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Case Study
Estudio de caso

A mentalizing approach to treating children with attachment trauma in group: Experiences from two cases

Un enfoque mentalizador para el tratamiento en grupo de niños con apego traumático: La enseñanza de dos casos

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Abstract
The purpose of the study was to discuss the methodology and techniques from the perspective of the mentalizing approach and to examine significant aspects of the treatment processes of children with attachment trauma in group therapy. Two cases of children with attachment trauma were presented and discussed. It was found that in group therapy, the ability in children to form significant relationships was activated and developed. Attachment trauma took shape as a problem in relation with therapist and/or group members. Therapists tried to understand them through a mentalizing stance and tried to help develop a secure attachment. Gradually, based on the relationship with the therapists as a secure base, children began to approach other members, developing chumship with them, and relational bonds were strengthened, where traumatic events were described and accepted, and dissociated parts were integrated in them. Interventions for uncooperative parents were also recognized as an important key.

Key words
Attachment Trauma, Mentalizing Approach, MBT (Mentalization-Based Treatment), Group Therapy, Childhood

Resumen
El propósito del estudio fue reflexionar sobre la metodología y las técnicas empleadas desde la perspectiva del enfoque mentalizador y analizar los aspectos más relevantes de los procesos terapéuticos en terapia grupal de niños con apego traumático. Se presentan y analizan dos casos de niños con apego traumático. Se encontró que, durante la terapia grupal, se impulsó y desarrolló la habilidad infantil para formar relaciones significativas. El apego traumático se plasmó en problemas relacionales con el terapeuta y/o los miembros del grupo. Los terapeutas trataron de entenderlos mediante una actitud mentalizadora y de facilitar el desarrollo de un apego seguro. Poco a poco, gracias a una relación con los terapeutas como base segura, los niños comenzaron a acercarse a otros miembros, desarrollando compañerismo con ellos, fortaleciéndose los lazos relacionales, pudiendo describirse y aceptarse los hechos traumáticos, y permitiendo la integración de las partes disociadas. Las intervenciones específicas para padres no colaboradores también fueron reconocidas como un factor importante del tratamiento.

Palabras clave
Apego Traumático, Enfoque Mentalizador, MBT (Tratamiento Basado En La Mentalización), Terapia Grupal, Infancia

INTRODUCTION

According to the Japanese Ministry of Education, Culture, Sports, Science and Technology (MEXT) (2021), the number of suicides among children under the age of 18 continues to increase in Japan. In the fiscal year 2020 (April 2020 to March 2021), 499 children committed suicide, an increase of 100 from the previous year, and the highest number ever recorded. Behind this increase is the issue of attachment - in which children are unable to ask for help from and trust others. In recent years, there has been increasing attention to the relationship between attachment challenges and clinical problems.

Attachment is defined as “a strong emotional bond with a specific other” (Bowlby, 1979/1989) and is characterized by “security and comfort” in a state of distress. In recent years, attachment theory has also influenced group psychotherapy research and practice because it has enabled us to shed light on and effectively treat psychopathology (Marmarosh, 2017). For example, Flores (2011) found the pathology of addiction

patients to be attachment disorder; Bateman & Fonagy found that the pathology of borderline personality disorder includes attachment disorder, which damages mentalizing, and that enhancing mentalizing through Mentalization-Based Treatment (MBT), which is aimed to the group (MBT-G, Karterud, 2015) plays an important role there. When it comes to the treatment of children, Bate, Nikitiades, Hoffman, Allman, Steele, Steele, & Murphy (2017) also reported on the practice of Attachment-Based Group therapy, which is a parent-child relationship restoration/reform program focused on infants and young children whose attachment is at risk, such as maltreatment. MBT for children (MBT-C) is treatment that approaches attachment in childhood. This is practiced on a family basis. In addition, attachment issues here are viewed as a trans-diagnostic underlying factor and applied to a variety of problems on the surface. Nevertheless, it is effective in improving emotional dysregulation and poor interpersonal relationships caused by attachment-related trauma (attachment trauma). On the other hand, when it comes to group treatment, there is MBTG-A (Malberg & Midgley, 2017) in MBT (MBT-A) in adolescents, but none in childhood. Although groups seem beneficial for repairing attachment damage (Ezquerro, 2016), it does not seem to be sufficiently systematized.

