

An Attachment-Based Treatment of Maltreated Children and Young People
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ABSTRACT

Repetitive, intrafamilial, abuse and neglect leads to a complex array of deficiencies and symptoms that reflect both the traumatic effects of maltreatment on children as well as the effects of their failing to develop a coherent pattern of attachment behaviors toward their caregivers. This article will attempt to describe principles of a psychological treatment for maltreated children and young people who have been placed in foster care and adoptive homes. This treatment, based on attachment theory, provides dyadic interventions that aim to be transforming and integrative. The co-regulation of affect and the co-construction of meaning are central to the treatment process, just as they are central features in attachment security.

Key Words: Childhood maltreatment, attachment, foster care, adoption, child psychotherapy

Maltreated children, as infants, are frequently reported to have disorganized attachments but are likely, as they mature, to develop rigid self-reliance that becomes a compulsive need to control all aspects of their environment (Lyons-Ruth & Jacobvitz, 1999). They are not likely to view caregivers as being a source of safety, with whom they can relax and whose direction they can comfortably follow. Instead, caregivers are more likely to be seen as the source of terror in their lives, and the children also believe that the caregivers must be controlled if the children are to keep themselves safe. They are likely to try to control them through manipulation, overcompliance, intimidation, or role reversal. Such children present a diagnostic puzzle. O'Connor & Zeanah (2003, p.323) refer to these children when they state: "How to classify children who are callous, superficially connected to others, emotionally aloof, and interpersonally provocative remains a significant challenge."

The psychological treatment of children and youth exposed to ongoing intrafamilial maltreatment can also present a challenge. Avoidance and anxious vigilance, along with terrorizing and intrusive memories secondary to trauma, all cause the child to be a reluctant, if not an unwilling, participant in treatment. When the traumatized child also manifests impaired social judgment and behavior, affect dysregulation, and negative attributions of the motives of his caregivers and therapist—all possible features of an impaired attachment schema—the course of treatment will be much more arduous, with a much higher risk of failure. Many of these children do not, and possibly never did, anticipate that adults will keep them safe. They are not used to experiencing satisfying, reciprocal, emotional interactions with adults. Due to pervasive shame they often try to actively avoid the exposure involved in developing a therapeutic relationship. When the therapist eventually tries to direct the session into areas of shame and trauma, they are likely to react with resistance or dysregulation. Their affect may become labile, their behavior impulsive and controlling, and their cognition rigid and avoidant.

There is a lack of research into the treatment of multi-problem, maltreated children who reside apart from their family of origin. Clinicians who try to treat these foster and adoptive children report a variety of complex symptoms which are difficult to treat (O'Connor & Zeanah, 2003). While cognitive-behavioral interventions in general tend to provide more effective interventions for specific symptoms of maltreated children than do nondirective, relationship-based treatments, standard CBT protocols may be insufficient to deal with the pervasive symptoms that are manifested by these children (Cloitre, et al, 2002; Saywitz et al, 2000). This article suggests that an attachment-focused treatment, based on

principles derived from attachment theory and research, may serve as the keystone for a treatment for multi-problem foster and adoptive children, who resist more traditional treatment and parenting interventions, including CBT. This article will present the characteristics of such treatment interventions after first describing the underlying principles that are derived from attachment theory and research.

ATTACHMENT, ATTUNEMENT, AND INTERSUBJECTIVITY

Attachment theory and research, beginning with John Bowlby and Mary Ainsworth, has evolved into a primary model of child development. Studies of attachment security demonstrate that it serves as a foundation for subsequent affective, social, cognitive and behavioral development throughout the life cycle (Cassidy & Shaver, 1999). For decades the primary purpose of parent-child attachment has been understood as functioning to keep developing children safe, in proximity to their caregivers, until they have had a sufficient amount of time and experience to begin to keep themselves safe (Cassidy, 1999). As infants develop, the need for physical proximity is tempered by the fact that they have an increasing ability to base their sense of safety on the knowledge that their caregiver is available and responsive to their expressions of need (Kobak, 1999). When their parents are able to remain psychologically present when they face dysregulating experiences, they are much more likely to integrate these experiences into their narrative. For this reason, the attachment security of the parent is central in the development of attachment security in the child (Hesse, 1999). The same is true in children's efforts to attain attachment security in their relationships with their foster carers (Dozier, et al, 2001) and adoptive parents (Steele, et al, 2003).

