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Group Attachment-Based Intervention

Trauma-Informed Care for Families With Adverse Childhood Experiences

Anne Murphy, PhD; Howard Steele, PhD; Jordan Bate, MA; Adella Nikitiades, MA; Brooke Allman, LMSW; Karen Bonuck, PhD; Paul Meissner, MSPH; Miriam Steele, PhD

This article outlines the main premises of an innovative trauma-informed intervention, group attachment–based intervention, specifically developed to target vulnerable families with infants and toddlers, living in one of the poorest urban counties in the nation. It also reports on the trauma-relevant characteristics of 60 families entering a clinical trial to study the effectiveness of Group Attachment–Based Intervention. Initial survey results revealed high levels of neglect, abuse, and household dysfunction in mothers' histories (77% reported ≥4 adverse childhood experiences, with more than 90% reporting 2 or more current toxic stressors, including poverty, obesity, domestic and community violence, and homelessness). **Key words:** *adverse childhood experiences (ACEs), body mass index, group attachment–based intervention (GABI), trauma-informed treatment*

Author Affiliations: *Children's Evaluation and Rehabilitation Center, Departments of Pediatrics (Dr Murphy and Ms Allman) and Family and Social Medicine (Dr Bonuck), Albert Einstein College of Medicine, New York City, New York; Psychology Department, The New School for Social Research, New York City, New York (Drs H. Steele and M. Steele, Ms Bate, and Ms Nikitiades); and Department of Family and Social Medicine, Montefiore Medical Center, Bronx, New York (Mr Meissner).*

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Correspondence: *Howard Steele, PhD, Psychology Department, The New School for Social Research, 80 Fifth Ave, 7th floor, New York, NY 10011 (steeleh@newschool.edu).*

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THEORETICAL CONSIDERATIONS

This paper describes an attachment-based intervention, delivered to groups of vulnerable parents and their children aged 0-3 years living in one of the poorest urban counties in the nation.[1]

There are several sources that inform the underlying theoretical context for Group Attachment–Based Intervention (GABI) including psychodynamic, social-emotional developmental theories, and studies of trauma. We understand vulnerability clinically in terms of attachment theory and contextually with regard to families' histories of adverse childhood experiences (ACEs). Attachment theory is foremost among the influences of the GABI intervention. Inspired by the work of John Bowlby and Mary Ainsworth and developed in subsequent attachment-based research, attachment theory is premised on

the centrality of an infant's relationship to a primary caregiver and the bearing of that relationship on the child's subsequent development.[2] Bowlby[2,3] described the attachment figure as someone bigger, stronger, and wiser who serves as source of security for the child, a base from which the child can explore the external world, knowing that he or she will be welcomed back and protected when he or she is frightened or in distressed. Over time, these experiences are consolidated into internal working models of expectations about self, other, and relationships but remain particularly salient with attachment figures at times of need.

Attachment models remain permeable to favorable and unfavorable influences across the life span. The second body of literature that has guided our work is the Felitti et al[4,5] Adverse Childhood Experiences study, which surveyed more than 8000 adults and identified 10 categories of ACEs. Adults exposed to 4 or more categories of maltreatment were found to be at significantly increased risk of multiple physical and mental health problems later in life. Among the families that participated in the development of GABI, 80% of parents reported 4 or more ACEs, 5 times the amount observed (16%) in the original ACE study.[5] An attachment perspective focuses on the mechanisms that help an individual shift a negative trajectory in the direction of attachment security by lessening the impact of adverse experiences. In this way, the well-known intergenerational cycles of abuse and trauma may be subverted.[6] The GABI model emerges from the conjoining of these 2 bodies of literature: the negative impact of early adversity, and its amelioration by interventions that promote secure attachment relationships. As we show later, parents who participated in GABI experienced a large number of ACEs, but their ability to form secure attachments and parent their children with care, protection, and nurturance remains possible.