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Among these, “attachment trauma” is a particularly important concept. It is defined by (1) the trauma that occurs in attachment relationships, and (2) the negative impact that such trauma has on the ability to form secure attachment relationships. This occurs when children are left psychologically isolated and helpless in an unbearably painful emotional state in the course of fostering (Allen, 2013).

Attachment in children is fostered and maintained by the caregiver’s mentalization (Fonagy, et al., 2002). Mentalizing, briefly defined as “holding mind in mind” (Allen et al., 2008), is “understanding oneself and others on the basis of what’s going on inside us” and includes “keeping mind in mind and seeing oneself from the outside and others from the inside” (Midgley, Ensink, Lindqvist, Malberg, & Muller, 2017).

Mentalizing is indispensable for the development of secure attachment. It is also promoted in secure attachment. In other words, attachment and mentalizing develop in an interactive way. On the contrary, non-mentalizing engagement destabilizes attachment and reduces mentalizing in the attachment relationships. Attachment trauma is the result of such processes being undermined, for example by child abuse in the nurturing process. Lack of or excessive distortion of mentalizing is itself, and its consequences, a dysfunctional attachment.

Based on this perspective, the Mentalizing-Based Treatment (MBT) was developed by Bateman and Fonagy (2004) with the aim of promoting mentalizing. A method of treatment that adapts the MBT techniques to children in childhood is called MBT-C (Midgley et al., 2017). It seeks to repair attachment instability or deficit by increasing the ability to mentalize.

In terms of group therapy, it has become an essential component of MBT for adults with BPD, with very beneficial effects. Group therapy has also been developed and implemented in MBT for Adolescents (MBT-A) (Malberg, 2012, 2017; Muller & Hall, 2021). However, group therapy in childhood has not yet been developed enough.

Kimura, Nasu and Nishimura (2020) and Kimura and Nishimura (2021) adopted the “mentalizing approach” to group therapy for children, finding that the mentalizing approach is effective for emotional regulation and peer relationship development in children with attachment problems. “The mentalizing approach” is a method of applying a mentalizing perspective to therapies already in practice, in contrast to MBT

and MBT-C, which are structured therapies. Allen et al. (2008) argue that therapists can use this stance more consistently and effectively if they are mindful of the concept of mentalizing and understand that the basis of it is the attachment relationship. Kimura et al. (2021) reported that, although interpersonal problems occur in the process of building relationships between children in group therapy, development occurs when the therapist approaches them with a mentalizing stance (described later), so that when children become able to mutually understand the psychological state behind their behavior, mentalizing can occur between children.

The purpose of this study is to discuss the treatment hypothesis and methodology from the perspective of the mentalizing approach and to draw concrete aspects of the treatment of children with attachment trauma in group therapy. Specifically, two cases of children with attachment trauma will be discussed based on the case studies.

The nature and purpose of the groups were explained to the children and their parents before they joined the groups. After participation in the group, research consent was obtained from both parties to present the research.

MENTALIZING APPROACH IN CHILDREN'S GROUP

The group becomes a kind of laboratory for interpersonal relations and a practice ground for mentalizing. It is ideally a mentalizing community where there is a climate of interest in the mental states behind your own and each other's behavior. For this reason, it is important that the group feels free and safe to express themselves in any way they wish. Such a climate is fostered by a therapeutic stance, in which the therapist is not evaluating the members' actions but is curious about and positively involved in their mental state.

Figure 1 shows how the "mentalizing mode" is enhanced by a series of interventions and how a "breakdown" takes place due to events, either individual or group-based, leading to the "non-mentalizing" mode and how it is later restored. Therapeutic activities (activities, art, etc.) are introduced to facilitate, develop, and evolve such interpersonal relationships ("a. therapeutic activities" in Figure 1). In particular, because children are still developing, their capacity for mentalizing is limited both linguistically and cognitively. It is one of the key challenges in group therapy for children to develop their own mentalizing abilities. Structured programs in groups can be beneficial in themselves but are unlikely to change children's attachment challenges. More direct and constant interpersonal experience are crucial for important roles in the change of attachment.