Once infants feel safe, much of their energy is expended in becoming engaged with others, and especially their primary attachment figures, in reciprocal, affective, social engagement behaviors. Whether these interactions are part of the attachment behavioral system, or represent a separate sociability behavioral system, may be debated. However, both safety and affective engagement work in tandem and serve as the foundation of children's ongoing development. Once infants' safety needs are met, their cerebral activities focus on learning and responding to the social and emotional signals of their caregivers (Schore, 2003ab, 2001; Siegel, 1999, Porges, 1997). The dyadic, reciprocal, interactions that arise within this relationship are central to young children's neuropsychological development.

Affect attunement between parent and child, described by Stern (1985) as "the intersubjective sharing of affect", is crucial in the development of both a secure attachment as well as a positive, integrated, sense of self. In countless moments of attunement, which occur frequently during the infants' quiet-alert state of consciousness, infants rapidly begin to engage in nonverbal communication with their parents. Both parent and child use eye contact and facial expressions (Schore, 2003ab, 2001; Grossman et al, 1986), voice modifications (Jaffe et al, 2001), movement, gestures (Goldin-Meadow, 2000), timing (Trevarthen, 2001), touch (Field, 1996), and interactive play (Panksepp, 2001) as the central means of communicating to one another, and of showing interest and delight in each other during their emotionally rich times together (Bowlby, 1969). Securely attached infants engage in far more of these interactions with their mothers than do anxiously attached infants (Grossmann et al, 1986). Affect attunement is the primary mode of nonverbal affective communication between parent and child during attachment-focused interactions. It serves to help children to feel safe and to regulate both negative affect under conditions of stress and positive affect during conditions of interest and joy (Schore, 2001; Siegel, 2001).

Attunement also provides the scaffolding needed to access, identify, and make conceptual the ongoing affective states that comprise children's developing sense of self. Such reciprocal attunement

experiences are evident at the neurophysiological level of the infant-parent dyad, proceed through the level of affect, eventually permeate the symbolic level, and are central components of a secure attachment (Field, 1996; Jaffe et al, 2001, Thompson, 2000, Schore, 2003ab, Siegel, 1999).

Gradually building upon the nonverbal communication of infancy, children begin, during the second and third years of life, to use verbal language as a means of being able to more fully communicate with their parents and others (Appelman, 2000; Nicely et al, 2000). Such communication, which begins in and emerges from the early attunement experiences, is primarily focused on their social-emotional world of relationships as well as on their efforts to explore and achieve mastery in their personal world. The more open and direct such communications are, the more likely that the parent-child dyad reflects a secure attachment (Kobak, 1999).

Both developmental and psychodynamic theorists are exploring “intersubjectivity” to better understand the crucial role of the other’s active presence in the psychological development of the child or client. Whether it is a motivational system separate from attachment as is suggested by Stern (2004), or a central aspect of a secure attachment dyad, it remains vital in the child’s overall development. Intersubjectivity is primarily a here-and-now, you-and-me experience in which both are sharing joint attention as well as similar affect, intention, and meaning. At the same time, in these states of “dyadic consciousness (Tronick, 1998) or “moments of meeting” (Stern, 1998), the members of the dyad are aware, either implicitly or explicitly, that they are engaged in this joint experience, and that the other is also aware of it. Much of this is established and communicated nonverbally with eyes, voice, movement, timing, matching intensity, etc. Through this process, the children are able to co-construct the meaning of the experience by integrating the meanings given to the experience through their and their parents’ interwoven perspectives. The child’s affective response to the experience is being co-regulated by the parent’s affective response, and the child’s attention is being held by the parent’s attentive stance. As parents respond to their child’s affective states, nonverbally and verbally, they mark the affect with an empathic, congruent response, which creates within the child a secondary representation of the original raw affect and leads to the capacity for reflective thought (Fonagy et al, 2002). They also are providing words for them to be able to gradually identify and more fully express their inner life. The secondary representations developed by parents and presented to their children do not emerge from an objective, rational stance. These representations emerge from the affective impact that the experience has on both the parent and the child. The affective, resonating quality, combines with the representational aspects and becomes the basis of its meaning for their children. The foundation for the capacity for self-awareness is being developed.

Within a secure attachment, the parents are communicating their understanding of their children’s mind, and as the process continues, their children are gradually beginning to understand their parents’ mind (Fonagy et al, 2002). These young children will increasingly be aware of and able to communicate their inner world of sensations and perceptions, thought and affect, memories and plans, values and judgments. At the same time they are increasingly aware of and able to interpret the inner world of the significant adults in their life. Young children within securely attached dyads are much more able to access and communicate about the inner worlds of self-and-other than are their anxiously attached, and especially their disorganized attached, peers.