PROMOTING SECURE ATTACHMENT AND PREVENTING DISORGANIZATION

The primary goal of GABI is to promote secure parent-child attachment and prevent disorganized attachment relationships in young children with parents whose histories and current adverse contexts place them at risk. *Disorganized attachment* refers to the apparent lack of a consistent strategy for organizing a response to the need for comfort and security when under stress.[7] A negative trajectory for children who demonstrate this pattern of disturbed parent-child attachment is well documented.[8,9] Disorganized attachment to the mother at 1 year has been linked to elevated levels of the stress hormone cortisol,[10,11] to child behavior problems at 5 years of age,[12,13] posttraumatic stress symptoms at 8 years of age,[14] externalizing symptoms at preschool and 9 years of age,[15] and to adolescent psychopathology.[16] Disorganized attachment is especially prevalent among children of maltreating parents. These parents often had few positive childhood experiences themselves and experience ongoing sources of stress and trauma that challenge their ability to deliver optimal care. Especially pernicious is the paradox whereby such parents simultaneously represent the only source of comfort for their children and a source of frightening and unpredictable, abusive behavior.[9,17] The antecedents of disorganized attachment are not limited to maltreatment. Behavioral or mental health difficulties often linked to parents' unresolved loss or trauma, depression, and marital discord impact the quality of parental care.[9,18] Preventing disorganization is the immediate goal of GABI. By focusing on the parent-child relationship while also providing a setting in which parents can engage with clinicians who are sensitive to understanding relational trauma, GABI assists parents in making sense of previous experiences of trauma and loss. GABI works with both parents and children to reduce ACEs and their consequences and thereby aims to

prevent longer-term social, behavioral, and mental health problems that may otherwise transmit across generations.[19]

GABI TREATMENT: AN INTERGENERATIONAL APPROACH TO TRAUMA-INFORMED CARE

Parenting is a domain that is sensitive to a history of trauma.[20,21] GABI is a trauma-informed practice that acknowledges the social and emotional needs of both the parent and the child. While the primary mission of GABI is to improve the parent-child relationship and support appropriate child development, the program focuses attention on trauma in the parents. In this way, families are enabled to engage fully in and benefit from the therapeutic process. To create a trauma-informed practice[22,23] requires an acute understanding of the complex histories and current life stressors of families, as well as the impact of these events on individuals' emotions and actions.

The frame

Parents with their infants and toddlers (birth to 3 years old) attend GABI up to 3 times weekly for 2 hours. The consistency of the frame provides a secure base for the families in the midst of shifting individual situations. Because of unpredictable schedules and chaotic daily lives, families often need to miss a session, but with multiple groups offered each week, there are additional opportunities to attend. The flexible schedule reflects an understanding of the context in which parents and children live. In general, a trauma-informed approach favors predictability and structure over rigid rules to avoid inducing shame about minor and ordinary events such as missed sessions. Moreover, GABI is delivered in a group model, with 2 lead clinicians and anywhere from 2 to 6 graduate students who work interchangeably as a team.

Clinicians thus increase their availability to meet the complex, often multisystem needs of families. Maintaining structure and establishing attendance policies not only benefit patients but also align with outcomes that matter to the organization (eg, service utilization, recidivism, cost-effectiveness). GABI expresses responsivity to the needs of clients and makes trauma-informed care attractive to key providers and policy makers, encouraging support both for trauma-specific services and, more broadly, for the creation of trauma-informed systems.

The therapeutic principles informing GABI, and the training of GABI clinicans: R.E.A.R.I.N.G.

Recommended guidelines include integrating a trauma-informed approach into all aspects of patient care, which involves educating staff at all levels to create a therapeutic, healing environment for highly stressed families.[21,22,23] In developing GABI, we identified a set of key principles that we considered central to effectively treating trauma-exposed parents and children. The conceptual model was developed from clinical findings informed by the theoretical and research findings in the attachment and ACE literatures.[3-8,24] Our approach derives much of its heuristic power from its grounding in clinical phenomena. Support found for the utility of the GABI model in understanding the nature of parent-child relationships in both normative and high-risk samples was established through observation of clinical practice. We reviewed more than 5 years of video footage to identify and conceptualize therapeutic action and produce a treatment manual to guide the training and implementation of GABI. The main theoretical components of GABI are operationalized for training purposes in the acronym R.E.A.R.I.N.G., which is applied when working with the parent, child, or their relationship:

- *Reflective functioning* is the ability to think about the thoughts, feelings, and intentions of another person.[25] It is the hallmark objective of GABI to which all of the clinical goals and tools are linked.

