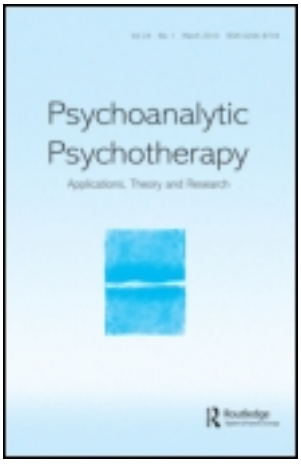

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Mentalization-based therapy with maltreated children living in shelters in southern Brazil: A single case study

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This study describes the mentalization-based child therapy of a boy who suffered from early abuse and neglect, who was living in a shelter in southern Brazil. This single case study aimed at assessing whether this kind of psychotherapy contributes to reducing depressive symptoms and developing a greater capacity for reflection on the mental states of self and other, as part of developing a more coherent sense of self. Structured assessments were conducted before therapy and after six months of treatment, and the audio-recorded treatment sessions were analyzed using content analysis, in order to identify key themes in the treatment itself. The results suggested a significant improvement in depressive symptoms and some changes in mentalization with the beginnings of a movement toward a more cohesive and integrated self. We argue that mentalization-based child therapy could be a promising therapeutic approach for children who have experienced severe disruptions of emotional bonds, due to the way it focuses on the capacity to regulate affect and develop a more coherent sense of self.

Keywords: children's psychotherapy; mentalization; depression in children; shelter; qualitative research; case studies

Introduction: children's early experiences of abuse, maltreatment, and institutionalization and their impact on attachment and the capacity for mentalization

Developmental research over the last 10 years has demonstrated the complex interaction between attachment, the development of the self, and the capacity for reflective functioning, or mentalization (Fonagy, Gergely, Jurist, & Target, 2002; Gergely & Unoka, 2008). There is now compelling evidence to suggest not only that secure attachment is a protective factor in both child and adult mental health but also that the parental capacity to mentalize may well be one of the decisive factors in promoting infant security (Bateman & Fonagy, 2012). Newborn babies are unable to regulate their own emotional states. But under favorable conditions, secure caregivers intuitively and continuously regulate their baby's shifting arousal levels and therefore their emotional states (Howe, 2005). The child begins to build a notion about where inner and outer reality begin and end and to establish

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a secure representation of attachment figures. Such attachment security, and the infant's own developing capacity to mentalize about their own and others' states of mind, is in itself a key element in the developing child's sense of agency, affective regulation, and sense of self (Fonagy & Allison, 2012).

Equally compelling is research that has demonstrated how early maltreatment and neglect and a history of institutional care can have a wide range of adverse effects, among which is a greater likelihood of 'disorganized' attachment patterns and failures in mentalization (Bleiberg, 2001; Cicchetti & Valentino, 2006). Such insecure attachments and difficulties in reflecting on the minds of self and other may in turn have a negative impact on the child's developing sense of self and are associated with a wide range of pathological developments in middle childhood and on into adult life (Sharp & Venta, 2012). Fonagy and Allison (2012) write that maltreatment can contribute to an acquired and partial 'mind-blindness'. Reflective communication between parent and child can be compromised, which affects the child's self-structure, creating splits, and contributing to disorganization of attachment.

There are a number of different ways in which early experience can disrupt a child's emerging sense of self. Bateman and Fonagy (2003) suggested that a parent's severe failures in the ability to provide contingent responses may leave the child unable to 'find' him or herself accurately represented in the mind of the caregiver as an intentional being. Instead, the child may internalize a distorted representation of the self which Bateman and Fonagy refer to as the 'alien self'. This alien self is an internalization of some aspect of the misattuned caregiver and in this way an alien state to the child's authentic self becomes embedded in the child's concept of themselves. At a later stage, this 'alien self' may become externalized onto an external figure, leading to addictive bonds and other damaging relationships; or it may be internalized, leading to attacks on the self, including self-harm (see Rossouw, 2012).

According to Howe (2005), 'both neglectful and abusive parents in their different ways, repeatedly fail to display "mind-mindedness" and "mentalization" when dealing with their children' (p. 25). Therefore, children who have experienced these interactional deficits are more likely to have an impaired mentalization capacity and a less coherent sense of self. In the case of institutionalized children, different from all other kinds of mistreatment, we face the lack of an attachment figure (Howe, 2005). Very often, these children have sparse institutionalized care and no key relationship in which they can explore their own and the other's mental states. This can also happen in the presence of depressed parents, mothers who have a serious drug habit, etc. In all of these cases, the three key risks, according to Howe, are as follows: neglect, severe deprivation, and gross understimulation; a deep, frightening sense of abandonment and being absolutely on your own; and a failure to form a selective attachment.