Much of their time with their parents, children are engaged in both nonverbal and verbal interactions that make them aware that they are “special” to them, and that assist them in giving meaning to themselves and the world of the family. Also there are frequent times when the parents are

“misattuned” with their children, causing a break in their intersubjective experience, either, intentionally as when the parents provide discipline, or unintentionally. When these breaks are actively repaired by parent and child, attunement is reestablished in a timely manner. What stress that does result from such breaks-and-repair does not lead to a sense of trauma or pervasive shame. Such sequences of attunement, break, and reattunement actually facilitate children’s ability to develop their autonomy, tolerate frustrations and cope with ambivalence (Jaffe et al, 2001).

PSYCHOTHERAPY BASED ON PRINCIPLES OF ATTACHMENT

Psychotherapy based on attachment theory and research, actively facilitates the experience of safety that is necessary if the child is to remain engaged in exploring and resolving experiences of terror and shame. The therapist first becomes nonverbally attuned with the child’s affective state and, while both are present in this dyadic experience of intersubjectivity, they enter into dialogue about the child’s inner and outer life, covering a wide range of experiences. As themes are explored, the therapist remains attuned to the child’s emerging affective states, co-regulates these states as needed with matched vitality affect, and develops secondary affective/mental representations of them which is co-constructed with the child for purposes of integration. The therapist allows the subjective experience of the child to impact the therapist. The therapist can then truly enter into that experience and from there express her/his own subjective experience. As the therapist holds both subjective experiences, the child experiences both. As the child senses both, the child begins to integrate them and re-experience the event in a way that will facilitate its integration and resolution. Due to the nature of the therapeutic themes—laden with shame and terror—there will be frequent disruptions in the intersubjective experience. The therapist will recognize each disruption, accept and explore it, and reestablish the dyadic experience. Through this intersubjective process of therapeutic attunement, affective/reflective dialogue, and interactive repair of the relationship, the child becomes able to define and integrate aspects of self and other that had previously been nameless, overlooked, terrifying, or disowned.

Co-Regulation of affect/Co-construction of meaning

Affect attunement is the primary therapeutic experience for both therapist and client. It is an intersubjective experience which involves the active utilization of eye contact, facial expressions, voice prosody, movement, timing, intensity and touch. It is an active process; the therapist’s stance involves the frequent—almost continuous—expression of vitality affects in response to the almost continuous expression of vitality affects by the client. By clearly demonstrating his/her own inner life in response to the client’s immediate affective presence, the therapist is providing a sense of interpersonal safety in order to facilitate the active exploration of themes of shame and terror. The therapist is co-regulating the vitality affect as it emerges, and is communicating how the themes affect him/her—without shame or terror—and how s/he makes sense of them.

This nonverbal dance occurs for both positive and negative affective experiences, making both more understandable, more able to be contained, and more validated and shared. Maintaining attunement during positive experiences enables the child to experience dyadic joy, delight, and pleasure. The child IS special to the therapist. The child can elicit delight in the therapist’s eyes and also has the capacity to elicit reciprocal enjoyment in interactions with others too. The child is an active partner with the therapist in creating interpersonal joy in the here-and-now-together. Maintaining/re-establishing attunement during negative affective experiences prevents the child from entering into a state of affective, behavioral, and cognitive dysregulation. The child can experience shame or terror and not be full-of-shame or terrorized. The child IS STILL special to the therapist and also is safe.

For example, the process of co-regulation of affect may occur quite directly, explicitly utilizing verbal/nonverbal means. The therapist may make statements such as the following, always with congruent nonverbal expressions:

While we talked about (the trauma), you looked so sad and frightened. I felt sad for you and for what you've been through. Would you look at me for a second. I want you to see how sad I am at what you went through.

You look upset about my talking about your hitting your mom yesterday. Maybe you're worried that your mom is now mad at you, and maybe even hates you for what you did. Would you look at your mom now to see if she is hating you or if she still loving you even though you hit her yesterday.

As themes are explored, the therapist remains attuned to the child's emerging affective states, co-regulates these states as needed, and develops secondary affective/mental representations of them which are presented back to the child for purposes of integration. The therapist allows the subjective experience of the child to impact upon her/him so that the therapist can truly enter into that experience and, from there, express her/his own affective/reflective response to it. The child is able to integrate the therapist's experience with his/her own and hence re-experience the event in a way that will facilitate its integration and resolution. Working together, the therapist and child develop a new common meaning for the traumatic experiences, shame-based behaviors, and the dyadic process itself. The therapist and client then hold both experiences of that event "in their hearts and minds" (Fosha, 2000, 2003).