- *Emotional attunement* is a critical skill in developing secure attachment relationships.[26] In GABI, clinicians try to engage parents in a way that facilitates recognition and understanding of their children's emotional states, conveying to the children a sense of being understood.
- *Affect regulation* is the ability to manage feeling states and maintain emotional homeostasis. By interacting with GABI clinicians who are trained to respond to the expression of either volatile or flattened affect, parents and children can further develop their ability to regulate affect.
- *Reticence* involves giving parents and children time and space to discover their own feeling states and enhance self-efficacy without a clinician rushing in to draw conclusions or impose solutions on families.[27]
- *Intergenerational patterns* refers to understanding how an individual's history of being parented affects how he or she parents.[28-30]
- *Nurturance* refers to providing sensitive care by being responsive to the needs of the participants. GABI focuses on nurturing both the parents and children to promote the nurturance of children by parents who often feel emotionally depleted.
- *Group context* is the model of delivery. GABI is able to deliver treatment efficiently to multiple families at one time. The group provides important sources of social support to the parents and facilitates peer relationships among the children, combating the social isolation faced by the participants.

The primary aims of GABI are closely aligned with the Layne et al Core Curriculum on Childhood Trauma, including such principal objectives as to enhance practitioners' *empathic understanding* of the nature of traumatic experiences from the child's and family's perspectives and the ways in which trauma and its aftermath influence their lives.[31] Similar to the Layne et al Core Curriculum on Childhood Trauma, GABI's R.E.A.R.I.N.G. understands empathy for the families to mean recognizing the uniqueness of each individual's and each family's situation, putting a dual focus on strengths and needs, and respecting the necessity to view them from multiple perspectives.[31] In addition, the R.E.A.R.I.N.G. framework was developed as a model for clinical practice that could also be adapted to a research context. Testing is ongoing to evaluate how effectively GABI training influences clinicians' delivery of the intervention in terms of the R.E.A.R.I.N.G. components. Beyond their role as therapeutic techniques, then the R.E.A.R.I.N.G. principles can be thought of as measureable skills or outcomes that we hope to promote in parents and children. As such, future research will aim to investigate both clinicians' use of these principles and parents' adoption of or improvements in these skills.

Therapeutic interactions at all levels

Trauma-informed guidelines recommend policies and procedures to ensure that at every point of contact patients experience a therapeutic approach.[21] In our center, this begins with developing relationships with referral sources, including pediatric and primary care providers, early intervention providers, and child welfare and family court systems. Not only does outreach to these systems inform clients of the services available but it also serves as an avenue through which we can educate community partners about the importance of screening for and recognizing the impact of trauma in the populations that they serve. Particularly in pediatric practices where families are seen regularly over the first 3 years of a child's life, coordination results in the establishment of more integrated pediatric care.[32,33] Coordinated care allows for direct linkages: pediatricians refer families to the clinic, ensuring a "warm handover" that increases the likelihood that the referral will result in patient engagement in treatment.[34]

The setting

The physical space where GABI is held is another avenue through which a sense of safety is established. We aim to create a calm environment with soothing colors and neutral stimuli. In choosing to omit commercial entertainment and traditional holiday decorations, we observe the potential of common, recognizable toys and ornaments to trigger painful reminders of the trauma and deprivations patients may have experienced in childhood. The space, including waiting areas, is also intended to offer nurturance, including basic comforts in terms of seating, toys, magazines (carefully selected), snacks (including milk and warm beverages), and diapers. Staff are instructed to anticipate patients' needs, offering these things in advance rather than assuming that a parent would feel comfortable expressing a need.

