Hughes, D. (2009). Attachment-Focused Treatment for Children. In Clinical pearls of wisdom. Kerman, M. (Ed.). New York: Norton. 169-181.

Through our understanding of infant research on attachment and intersubjectivity, we have become aware of the central importance of the reciprocal, contingent, nonverbal (bodily) communications between parent and child in facilitating optimal human development. Such dialogues, happening long before verbal communication, enable the young child to discover who he or she is, the nature of the social/emotional world, and how to have an impact on that world. As children mature, these nonverbal communications gradually include words as well and become shared conversations with the parents and others. Children discover who they are—including the vast, diverse qualities of thought, emotions, perceptions, memories, and intentions that constitute their inner lives—through their experience of their parents' experience of them. The research and theories of Colwyn Trevarthen and Daniel Stern greatly influenced my awareness of these important developmental factors (Trevarthen, 2001; Trevarthen & Aitken, 2001; Stern, 1985, 1998).

PEARLS

The following three interventions are based on these theories of attachment and intersubjectivity, both of which are central features in human development, being crucial for both safety and exploration.

Pearl #1. Match or lead the expression of affect.

When an adult matches a child's nonverbal affective expression of his or her underlying emotion, the child often is able to experience the adult's empathy for his or her experience and better regulate the underlying emotion. The adult's affective communication of his or her experience of the child's emerging experience enables the child to become aware of—and deepen—his or her own experience.

When children (and probably adults as well) give expression to their inner lives, they do so with an expression of affect that reflects both the information and energy that characterize the focus of their attention. The particular emotion associated with an event that they are describing is conveyed with a unique facial expression, voice prosody, and gestures and movements that best convey the particular meaning of that event for the child. The rhythm and intensity of the nonverbal expression conveys "how" and "how much" the event affected the child. When the adult matches that affective expression (often without feeling the child's underlying emotion), the adult is able to convey that he or she "gets it," and the child feels "felt." In other words, the child experiences the adult's experience of empathy for him or her in a way that words would never communicate alone. For example, if a child screams "I *hate* my dad!" in a therapy session, and the therapist replies, with the same intensity and rhythm as the child's expressions, "*You* are *really angry* with your *dad* right now!" the child is likely to feel that the therapist does "get" his experience. If, however, the therapist says "you are really angry with your dad right now" in a flat tone of voice, the child is not likely to experience the therapist as "getting it."

Along with conveying empathy for the child's experiences, matching the affect also

helps the child to regulate his or her experience. When a child experiences intense anger, that expression of anger is demonstrated by an intense affective expression in his or her voice, face, and gestures. If the child does not experience a similar response from an adult, the intensity is likely to escalate, as the child may struggle to regulate the emotion. If the child lacks general affect-regulation skills, any increase in intensity only increases the risk of dysregulation. By matching the intensity and rhythm of the affective expression (and remaining regulated him- or herself), the adult is able to help the child to remain regulated. By finding the adult with him or her in the intense experience, and communicating with the adult about it, the child often finds him- or herself becoming less distressed and agitated.

Children may have trouble identifying an experience because it is new. They may be uncertain how to communicate it or worry that maybe they should not have it. This is especially true of children raised in circumstances where aspects of their inner lives are not seen or encouraged or when they have experienced traumatic events. In those situations, if a therapist is able to make sense of the child's experience and take the lead in its nonverbal affective expression, the child is often able to experience it more deeply and communicate it more fully him- or herself.

Pearl #2. Be Curious about the child's inner life.

When curiosity is directed toward the child's experiences—rather than toward the factual events of his or her life—and when it is conveyed with both affective and reflective features, the child is likely to go with the therapist very deeply into his or her life's story, coregulating any emotions that are associated with what is being explored and cocreating the meaning of the events.

Curiosity, used in this sense, is not a barren or intrusive exploration into the recent or remote past, but rather is an act of discovery—an experience of fascination—with who this child is and how his or her life has unfolded, along with the impact of that history on his or her sense of self. The facts themselves are not as important as the meaning of these events on the child's developing narrative. Through nonjudgmental, "not-knowing" curiosity, the therapist is often able to assist the child in deepening the experience of the event, along with reorganizing it and integrating it into his or her narrative. A word of caution: If the child experiences the adult's interest as suggesting what he or she *should* have thought, felt, or wanted, the child is likely to begin losing interest in the process and may actively conceal his or her inner life from the adult.

