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RESEARCH ARTICLE

Treating disorganized attachment in the Group Attachment-Based Intervention (GABI©): A case study

Hannah Knafo[1] | Anne Murphy[1] | Howard Steele[2] | Miriam Steele[2]

[1]Montefiore Medical Center, New York

[2]The New School for Social Research, New York

Correspondence
Hannah Knafo, PhD 1225 Morris Park Ave. Bronx, NY 10461.
Email: hknafo@montefiore.org

Abstract

This paper describes the treatment of a mother and child who demonstrated disorganized attachment behaviors in their interactions with one another. The mother, who was diagnosed with Borderline Personality Disorder, felt incapable of managing her aggressive toddler and his emotional needs. The dyad was referred for therapy due to concerns about his developmental progress, evident delays having been mainly attributed to the problems observed within the parent–child relationship. The primary intervention applied to working with the dyad was the Group Attachment-Based Intervention (GABI©), developed by Anne Murphy in collaboration with Miriam Steele and Howard Steele. The mother also received individual psychotherapy as a supplement to the dyadic and group work of GABI©. The process and outcome of this comprehensive approach to treating a vulnerable dyad is explored in this case study.

KEYWORDS

attachment, dyadic therapy, group, intervention, personality disorder

1 | INTRODUCTION

According to attachment theory, a child's feelings of safety and security are formed from the quality of attention and caregiving provided by parents during infancy. From these early interactions, children develop expectations of how they will be cared for, as well as beliefs regarding the kind of care that they deserve. These *internal working models* of the self and others guide the child's development as he or she forms an identity, establishes new relationships, and perhaps grows up to have children of his or her own (Bowlby, 1988). These models, imprinted so early on in the brain, continue to influence relationship patterns and self-esteem throughout the lifespan, though not without the opportunities for change (Bowlby, 1973).

Previous research has illustrated that adverse childhood experiences—defined as abuse, neglect, and household dysfunction—have deleterious effects in adulthood with regard to physical health, mental health, attachment representations, and parenting stress and behaviors (Felitti et al., 1998; Hesse & Main, 2000; Steele et al., 2016). Given the

evidence for the intergenerational transmission of attachment patterns (Fonagy, Steele, & Steele, 1993) and the cycle of maltreatment that is so often seen working with families in clinical settings, it is imperative that interventions for at-risk families target the parent–child relationship and disruptions to the development of a secure attachment relationship in the earliest years. The parent's painful memories—*intruders from the past* or her *ghosts*—can interrupt her ability to effectively parent and nurture her child (Fraiberg, Adelson, & Shapiro, 1974). Similarly, however, most people also have some positive memories of love and affection (however small and brief), which can provide an *angel in the nursery* to fight off these intruders (Lieberman, Padron, Van Horn, & Harris, 2005). The process of helping parents identify the ghosts of their pasts and uncover the angels can help break the cycle of maltreatment through the generations.

Group Attachment-Based Intervention (GABI©) was developed by Anne Murphy in collaboration with attachment researchers Miriam Steele and Howard Steele. GABI© was created in response to the needs of vulnerable parents who express the desire to become a different kind of parent for their children than their parents grew up with (Steele, Murphy, & Steele, 2010). Broadly, the intervention aims to bring together extremely socially isolated parents with limited access to resources and to help their children feel safer and more secure in their relationships with their caregivers.

GABI© is offered three times a week, two times a day, in order to provide parents with ample opportunity to receive social support from other parents, spend time with their children in a therapeutic and safe environment, process their own overwhelming emotions, and receive nurturance and concrete assistance with the daily struggles of living in poverty. Families are given the option of attending up to three groups per week, however, there is a great deal of flexibility with regard to attendance. Many families attend one group per week, and some families may even attend groups more seldom. This flexible approach recognizes that the stressors and demands in the families' lives may make frequent attendance difficult at times, thus the GABI© model allows parents to maintain consistent attendance over time that meets their particular needs at given times. The groups are held at a hospital based clinic for children in the Bronx, where various developmental evaluations and therapies are delivered (e.g., physical therapy, occupational therapy, speech therapy). GABI© is delivered in a unit of this clinic dedicated to trauma services and the treatment of families with children under 5 years old. Each group is 2 h long, with the first hour devoted to dyadic therapy that occurs within a group context. With multiple therapists in each group, each dyad has the attention of a clinician who helps the parent observe, attune to, and reflect on his or her child's play. After an hour of *parent–child time*, the parents separate from their children and go into a separate room where they participate in a *parent group* led by one clinician. During this group, parents discuss topics such as current stressors, challenging child behaviors, relationship difficulties, past traumas, and general emotional distress. In facilitating the discussions, clinicians often guide parents to reflect on their own mental states and the mental states of others, enhancing their mentalizing capacities as they listen to each other, talk about their own childhood experiences, and think about their own children.