There are 4 general steps of mentalizing intervention. Step 1: Empathy, support, and encouragement (including empathic validation); Step 2: Clarification, elaboration, and challenge; Step 3: Basic mentalizing (putting into words how you are feeling here and now. E.g., "How do you feel now...?") and Step 4: Mentalizing of relationships (mentalizing interpersonal relationships as they happen in the here and now). The general strategy is to carry out steps 1 and 2 when the group's sense of safety is low, and then proceed to the next higher step after the sense of safety has settled.

It is inevitable and unavoidable that there will be breakdowns in mentalizing processes which are triggered by events. It is important to engage with this, to understand, and to try to repair it ("b. interventions to restore mentalizing" in Figure 1). For children with limited mentalizing abilities, such as those with developmental disorders, it is a very challenging but very significant task to find ways of adapting to them so that they can mentalize their own selves and others.

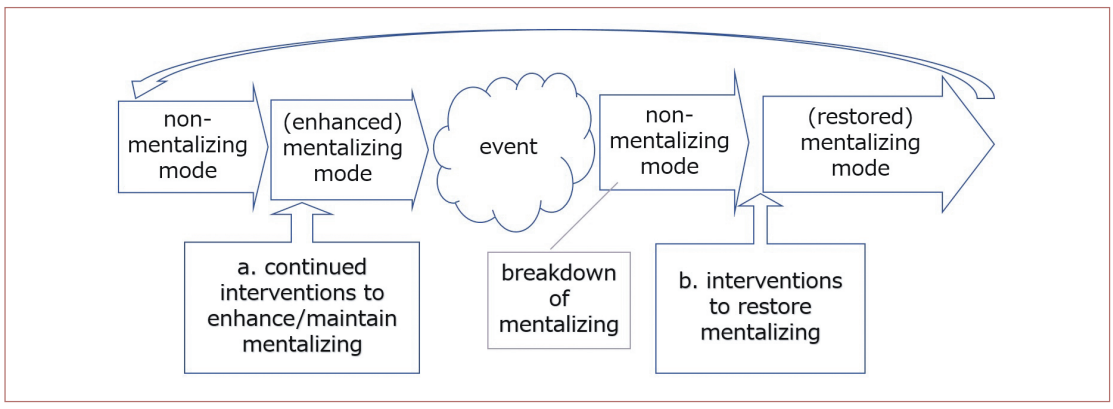

Figure 1. Process of mentalizing in group

THE GROUPS

The groups presented here were a free community-based program, organized by a university institute (aimed at children aged 7-12 years) to support their development and promote their growth, without focusing on specific pathologies or problems. About half of the children in the groups showed adjustment problems or developmental disorders (ASD and/or ADHD). They had been referred to our groups by the parents of other members, school teachers, and the public educational service in the district. The groups were organized by gender, with a clinical psychologist for each group as leader and volunteer undergraduate students working with them. They were supervised at each session.

The groups were held every Saturday for two hours. Their parents were able to attend a monthly psycho-educational group if they wished.

The program consisted of check-in, study, physical activities (game of tag, tree climbing, ball games, etc.), expressive activities (arts and crafts, role play, etc.), and "wrap-up". There were group rules about confidentiality, safety, participation, and boundary maintenance.

CASES

Case A

A (6th grade girl): She had behavioral problems, such as shoplifting, and interpersonal problems, such as isolation at school, and went to a Child Guidance Center with her mother every month. She was referred to our group by a friend of her mother. Her family members were her father, mother, and an elder brother. Her father was often away from home for work.