For curiosity to go deeply into the child's life story, it must contain not only a reflective but also an affective component. It must not be a detached, professional, observer's interest, but rather the experience of someone who is truly deeply interested in the inner life of the other. While exploring the child's narrative, the therapist needs to be affected by what they are experiencing together through the act of discovery. In his or her wondering—his or her deep interest—the therapist is likely to express him- or herself in deeply affective manner, such as: "Wow! Do you think that maybe . . . ?!" or "*Wait* a second, wait a second . . . I wonder if . . . ?!" or "*Yes*, I think I get what you are saying! *It's* like . . . !" or "So *that's* what made it so hard for you! Now I get it, now I get it. You had always thought . . . !" The therapist's enthusiasm for the process of discovery or his or her

compassion and empathy for what they are discovering together helps the child to experience his or her inner life as being very important and meaningful, and the process of discovery as being safe. What the child thinks, feels, remembers, and makes sense of in his or her life is completely accepted by the therapist. Further, this joint exploration "touches" the therapist. What they discover together gradually elicits less shame or fear. The child now is much more able to begin to establish a coherent narrative.

Pearl #3. "Talk for" and "talk about" the child.

Children who manifest various psychological problems often have gaps in both their affective and reflective skills. They often have difficulty regulating, identifying, and communicating their inner lives to others. Giving them the safety to "find the words" can often be a slow and unproductive process—they truly do not "find" them. Utilizing metaphor to express their inner lives is often insufficient for empowering them to be able to integrate and communicate their narrative. Taking the lead in assisting them to give voice to the events of the past often also greatly assists them in organizing these events into a coherent narrative.

When a therapist "talks for" a child, he or she tries to replicate the child's own speech and voice prosody and speaks in the first person as if he or she were the child. The therapist's words are embedded in nonverbal affective expressions. The child is then able to "try out" the therapist's expressions as if they were his or her own. The child often then makes use of the expressions that resonate with the wordless experience of his or her inner life, which frequently leads to a spontaneous elaboration of it, or a modification that best describes that unique experience. The therapist's guesses that do not resonate with the child's inner life tend to be quickly discarded and forgotten. Throughout this process the therapist is clear that when he or she speaks for the child, he or she is guessing what the child might want to say if he or she had the words. The therapist is clear that he or she always accepts the child's statement as to whether or not the guess is accurate. If the child tells the therapist *not* to guess, the therapist always complies with those wishes. When the therapist *is* able to take the lead in finding the words to describe an experience of an event in the child's life, frequently the child begins a process of being able to identify and communicate an aspect of his or her inner life that previously had been unknown, nameless, and often frightening and chaotic. This process also often leads the child to begin to deepen and integrate his or her emotional experience of the event. The nonverbal affective expressions of the therapist, associated with the verbal content, often lead the child into an emotional experience that is congruent with the expressed affect. We tend to forget that this same process occurs countless times in the intersubjective activities that exist between parent and infant.

"Talking about" a child is often a valuable complement to the affective meaning-making that is often facilitated by "talking for" a child. Talking about a child involves turning to his or her caregiver and reflecting something that just happened with the child, often connecting it to a deeper or more comprehensive aspect of the child's narrative. This reflection always conveys a positive, accepting tone. This intervention can also be used by talking to a poster, stuffed animal, or even oneself by "thinking out loud" about the

therapist's experience of the child's strengths and vulnerabilities. This process tends to lower the affective tone of the discussion and help the child to move into a calmer, more reflective stance. Such a stance enables the child to stay regulated while exploring stressful events from the past. It gives him or her a break from the affect generated by the explorations. At the same time, it enables the child to step back and reflect upon what he or she and the therapist (and possibly the parents or other significant people in his or her life) have just experienced together. During the affective exploration, the child experiences unique events in his or her narrative, and through the reflection the child is able to take a more distant and integrative perspective. When the therapist talks about the child rather than to him or her, the implied message is that the child does not have to respond, and he or she often more fully listens to what is being said without being distracted by having to prepare a response. Children also often more fully accept what is being said about them because they are less likely to experience the words as trying to influence them.

CASE EXAMPLE: ROBBIE

Robbie was a 10-year-old boy who was adopted at the age of 8 by Jane and David. He had been physically abused by his father and exposed to domestic violence while residing with his biological parents until he was placed in foster care at the age of 5. After two foster placements and no efforts by his parents to resolve their problems, he was freed to be adopted. Jane and David were very committed to Robbie; they also had a strong marriage and no unresolved issues from their own childhoods.

Robbie's behavior in foster care and with his adoptive parents was characterized by habitual oppositional-defiant features as well as verbal and physical aggression primarily directed toward Jane. He often reacted with anger to routine discussions or discipline, and this was quickly followed by his withdrawal and resentment. His extreme reluctance to explore his abusive past as well as his current symptoms appeared to represent a mixture of both fear and shame. He also had great difficulty giving expression to his inner life, which appeared to reflect a poor ability to identify and express his thoughts, emotions, and intentions.