Screening

The literature on trauma-informed care emphasizes the necessity of assuming and screening for histories of trauma.[21,22] We recognize that there are often limits on the length of time allowed for intake appointments and parents may focus solely on immediate concerns. However, asking directly about trauma communicates to parents our understanding that traumatic experiences may contribute to the presenting problems and establishes the treatment as a place where unconditional respect is available. This is particularly valuable for parents who are struggling with young children. It can be helpful for parents to begin to think about their own histories of abuse and neglect as explanations for current problems, rather than labeling themselves "bad" or incapable parents, a designation they may believe, particularly those who have lost custody of children in the past. During the a GABI intake, we use the Adverse Childhood Experiences Questionnaire (both parent and child versions), which was derived from the ACE study and asks about experiences with 10 categories of abuse, neglect, and household dysfunction.[4,34] Asking parents first about their own ACEs and then about their children's ACEs sets up a contrast that often illuminates the ways parents have been and can be increasingly more successfully effective in protecting their children. This process of reflection helps parents transition from seeing themselves as a child of their parents to see themselves as a parent of their children. Even when one's child has been exposed to trauma, going through these questions with a clinician who maintains a nonjudgmental stance signals the understanding that most parents strive to be a different kind of parent.[35] The intake process establishes the clinician and parents as partners who will collaborate to help improve the family's situation. The Adult Attachment Interview, also administered to parents within their first few weeks of treatment, is yet another tool that prepares parents to think about their own childhoods.[36] As Selma Fraiberg[18(p412)] wrote, "In remembering [parents] are saved from the blind repetition of that morbid past." GABI reinforces the connection between past and present experiences at multiple points in the treatment process to lay the foundation for change.

Intervention and treatment

Integrating treatment of trauma within the context of psychotherapy that targets other goals, such as parenting and child development, is an important feature of trauma-informed care. When treatment of trauma is kept separate from the treatment of other psychological or behavioral problems, we risk failure to see how various challenges contribute to each other, how recovery in one area can effect change in another. GABI maintains an intergenerational focus, encompassing the parent, the child, and the relationship. By exploring past experiences alongside current struggles of raising young children in impoverished physical surroundings (ie, homelessness and social isolation), GABI helps parents repair their own relationship histories. The attention to the past affords parents the opportunity to build secure attachment relationships with

their children, which may serve as protective factors against trauma and promote social, emotional, and cognitive development. Clinicians pay attention both to the traumatic experience itself and to how such experience continues to affect parents and children emotionally and cognitively as they interpret and react to current emotionally charged situations.

Embedded in this approach is an assumption that the ways in which parents relate to and respond to their children are influenced by the parents' own histories of trauma.[37] For example, parents in the group frequently come to realize how their children's expressions of anger, defiance, or fear are difficult for them to acknowledge because they trigger unconscious memories of a historical or more recent trauma of their own, one often embodied at a physical level. In addition, guilt and shame are common experiences for individuals exposed to trauma. Such emotions can interfere with the abilities of parents to be emotionally available and sensitive to their children.[38] GABI clinicians are particularly attuned to potential traumatic triggers that may arise in the context of the therapy, such as group-session exchanges or client-clinician interactions that lead to reminders or reexperiencing of trauma.[20] Importantly, when reexperiencing does occur, either within or outside the group, these troubling emotional responses become a focus of treatment. Clinicians guide parents' attention to how they and their children are affected by stress so that they can become more conscious and better able to manage their reactions in the moment.

In GABI, the parent, the child, and the relationship are treated simultaneously. Clinicians work to understand and validate the parents' experiences, with the ultimate goal of helping parents be more attuned to their children's perspectives and experiences. For example, when a mother goes into detail about a heated argument that left her overwhelmed, the clinician listens to the mother's retelling of the experience helping her de-escalate and then gently inquiring where her young child was during this event. The clinician redirects the parent's attention to the child, increasing their capacity for reflective functioning by wondering aloud what it may have felt like to be in the child's shoes at that moment. An attachment framework recognizes that change, including trauma recovery, happens through interpersonal relationships that are the opposite of traumatizing.[20] GABI seeks to create a nurturing environment in which the parent may feel less threatened and better able to attend to the child's fear states. In turn, the child feels secure to relive and repair those traumatic experiences through play. Nurturance and containment are established in several important ways. First, the hierarchical structure of psychotherapy is minimized as clinicians ally with parents in respectful, collaborative partnerships.[20,21] Elliot et al write, "Parents should be empowered as the best sources of information about their children and encouraged to view their own recovery as part of healing the parent-child relationship."[20(p472)] Parents do not do this alone, however.