A was fashionable and athletic. She teased people head on, even when they were adults. During the intake interview, she was hyperactive and restless, walking around the room and touching equipment. Difficulties with attention control were observed and she appeared to have ADHD tendencies. However, as if overwhelmed by her prolific daughter, the mother seemed flustered and unable to speak due to strong feelings, suggesting emotional neglect. It became apparent later. Because it was predictable that the group would become involved in A's problems (such as lack of attention and hyperactivity) and breakdown would occur, we aimed to achieve the therapeutic goal of helping A to feel safe in the peer group and to explore and talk about what was happening if some problem arose. It seemed that the emotional regulation of the therapists themselves and the group as a whole were also important in building the relationship with A.

Process

A joined the group alone from the first session (it was unusual that she was not picked up by her parents, even though they were both working, as the group required parents to take their children to and from the group). She begged the group's therapist for a piggyback ride and made a lot of noise, but the members were silent and indifferent to A. A had difficulty verbalizing her emotions in a situation of heightened anxiety and tension and instead expressed them through physical contact and noisy behaviors. After the session ended, A told the therapist that, "I'm bored because nobody's home when I go home." The therapist noticed that it was difficult for her to separate from them and said, "I think that you will be lonely when you get home and are alone because you enjoyed your time in the group." A responded by silence.

After a few sessions, A began to verbally attack the therapist in the group, calling her a "hag". The therapist felt A's strong ambivalence in their relationship

In an activity talking about her father before Father's Day, A refused to join that and said, "I don't want to talk about my family, because my family is strange. I have had bad experiences talking about them at school." When the therapist said, "Oh, it must have been so uncomfortable for you", A said, "If you know I don't like it, why do you make me do it!". The therapist needed to pay attention to A's emotional state, but A's strong rejection made it difficult for her to regulate her own emotions and led to a breakdown in mentalizing. A spent the rest of the session distancing herself from the therapist. On her way home, the therapist said, "I will never hate you", and A looked at her in silence and went home.

Talking about her father and family was a "hotspot" (Holmes et al., 2005) that destabilized A and increased her arousal; A's anxiety was intensified. However, the therapist's understanding of A's abandonment anxiety after a quarrel with her and telling her that "I will never hate you" were important interventions in continuing the relationship.

The following week, A attended the group as usual; she begged a volunteer student to carry A on her shoulders, and when the therapist saw this and said, "You're such a baby!", to which A smiled and said, "Yes!". A said that her parents don't give her a ride on their shoulders, "I don't talk to my parents anyways". When the therapist said, "It must be lonely," A replied sadly, " Yes".

A few months later, A's mother called the therapist to tell her that A had stolen a handmade stuffed animal from a classmate at school. A's mother was so upset

that she cried, "I can't do this anymore!" In the group a few hours later that day, A was not settled, wandering around her therapist. When the therapist said, "You look very unsettled today," A shouted, "I'm always unsettled!". The therapist replied to her, "I know you struggle to calm down." Then she was almost about to cry but she did not.

She decided to go to a private school because she was afraid of being isolated in the public school she was supposed to enter. However, A got more stressed as the entrance examination for a private junior high school approached. She began to tell her group members about her unrealistic and exaggerated self-image as a "celebrity honor student" (e.g., "I always wear expensive kimonos at home" or "I study very hard and am in the top class at my cram school"). A's academic performance was not good and such "fishy stories" seemed to be a struggle to cope with the unacceptable reality. A's "fishy stories" continued for a few sessions, and the members enjoyed those stories instead of criticizing them. When playing a funny game in a session, A suddenly mumbled, "I'm an idiot…the junior high school that I will enter is lower level". The members of the group replied with smiles and accepted A's self-disclosure. After this session, A got closer to other members and was willing to be supported.

As a matter of fact, A succeeded in her junior high school exams and looked radiant at the last session of the group: "This group was a place where I felt relaxed and could release stress. I enjoyed it," she said.

One year later, A joined a reunion program. A told the therapist that her parents had divorced soon after she graduated from elementary school. The therapist said, "That must have been difficult", to which A replied, "Well...". After some hesitation, A hugged the therapist from the front, and the therapist felt A's pain and held her close, almost crying. On the way home, A said: "I'm going to look into abuse for my school report. Can you tell me about it?" The therapist agreed to her request.