Our first joint session included Robbie, Jane, and David. (I had previously met with the parents to understand their concerns as well as to give suggestions regarding how I would like them to respond to Robbie during our conversations in therapy. Such suggestions—and the parents' ability to understand and follow them—are crucial if the sessions with their child are to be effective.) Robbie sat between his parents on the couch and I sat in a chair near them. After an initial discussion of Robbie's interest in basketball, I turned our attention to the fact that he had again hit his mother over the weekend when she would not allow him to ride his bike until his dad returned from the store and could go with him. (Robbie was not allowed to ride on his own because he was impulsive and disregarded the rules around riding his bike.) As I began to explore this with him, he yelled, "*They* are *so stupid! They treat me like a baby!*"

In order to match Robbie's nonverbal affect, I used the same intensity and rhythm that he had: "*You think that they treat you like a baby! And you're 10! No wonder* you get mad if you think that!"

"*They do!*" Robbie said.

"That is *certainly* how it seems to you! If you're right—why *would* they do that*? Why would they?*" I asked.

"*I don't know!*"

"Let's figure that *out*!" I said. "*Let's understand* why if they do treat you like a baby, *why it could be*? What could it be? Wait! *Wait!* . . . Maybe *they worry about you*! Maybe they don't want *you* to get hurt!"

"I won't!" Robbie said.

"So you think that they have no reason to worry! But if they do . . . *why would they worry about you?* . . . Maybe . . . *maybe* . . . they don't want you to get hurt . . . *because they love you!*"

"That's stupid!" Robbie said.

"That they *love you*?" I asked.

"*Sometimes I wish they didn't!*" Robbie said.

"You wish they didn't! *Wow!* Not love you! *What's that about?*" (This comment illustrates pearl #2—showing curiosity about the child's inner life.)

"*I don't need* their love!" Robbie said.

"*Ah!*" I said. "I wonder if you're saying that sometimes you don't want their love."

"I don't!" Robbie said.

"Can you tell your parents that?" I asked. "Can you tell them that sometimes you don't want their love?"

"No!" Robbie said. "That's stupid!"

*"*Would you let me say it for you, if that's want you think and feel sometimes?*"* (This was an attempt on my part to "talk for" and "talk about" Robbie.)

"I don't care," Robbie said quietly

"If I get it wrong and say anything that you don't think or feel, just tell me and I'll change it the way you want me to," I reassured him. "Or you can say it yourself if you want. Okay?"

Robbie looked down and whispered, "Yeah."

I moved my chair closer to Robbie, put my hand on his arm, and spoke to his parents as if I were him. "Mom, Dad," I said, "sometimes I don't *want* you to love me! I just *don't*! Sometimes I just want you to stop *worrying* about me, stop *caring* for me!"

Jane conveyed compassion for her son as she leaned toward him and quietly said. "Robbie, I'm *so sorry* that you sometimes don't want our love. We love you *so much* and want you to be our son and be glad that you are!"

Speaking for Robbie again, I replied, "Why *would* I be glad? You *never* let me do what I want!"

"I know that we say 'no' a lot, Robbie, and I know that you get angry about that!"

"If you really loved me you'd let me do what I want!" I said.

Jane squeezed Robbie's hand as she said, "I still love you when I say 'no' Robbie. I'm sorry that it's hard to believe that!"

"It *is* hard for me to believe that you love me," I replied. "Why *would* you, anyway?" As I said this, I was watching Robbie to see if he was listening, engaged, and

seemed to be accepting what I was saying for him. Robbie was quiet and attentive, with no signs of anger or distress, so I continued to deepen the possible meaning of the discussion for Robbie.

"Because you are *so special* to us!" Jane said. "Because you have *not given up*! Because you want a better life for yourself and we want to help you to get it!"

Robbie was still quietly attentive, so I continued to speak for him: "But I don't feel that! I don't think that I'm so special! And I don't think you do either when I hit you!"

"I do get angry when you hit me, Robbie, but I still love you and hope to be able to make it easier for you someday to be able to accept my 'no' and my love."

"I think you might give up first!" I said. At this, Robbie anxiously glanced at his mother.

"That's not going to happen!" Jane said. Her eyes began to well up with tears. "I will never stop loving you!"

At this point I softened my voice and said quietly and sadly, "But my first parents gave up. They didn't seem to think that I was so special. I don't think I was worth much to them."

Jane choked back more tears. "I don't know why they didn't take better care of you, Robbie. But I'm so sad that you didn't think that you were special to them. That must have been so hard for you. You must have felt so alone."

"I did," I said in a whisper. "And I never want to feel that again." I glanced again at Robbie, who looked very sad as he sat on the couch between his parents.

"I hope that you someday will not feel so alone with us, Robbie," Jane said. "I hope that someday you will want our love and not feel so alone."

"Do you feel the same way that Mom does, Dad?" I asked.