The client and therapist are co-creating a new autobiography. This autobiography is more coherent and continuous. The shared vitality affect that exists in the present is joined to the categorical affects associated with the past experiences, bringing the past into the present lived-moment. The past event is experienced again, verbally and nonverbally, cognitively and affectively in the present. But this time it is not experienced alone. Thus, the affective dialogue about the past event is experienced as both then-and-there and also *here-and-now* as it enters fully into the client's personal narrative.

One twelve year old girl I treated had spent her first six years in an orphanage. She demonstrated little ability to identify or express her affective states and she had very little insight into the source of her destructive acts that regularly followed her adoptive parents' discipline of her behavior. Her memories of her life in the orphanage were minimal and lacking in any affective tone. When asked what she thinks and feels about herself, she replied, quite casually, "garbage". She would not, and seemingly could not, elaborate on that word.

Over the course of the first four sessions she began to recall orphanage experiences. She spoke about them, but still lacked any evidence of experiencing an affective response. Gradually, however, as I openly expressed my affective response to various experiences, such as her having to sleep without a blanket on the tile floor in the bathroom if she did something wrong, she became more reflective and she quietly said, "I never knew how hard it was." The sadness in her face and voice elicited tears in her father's eyes and he then said, "I never know how hard it was."

After she recalled a time in the orphanage when she told older children to hit her rather than a 3 year old girl who she was protecting, I asked her if she still had the feeling of "garbage" when she thought of herself. She said that she did. I asked her to communicate the "garbage" feeling to her

adoptive mother only with her eyes. After some encouragement, she looked into her mother's eyes but then she quickly looked away and seemed to be frightened. I asked her why she looked away and she replied that she could let her mother see the garbage feeling, but she got scared when her mother started to feel it. I briefly told her that when a daughter is attached to her mother, and communicates such feelings, the mother often feels the feeling with her daughter. I asked her to look into her mother's eyes again, and this time let her mother feel the "garbage" feeling. They looked into each other's eyes for a few minutes, both crying and then embracing. I asked the girl if, at home, whenever she began to feel "garbage" for whatever reason, she would look into her mother's eyes. She did so and her mother reported that she became more able to regulate her negative affect, through allowing her mother to co-regulate it with her nonverbally.

Acceptance & Curiosity, Empathy &/Playfulness

The primary intersubjective stance is one of acceptance and curiosity, empathy and/or playfulness, all the while committed to remaining emotionally engaged and available to the child. It is an active, affectively varied, dyadic interaction that interweaves moments of experience and reflection. This stance applies to the child's initiatives and responses, to resistance and to deep engagement. The child's nonverbal cues are crucial signals as to whether or not the child is affectively present with the therapist during the affective/reflective dialogue. Any communication is not effective unless the child becomes affectively engaged in it. The therapist actively attends to the nonverbal cues, accepts them, and tries to integrate them into the ongoing interaction. By doing so, the child is much more likely to feel that his/her inner life—as manifested by his/her nonverbal expressions—is noticed and valued. What the child thinks and feels is both important and also understood. The child begins to feel safe at a sensory-affective level of experience, rather than just thinking that s/he is safe. At a preverbal level of experience, the child knows that s/he is being heard, understood, and validated. Reflective dialogue now has an affective context in which its "meaning-giving" power impacts and transforms the child's fragmented self, thus beginning its integrative functioning.

The therapist's intention is also joined intersubjectively with the intention of the child. This intention is to experience—and communicate—acceptance, curiosity, empathy, and, at times, playfulness for the child's narrative. If the therapist engages in these expressions for another intention—to change the child—the child will be aware of this intention nonverbally and may refrain from joining the therapist's intention and then resist the interaction. When the intention is simply to experience and communicate acceptance, curiosity and empathy or playfulness, the client is more likely to have a reciprocal intention of experiencing the therapist's intentions.

Attunement, Disruption, & Repair

The attachment sequence of attunement, disruption, and repair occurs frequently in an attachment-based model of therapy, just as it does in the parent-child relationship. Themes associated with terror and shame may frequently cause a disruption in the relationship. The therapist does not avoid these themes and the associated disruption, but rather provides a safe setting in which they can occur and then the therapist repairs the relationship before proceeding. "Resistance" is not interpreted as a lack of motivation but rather as a sign of a disruption in the relationship due to the theme itself or simply to the nature of ongoing relationships. It is understood as a possible sign of the distress caused by the theme as well as a strain on the relationship caused by any number of factors. The affect present is co-regulated by the therapist with acceptance and empathy. Through curiosity, the meaning of the "resistance" is co-constructed as being a natural and important quality of the therapeutic process. It

reflects strength and courage, as well as possible ambivalence about relying on the therapist for comfort and guidance.