Hence, these children's internal working model will represent the self as unlovable and without value. The boundaries between self and others may be diffuse and needs, desires, and wants will not be regulated by thought, reflection, and social understanding (Howe, 2005). The self is helpless to change events and

influence people, feeling worthless. Many of these children, as they grow up, put themselves in situations of danger. With respect to their internal working model of others and relationships, severely deprived children often believe that other people at times of need and distress are simply not available. Since they had no mindful care, relationships may have no value, importance, or significance and serve only to satisfy some immediate need. Offering appropriate therapeutic support to such children is of great importance, but the particular way in which the abuse has impacted on their development often makes such children very hard to engage in meaningful therapeutic work.

Mentalization-based child therapy

Mentalization-based therapy was originally developed for adult patients with borderline personality disorder, although in recent years it has been adapted as a treatment for a wide range of disorders (Bateman & Fonagy, 2012). Most of the literature about this kind of psychotherapy has focused on adult patients (Allen & Fonagy, 2006; Bateman & Fonagy, 2003, 2004, 2006), although in the last few years some clinicians have begun to explore the application of mentalizing ideas to work with children, young people, and families (Fearon et al., 2006; Midgley & Vrouva, 2012; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008).

According to Bateman and Fonagy (2003, 2006), the overall goals of mentalization-based therapy are as follows: to enable the patient to establish secure relationships; to stabilize the self-structure through the development of stable internal representations, forming a coherent sense of self; and to identify and express affects appropriately. The task would be to move the patient toward a more secure attachment or at least toward the emergence of more secure attachment representations, alongside the earlier, less adaptive representation. There is often a gap between primary affective experiences of 'borderline' patients and their symbolic representations, when the mentalization capacity fails. This gap must be filled in psychotherapy (Bateman & Fonagy, 2003). For this, the therapist needs to maintain a mentalizing stance, which means the ability to continually question what mental states, both in the patient and him or herself, can explain what is happening here and now (Bateman & Fonagy, 2003, 2004, 2006). The therapist also needs to keep mental proximity, i.e. accurately representing the patient's affective state and its corresponding internal representations.

Therapists using Mentalization-Based Treatment (MBT) to work with families have had to adapt some of the core ideas of MBT to a somewhat different setting and a different population. Fearon et al. (2006) describe a conceptual model which underlies this kind of psychotherapy, involving three key concepts: first, the assumption that difficulties in family relationships derive at least in part from family's problems with mentalizing; second, that stress and the consequent emotional arousal interferes with mentalizing; and third, that this leads to interactions which are unsupportive and unsatisfactory (Asen & Fonagy, 2011; Fearon et al., 2006; Keaveny et al., 2012).

Verheugt-Pleiter et al. (2008), working individually with children, describe a mentalizing approach to psychoanalytic child psychotherapy and offer the most complete account to date of a model of individual mentalization-based therapy for children. This work was based on a project in which they evaluated the early stages of treatment with six children, aged between seven and 11 years old, all of whom suffered from what the authors, using a term introduced by Fonagy et al. (1993), describe as 'mental process' disorders. By this, they mean disorders where the difficulty does not derive from conflicting ideas (as may be the case in the 'classical' model of neurosis, where there may be a conflict between an unconscious wish and a defensive ego), but rather from a failure to develop core capacities for thinking and mentalizing *per se*, which may leave the child with a precarious sense of self and difficulties with affect regulation and capacity for attention.

Mentalization-based therapy, according to this model, attempts to develop a transitional space, an area between fantasy and reality because mental process disorders involve an inability to develop mental representations (Verheugt-Pleiter et al., 2008). For the authors, creating such a transitional space is a prerequisite for the enhancement of mentalization and for the development of a coherent sense of self. Rather than removing repressions and bringing 'unacceptable' ideas into consciousness, the aim here is to expand self-borders in order to recover, through the containment of the psychotherapist, the parts that have been split off or that have not fully developed.

As in other versions of psychoanalytic child psychotherapy, the therapeutic relationship is central in this kind of treatment, but the therapist should work 'in' the transference, rather than primarily *interpreting* the transference, at least until the point at which the child is able to develop symbolic representations (Verheugt-Pleiter, 2008). The predominant orientation is not to analyze transference, intrapsychic conflicts, and resistance, or to try and bring any specific 'mental content' into consciousness. Rather, in mentalization-based child therapy the focus is on helping to develop the capacity to regulate affect and mentalize the self and others; the therapist constantly pays attention to what is happening in the 'here and now' relationship but may not interpret the transference, as this may create such a powerful activation of the (disorganized) attachment system that it leads the child into a state of affective dysregulation, rather than being a means of integrating unconscious, split off aspects of the self or experience.