"I do, son, I really do," David said. "You are my boy and you always will be!"

"You must hate me, Dad, for hitting Mom," I said.

"I don't want you to hit your mom, son, and I get angry about it, but I don't hate you when you do."

Suddenly Robbie looked quickly at his dad and spoke up, with panic in his voice: "I don't want to hit Mom, Dad! Sometimes I just can't stop myself—I get so mad."

"I believe you, son, I really do!" At this point Robbie became tearful, and David did as well. He leaned over and put his arm around Robbie, pulling him to him. "We'll help you, son. We'll help you because we love you."

After a few minutes of quietly hugging his dad, Robbie turned quickly to his mom. "I'm sorry, Mom, I'm sorry that I hit you!"

Jane moved toward her son, stroking his hair. "I know, son, I know. We'll get through this. Yes, we will. And we'll still be loving you!"

After sitting in silence with the family for a few minutes, I began to quietly talk about Robbie to his parents. I spoke in a rhythmic, almost singsong voice that usually works to elicit a receptive openness to what is being said and often leads to an increased reflective stance on the immediate experience as well as the bigger picture of the narrative. For Robbie, a similar process of intersubjective exploration occurred in future sessions around the aspects of his narrative associated with abuse and neglect.

I saw Robbie and his parents for 25 additional sessions over the following 9 months. As progress was made in facilitating his attachment security with his parents, he became increasingly able to rely on them for the comfort and support that he needed to begin to address his history of abuse and neglect and move toward their resolution and integration into his narrative. Jane and David's support in his trauma treatment facilitated his attachment with them and vice versa.

CONCLUDING COMMENTS

As I discovered how intersubjective experiences with attachment figures propel the young child's development of his or her inner life, I have become convinced that such experiences should be the central feature in the therapeutic alliance developed with the child. The more traditional therapeutic stance tended to create ambiguity in how children experienced their therapist's experience of them. Such a stance valued providing safety for the children so that they could resolve distress and organize their inner life mostly on their own, without depending on the therapist to do it with them. Another intention of this stance was to facilitate the "transference" of the child's implicit relational knowledge onto the therapist.

Over time, it became evident that many children did not have the inner resources to identify, regulate, and organize their inner lives without the active intersubjective participation of the therapist in the process. These children often experienced intrafamilial trauma and manifested disorganized attachment patterns. They also tended to demonstrate a history that lacked the very intersubjective experiences they so needed to be able to develop a coherent narrative. A new stance appeared to be necessary. In this new affective/reflective stance, the therapist makes his or her experience of the child very explicit. As the therapist becomes more explicit regarding the positive impact the child has on him or her, the child experiences felt safety more quickly and deeply. Nonverbal communications regarding the impact that the child has on the therapist are exaggerated—much like parents exaggerate their responses when with their baby. In taking such a stance, the therapist becomes responsible for ensuring that the child has a positive impact upon him or her. The therapist is able to explore, with nonjudgmental, active curiosity, the child's inner life that exists under the problems, defenses, or symptoms. He or she is able to discover the child's strengths and vulnerabilities lying within and then respond to these discoveries with empathy and deep appreciation. The therapist experiences the child's courage, honesty, persistence, and various other qualities that the child might not have been aware of him- or herself. Affected by the child's inner qualities, the therapist is then able to intersubjectively have an impact on the child.

The three interventions described in this chapter have all been very effective in facilitating the coregulation of affect and cocreation of new meanings that are the hallmark of effective therapy. Matched affective expression is often the starting point of intersubjective experience (described as attunement by Dan Stern and synrhythmia by Colwyn Trevarthen). Without losing this affective engagement, the therapist's active, not-knowing, nonjudgmental curiosity leads the child into his or her inner life, where he or she can begin the process of addressing the many traumatic or confusing events of his or her life and developing them into integrative experiences that will evolve into a coherent

narrative. Because many children lack sufficient reflective skills to take the lead in this process, the therapist must be ready to facilitate the flow of the affective/reflective conversation by offering to guess about the child's inner life. Such guesses constitute "talking for" the child, and later "talking about" the child, and these dialogues often enable the child to develop communication skills. These initiatives activate greater affective resonance within the dialogue than would occur if the therapist simply talked to the child. Such "talking for" communications become unnecessary as the child develops his or her own reflective and communication skills, spontaneously—and creatively—taking the lead in the process of weaving the tapestry of his or her inner life.

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BIOGRAPHY

Dan Hughes is a clinical psychologist who resides in Lebanon, Pennsylvania. After receiving his PhD in clinical psychology from Ohio University, he specialized in the treatment of children and youth who had experienced abuse and neglect. He developed an attachment-focused treatment and parenting model that relies heavily on the theories and research of attachment and intersubjectivity, and he gradually expanded the model to make it applicable for all families.

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