During this hour, the children remain in the playroom with the rest of the clinicians. Ideally, each child receives the attention of a therapist as they respond to being separated from their parents, interact with other children, and play. With 15 min left to the 2-h group, the parents return for a "reunion" with their children, and a goodbye song is sung by the group to each dyad as they get ready to leave. Each part of this intervention is meant to address the various complex needs of the dyad as well as the needs of individual parents and the individual children. There are also aspects of social support built into every aspect of the intervention. While parents and children have the opportunity to meet with therapists, they also have opportunities to spend time with each other, learn from one another, and develop their interpersonal skills and support networks.

The conceptual framework of GABI© was developed from the integration of clinical experience with the theory and research findings in attachment theory. The acronym R.E.A.R.I.N.G. is used to outline the main components used in the intervention (Reflective functioning; Emotional attunement; Affect regulation; Reticence; Intergenerational patterns; Nurturance; and Group context). *Reflective functioning* (RF) is considered the hallmark of this intervention, making possible all other aspects of the therapy. RF—the ability to acknowledge, understand, and reason with the mental states of others, as well as one's own—is encouraged, modeled, and elaborated on during every aspect of the intervention. Research has shown that the parent's capacity for RF is a strong predictor of infant attachment security, particularly in cases when parents experienced deprivation in their own childhoods (Fonagy Steele, M., Moran, Steele, H., &

Higgitt, 1993; Fonagy, Steele, M., Steele, H., Higgitt, & Target, 1994). These findings suggest that RF is a crucial ingredient in the cross-generational transmission of attachment security and the prevention of a continued cycle of childhood maltreatment.

Using RF, clinicians support parents in successfully attuning to and regulating their children's emotions. *Emotional attunement* involves the caregiver's recognition, acknowledgement, and responsiveness to a child's emotional needs. These needs, expressed through the child's verbal and nonverbal gestures, are being communicated constantly to parents. The parent's ability to reflect back the child's internal states is essential for the child's development of a sense of self (Stern, 1985). This capacity also helps the child feel seen and nurtured by his or her caregiver and contributes to the ability to self-regulate. *Affect regulation* is closely connected to the parent's emotional attunement to the child. Initially, affect regulation is a dyadic process, during which the parent helps the child regulate through successful attunement, ultimately teaching the child how to self-regulate. These processes of attunement and regulation are modeled, facilitated, explained, and encouraged by clinicians during the parent–child time of GABI©.

A key component of delivering GABI© is to employ *reticence* when working with families. Parents' thought processes, children's activity levels, and rising interpersonal conflicts in the group can often occur at a fast pace. The reticent clinician observes before acting, and times her interventions thoughtfully. Clinicians trained in GABI© are often taught to "slow down" and to remember that the most powerful interventions can be those that are simple, short, and well timed. GABI© clinicians are also trained to adopt a nurturing therapeutic stance when interacting with parents and children.

Nurturance plays a vital role in the intervention and is expressed in several different ways, including the physical space, the therapeutic stance, and the social atmosphere. The GABI© space is thoughtfully planned out, with clean, comfortable, colorful furniture and mats in the playroom and children's drawings on the walls. The nurturance conveyed by GABI© clinicians goes beyond the traditional therapeutic stance. For example, therapists offer tea, hot chocolate, or coffee to parents, and snacks or juice for the children. These small acts help to create a warm, comforting environment for the family. It is also not uncommon for a family to arrive to the GABI© group without having eaten that day, in which case GABI© clinicians help nourish the family before they are expected to engage in the intensive therapeutic work.

In the parent groups, parents are encouraged to consider their own experiences of being parented as they work toward becoming a different kind of parent for their children. By acknowledging and developing a deeper understanding of the *intergenerational patterns* that have persisted in their families, parents can begin to recognize how they might fight these forces and feel motivated to break the cycle of abuse and maltreatment. Feeling empowered by the *group context* of GABI©, families can feel more capable of making these difficult changes in their relationships and patterns. For extremely socially isolated parents with limited access to resources, it is incredibly useful and meaningful to receive support from other parents, to form relationships with others based on shared experiences, and to provide a safe environment for their children to interact with others.