Verheugt-Pleiter et al. (2008, pp. 55–57) identify four key elements of a mentalizing focus within psychoanalytic child psychotherapy:

- Work in the 'here and now'. The therapist constantly monitors the affective quality of the interaction with the child, with the aim of reflecting the child's experience in a contingent and marked way. This bears some resemblance to the process described by Bion as 'containment' or to Winnicott's concept of 'holding.' It is an 'ego-supportive' technique, which aims explicitly at helping the child to develop a capacity to mentalize their own and others' states.

- Recognizing the child's level of mental functioning and establishing contact at the same level. There is a danger that therapists may assume that the child has an affective language for their inner states, whereas the child may be operating at a 'pre-representational level' (Greenspan, 1997). Where this is the case, the therapist must match their interventions to the mental state of the child. This may involve giving reality value to inner experiences by trying to state explicitly the child's perspective.
- Playing with reality. Many children who have experienced early maltreatment and abuse are caught in the 'equivalent mode' and thoughts and feelings are taken literally. To overcome this difficulty, the therapist must dramatize the play so that the child is encouraged to move more into the 'pretend mode'. The therapist may actively promote the elaboration of play, in order to help them develop a capacity to use play as a way of exploring experience by means of fantasy.
- The importance of the process. The process takes precedence over technique and largely takes place in the non-conscious, implicit relational work.

Verheugt-Pleiter et al. (2008) describe how the interventions used by the therapist in MBT with children focus on three primary aims: interventions aimed at regulating attention, those that relate to affect regulation, and interventions to promote children's mentalization capacity. When used appropriately, these interventions will enable the child to feel understood, gradually learning to control his or her impulses, and to tolerate frustration. In this way, the child will also be helped to acknowledge his or her emotions and to distinguish inner and outer reality. Initially, the therapist accepts responsibility for the child's affects – what Bateman and Fonagy (2004) call a 'benign internal split'. As with psychoanalytic work in the tradition of Bion (1962), the therapist should contain these intense emotions and return them in a metabolized form, thus supporting the child's projective identification.

Although mentalization-based treatments for children are still in their infancy, there are reasons for expecting that this approach could offer something of value to abused, maltreated, and institutionalized children. For these children, the acquisition of the ability to create a narrative of their own thoughts and feelings – a key component of the mentalizing capacity – may help to overcome shortcomings in the self-organization that resulted from disorganized early attachment experiences and from conflicting, traumatic experiences of loss and disruption of ties.

Setting for the current study

In what follows, we describe the mentalization-based treatment of a seven year-old child living in a residential home in Brazil. Caretakers and other people who could give any information or support the treatment participated as well.

The shelter where this child was living at the time of the therapy is a nongovernmental organization that is maintained with local and federal resources as well as donations. The aim is to assist children and adolescents in the following situations: children referred by the courts because their family ties were broken, those needing to be protected from abusive backgrounds, and those who were at physical or mental risk.

The protection of children's and adolescents' rights in Brazil and the care of the the vulnerable child and adolescent population have changed in recent decades with the advent of the new Child and Adolescent Constitution. This federal law, approved in 1990 and replacing the old one, brought a new vision of childhood and adolescence. Its main target is the protection of children's and adolescents' rights in order to promote their integral development and to protect their family and community ties.

The law establishes that when the family is unable to care for the child, the host institution should provide an experience similar to that of a family, working as a sort of temporary adoption. Positive features of such institutions include homes with few children, a permanent couple of caregivers, preferably a man and a woman, and the placement of siblings together. The children must be able to attend school, clinics, and other community resources. When it is possible, they visit their families on weekends. The length of stay in institutions should be short, looking for a return to the family of origin when possible, or for late adoption when it is not.

The Social Development Ministry of Brazil launched a national survey in 2009, identifying approximately 2400 government and non-government shelters and more than 54,000 children and adolescents living under state protection in the whole country (Brazil, MDS, 2010). The preliminary results show that the most common reasons for residential care are neglect in the family, drug addiction among the parents or guardians, abandonment, lack of material resources, and domestic violence.

Design of the study

This paper forms part of a larger study undertaken by one of the authors of this paper. The larger study included 14 case studies of children and adolescents. These children and adolescents have suffered some form of breaking of bonds, whether by domestic violence or by contentious divorce of their parents. The aims of the study were to analyze the mentalization capacity of these children and to assess the possibility of developing this capacity in the therapeutic process. The larger study consisted of several subprojects, and one of them is presented in this article.

In this study, a child was supported in psychotherapy once a week by a trained psychotherapist who had five years of experience. She had weekly supervision with an experienced psychotherapist with training in psychoanalytic psychotherapy. Shelter caregivers were also supported by the same therapist. These interviews took place fortnightly on average.

The research project was submitted to the Ethics Committee of the researcher's university and was approved. All the ethical considerations were observed, prioritizing the well-being of the child. This paper reports on the analysis of the first six months of psychotherapy.