The child's sense of pervasive shame is often the primary barrier to his/her engaging in this process. While the attachment schema is ready to be activated in the presence of fear, shame is more likely to inhibit attachment behaviors and lead to "hiding" from attachment figures. The therapist's primary response to shame as it intensifies is one of empathy, joined with expressions of deep curiosity about the impact on the child of this negative affective state.

With many children, the therapist's empathy is experienced more deeply if the therapist guesses what the child might want to say, speaking for the child. For example, the therapist might say:

Wow, it looks like you want to say to me now, 'Why did you bring that up? Don't you know I don't want to talk about it.' Is that what you were just thinking?

If the client senses that the therapist accepts and understands his/her resistance to exploring a traumatic or shameful theme, the child is more likely to remain engaged with the therapist if s/he goes deeper into the resistance in order to understand its presence and strength:

I can really see how much you'd rather not talk about this. You really, REALLY, don't want me to bring this up. . . . What, do you think makes this so hard for you to discuss? So hard.

The therapist must be careful to maintain the nonverbal communication of acceptance when asking this question or the client may experience the question as being judgmental and critical. Frequently the child will not answer such a question. It can be helpful for the therapist to offer a suggestion about the meaning of the resistance.

You might be feeling upset that you yelled at your mom yesterday. You might be worried that if we talk about it, and she thinks about it, she'll get mad at you now. Maybe you're worried that she'll think that you're a bad kid and she won't want to be near you.

The therapist accepts and is curious about the whole child, including the shame/terror experiences of the past, and in so doing, a new meaning is co-constructed, and this meaning is neither shame-based nor terrifying. The crucial therapeutic stance remains one of acceptance, curiosity, and empathy. The therapist is not judging the client, nor trying to convince him/her that the child should talk about a theme.

Children with disorganization in their attachment schema may show some dysregulation during this treatment process, just as they frequently show dysregulation in their daily lives. At these moments, the therapist needs to remain regulated, with acceptance and empathy. These states too are being co-regulated and their meaning are being co-constructed. They too become less shameful and less terrifying.

Facilitating Emotional Communication

Emotional communication about one's inner life is very difficult for the traumatized child with attachment disorganization. Both the nonverbal quality of trauma as well as pervasive shame prevent thoughts and words from accessing the painful affect. Developing both interest in the process of self-exploration, as well as the skills to make sense of what s/he thinks and feels as well as who s/he is—

across a wide range of experiences—are basic to the therapeutic process. Through becoming engaged in the process, the child, often for the first time, is beginning to develop a coherent autobiography.

Emotional communication must be highly nonverbal in its overall expression. It is not “just talking” and it cannot be a monotone. Rather, the therapy more closely resembles the dialogue of a story-teller, rich in voice prosody, gestures and facial expression. The nonverbal component of the conversation is crucial if the cognitive/verbal aspects of the dialogue are to become integrated with the affective/experiential implicit memories. This communication must be much more than “verbal” therapy. Words are crucial in helping the child to “name the nameless”. But, to be effective, the words must be embedded in the intersubjective affect, perspectives and meanings brought to the dialogue by the therapist and caregiver.

For example, a therapist commented on how hard it was for a foster child to have lived with six families.

The child yelled, “Don’t TALK about that! It **wasn’t HARD!**”

The therapist matched the intensity of the child’s voice, as well as the cadence and duration of each phrase. “Of COURSE you don’t want to talk about it!. .Who WOULD?It’s the PAST!”

After allowing some quiet time, breathing with the child and noticing as he slowly becomes more regulated, periodically looking away in order to give him some sense of privacy in his attempts not to feel, the therapist gently asked, “What were you able to do, . . . so that moving. . . so much . . . **.wasn’t. . . hard** for you?”

After five seconds, the child replied, matching the therapist’s quiet tone, “I just didn’t think about it.”

After five seconds, the therapist responded, matching the child’s tone, “Ah.”

After another five seconds, the therapist, still within the matched vitality affect, added, “I am sad that there was so much in your life. . . . that you had to. . . .not. . . think about.”