2 | CASE ILLUSTRATION

2.1 | Presenting problem and client description

Anna was a single mother in her late twenties living with her mother, father, sister, and her 2-year-old son, Danny. Danny's father, Jason, lived with his own family and was intermittently involved in his son's life. By Anna's report, Jason was emotionally unstable, verbally and physically abusive toward her, used illegal drugs, and did not adequately support his son financially or emotionally. Anna and Danny were referred to our clinic by her son's pediatrician with concerns about Danny's developmental progress. Anna reported a history of mental illness beginning in her childhood, stating that she had been previously diagnosed with Bipolar Disorder and Obsessive Compulsive Disorder. After identifying Anna's long history of difficulties with interpersonal relationships and emotion regulation, her diagnosis was changed to Borderline Personality Disorder. Anna also identified her struggles with addiction (e.g., Cannabis Use Disorder), but

reported that she had not been using for several months when she started treatment with us and was regularly attending Marijuana Anonymous groups.

Anna's emotional difficulties were almost always related to interpersonal conflict, past and present. Her relationships with family, romantic partners, and acquaintances were rife with feelings of shame, fear, insecurity, anger, violence, sex, substance abuse, deceit, and rejection. She strongly desired connection with others, but she felt threatened by increasing closeness and intimacy and became combative and defensive as a result of this fear, unwittingly creating relationships filled with conflict from the start. Danny mirrored Anna's approach-withdrawal tendency in his own relationships with others. Though he also showed a desire to connect with others, he was inclined toward violent behaviors in his interpersonal interactions as well as in his symbolic play. When evaluated by a neurodevelopmental pediatrician at our clinic, he was diagnosed with "Parent-Child Relational Problem." His challenges in meeting developmental milestones, regulating his affect, successfully relating to others, and managing impulsive behaviors were all understood to be directly connected to the unpredictable and sometimes frightening nature of his relationship with his primary caregiver.

2.2 | Case formulation

Both Anna's symptoms and Danny's emotional development were conceptualized within the framework of attachment theory. As John Bowlby (1988) wrote: "The capacity to make intimate emotional bonds with other individuals, sometimes in the careseeking role and sometimes in the caregiving one, is regarded as a principal feature of effective personality functioning and mental health" (p.121). Both Anna and Danny lacked this capacity, causing them to struggle in their relationships to one another, as well as in their relationships with everyone else.

2.2.1 | Anna: Childhood trauma

During her childhood, Anna reported witnessing frequent incidents of violence between her parents and was frightened of her father, who was an alcoholic. She also had vivid memories of being exposed to pornography as a young child and witnessed various adults in her family engaging in sexual acts. Anna frequently felt ignored and rejected—mostly by her parents, but she also reported incidences of rejection throughout her life by teachers, her sister, social workers, and therapists. Her primary caregivers consistently dismissed her, and she developed an internal working model that she was not worth being cared for. As a result of feeling repeatedly rebuffed by those who were meant to protect her and care for her, she developed a very low sense of self-worth and a powerful rejection sensitivity, which followed her into every new relationship she formed including her relationship with her son. The confusing, fragmented, and detailed aspects of Anna's narrative about her childhood were consistent with aspects of an unresolved/disorganized attachment pattern (George, Kaplan, & Main, 1985; Hesse & Main, 2000). It was clear that the traumatic and shameful experiences of her childhood still felt quite close, and remained intrusive and disorganized in her mind. Initial diagnostic impressions of Anna were that she suffered from a personality disorder. Her intense emotions, troubled interpersonal relations, self-destructive behaviors, and apparent identity diffusion were all defining characteristics of Borderline Personality Disorder (Yoemans, Clarkin, Kernberg, 2002).

2.2.2 | Intimate partner violence

Anna's relationship with Danny's father, Jason, was emotionally and physically abusive, resembling the violent relationship she had witnessed between her own parents. Anna knew that she wanted to protect her son from this violence, but she was extremely conflicted about her own connection to Jason. Although she identified the ways in which her relationship with Jason negatively affected Danny with its constant volatility and violence, she remained ambivalent. Though abusive, this was the most intimate relationship she had ever known, and it terrified her to lose it. The relationship also helped her feel momentarily less empty inside as she described that she felt her emotions more acutely and intensely when she was with Jason.

2.2.3 | Danny: Challenging behaviors

When they were referred for treatment, Danny was an active 2-year-old presenting with delayed language, hyperactivity, and aggressive behaviors. Danny had difficulty socializing with other children, often hitting them during play. Although his behaviors were frequently violent, he did not always hit because he was feeling angry or aggressive. Rather, this seemed to be how he had learned to connect, elicit attention (albeit negative attention), and play with others. When limits were imposed on him, he became angry and dysregulated, expressing his emotions by lying on the floor screaming, crying, and biting. When particularly overwhelmed by negative affect, he would force himself to vomit by putting his finger down his throat. This coping strategy was used so frequently that after some time he did not need to use his finger to induce vomiting anymore, but would automatically start to heave as a response to being upset. Anna had developed the habit of packing several changes of clean clothes for Danny, anticipating that he would vomit at least once a day.