Participants, data collection, and data analysis

The participating child in this study (Pedro) was referred to psychotherapy because of depressive symptoms. Pedro was a seven year-old boy who resided in the shelter for more than two years. His mother was homeless and had four children. Pedro was the second and the only boy. He and his two sisters were in the institution because their parents were prisoners and there was no one who could be responsible for providing the children with basic care.

The shelter principal reported that between the three children, Pedro seemed to be in the worst emotional state. He appeared to have been the one with the most severe traumatic experiences: 'Pedro has been rejected many times'. Initially, it was his mother who brought him to the shelter, saying that she no longer wanted him because he bothered her too much. She kept the eldest and the youngest daughter at that point, but 'the boy she no longer wanted because he was terrible, he was a devil'.

Pedro's mother had been monitored by the network of Health Care in the city since her youth, because, besides being homeless, she also used illicit drugs and was a prostitute. Pedro's father never had contact with the shelter, had been in prison for many years and the child 'hardly knew him'. The children had experienced violence and neglect. Thus, there was a recommendation for residential care for the children, and hospitalization and drug treatment for the mother.

Pedro was referred to psychotherapy because of his history of suffering. According to the shelter caretaker, he was a sad boy, who isolated himself from other children and had many learning difficulties. He was a very shy boy and hardly played. The caregiver reported that Pedro was lethargic and not very responsive but was also often involved in fights with his peers. At school, Pedro was not doing well, he was not literate, and he risked failing the school year.

As part of the assessment process for therapy, semi-structured interviews were conducted with the caretakers aimed at hearing about Pedro's life history. Evaluation interviews were conducted with the child in order to assess his difficulties and need for psychotherapy, and the following instruments were used: the Children's Depression Inventory (CDI), used to evaluate depressive symptoms in children and adolescents; and an adaptation of the Manchester Child Attachment Story Task (MCAST), aimed at evaluating attachment representations of school-age children and to examine the attribution of mental states to the characters.

The CDI and MCAST were used before and after the first six months of psychotherapy. Furthermore, in this project we analyzed the first six months of the therapeutic process. All the sessions were audio-recorded with the permission of the child and his caretakers.

During the psychotherapeutic process, the sessions were supervised weekly, focusing on understanding the mental state of child and caring about his emotional needs. Only after six months, when the formal analysis of the data began, was this material examined in light of the established categories of analysis for the study.

The data analysis procedure followed these steps:

- All interviews and psychotherapy sessions were transcribed.
- The results of two MCAST applications were analyzed and interpreted independently by two therapists with experience of over 25 years.
- The CDI score (second application) was calculated.
- After six months, each session of the psychotherapeutic process was analyzed, based on the method of content analysis (Turato, 2003), identifying in particular the following categories, taken as indicators of mentalization: (i) self-representation; (ii) perception of own mental functioning; (iii) perception of others' feelings and thoughts. Issues related to depression indicators and its evolution were also analyzed, along with psychotherapy. This analysis was performed independently by two therapists with experience of over 25 years.
- All data (psychotherapy sessions and instruments) and results were integrated into the general understanding of the capacity for mentalization and its evolution over psychotherapy, at the level of the individual case.

The mentalization-based treatment of Pedro

Depression and attachment – assessment before psychotherapy

During the CDI first application, Pedro had trouble concentrating and said that he was exhausted. His score reached 40 points, which was clinically significant because of the presence and severity of depression symptoms.

In the meeting scheduled for applying the MCAST, Pedro did not want to perform the procedure and we had to stop. He appeared extremely anxious, inattentive, and looking for other toys. Some hypotheses were considered for his difficulty in performing the procedure: (a) that it was indicative of insecure attachment, with elements of disorganization; (b) that the separation from his parents due to residential care and depressive symptoms affected the child's attachment representations, preventing access to them, due to his anxiety during the assessment; (c) that his mentalization capacity was possibly impaired due to his experiences of neglect, and disruption of attachment bonds which prevented completion of the procedure; (d) that the instrument was inadequate for a child with Pedro's characteristics.

The boy's life history pointed to experiences of neglect, violence, deprivation, loss, and abandonment. Pedro has not only suffered a lack of continuity and holding by his caregivers but he was also rejected and abandoned by his mother. This rejection would be repeated later in the experience of being cared for by his

aunt while his mother was hospitalized for treatment of drug dependency. The boy had also lost contact with the father since his arrest. All of these experiences are compatible with the hypothesis of depression associated with an experience of broken ties, involving insecure attachment and deficits in reflective function and mentalization (Bateman & Fonagy, 2003; Fonagy, Gergely, Jurist, & Target, 2002; Runyon, Faust, & Ovaschel, 2002). Pedro's disorganization in the first sessions, as well as his difficulty during the MCAST assessment, may be related to his experiences of maltreatment, abandonment, and rejection by caregivers.