Review of the process

A had difficulty in affect regulation, attention control, and mentalizing skills. However, underlying this was a problem of attachment trauma, in which attachment formation in the family was underdeveloped and disorganized. She was traumatized by the pain caused by the relationship between her parents and was unable to form stable attachment with either parent.

She had poor experiences of being soothed when she felt sad or isolated. She behaved in such a way that no one would notice her loneliness. But actually, when she felt very lonely, she "acted out" that feeling by stealing something lovely to soothe her instead of expressing the lonely feelings with her caregiver. In the group, she was unable to verbalize her difficult feelings, and expressed them through her behavior, which confused the group members and made them distance themselves from her. A also became aggressive toward her therapist when they addressed her hotspots that increased A's arousal. She also sought a sense of security on a physical level (which is exactly what she had been seeking but had not obtained from her parents).

Later, after she found her therapist would never abandon her when she expressed any feelings, she formed a sense of security. Then, A began to approach her peers by telling "fishy stories." The group accepted this way of approaching. It enabled her to self-disclose the real "shameful" and embarrassing facts to the group in a safe and natural way. The group functioned as safe haven and helped A to survive the difficult time.

Case B

B (5th grade boy) was unable to attend school after he broke his leg while playing soccer in his fourth grade. His parents divorced before B entered elementary school, and his mother raised him alone. He had no siblings. B's mother worked as a children's nurse until late at night. A parent of B's classmate introduced them to the group.

Early phase and Assessment: When B joined the group in the beginning of fifth grade, he spoke to the therapist in a respectful manner and looked like he had a serious mind. He said he was confident in playing sports and participated actively in a loud voice. Two months after joining the program, he said that his father was "scurvy". He also expressed anger towards the therapist who was concerned about it, saying, "I wouldn't tell you what I feel, you idiot!". But the next week, he massaged the therapist's shoulders and said, "I'm an apple polisher," with an insinuating manner. Thinking that he was concerned about the last session where he lashed out at the therapist, the therapist told B that they really cared about B, and B didn't have to please them. B smiled shyly.

The therapist thought that B was coping with distress by not activating his attachment needs, even though he was experiencing abandonment anxiety as a result of his parents' divorce and still spent time without attention from his busy mother.
Therefore, we thought that he was superficially emotionally healthy, but he had difficulties regulating his emotions when he got stressed.

Process

Several months after he joined the group, although B played energetically in the group, he sometimes got sick and vomited. Since he did not go to school and had little physical activity, his body did not seem to be able to keep up with the sudden intense exercise. However, it was inferred that he had a strong age-appropriate desire to move and have fun. When he played the role-play of helping a bully, B was good at helping, but when he played the role of being bullied, he quickly became at the mercy of the bully and could not resist.

B's absence from school continued and he began to lead a life where his days and nights were reversed, and he was unable to come to the group. Because of his continuous absences, it was difficult for him to form close relationships with certain members of the group.

In sixth grade, B began to attend school little by little. His participation in the group became more stable, and he began to play soccer with a boy at his age, leading other members to play together. He began to talk to his therapist about his family life, saying, "My mom had a drinking party and didn't come home until midnight." When the therapist said, "You might be lonely", B then responded "I'm fine". But in subsequent sessions, he talked about his mother's late return repeatedly.

Consequently, B began to skip group sessions again. After talking with his mother, it was clarified that she was causing B to be absent from the group due to not being able to pick him up for her own reasons. B's mother seemed to think that it would be difficult for him to come to the group by himself. The therapist understood the mother's stresses but thought that B might not be able to assert himself to attend the group and told her that it would be good if B could come to the group by himself on his bicycle. The therapist also suggested to B that he try to come to the group by himself. After that, B started to come to the group on his own or with other group members who lived in his neighborhood.

In the latter half of sixth grade, B's relationship with the group members deepened. In one session, the boy who led the soccer game with B said to him, "I thought you were in the fifth grade because you are not good at studying." When the therapist said, "I wonder if B might have felt something", B shouted, "I don't want to study!" He liked B's reaction, and later they discussed the difficulty of kanji (Chinese letters) and enjoyed the penalty shootout.