Autonomy is a goal that patients work toward with supportive clinicians, who make themselves available via text messaging for scheduling purposes and brief consultations. Availability builds rapport and signals to patients that they are being held in mind. For many parents, who may have been forced to be prematurely independent early in their lives, connection with a sensitive and responsive clinician can be a transformative relational experience that helps them consolidate their resources and be more attuned parents. Second, GABI clinicians and staff appreciate that parents strive to give their children an experience different from the childhoods they experienced. Emphasis is placed on understanding the rationales for the actions of a parent or child rather than quickly labeling a behavior pathological. We frequently find, for example, that mothers have not received appropriate prenatal care. A trauma-informed approach considers that obstetrical and gynecological examinations and procedures may be perceived as invasive—making a woman feel vulnerable, exposed,

or out of control—and may trigger trauma responses.[20] The GABI program underscores how critical it is to have an understanding of how trauma affects individuals' comfort with seeking and obtaining medical care rather than making judgments or applying labels to those who have not done so. Third, GABI is a strengths-based program in which parents' strengths and abilities are noted, and the barriers they face are understood in the sociopolitical and cultural contexts from which they arise and in which they are embedded.[20,21] The group format of GABI provides an opportunity for parents to relate with other parents in a mutually supportive way, which encourages them to highlight each other's abilities, promote competence and self-worth, and reduce social isolation. In addition, when clinicians fully appreciate the positions in which families find themselves; they also better realize how coordination of services with other agencies for continuity of care is indicated as part of psychotherapy.[33] In the following, we present baseline survey data results from an ongoing clinical trial of GABI in which 60 mothers and 60 children participated. Our purpose is to highlight some of the challenges faced by the parents and children in whose lives our program hopes to effect change.

METHODS

Procedure

Participants in the ongoing randomized clinical trial are families referred by mental and health services providers who judged caregivers to be at risk of failing to provide adequate care to their children aged 0 to 3 years. Referral sources included primarily pediatricians and child welfare systems and early intervention professionals. Exclusionary criteria are nonbirth parents, non-English speakers, and children older than 36 months. All mothers included in the trial completed intake interviews and signed informed consents for their own and their child's participation. The baseline assessment took place prior to treatment and included questionnaires that cover basic demographics and trauma-relevant domains, as well as a height and weight measure, detailed later.

Sample

Participating families for the current report included 60 mothers and 60 children, whose demographic characteristics are presented in the "Results" section.

Trauma-relevant assessments

Adverse Childhood Experiences Questionnaire

A 25-item questionnaire covers the 10 categories of abuse, neglect, and household dysfunction as reported in the ACE study.[4,5] In that study, exposure to 4 or more ACEs was linked to a wide range of psychological and physical health problems, including obesity, throughout the life span.[4,5] Dube et al[5] reported that the threshold of 4 or more ACEs was observed in 19.3% of women studied. In our research, we asked both about parents' exposure to ACEs in their first 18 years of life and about their children's exposure to ACEs since birth.[5]

Body mass index

Mothers were weighed using the Tanita Body Composition Analyzer, model TBF-410, to obtain information on body mass index (BMI), a calculation of height and weight. For adults 20 years and older, a BMI between 18.5 and 24.9 is considered normal, a BMI of 25.0 to 29.9 is overweight, and a BMI greater than 30 is obese.

Diagnostic classification: ZERO TO THREE Psychosocial & Environmental Stressor Checklist

This checklist includes stressors, including challenges in the following 10 domains: (1) child's primary support group; (2) the social environment; (3) educational and child care; (4) housing; (5) economics; (6) occupational; (7) health care access; (8) health of child;

(9) legal/criminal justice; and (10) other (eg, war, natural disasters, child abduction, witness to violence). For the current study, respondents were asked to indicate whether challenges in any of these domains had occurred since their children were born. Results focused on the number of mothers who reported 1 or more challenges since the birth of their child in each of these 10 domains.

RESULTS

Results are depicted in 3 tables showing demographic and trauma-relevant characteristics of 60 participating families in the ongoing clinical trial. Children's ages in terms of months indicated a wide range between 0 and 3 years: mean = 15.9 (SD = 10.3), range = 1-44 months. Mothers' ages in years: mean = 27.0 (SD = 6.7), range = 17-44 years. Table 1 shows further basic demographic and health/trauma characteristics of the mothers, with ethnicity information for themselves and their children.