The limitations of mentalization characterized by depressive disorders may be linked, therefore, not only to difficulties in relationships with attachment figures but also to the difficulty in identifying emotional states, which may seem unbearable, associated with the painful experiences that Pedro suffered in living with these figures. Given the situations experienced by Pedro, facing such feelings of helplessness, both his own and his caregivers, would have been very difficult in the initial period of psychotherapy.

The main themes of psychotherapy

Pedro was a little boy for his age, with dark skin and a face that seemed to have been carefully designed, and hazel brown eyes. With a shaved head, he was a very handsome boy. He spoke softly and often it was difficult to understand him as his vocabulary was limited and confusing, and he often exchanged letters. Pedro appeared to be an apathetic child, who lacked energy to play.

In the first intake interview, Pedro arrived very anxious, asking many things about the therapy room and about who attended. He stood outside, sat for a while, then walked through the therapy room, looking at the toys, the games, and the therapist. He sat down only when invited. He seemed confused and lost, and that was how the therapist felt in these early stages. She wondered about the boy's feelings, and how an abandoned child like Pedro could feel, and how difficult it would be for the boy to get in touch with her and with these feelings.

In the early sessions, the therapist tried to provide a safe atmosphere, ensuring that she would be there at the days and time arranged and that there would be sufficient time for being together. She aimed to create a relaxed atmosphere, in which she carefully followed Pedro's own lead, helping to modulate his emotions if he became too excited or anxious, but without actively attempting to interpret or challenge his beliefs. These interventions were aimed at the regulation of arousal and promoting a secure relationship. According to Verheugt-Pleiter (2008), it is important for the therapist to adjust her reactions to the child's mental functioning level, to create an atmosphere of acceptance and to make it possible for the child to gradually explore some aspects of his tense and often impulsive inner world.

In the initial period of psychotherapy, Pedro was concerned with the duration of the sessions, wanting to know the time constantly. He used to ask: 'Will it take long? A long time here?' The therapist thought that Pedro was concerned about having

enough time for his treatment and that he was afraid of being abandoned. However, she did not share these thoughts with the boy. She examined the clock with the child, showed the clockwise position and the time they were to have together.

All the interventions in this period aimed at what Verheugt-Pleiter (2008) called 'attention regulation'. According to this author, the therapist needs to pay attention to the content of the child's play or activity, introducing structure. 'The therapist moves along with the child's rhythm. This is more about creating patterns of being together than about what is actually said. Doing the same thing together rhythmically, often repetitively, is reminiscent of a children's song' (p. 113). For instance, when Pedro was excited and ran from one side to another in the consulting room, the therapist asked: 'Is it difficult to play today?' When the boy spread the toys, unable to do anything with them, the therapist used to say: 'Let's see the toys. Let's count the toys. Which ones do you like? Which ones don't you like?' Sometimes she only observed Pedro, attentively, and sometimes she just repeated what he was doing. According to Verheugt-Pleiter (2008), in order to achieve attention regulation, it is important to accept the child's own regulation profile and to attune to the same level, to work on the child's ability to make contacts, and to give reality value to preverbal interactions by taking the child's own style seriously.

When Pedro did play, the material was frightening. In this period, the boy was anxious, restless, and could not talk about his feelings and experiences. His obsessive concern with the sessions' duration, repeated requests to carry the therapist's cell phone and the recorder showed the insecure nature of his emotional attachment. Given the boundaries, he could not stop and think. He exploded with anger: 'Ah! I don't want to play anything! I don't want anything! I beat people up in the shelter. I don't want you to care for me! I don't want to stay here! I will not! I am the devil!'.

At times like this the therapist used to say, with feeling in her voice: 'Pedro is very very very angry!' She aimed at naming or describing the anxiety, the feelings of threat, and the states of animosity (Verheugt-Pleiter, 2008). Before we can begin to promote explicit mentalization, helping a child like Pedro to develop both attention regulation and some capacity for affect regulation is very important. Such regulation means that the affective experiences of a child can take on their full meaning, their emotional quality. In normal circumstances, this should happen in the child's relationship with his primary caregivers. When this has been lacking, as it was in Pedro's early life, the therapeutic relationship becomes an opportunity for an experience of being recognized as a child with a mind. The marked and contingent recognition of a person's own affect in a significant other, an attachment figure, is the necessary condition for the child to develop his own affect regulation (Fonagy et al., 2002). Because of this, the interventions of the therapist were aimed at the regulation of attention and then at affect regulation: helping the child to pay attention to internal and external reality, recognising his emotional experiences and giving reality value to them.

In practice, this process is not always easy. Sometimes Pedro tried to attack the therapist, pretending that he would kill her with a toy pistol. She dramatized the situation in the here and now, without making links to Pedro's earlier experiences

or making transference interpretations. She allowed him to play at attacking her (just pretend) and spoke about his anger and then showed him that everything was still okay. Sometimes, these manifestations were very intense, as was the confusion and resistance of the boy. The therapist felt discouraged, helpless, and was left wondering if she was helping Pedro. Analyzing and discussing the situation in supervision, we thought that it would be important to accept the projections of the boy, as that was a way of learning about how he probably felt and that it might be possible, very slowly and gradually, for these feelings to be returned to him. As in the work of Bion (1962), the therapist should accept the child's projective identifications, gradually attempting to transform the 'beta elements' through 'alpha functioning', as part of the process of promoting his capacity to think and make links.