In affective/reflective dialogue the therapist is active in helping the child to make sense of his nonverbal and verbal statements and behavior that s/he expressed during the session as well as in daily life. Since many of these children do not have the skills needed to understand the meaning of their behaviors or to access their inner lives of thought and feeling, and since they have often long stopped trying to develop these skills, the therapist needs to actively lead them into becoming engaged in the process of understanding themselves. The therapist often speaks for children when they are unable/unwilling to speak for themselves. As the therapist gives expression to the child’s subjective narrative, s/he is continuously integrating the child’s nonverbal responsiveness to the dialogue, modifying it spontaneously in a manner congruent with the child’s expressions. The dialogue is likely to have more emotional meaning for the child if the therapist, periodically, speaks for the child in the first person with the child’s own words. Often, with the therapist taking the lead in the expressions by speaking for the child about his/her inner life, the child feels a much deeper degree of affective resonance with the events being explored, a new—more fully accessed—meaning about the events, and also a much deeper level of emotional connection with the caregiver. Certainly the therapist does not speak for the child when the child does not accept the therapist’s role at that time or when the child

says that the therapist is not correct in his/her statements. At those times, the therapist accepts the child's directives and asks the child if s/he is able to find her/his own—more accurate—words.

Here is an example of such an intervention with a four year old adopted boy, Robert and his adoptive parents. Robert was placed in his preadoptive home when he was 30 months of age after experiencing domestic violence and physical abuse while living with his mother and step-father, Steven. He quickly demonstrated aggressive outbursts directed toward his foster/adoptive mother. Robert had identified with Steven in order to attempt to establish some sense of meaning and safety. He also felt rage toward his mother for failing to keep him safe from Steven, which also contributed to his aggression toward his new mother. My goal as a therapist was to help Robert to understand his story in a manner that would assist him in seeing other meanings for his aggressive behaviors. His clinging behaviors and his repetitive statements of loving his adoptive mother were suggestive of his shame and his fear that he might lose her.

After speaking with his adoptive parents within his presence about his history and his current life and functioning, I asked Robert to sit between his parents. After speaking with him about some of his enjoyable daily activities with his adoptive parents, I gently introduced the theme of his aggression toward his mother into the conversation. He immediately demonstrated shame by briefly averting his eyes and then very slowly raising his eyes to look at me while his face was still lowered. He also sat quiet and motionless. Following some of my statements, he whispered to his mother what I had just said, while still staring at me. His story took 10 minutes to tell, but not once did Robert lose his focus.

The dialogue proceeded as follows:

“. . .and Robert, your mom and dad told me that sometimes you hit your mom. (His facial expression immediately manifests shame.) Ah, yes, you wish they hadn't told me. You probably want to say, 'Mom, dad, why did you tell him? I didn't want him to know. He might not like me now.'

"Oh, Robert, I know you don't want to hit your mom. You try to stop. You try and you try. And mom and dad try to help you, yes, they try. And they want me to help. They want me to try. And I think you want me to help too. I know you want to stop. If only we can find a way to help you to stop. We have to find a way! We have to. . .

"WE can do it!! (With hope and enthusiasm) I know we can! OK, Robert? Let's do it! OK? (Nods assent.) Yes! Yes! I knew you wanted to! I know we can do it! Yes! Yes! Yes we can! (I pause, maintaining eye contact, with both experiencing our joint endeavor.

"Let's figure it out! Let's do it! Let's see. Let's see. . . .

"(quietly) You started hitting your mom when you were just two. You were just two (High pitched voice while holding my hand two feet above the floor.) Just two! And now you are four! (Lower pitch voice. Raising my hand higher above the floor.) You were just two (Higher pitch, lower hand.) And you started hitting your mom when you were just two, when you first met her! And now you're four (lower pitch).

"How could that be. . . how could a two year old boy (Higher pitch, hand low over floor.), just two, even know about hitting moms? How could he, just two, know about hitting moms?

“Wait! Wait! I think somebody (Large voice, large eyes) BIG—A BIG PERSON—told you it was ok to hit moms! Some BIG PERSON said it was ok to hit moms. And you believed him! You were just two! (High pitch, hand low over floor.) Two year olds don’t know that big people can lie. You didn’t know!

“A BIG PERSON LIED TO YOU!! That’s what happened! When you were two, a BIG PERSON LIED and said that it was ok to hit moms! You didn’t know it was a lie, you didn’t know. You were just two. . . (High pitch, but quieter, with hand moving down slowly toward the floor.)