Anna herself had a great deal of difficulty regulating her emotions, so Danny's dysregulation was an overwhelming daily challenge for her. Anna also identified with many of Danny's behaviors and emotions which further impeded her ability to be a strong and comforting caregiver. In reflecting on his tendency to induce vomiting when he was upset, Anna admitted that she often coped with overwhelming emotions in the same way, and suspected that Danny had witnessed this behavior and was imitating her. Although Danny's behaviors were extremely challenging, his mother was able to recognize his strengths, his sweetness, and his bond to her. She wanted others to see these aspects of his personality, too, but she experienced shame when going out with him in public because his behaviors typically garnered negative attention from strangers. Anna reported that family members also shamed Anna for her insufficient parenting skills and blamed her for her son being "out of control."

2.2.4 | Disorganized attachment

With both Anna and Danny experiencing such difficulty regulating their emotions, they activated each other in ways that became overwhelming and frightening to themselves and each other. As the parent, Anna wanted very badly to be able to comfort Danny, but she usually felt this to be an impossible task when she herself was so triggered and paralyzed by anxiety. Researchers studying mothers of disorganized infants postulate that these mothers "cannot process and respond to emotional information in the moment because they are flooded by their experience of the infant's distress, which may re-evoke earlier traumatic states of their own. They may shut down their own emotional processing, and be unable to use the infant's distress behaviors as communications" (Beebe & Lachman, 2014, p.129). This was very likely Anna's experience with her son. In her efforts to comfort him or connect to him, she was often intrusive and unintentionally frightening, unable to attune to Danny's internal states and meet his needs due to her own heightened anxiety. Danny wanted to be close to his mother and was also afraid of her because of her unpredictability. He approached her and then withdrew or behaved aggressively toward her, which Anna perceived as rejection. This pattern of approach and withdrawal within the dyad is a distinctive feature of disorganized attachment and illustrates the coconstructed origins of these defensive attachment behaviors (Beebe & Lachman, 2014). When attachment measures such as the Strange Situation Paradigm (Ainsworth, Blehar, Waters, & Wall, 1978) and the Adult Attachment Interview (George et al., 1985) were administered for research purposes, both Anna and Danny showed evidence of disorganized patterns of attachment.

The unstable and ambivalent relationships that Anna had formed with her own parents, partners, and friends were also being formed with her young son. Her automatic defensive responses to intimate connection arose in response to her son's affect. Anna was able to identify how she was mistreated as a child and how this contributed to many of her maladaptive patterns and persistent emotional distress. She expressed a strong desire to ensure that her son did not have the same experiences that she had, but she seemed to feel helpless in preventing this. She worked hard to show Danny affection—but her behaviors were too often mismatched with his affect and emotional needs. Additionally, Danny's violent and aggressive behaviors made it difficult for Anna to provide him with the warmth she tried so hard to muster. To soothe him when he was upset meant to endure his biting, kicking, slapping, and vomiting. Anna found these difficult to tolerate, and she reacted by dissociating or by becoming very emotional, angry, and harsh.

Danny was frequently overwhelmed with emotion—fear, anxiety, sadness, anger—but had no effective strategies for expressing his feelings and receiving comfort in exchange. Instead, he expressed his emotion in such a way that garnered negative attention, aggression, fear, or rejection from others. From an attachment theory perspective, the development of these aggressive behaviors can be linked, at least partly, to his mother's unpredictable, intrusive, sometimes hostile, and sometimes withdrawn caregiving behaviors (Lyons-Ruth, 1996). He did not know how to express his needs because no strategy he had employed had been consistently effective in getting what he needed from his mother.