As well as drawing on ideas from the work of analysts such as Bion and Winnicott, the therapist was also informed by what Fonagy et al. (2002) describe about building an inner world, a representational structure with which to reflect on primary affect states. For this, the child must be seen as a person in his own right, linking inner experiences to a representation perceived as true or real. In this way, it may be possible to make room for the deduction of 'second-order affect representations'. The beginnings of this process can be seen in the initial period of therapy, when Pedro used the doll's house toys, saying that it was inhabited only by a poisonous and deadly snake. The therapist tried to introduce fantasy to facilitate the pretend mode, as well as joining in the pretend mode. She would exaggerate and dramatize situations to help the child know about his emotional life and to experiment with boundaries between the inner world and the outer world. For example, she would say: 'What a fear! What a big snake! So ugly and so poisonous! What else is in the house? And how is outside the house? What is going on there?'.

In this period, Pedro chose five equal cars but with different colors. He said he would stay in the blue car (he was wearing a blue shirt), the color of his favorite team. Pedro asked the therapist: 'How far can the blue car go?' The therapist replied that it would go as far as it wanted. Pedro then looked at the therapist's white blouse and asked: 'The white car can't reach the blue one?' The therapist replied that the white car did not leave the blue one alone. Then, Pedro went to the doll's house and asked for help to remove the snake from inside the house. The therapist said: 'The white car will help the blue one.' Pedro answered: 'No, because he is evil.' He got a magic wand and said: 'The wand will turn him into a donkey,' referring to the blue car.

In this interaction, Pedro seemed to show a negative self-representation, low self-esteem, and a lack of trust in others and in his abilities and possibilities. The therapist did not interpret his unconscious fantasies nor the negative transference. Based on the therapeutic relationship, she sought to show Pedro that he was in a safe environment and that she would be by his side as needed. As Pedro was unable as yet to recognize his affects and mental states, the feelings were named through an intermediary: a figure in the play situation or as a feeling of the

therapist, as recommended by Verheugt-Pleiter (2008) and Hurry (1998), in her account of 'developmental therapy'.

The absence of an integrated self-representation was visible: Pedro looked at the mirror on the wall, and when the therapist asked what he was seeing he could not answer. He ran anxiously through the therapy room, touching various toys without playing with them. So the mirror was taken literally too. The therapist invited Pedro to look at himself in the mirror and she described to Pedro his mirror image, talking about his characteristics and feelings: 'I see a boy, he is serious,' or 'He is smiling. He wears a blue shirt. He's cute. Pedro looks sad,' or 'Pedro seems nervous' and so on. This play was repeated many times in many sessions, and Pedro delighted in hearing the therapist describe his appearance in the mirror.

Then, Pedro decided to choose the game of hide-and-seek. He also asked for toy bottles and a soother and joked that he was a baby. During this time, he asked for food in some sessions. The therapist proposed that they pretend to cook and eat and he asked: 'Let's play that you were my mother?' Therapist and patient played that they were mother and son for several sessions, dramatizing all the routines of a child. Pedro also asked to draw and called the therapist 'mother'. He asked her to stay looking as he drew. He drew a boy called 'strong one'. He drew muscles in the boy's arms. He told the therapist that she should be looking at the strong boy and so she did. At this stage, the therapist did not attempt to interpret his wish for her to be his mother, and nor did she attempt to bring out the negative aspect of the maternal transference. By staying in the play of mother and son, she tried to provide an opportunity for Pedro to experiment with a kind of safe relationship, in which the caregiver was able to understand the child's needs, feelings, and to answer in a contingent and marked way. This mirroring could perhaps help in the development of a more integrated self-structure. Furthermore, the introduction of fantasy facilitates the pretend mode, and playing in the pretend mode leads to the capacity to mentalize.

In general, Pedro did not talk about other people. However, after the sessions in which he played hide-and-seek, he drew his family: his sisters and his mother, but the mother figure was more rudimentary, her body was a tangle of lines and had no face, while the other figures were more integrated with defined face, hair, body, and limbs (see Figure 1, below). He wrote several times the word *uncle* and *aunt* in a cloud and the name of his sponsor too (these names have been removed from the image to preserve confidentiality). He said that his father was in prison. Then the therapist tried to help him think about his family, talking about his reality: 'He was at the shelter because his parents could not care for him and he had uncles and aunts in the shelter who do care about him'. Pedro did not answer.