In such an atmosphere, B began to talk about how he felt when no one came to see him when he broke his leg, or how he felt when his mother drank until midnight, and before he was afraid of spending the night alone. The members listened attentively to B's stories.

During the session where he graduated from the group, he expressed his sadness about separating from his intimate peer and the group and encouraged each other.

Review of the process

B had experienced his parents' divorce and had a strong sense of loss that remained unprocessed. B's care (and fear of abandonment) for his mother, who worked late as a single mother, kept him from causing any serious trouble. This also meant that he did not have the experience of having his emotions such as anxiety and anger being regulated.

B was initially an active "good boy" in the group, but although he expressed his anger to the therapist about the topic of his father, it aroused anxiety in B. In the next session, B started to get into a good mood with the therapist.

Considering that B was anxious of being abandoned, the therapist tried to convey the message that the group would not abandon B no matter how he expressed his feelings. Thereafter, the therapist continued to focus on B's emotions.

As the process progressed, B's emotional regulation issues became apparent. When he felt strong emotions related to anger, even in situations where he was allowed to be assertive, he would freeze and not be able to feel those emotions (a sign of attachment trauma).

The therapist suggested to B and his mother that he should come to the group alone. The therapist also had him lead an activity (soccer) with a same-age boy in the group, and playfully encouraged B to be more assertive to him. By coming to the group more often, B's developmentally appropriate wishes to have fun and interact with peers was moderately satisfied, and his self-confidence was further strengthened through secure peer relationships.

B was able to verbalize traumatic events related to his loneliness and anxiety and share them verbally with the group members. As he was able to mentalize his own emotions, his emotional expression toward the members became enriched.

DISCUSSION

Mentalizing attachment trauma in children's group

Attachment trauma causes difficulties in forming attachment, including self-regulation and interpersonal

relationships. In a children's group, it takes shape through the relationship with the therapist and/or relationships with other members. For the therapist, it is difficult to build a bond with child with attachment trauma. However, by utilizing the mentalizing approach, therapist consistently tries to focus on child's mental states and seeks to make it explicit through activities and dialogue.

It is not the interpretation of the unconscious nor behavior modification. It is a process of carefully listening to and organizing its content into a story, and of finding "meaning" by exploring mental states. If verbalization is difficult, symbolization (whether in art or music) should be encouraged. If that is difficult, we can start by joining our attention and focus through physical exercises. Reflecting on the intention behind a child's behavior and responding through mirroring, clarifies the child's needs, increases the sense of being understood, and helps with self-regulation (Midgley et al., 2017).

The therapist may, however, unknowingly step into a hotspot. When this happens, the therapist needs to go back to the moment of break-down in mentalizing and adjust arousal level. At times, the therapist needs to acknowledge failures and communicate affection openly.

Based on such a relationship with the therapist, a child can start exploring the group, developing an age-appropriate desire for intimacy with peers and attempting to form a chumship, as described by Sullivan (1953). Subsequently, child can self-disclose through interaction with the members. In addition, through being accepted by members (empathic validation), self-inquiry is deepened and relational bonds are strengthened. Figure 2 illustrates how a child is connected with a peer in a group, based on the attachment with the therapist. A child may have conflict between "willing to tackle something novel" and "willing to maintain a sense of comfort." As the therapist works as a secure base, mentalizing child's curiosity and anxiety, she is encouraged to get close to the peer.