2.3 | Course of treatment

2.3.1 | Group Attachment-Based Intervention

When she began attending the GABI© groups, Anna was friendly, well-related, engaged in the therapeutic process, curious, and responsive to therapeutic interventions. Danny was a challenge to have in the groups because of his aggressive and disorganized behaviors and his difficulties with affect regulation. Anna was attentive and present in the playroom with him, but also appeared quite nervous and tentative. She was mostly concerned about how other people viewed her son's behaviors and seemed uncertain about what the appropriate response was to his emotional distress. She did not trust her instincts and felt vulnerable in this setting to judgment and criticism from other parents and therapists. Anna observed Danny closely in the parent–child time of GABI© and was active in her attempts to follow his lead and play with him. She was usually keen to receive feedback and guidance from therapists, likely because this helped her feel safer and less unsure of herself. She responded as fully as she could to suggestions and questions, and shifted her approach as much as she understood how to, showing an eagerness to learn. On occasions, however, this process became overwhelming for her. Although her motivation was evident, her ability to tolerate her own anxiety regarding Danny's behaviors was limited. In those moments, she coped by withdrawing or dissociating.

Upon meeting Anna and Danny, I (first author) was immediately drawn to working with them. I saw in both of them a powerful desire to relate to others and to each other without quite knowing how. This made me want to connect to them. I approached the dyad through play, following Danny's lead one day as he explored the room. He went to rummage through the box of toy animals, where he usually found a family of lions to play with—his symbolic play typically limited to using the lions to roar aggressively at each other and at other people. On this day, he pulled out a giraffe, and then found two more giraffes, handing one to me and one to his mother. Danny barely had any language, and communicated mostly by babbling and with nonverbal gestures. We played out a family scene with giraffes without using any words at all. I smiled at Anna, inviting her to join more actively in the play, and I commented on the fact that Danny had chosen the giraffes instead of the lions. She smiled proudly and said, "Yeah I think he is feeling more gentle today, so he wanted the giraffe instead." Anna was making a clear attempt at linking something in his play to something that he was feeling. Perhaps this statement was more of a wish than an actual belief, but her attempt to understand her son's play and link it to his emotional state was impressive at this early stage of treatment.

During this session, Anna had seemed in awe and tentative at first when Danny and I began playing; she seemed afraid to join as if she would burst the bubble of brief, relative calm that had been created between us. However, with my encouragement she did join and was able to feel the satisfaction of a back-and-forth in a simple game with her son. It was a small moment; it may have lasted for less than a minute. But this brief encounter was important for a number of reasons: Anna saw Danny's ability to play; she discovered her own ability to play; she saw me gently and kindly interacting with her son; and she felt accepted by me because I accepted her son.

Another compelling moment occurred during a busy group when Danny and another boy clashed over a toy. Danny became intensely distressed and produced loud, high-pitched, prolonged screams. I sat with him there, holding him firmly but gently and speaking to him in my arms. Though he writhed, he was not fighting me, and as his screams slowed his body began to relax and he began to lean into me. Anna sat in a chair watching us, appearing nervous and unsure of what to do, but paying close attention. She expressed concern in a distant manner from her chair, saying in a somewhat flat tone, "It's okay Danny." I waved her over and she immediately took my cue, joining me and Danny on the floor and stroking his head gently, helping him to regulate his emotions and watching him fully recover. Soon after Anna had

joined us on the floor, Danny bounced up and went about the room ready to explore. It was a new experience for Anna—to see another adult treat her son with such softness when he was behaving in such a challenging way. It was also likely a new experience for her to watch Danny manage to self-regulate with a little help from the adults. As Danny explored the room, we reflected on the moment that had just passed together.

The experience of relief that followed this difficult moment created an ideal opportunity for collaborative reflection. Anna sat with me and joined me in a conversation about Danny's internal world. Although her comments about his mental states were often somewhat scripted and simplistic, she was very open to this exploration, and seemed interested in hearing my elaborations on her reflections. She would often be heard repeating reflections and observations that therapists in the group had shared about her son. She was clearly listening and learning, and when she was in a relatively calm, stable, and clearheaded state, she was quite capable of pulling from this growing store of knowledge when interacting with her son. Unfortunately, the external stressors in her life and their impact on her emotional stability were constant mounting disruptions that made it difficult for her to consistently meet Danny's needs.

2.3.2 | Group ruptures

The complicated aspects of Anna's personality structure and her challenges in interpersonal dynamics revealed themselves quickly in the parent-group portion of GABI©, and she experienced several ruptures with other parents in the group. Conflicts arose as she perceived judgment and attacks from nearly everyone, and reacted to the constant feeling of rejection that she felt in all social settings. She also felt judgment about her son, and was sensitive to other parents' and therapists' reactions to his behavior. Although she had once attended groups two or three times a week, her attendance became quite infrequent as she and Danny missed groups for weeks at a time. When she was absent from group for a few weeks, concerns about her and her son were raised by the GABI© team. At this point in time, my role at the clinic had shifted to providing individual therapy for certain parents in GABI© as a supplemental "parental mental health" treatment program, and as a result I was spending less time in the groups. In a team meeting, we agreed to reach out to Anna to express our concerns and offer her individual treatment as a way of reengaging her in treatment. Anna was very amenable to this recommendation, and expressed her gratitude over the phone. The treatment plan was for her to continue attending GABI© groups with her son and to also receive individual psychotherapy with me.