After this, the sessions became somewhat calmer and Pedro could start talking about his reality, his parents' situation in prison, and the reasons why he was living in the shelter. His understanding about his parents' situation was limited, but he said that 'my parents were arrested because they did wrong things'. However, he stated that he was in the shelter because he bothered them too much. The therapist tried to explore alternative explanations: 'Was it really

Figure 1. Picture 9th session.

because you bothered them? Are there other reasons?' Pedro looked at her, thoughtfully, but did not reply.

Some games used by Pedro in his sessions seemed essential in the process of attempted mentalization development, as well as in helping to promote greater self-cohesion: the play in front of the mirror and the games 'Crazy Man' (a game which consists of picking cards and putting together an image of various people's faces) and 'Face to Face' (which aims at discovering characteristics of the opponent according to the characteristics of his face). The therapist used to say: 'Who is this man? Who is this woman? Who is this boy? What is he/she feeling? What is he/she thinking?'.

The games were followed by drawings in which he made a 'strong boy and the person who trained the boy'. In the corners of the sheet, he drew faces with different expressions, saying one was 'rude', the other was 'angry', the other 'nice', and so on. It seemed to be the rudimentary beginning of the recognition of mental states, his and others. Verheugt-Pleiter (2008) states that if the relationship has become safe enough, the child can gradually internalize the function of the therapist as the representer of affects. This leads to second-order representations, when the child can do it on his own. Through these toys, Pedro gradually recognized and began to identify some of his own feeling states. He started talking about his feelings: anger, sadness. His drawings became more organized, he represented himself on a skateboard, drew his family, drew the house where he lived before going to the shelter. The mother was always drawn in a very primitive way.

Pedro started to play harder, thus concentrating on games, creating rules for the games, and having fun with them. He went through a period in which he spoke about his family, his mother, his father, his sister, his home, and how he saw all of this. Then, in the 17th session he drew two houses: the one that he lived in before the shelter, in which he drew a very rough figure that he said was him; in another house he drew a picture of a boy which looked far more integrated, which he said was also him (see Figure 2). This seemed to show the beginning of an idea about himself, his trajectory, and some notion of autobiographical continuity.

Pedro brought, from the 17th session onwards, the drawing of Ben 10, a super hero character from a television animation who has a clock. It seemed that the relationship with the clock (with time), present throughout the psychotherapeutic process, and the ability to articulate a narrative of his life history and his current status allowed him to create a representation of himself – or at least the beginning of a representation. This view of himself was less depreciated, expressed in an identification with a super hero, someone who has some power and value – but it was not yet a realistic self-representation, which could include both a sense of agency and of vulnerability and need.

In this period, Pedro brought a drawing to the therapist a drawing and said: 'Look, I made it for you. It is the Ben 10 clock'. Pedro began to ask for help from the therapist. When mounting a clay doll, the arms fell off. So he said: 'Could you

Figure 2. Picture 17th session.

help me? Everything is falling. I'm not able to manage'. Previously, he would have given up playing.

Pedro was doing the movements, filling the gaps left by the absence of a minimally sufficient reflective function, mirroring gaps offered by caregivers who would enable the development and stability of his mentalizing capacity (Fonagy, 2006; Fonagy et al., 2002). In the here and now of the treatment relationship, the therapist tried to give reality value to the child's affects and add a play dimension. In this way, the boy could gradually discover that his affects exist and could be acknowledged (Verheugt-Pleiter, 2008).

Taking responsibility for the affects externalized by the child is a necessary condition for the child to become familiar with them and to assimilate them. This is the 'benign split' (Bateman & Fonagy, 2004), when the therapist contains the intense affects of the child and gives them back in a digestible form. We believe the first steps were taken in order to help Pedro to develop his mentalization capacity. According to Verheugt-Pleiter (2008), in child psychotherapy, mentalizing interventions are only useful if there is first a foundation of attention regulation and affect regulation. We tried to promote this in these early stages of psychotherapy. The therapist sought, all the time, to mirror the child's mental states and processes in a contingent, congruent, and marked manner. We are aware that much work still needs to be done to help Pedro with the gaps in his sense of self that are a consequence of the non-contingent behavior of his attachment figures and the accompanying development of an 'alien self'.

Depression and attachment – assessment after 6 months of psychotherapy

The second CDI application showed a clinically significant improvement in depression indicators, with the CDI score dropping dramatically from a score of 40 down to a score of 5 – well below the clinical cut-off point. A qualitative analysis of his responses revealed a positive assessment on topics such as: 'I like myself,' 'I make decisions easily,' 'I do not fear pain or illness.' Statements such as 'I do most things well' and 'I'm as good as other kids' denote a possible change in his self-esteem, although one would have to treat these ratings with some caution, as they were not corroborated by other measures.

