interpret sadistic and hostile associations in the patients during this period, the feeling of guilt experienced by some therapists (owing to being more involved with themselves and by the imminent maternity leave) and the fear that the anger and aggression of the patients may harm the baby, generating blind spots in the therapeutic process. It is to be expected that both poles are present in a therapeutic process conducted by a pregnant therapist, more so in a case of child psychotherapy. Pregnancy can facilitate and/or hamper the progress of the therapeutic process, depending on the therapist, the patient and on what both build together through the new variables inserted in the *setting* as a result of this event (Schmidt, Fiorini & Ramires, 2015). In the current case, the pregnancy worked as a catalyst for the emergence of some of Alice's unconscious conflicts, which might otherwise have taken longer to appear in the transference. Since the decision to finish psychotherapy coincided with the return from maternity leave, it is possible that some discomfort of the mother regarding the pregnancy might have interfered with the process, although the therapist tried to work on these unconscious factors of the mother in the sessions with her.

The results of this case are consistent with existing knowledge (Sadock & Sadock, 2007) that psychotherapy is the first choice of treatment for adjustment disorders. Psychodynamic therapy offers opportunities to explore the nature of the stressor, so that previous traumas can be elaborated, helping the patient to adapt to events that are irreversible or that endure (Sadock & Sadock, 2007). Psychodynamic psychotherapy is suitable for children with internalizing symptoms (Göttken *et al*., 2014; Midgley & Kennedy, 2011).

CONCLUSION

This study contributes to the research on the therapeutic outcomes of child psychotherapy, by focusing not only on the therapist's account but on multiple perspectives. Specific instruments were used to assess therapeutic results. These were supplemented by traditional clinical reports. The Rorschach proved a useful method to evaluate changes in the dynamic functioning of a child after 14 months of psychotherapy. It also raised clinical issues about therapists' pregnancies and the potential repercussions on the treatment of a child, a subject that requires further empirical study (Schmidt, Fiorini & Ramires, 2015).

The interviews and questionnaires indicated positive results for the psychodynamic psychotherapy of a girl with internalizing symptoms, from the perspectives of the patient herself, her mother and her therapist. CBCL revealed that the mother and teacher did not observe a significant behavioural improvement from the initial to the final measures. For this reason, future studies should emphasize the importance of mixed method assessments for psychotherapy results, as different methods yield different improvement indicators.

The success of the Rorschach test in this case was due to its encompassing different emotional and cognitive dimensions. Its usefulness in assessing psychotherapeutic change is widely debated. Some authors question the temporal stability of the variables (Parker, Hanson & Hunsley, 1988; West, 1998), while others emphasize this as a strength (Exner & Andronikof-Sanglade, 1992; Gronnerod, 2004; Weiner, 2004). This method is typically used to evaluate psychotherapeutic change in an adult population (Bram, 2010; Heedea *et al*., 2009; Nascimento, 2001; Weiner & Exner, 1991). In the current study, the Rorschach revealed improvements in the cognitive triad of the patient, in her interpersonal relations and in her ability to regulate affect, relational experience and interpersonal expression of emotion.

Thus, this study contributes towards breaching the gap in the literature of studies of the Rorschach in children, reinforcing the potential of this method to assess patients in psychotherapy.

The literature on psychodynamic psychotherapy is abundant with descriptive case studies by therapists, but cases in which clinical material is analysed from multiple perspectives and with objective measures remain scarce. We emphasize the importance of constantly evaluating the results of the psychodynamic psychotherapies and the need to rely upon multiple informants in the assessment of children's treatments, taking into account that the perspectives evaluated are not necessarily coincident but may be supplementary.

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NOTE

1. Definitions for Table 1: ↑ increased result compared with the mean and standard deviation of the age group; ↓ decreased result compared with the mean and standard deviation of the age group; Lambda index: ratio that compares the pure form (F) response frequency with the other; indicates openness to experience; W:D:Dd: proportion of responses with global or partial location, reflecting the interest or effort in data processing; W:M: proportion of responses with global location and responses of human movement; Zd: indicates the efficiency of information organization; X–%: distorted form, indicating whether a person perceives his experiences realistically; Zf: reflects a capacity for establishing a connection among the stimuli elements; DQ+: reflects sophisticated analytic and synthetic capacities; DQo: reflects accurate analytic and synthetic capacities, without major creative efforts; DQv: reflects immature information processing; DQv/+: reflects a tendency towards more sophisticated cognitive elaboration, with impaired form definition capacity; PSV: indicates rigid thinking; OBS: indicates perfectionistic tendencies; HVI: indicates a tendency towards a hypervigilant style; X+%: indicates perception conventionality; F+%: reflects the perception conventionality on Pure Form responses;

P: indicates adaptation to the group norms; S–%: indicates the degree of emotional interferences on the mediation processes; FQ–: reflects impairments on mediation processes; EB: relation between responses of human movement and weighted sum of the chromatic colour responses, expressing the individual's experience; EBPer: indicates the predominance of a style of EB in decision-making and the ability to use ideation efficiently without compromising emotional stimulation; FM: reflects ideation processes caused by dissatisfaction of basic needs; a:p: proportion of active and passive movement responses, indicating greater or lesser passivity in interpersonal relationships; Afr: indicates the responsiveness to emotional stimuli; Ma:Mp: this variable concerns constructive thinking, the ability to use ideation realistically while focused on action; MOR: indicates negative or unfavourable attitudes facing the body and its functions; 2AB+(Art+Ay): intellectualization index, reflects a tendency to neutralize emotional states using cognitive processes; Sum6: sum of special codes, indicates lapses or logical flaws on ideation; WSum6: weighted sum of special codes; M–: indicates significant difficulties in thought; Mu: reflects an ideographic and personal form of ideation. m: indicates feelings of losing control; 3r+(2)/R: egocentricity index; Fr+rF: indicates narcissist components; FD: capacity for introspection and self-inspection; An+Xy: indicates increased concern with the body, disturbances in self-image; V: indicates devaluation associated with introspection; Pure H: responses of human content. Involves the percept of whole human form; Hd: indicates a biased view, and a cautious and reserved approach towards others; (H): reflects detachment from the real world and greater investment in fantasy; (Hd): indicates a more distant and less realistic perception of the human being; CDI: index of relational deficit; Fd: responses of food content, indicating dependent behaviour; M: responses related to human movement; human content: total responses of human content; COP: indicates a trend to establish positive bonds; AG: indicates a tendency to keep hostile attitudes toward others; Isolate/R: reflects social isolation; T: indicates needs for closeness and emotional contact; Y: relates to reactions to stressful situations; DEPI: index of depression; FC:CF+C: proportion of responses of colour determinant and combination of colour and form, indicating the balance of style to modulate affects; CP: indicates a tendency to mask dysphoric feelings; Blends:R: indicates cognitive level of development; Pure C: reflects a tendency towards sudden and unmodulated affective discharges; SumC':WsumC: proportion of chromatic and achromatic colour responses, indicates the relation of emotional constriction with the emotions of deliberated processing level; S: indicates a quest for independence and self-assertion or opposition style and negativity; Xu%: indicates the degree to which the person interprets experiences in a conventional manner; EA: available resources to initiate deliberate conduct; Es: reflects the internal stimulation experience, such as irritation, discomfort or annoyance; Adj D: indicates the ability to control and direct conduct.

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