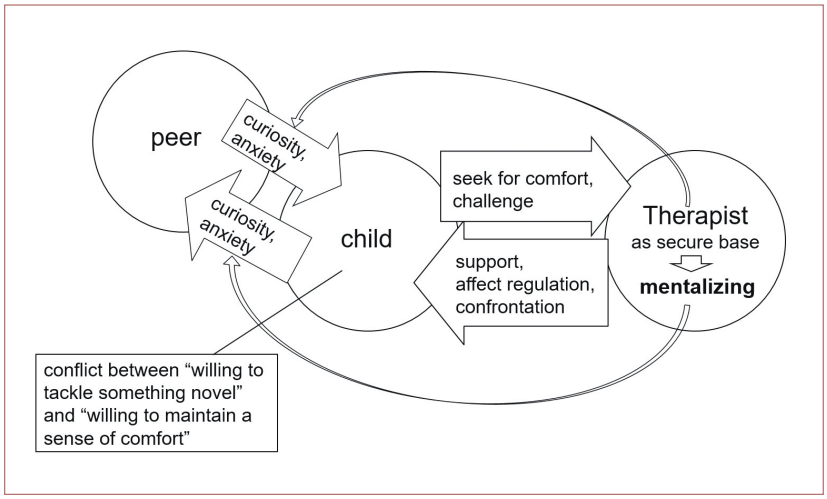

Figure 2.
Attachment and mentalizing between children and therapist in group

Treating traumatic events

Another aspect of attachment trauma is that traumatic events in interpersonal relationships are left unprocessed, leaving emotionally disruptive hotspots (Holmes et al., 2005). Our groups do not have any explicit purpose of trauma care. However, the materials of the group activities, especially the topics related to family, may evoke attachment trauma and bring up issues that need to be addressed. Talking about fathers in anticipation of Father's Day is a "normal program" and is not intended to embarrass children. Both A and B became more aroused during the "father talk" and had difficulty with emotional regulation.

Although a major "disruption", will take place, attachment can be formed through mentalizing about the disruption. This can lead to discussions among the children, and emotional regulation can be done by the whole group. Through such events, it can be said that the core events of attachment trauma can now be incorporated into narratives and kept in mind without dissociation.

Children with attachment trauma tend to avoid intimate relationships. This is because their augmented need for attachment increases feelings of anxiety related to betrayal and abandonment within them. As a result, they tend to adopt a bland or likeable attitude, which is an effect of alien self (Bateman & Fonagy, 2004). The emotional outbursts of A and B on Father's Day were validated. The group can also handle "negative talk" and other playful forms.

Skinship, piggyback, huggy

Attachment is not the same as skinship. In psychotherapy, it is generally said that physical contact should be avoided, even when working with children. However, in our practice, children often ask for skin-to-skin contact, such as a piggyback ride regardless of what problems they present. In particular, it is common for children with attachment issues to ask for skinship. As the cases show, we do not reject such requests for skinship. It has never caused any problems. This does not mean that it is enough to offer skinship, but it is accompanied by understanding, i.e., mentalizing, mirroring, and explicitly verbalizing and sharing that it is a request for comfort - a request for soothing. It is important to express that their need is being acknowledged.

Uncooperative parents

Our groups have no legal power for children and parents to adhere to the participation rules. When parents are uncooperative, some neglect takes place, directly amplifying attachment trauma. In those cases, the strengthened relationship with parents was found to be crucial. In terms of these cases, we needed to provide individual and/or family therapy to the parents of A and B. In fact, our group had a psychoeducational group for parents, separate from the children's group. However, A and B's mothers did not participate in that group. It was difficult in that establishing relationships with therapists, and pressuring parents to cooperate in such cases would likely be perceived as threatening to them. It is necessary to provide persistent and adequate encouragement to seek cooperation, while mentoring the parents about their difficulties.

CONCLUSION

In the present study, we illustrated aspects of how group therapy utilizing the mentalizing approach can be useful through a case study of two children with attachment trauma. Group therapy is thought to promote the ability to form significant relationships in children which has been inhibited by attachment trauma. Throughout the group, the attachment trauma became tangible in the relationships with therapists and with members, where the therapists tried to understand it. Eventually, on the basis of the relationships with the therapists, children began to approach other members, and by being accepted by them, began to express and explore themselves.

In this way, group therapy with children was found effective in promoting the development of children's ability to form secure attachment, which has been hindered by attachment trauma, through the therapist's involvement with mentalizing attitude.

Through this study, we were able to examine the process by which therapists connect children with attachment trauma to peer relationships (groups). On the other hand, further examination of the subsequent developmental process of peer relationships is a topic for future research.

NOTE

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