The second MCAST application indicated an insecure attachment in most of the vignettes. Pedro was anxious during the procedure, but unlike at the initial assessment, he was able to engage in the process to a limited degree. In four vignettes, results pointed to avoidant attachment strategies. The boy focused on self-care, without seeking proximity to the caregiver (*I don't know . . . he dreamed of a snake that was in the house. Tear it off your head*! Or *He puts on a bandage. He walks with one foot*.) One of the vignettes pointed to disorganized phenomena, with breaks in the narrative, and a lack of a logical sequence (*I can do this thing here, oh, I came running*.).

Looking at the MCAST stories, Pedro's mentalization seemed limited or could not be identified (How is he feeling? *Bad*. What is he thinking? *A hot dog*.).

The results showed the need – nor surprisingly, given the impact of his early history – to continue psychotherapy, which had been assured for the boy.

Discussion

Reviewing the purposes of this study regarding the understanding of the child's affective bonds, we can see that Pedro suffered a disruption of his emotional ties in a concrete way at the time of institutional care, but even before, he experienced insecurity of attachment based on a history of severe neglect and emotional abuse.

Pedro's loss seems to refer to experiences that were never lived, rather than to something that he had experienced and was then lost. According to Winnicott (1999), it refers to the privations experienced in the stage of absolute dependence of the child.

Bowlby (1998) distinguished between sadness and depression (states experienced by most people), and depressive disorders, noting that in the latter case one can observe a chronic mourning and a sense of helplessness associated with an inability to establish and maintain relationships. For Bowlby, these feelings may be attributed to experiences in the family of origin, but will later be repeated in the child's relationship to other significant figures. This was reflected in Pedro's relationship with the therapist and his behavior during the first six months of the psychotherapeutic process. From the beginning, Pedro brought his fantasies that there would not be a place for him, that there would not be enough time for his care, and that he could lose it (concerns about time and the clock). Pedro expressed, in his first session, the feeling that there was something threatening inside him and his home and no one could stand him. He expressed, symbolically, his fantasies of abandonment, and his fear that the therapist would not approach him effectively, or stay with him.

Still, after six months of treatment it appeared that the therapeutic process contributed to a decrease in depressive symptoms, which was one of the objectives of this study. According to the indicators for the second CDI application, Pedro showed significant improvement in depression symptoms after six months of psychotherapy. Obviously, an improvement in symptoms does not mean that the difficulties underlying such symptoms have been overcome, but it means, no doubt, the start of a possible reorganization in the direction of self-integration and cohesion.

Pedro showed insecure and disorganized attachment indicators, as well as a difficulty in reflecting on the mental states of self or others. To him the world seemed unpredictable and/or dangerous, and he had limited capacity to deal with such a world. Accordingly, the therapeutic work was directed so that he could recognize himself in the mind of another, within a welcoming and safe setting. Thus, he could express his anxieties, fears, frustrations, and confusions. Although the change in capacity for explicit mentalization was modest in the first six months of psychotherapy, this is not surprising, given the need to first establish the 'building blocks' of mentalization, i.e. first-order representations of affects

and a limited capacity for attention and affect regulation. But during the course of this early period of therapy, it was possible to see a tenuous movement towards a more cohesive and integrated self. Pedro became better able to articulate a narrative about the past and present, recognizing the feelings associated with his experiences, such as anger and sadness, among others. After the six months of therapy that have been considered in this study, he could talk about his mother in a more critical and realistic way.

The observed changes during the psychotherapeutic process appeared to result from the experience of something that he had not experienced before. The focus on psychological processes, rather than on mental contents, as recommended by the therapeutic approach used in this study (Allen & Fonagy, 2006; Bateman & Fonagy, 2003, 2004, 2006), appeared to constitute itself as an effective and promising way of enabling Pedro to find new ways to cope with his internal world. The continuation of the psychotherapy process was necessary allowing, maybe in the future, the analysis of mental contents, i.e. analysis and integration of his painful losses and grief.

Mentalization-based child therapy, therefore, could be a promising possibility for children who have experienced disruption of emotional bonds, as it focuses on their capacity to develop mental representations. The history experienced by these children cannot be changed, but such therapy can promote a reinterpretation of history, their identity, and their bonds, thereby enhancing greater autonomy and resources to deal with life's adversities.

The limitations caused by the lack of availability of instruments for assessing attachment and mentalization in children in our country, and the consequent need for adaptation of instruments developed in other contexts should be pointed out. This is an issue that should receive the attention of researchers in future studies in Brazil. We are aware of the limitations and the risks of the dual role of researcher and therapist as well. The necessity and importance of developing more focused measures of mentalization in depressive and in other disorders of childhood are clear, as is the need to use a wider range of measures which capture the child's functioning in a range of areas, and from a number of different perspectives (Vrouva, Target, & Ensink, 2012). But we hope that this initial study will encourage others to explore this work further, as we are doing ourselves in the larger study of which this case history is only one part.

Notes

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