2.3.3 | Parental mental health

Anna approached individual therapy with an open and motivated attitude. She expressed gratitude for the opportunity to meet with a therapist alone, feeling nurtured by this more targeted approach to her treatment. She attended her first two sessions and spoke openly about her present emotions and interpersonal conflicts, shared some of her past experiences, and expressed her desire for change. However, she revealed her cautiousness and hesitation about this new relationship with me in some initial resistance to therapy, which manifested in an absence from treatment during its second month. Once she returned to therapy, her attendance became more consistent and she quickly attached to me, opening up about various aspects of her present stressors and her past traumas. The insightful, receptive, and engaged patient that I saw in the GABI© groups was evident in her individual treatment, too, but I found that her insights were often filled with jargon and were not very coherent, as if repeated slightly inaccurately from a book or another therapist. This canned quality to her comments about mental states is a marker of low RF (Fonagy, Target, Steele, & Steele, 1998), a common feature of individuals with personality disorders (Fonagy, Target, & Gergely, 2000). When I shared my own reflections, observations, and interpretations, she listened attentively, nodding and appearing incredibly moved when she felt understood. I soon realized that she absorbed much of what I said like a sponge, and she committed my words to memory. They were meaningful to her, and she wanted to use my words to explain her experience because she did not have the organized narrative to explain it herself. However, the true insights she shared were those that were heavy with intense emotion, fragmented, and often incoherent.

In individual treatment, a clearer picture of Anna's psychological functioning emerged. Her thought process was frequently tangential, her emotions were labile at times, and her anxiety was intense—manifesting in psychomotor agitation, avoidance of eye contact, and paranoid thinking. She spoke of her early childhood in a disorganized and

incoherent manner, perseverating on details and visual images from traumatic memories rather than conveying a coherent narrative about her childhood. For example, she frequently shared a memory of her father hitting her mother, but the most vivid detail that she remembered and repeated was the green dress that her mother was wearing at the time. She became flooded with emotion when anything reminded her of this green dress.

Anna was swimming in painful memories of neglect and abuse that she suffered during her childhood, and relived experiences every day residing in her parents' home. She felt so rejected by her family, but she still desperately sought acceptance and love from them, continuously reexperiencing the rejection that had been so pervasive throughout her childhood. She sobbed when she spoke of her mother's coldness, deceit, and preferential treatment of her sister. But she also spoke of her mother with admiration and empathy, marveling at how her mother endured an abusive marriage for so many years, a sacrifice she made, as Anna explained it, for her children. Although she spoke of her family with powerful anger and resentment much of the time, she also felt protective of each of her family members, and she expressed shame in speaking ill of them. She felt afraid and ashamed of her own anger and did her best to hide from it or avoid situations that exacerbated it.

I often felt that Anna began sessions as if she were continuing a conversation she had started having with me while waiting for me in the waiting room. It felt like I was jumping into the middle of an ongoing thought and I was expected to understand where this thought was coming from, who she was referencing, and what precipitated these feelings. When I would interrupt and ask her clarifying questions, she did not seem irritated, just confused that I did not already know the answer to the questions I was asking. She would clarify, but I would still feel like I did not have the full picture. I later realized that part of what made her narratives so confusing were her efforts to conceal certain parts of her life that she worried would get her into trouble or would make her appear "bad" (i.e., smoking marijuana and the violent fights she had with her son's father). She made ambiguous and confusing statements about her son's father, possibly wishing for me to ask questions for further clarification. She sometimes answered me honestly right away and other times she would return the following week expressing shame for having told a lie and relief at being able to tell me the truth. Toward the end of our work together, Anna often told me that I was the first person she felt she could be fully honest with and this was quite satisfying to her. She told me that she felt relieved when I "figured out" that she was smoking marijuana again. She shared this with me as she was beginning to develop new relationships with a new therapist and a new group of patients at another clinic, using her relationship with me as a reference point for which aspects of closeness felt good for her.