Table 1 shows that the mothers and children reflected a diverse set of ethnicities representative of the population (Bronx, New York), with the largest group identifying as Latino (37%), the next largest group black or African American, and then biracial and white. Table 1 depicts the education levels attained by the mothers and reveals that 68% of the mothers had no schooling beyond high school, and two-thirds lacked a high school diploma; a similar number of mothers (65%) were unemployed and not enrolled as students. All mothers (100%) received Medicaid assistance. Twenty-two percent lived in shelters, and 19% of the mothers had lost custody of a prior child or children before coming to treatment. Table 1 additionally indicates that a minority of mothers (15%) had been hospitalized previously for a psychiatric reason whereas 10% had been previously incarcerated. Finally, Table 1 shows BMI results indicating that 28% of the mothers were obese whereas another 28% were overweight. A profile of the extent to which mothers and their children had been exposed to ACEs is shown in Table 2.

Table 1. Demographic Characteristics of Participating Mothers (and Children): The Picture From Categorical Measures (N = 60)

	Mothers	Children (55% Girls)
Ethnicity		
White	12%	4%
Black	31%	29%
Latino	37%	37%
Biracial	15%	27%
Other	5%	3%
Mothers' schooling level		
No high school	3%	
Some high school	41%	
High school diploma/GED	24%	
Some college	25%	
College diploma	7%	
Not employed	69%	
Medicaid	100%	
Lost custody of prior child(ren)	19%	
Previous psychiatric hospitalization	15%	
History of incarceration	10%	
Homeless/shelter	22%	
BMI normal	28%	
BMI overweight	28%	
BMI obese	44%	

Abbreviation: BMI, body mass index.

Table 2 indicates that most mothers experienced extreme adversity in their childhood, with 77% reporting 4 or more ACEs. This contrasts, as Table 2 makes clear, with the substantially smaller number of children in our sample who had encountered 4 or more ACEs in their lives (28%). Table 2 shows in descending order from greatest to least exposure the ACEs that mothers reported experiencing in the first 18 years of their lives. The list is as follows: parental separation or divorce (87%); emotional abuse (62%); physical abuse (62%); growing up exposed to adults who used alcohol or drugs (62%); growing up in a household where 1 or more people suffered from mental

Table 2. Prevalence (%) of Childhood Exposure to Abuse, Neglect, and Household Dysfunction in Mothers (n = 60) and Children (n = 60)

ACEs	Mothers	Children
Abuse by category		
Emotional	62	30
Physical	62	12
Sexual	57	2
Neglect by category		
Emotional	48	2
Physical	40	25
Household dysfunction by category		
Mother treated violently	48	27
Parental separation or divorce	87	58
Mental illness in household	57	50
Household substance abuse	62	22
Incarcerated household member	45	22
ACEs Questionnaire score		
≥4	77	28
Mean number of ACE categories	5.7 (2.7)	2.6 (1.8)

Abbreviation: ACE, adverse childhood experience.

illness (57%); sexual abuse (57%); having seen their mother being treated violently (48%); emotional neglect (48%); incarceration of a family member (45%); and physical neglect (40%). For children, Table 2 reveals markedly reduced levels of ACE exposure compared with their mothers. Two ACEs have been experienced by a majority of children: parental separation or divorce (58%) and living in a house with a mentally ill adult (50%). One child (2%) was sexually abused, and one child (2%) was reported to have experienced emotional neglect. Still, as mentioned earlier, 28% of children were reported by their mothers to have experienced 4 or more ACEs. To understand the extent to which mothers experienced challenges from current stressors in their lives, the *ZERO TO THREE Psychosocial & Environmental Stressor Checklist* was collected from 57 mothers prior to treatment in our trauma-informed clinical trial. These results are shown in Table 3.

Table 3 shows the extent to which mothers reported being challenged by each of 10 discrete stressors. Notably, as the bottom of Table 3 indicates, 93% of mothers indicated that they felt challenged by 2 or more of the listed stressors. In descending order from the most common stressor to the least common stressor: child's primary support group (81%); social environment (68%); education and child care (56%); legal/criminal justice (54%); housing (53%); economic (53%); occupational (51%); health of child (40%); other, such as "witnessing violence" (32%); and health care access (11%).