Now I sit quietly, with eyes resting on Robert’s communicating sadness and some sense of being tired at how hard his life was because someone had lied to him about hitting his mother. (“Lie” was being used, and was taken by Robert, as a symbol for domestic violence and not meant literally.)

“I think Robert. . .(I start to speak again, slowly and quietly, while building the momentum and force of the communication.) I THINK ROBERT. That we have to know. . . .

“We Have To Know. WE HAVE TO KNOW WHO LIED TO YOU!!! Yes we do! WE HAVE TO KNOW! YES! YES! WE DO!

“Let’s think, let’s think. (Quieter again, almost a whisper, while bringing my hands up to my face and staring up to the ceiling.) We have to know. Let’s think. Who could it be?Who lied to you?We have to know. . . . We have to figure it out. . . .

(Suddenly breaking the silent, thinking-out-loud tone with a loud, excited voice, with large eyes again.) “I THINK I KNOW! I THINK I KNOW!

“WAIT! Wait! Wait. Have to be sure. Have to be sure. (Quiet again, covering my face and talking to myself, followed by 10 seconds of silence and then another verbal explosion.

“YES, I KNOW THE BIG PERSON WHO LIED TO YOU! I KNOW! I KNOW! (During which time Robert is frantically whispering to his mother, pulling on her sleeve, while still staring at me.)

“IT WAS STEVEN! STEVEN LIED TO YOU! AND THAT WASN’T RIGHT!!

Robert suddenly sat backwards in his chair as if I had pushed him. He continued to stare at me for 10 seconds and then he climbed into his mother’s arms and buried his head against her chest. Then his hand reached down to her stomach and he began to knead her stomach as is frequent with nursing babies.

Robert’s father moved over to embrace his wife and son and the three of them sat together without speaking for a number of minutes. I then quietly told Robert’s parents that he had realized something very important and that he just needed to be close to them the rest of the day.

Robert immediately stopped hitting his mother. He frequently told his mother that he was no longer hitting her. He frequently asked his father to never lie to him. He also often said to his father, “It’s not ok to hit moms, is it dad?”

My vitality affective expressions, each congruent with the stage of Robert’s story and his nonverbal responsiveness, enabled him to experience his story affectively—with me co-regulating the

affect—and then to open his mind to a possible new meaning for his story that I was presenting to him. The affect and meaning resonated with his inner life and he was able to immediately shift his joint experience of self-and-other with respect to his relationships with both of his adoptive parents as well as his relationships with his birth mother and step-father. It was the interwoven blend of vitality affect and meaning which drew Robert into his narrative and enabled us to jointly reconstruct it. This entire nonverbal/verbal dialogue, matched to 4-year-old Robert and his affective/cognitive state, would have been modified with an older, different child. While usually progress is not so rapid, similar, but more slowly developing results are frequently evident within such co-regulating, co-constructing intersubjective experiences.

Presence of Caregiver

The active presence of one of the child's primary caregivers greatly enhances psychological treatment that involves establishing dyadic interactions of nonverbal attunement, affective/reflective dialogue and frequent repair. Such participation by the caregiver makes it easier for children to incorporate these transforming experiences into their daily lives. They will have experienced their caregiver's empathy, curiosity, acceptance and playfulness about the full range of experiences explored. The caregiver, too, may intersubjectively enter into the shame/terror experiences in the child's past, allow it to have an impact on her/him, and give expression of his/her subjective experience of it which the child can also now hold along with his/her own and the therapist's.

The affective/reflective capacities of the foster/adoptive caregiver—along with those of the therapist—must be adequately developed if children are to develop similar abilities within themselves. This therapy presupposes that the therapist and parent are able to remain engaged with the children when their attachment schema is activated by the stress of the dyadic interaction and the therapeutic theme. Thus, both therapist and caregiver need to have resolved any issues from their own lives that may be triggered by the child's history and attachment schema. The child will not be able to engage in the dyadic treatment successfully without the adults' continuing intersubjective presence. As a result, the therapist cannot assume that the caregiver is functioning in a manner consistent with autonomous and/or resolved attachment in adulthood. The therapist needs to explore any relevant past experiences of the caregivers to determine if they have the ability to remain present with the child whenever the child is at risk for affective, behavioral, and/or cognitive dysregulation. The therapist needs to continuously observe how the caregiver participates in the treatment during various themes and affective states in order to notice if the caregiver is becoming dysregulated. If that occurs, the therapist will reduce the affective intensity of the session and separately explore with the caregiver the source of the dysregulation. Unresolved features of the caregiver's own attachment history may well have been activated.