2.3.4 | Intimate partner violence

One of the main themes of our conversations, particularly at the start of treatment, was her relationship with Jason. She described Jason as emotionally abusive (constantly degrading her and putting her down), physically violent, mentally ill, living in a filthy apartment, and a drug addict. Similar to the way she described her family, Anna spoke about Jason with clear anger and disgust but also was protective of him and expressed shame for speaking ill of him. Her ambivalence about this relationship mirrored her ambivalence about all of her relationships. She was incredibly lonely, simultaneously fearing and desiring true intimacy with others. She was afraid of the loss of relationships, but by prematurely anticipating these losses, she had difficulty maintaining any close relationships. She reported that the only way she knew how to get close to somebody was to have sex with them. She knew that this did not satisfy her need for intimacy, but she had no other strategy for ridding herself of the profound loneliness and emptiness that she felt. She did not know what it meant to be fully connected to somebody in an honest and trusting way, and as she later told me, this level of intimacy terrified her.

As she opened up more about her relationship with Jason, beyond her frustration with him for not being an active parent in Danny's life, it became clear that Anna's sense of self was quite dependent on this abusive relationship. Although Anna readily acknowledged her addiction to marijuana, it took her some time to acknowledge that she was also addicted to the intense emotions she felt when she was with Jason. In our work together, she was also able to explore the idea that she used the relationship as a means of punishing herself for being "bad" and self-harming through the abuse she continued to endure. Anna had readily admitted at the start of treatment that she did not think that her

relationship with Jason created an appropriate environment for Danny. However, it took her a longer time to admit that the relationship was also holding *her* back from being the kind of mother and person she wanted to be. As our rapport strengthened and her trust in me grew, she was able to share these thoughts without fear of judgment or punishment.

2.3.5 | Ruptures in individual therapy

There were times, of course, that I got it wrong; times Anna felt I did not really understand what she was trying to tell me. Because of her wish to be "good," compliant, and polite, she very rarely told me when I misunderstood her or said something that made her angry. Instead, she managed her anger at me with avoidance. One such rupture occurred after she came in for a session sobbing and telling me she had finally broken up with Jason, explaining with appropriate sadness and insight why she knew she had to end the relationship. I reflected on the difficulty of this decision and the pain she felt in experiencing this loss. I also reflected on some of the things she had shared with me in the past about the relationship that had been so painful and destructive for so long. My relief at hearing about her break-up was likely evident. My wish for her to achieve greater emotional stability and provide a consistent and safe environment for her child was dependent on her separation from this very confusing, abusive, unstable, and destructive relationship. However, my relief and my departure from my neutrality was premature.

Anna did not show up to her appointments after that for two months, and she did not return my phone calls. I finally managed to arrange a conversation with her when she had come in for a GABI© group, and she immediately opened up to me about why she had been avoiding me, appearing relieved that I had approached her about it. She let me know that she was upset with me because she had hoped during our last session that I would tell her not to break up with Jason, and then she was embarrassed because she had gone back to him. During this rupture and subsequent impasses in our work together, Anna experienced these intertwined and indiscernible feelings of anger and shame.

As I learned her patterns I was able to anticipate her responses to ruptures to some extent, and could directly address what I thought she might be feeling. As we later had the experience of past ruptures to reflect on, we were able to together recognize these patterns of relating and develop new patterns in the face of conflict and discomfort. When I was able to recognize her anger behind the veil of politeness, shame, and avoidance, Anna felt seen and understood. She was pleased when I could see past her veneers.

2.3.6 | Decompensation and crisis

Several months into our work together, Anna began to decompensate. The severity of her mental illness and its impact on her ability to effectively take care of herself and her son were more apparent than ever. She was feeling incredibly alone and self-loathing, unable to stay away from her abusive partner, unable to find support in her family, and unable to see herself as "good" in any way. Thoughts of self-harm and drug use grew prominent and intrusive. She began to isolate herself and did not attend our sessions or reach out. She avoided my phone calls. Because of Anna's continued involvement in GABI©, I was able to reach out to the other GABI© clinicians to let them know of my concerns. Together, we called from the GABI© clinician's phone and Anna picked up. When we later discussed her clear avoidance of me, she identified the closeness of our relationship as the primary reason she avoided me. She was terrified and ashamed of her dependence on me, as well as the intimate details of her life that she had shared with me.

On the phone, Anna sobbed as she told us of her incredible emotional pain. As she spoke tangentially about her feelings of hopelessness, desperation, fear, sadness, and loneliness, we heard Danny screaming and crying in the background. Anna also told us she had shaved her head that day. We later learned that this was her attempt at avoiding the more self-destructive and self-harming behaviors that she was tempted to engage in. She explained that she shaved her head in the hopes that it would make her feel less attractive and so she would not be as tempted to seek out drugs or sex. Although this behavior was initially alarming—seeming impulsive and rash—it was later clear that Anna was doing everything she could think of to avoid falling into old self-destructive patterns that she knew would make her unsafe and put her child at risk.