Table 3. Percentage of Mothers Reporting 1 or More Current Challenges in 10 Domains of Psychosocial and Environmental Stressors (N = 57)

Psychosocial/ Environmental Challenges	Mothers
Child's primary support group	81%
Social environment	68%
Educational and child care	56%
Housing	53%
Economic	53%
Occupational	51%
Health care access	11%
Health of child	40%
Legal/criminal justice	54%
Other (eg, witnessing violence)	32%
Endorsing ≥2 challenges	93%

DISCUSSION

Demographic data collected at intake and reported in this article reflect the complex needs of the parents and children who are referred because of concerns about the parent-child relationship, which may present itself based on parent's comments, behavior, and current stressors of history; the child's symptoms (ie, sleep, regulatory problems, development, or behavior); and/or observations of troubling parent-child interactions, for preventive treatment. The majority of mothers in our sample had been exposed to 4 or more categories of abuse, neglect, and household dysfunction in childhood, placing them at significantly increased risk of physical and mental health problems.[4,5] From birth to 3 years, their children had experienced lower rates of ACEs, although nearly one-third of these babies and toddlers had experienced emotional abuse, a quarter had experienced physical neglect, and more than a quarter had witnessed domestic violence, according to parental report. Furthermore, a significant percentage of the mothers had previously lost custody of a child. In addition to their exposure to trauma, the majority of parents and children in our study identified with ethnic minority groups, and all met the federal poverty guidelines, with a significant percent living in homeless shelters. These factors are known to further contribute to chronic stress.[39] Nearly all mothers endorsed 2 or more psychosocial or environmental challenges since birth of their child, with the most common challenge arising from stress regarding their primary support group. More than half of mothers reported economic, legal, childcare, and housing problems. In addition, the majority were overweight or obese, a previously established adult correlate of high ACEs.

The markedly lower rate of ACEs in the lives of their children, as compared with the ACE levels in the history of the mothers' reporting and their high levels of current maternal stress, points to the powerful motivation in the minds and behaviors of these mothers to not only retain custody of their children but also work at the task of seeing that their children feel loved, special, and protected. The possibility that the parents will be able to protect their children from the high numbers of ACEs they experienced offers some hope, redemption, and repair, which appear based on parent feedback to inspire them to parent much differently than they were parented.

GABI appears to be a promising trauma-informed intervention that can support parents in their pursuit of these goals and so subvert the intergenerational transmission of trauma. The immensity of the task at hand cannot be underestimated, keeping in mind the well-known trajectory of increased physical health and mental health problems that high ACEs create throughout the life span. The baseline data reported here have implications for providers of health and therapeutic services to vulnerable parents with young children. Specifically, vulnerable and marginalized families need to be looked at through a trauma-informed lens to understand unique sensitivities arising in no small measure from their frequently activated acute sense of social isolation. The group element of GABI is thus an intrinsic benefit to the approach provided, as strong social bonds often form among the parents attending GABI, thus combating social isolation.

The development of GABI has been an iterative and evolutionary process, consolidating our trauma-informed approach. It has required thinking about engagement with families with extensive past and current trauma histories from a broader, multileveled perspective that includes the therapy group (GABI), the clinic in which the group is based, the medical center of which it is a part, and the particular temporal, sociocultural, geographic contexts in which all exist. Although highly stressed families often have a strong desire for help and a desire for change, but vicarious traumatization and the daily experience of working with patients who are overwhelmed by multiple unmet psychological and physical demands can contribute to clinician burnout. The group practice model used in GABI helps

safeguard against this risk by sharing clinical responsibilities and by providing on going peer support and supervision.

The training processes that are used in the dissemination of trauma-informed treatments have not been sufficiently studied. To build a workforce trained specifically in trauma-informed interventions requires systematic study of the effectiveness of training programs. A unique aspect of GABI's R.E.A.R.I.N.G. model is that it was designed both to inform clinical practice and to be adapted for research use, providing operational outcomes for clinical competence and trainee adherence to the model. As the field becomes increasingly trauma informed and screening becomes standard practice,[21,22,32] there will be urgent need to implement trauma-informed interventions such as GABI. Marginalized families that are chronically homeless and living in poverty and that have experienced psychological and physical trauma across the life span present a challenge to health care professionals. Programs such as GABI offer a means to break the intergenerational cycle of abuse and neglect.

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