When the primary caregiver is the child's parent who was responsible for the past abuse and neglect, or who failed to protect the child from the trauma, it is crucial that the parent has fully accepted responsibility for these past failings with the child. The parent needs to be able to validate the child's experiences, support the child's need to understand and express the emotional meaning of the events from the past, and remain engaged without defensiveness while the child explores and struggles to resolve and integrate these events into his/her personal narrative. The therapist needs to constantly assess the parent's willingness and ability to experience and reflect on these past events in a manner that is in the best interest of the child. If separate sessions with the parent, or psychological treatment for the parent are necessary, the therapist will make certain that these interventions are in place before asking the child to explore these experiences with his/her parent.

It must also be said that the therapist too, needs to reflect on her/his own attachment history and be aware of any countertransference responses that are being elicited. The therapist's own reflection, participation in supervision or in his/her own psychotherapy may be necessary to insure that s/he is able to integrate any emerging issues that might prevent her/him from remaining intersubjectively present with the child. The therapist must be certain that s/he is able to remain fully present for the child at those times when the therapist is needed the most. In this model of psychotherapy, which is so much based on the use of the self within the here-and-now intersubjective space, the attachment history of the therapist is likely to be activated more than it is in other models, and it is even more important that it be resolved.

While this activation of the therapist's attachment history may be more likely to occur than is generally the case, and hence may increase the risk of acting out countertransference, the attuned nature of the interactions may also serve as a protective factor against such reactions. Within the ongoing contingency of matched, nonverbal, affective communication, the sensitive therapist is being continuously brought back to the experience of the child. Whereas when the therapist is relying to a much greater extent on more distant representations of the experience, there may be a greater likelihood that the therapist's own attachment history may distort their meaning. Whether this model of intervention causes countertransference distortions to be more or less likely to occur, this issue cannot be ignored when we are developing a therapeutic alliance with children and young people who have experienced trauma, losses, and extreme negative affective states. Developing this important theme further is beyond the scope of this paper.

Attachment-based treatment can be utilized within the individual treatment format without the presence of a caregiver, but it must then be done so with even greater concern for safety. The therapist must set a slower pace since the child does not have a secure attachment outside of treatment to assist him in regulating and integrating the therapeutic experiences. Such a pace is also necessary because, without the supportive presence of an attachment figure, it will be more difficult for the therapist, alone, to co-regulate the affect associated with the emerging themes.

If the child resides in a residential facility or group home, an especially selected childcare worker may serve as the caregiver within treatment, though only if a minimum degree of training, commitment, continuity, and personal attachment security is present. The specifics of such a person participating in the child's treatment session is beyond the scope of this paper.

Finally, the model of therapy may well incorporate cognitive-behavioral interventions that have proven to be effective in helping some children to resolve the effects of trauma or other psychological symptoms. However, these interventions are often likely to be more beneficial if they follow the interventions that establish the conditions of safety, co-regulation of affect, and co-construction of meaning that have been detailed in this paper. The interventions described in this paper serve to achieve a level of affective/reflective skills and secure attachment behaviors that are crucial if the CBT interventions are to be effective with these multi-problem children and young people.

SUMMARY

When children experience repetitive intrafamilial maltreatment, thus having no setting that provides attachment security, they are at high risk for developing a fragmented sense of self and disorganized attachment patterns. Basic survival requires all of their psychological and physical energy.

Their affect is likely to be reactive, cognition may be rigid, and their behavior may be impulsive. They also are at risk to be dissociated from their experiences with gaps in their personal narrative. These patterns, along with habitual controlling and avoidant behaviors, are likely to permeate their daily functioning and to be present during therapy as well.

The goal of treatment is to provide these children with an opportunity to safely become engaged with their therapist—as well as their primary attachment figure when appropriate—across a full range of experiences. Their attuned presence enables these children to be more likely to activate aspects of self which they had previously failed to do. With successful treatment, their affect—being co-regulated—is now more able to resonate across a much wider range of implicit and explicit memories and here-and-now experiences. Their reflective abilities are more able to expand and incorporate the affective/reflective responses of their caregiver and therapist. Their behavior is more flexible, responding in the unique manner that will meet their best interests. They are able to remain present over the course of the sessions, including the memories elicited, and in so doing, are able to begin to build a coherent personal narrative. Their sense of self is becoming integrated. The intersubjective experiences of the therapist and caregiver—with them now in the terrifying and shameful events of the past—have provided them with new ways to give meaning to those events so that they can more fully enter into their autobiographical narrative.

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