Together with the GABI© clinicians I evaluated Anna and Danny's safety. Although she told us tentatively that she thought she could be safe that night, we were unconvinced. The profound pain that could be heard in her trembling

sobs and groans was more convincing than her weak words of assurance. We asked her if she would feel comfortable going to the hospital, and if her mother could take care of Danny. She agreed that this might be a good idea. In a taxi, I went with a GABI© clinician to pick up Anna from her apartment and bring her to the hospital. She kissed her son goodbye at the front door of her building, as his grandmother held him and expressed her bafflement at her daughter's state.

At the psychiatric emergency room, we waited with Anna for three hours, hoping to speak to the psychiatrist who would meet with her. At around 10 pm, she told us that she would be happy to just watch TV until the psychiatrist arrived. It was clear that she would prefer to be left alone by then. We left our phone numbers with the nurses, and went home for the evening. The next morning, I called the hospital and learned that Anna had not been admitted. The resident who answered the phone informed me that Anna had assured the doctors of her safety and called her "boyfriend" to pick her up. She had been released into the care of her abusive ex-partner.

I felt frustrated, concerned, angry, and somewhat helpless. I was also extremely concerned about her child's well-being. A case with the Administration for Children's Services (ACS) had previously been opened in response to Anna's reports of Jason's living conditions, violent behaviors, and mental health problems. I called Anna's ACS worker to notify her of Anna's current crisis, but it took some time to receive a response. I felt like this family was falling through the cracks and I was furious. I later understood my particularly intense emotional response as a countertransference reaction, one that helped me better understand the feelings Anna so often experienced in her life when dismissed and rejected by others.

In discussing these events later with Anna, I explored with her what it was like to be taken to the hospital only to be discharged that night, or to have ACS called only to have no changes or interventions implemented. Anna expressed that it felt like she was being ignored, and drew comparisons with her childhood. She referenced a time she told a social worker at school that her father had a gun at home and that she was afraid of him; she had hoped that the social worker would call ACS. Instead, in Anna's memory, nobody did anything. She also shared a story about a time when her mother took her to a clinic for therapy when she was 11 years old. In Anna's memory, they were turned away from the clinic because she had not experienced "severe trauma." Whether or not these events occurred exactly as Anna tells them is irrelevant. The point is that she walked away from these turning point moments in her life, moments when she was asking for help, with the impression that she would be rejected for reasons she did not quite understand. My actions—calling ACS and taking her to the hospital—were actually welcome and comforting to Anna. I took her seriously, I expressed concern, and I took action. However, the events that followed—discharge and dismissal—felt like another rejection, and confirmation of Anna's internal working model.

As helpless as I felt following these events, I realized how important it was to persist in helping Anna get the additional services that she and her son really needed. She needed to have a corrective experience of asking for help and being taken seriously. She was incredibly receptive to each referral I made, and felt nurtured by my assistance. I only initiated the process, it was her follow through and determination (despite several challenges and interpersonal conflicts she faced along the way) that successfully connected her to these programs.

2.3.7 | Referrals

I made two referrals for Anna and Danny that would provide them each with more intensive treatment. I referred Danny and Anna to a therapeutic nursery that accepted him immediately after conducting an observation of his play and social behaviors. The nursery would not just serve Danny, but also would provide a significant amount of parental support and dyadic therapy. He would receive intensive treatment alongside his education, and Anna would be involved in this process. With this new school schedule and integrated treatment, Danny transitioned out of GABI©. Anna was referred to an intensive treatment program for patients with personality disorders where she would attend groups five mornings per week, receive psychiatric treatment, and meet with an individual therapist. Anna followed through with her intake appointment and was immediately accepted for treatment. Anna's new therapist and I agreed to work collaboratively for several months as Anna transitioned her treatment more fully to this new clinic. She continued to see me for individual sessions, and also saw her new therapist on a weekly basis. She began to use our sessions to

discuss some of her anxiety and overwhelming feelings in her relationship with the new therapist, as well as the new relationships she was forming in the groups at the new clinic.

2.4 | Outcome and prognosis

As Anna's treatment at the new clinic progressed, she grew more comfortable with her therapists there and seemed to thrive on the structure this intensive treatment provided her. She also began biweekly dyadic therapy at her son's school, and she was beginning treatment at an outpatient addictions treatment program. With her schedule filling up with these various therapy appointments, Anna brought up the idea of termination. She was tentative about this because she was sensitive to my feelings—did not want me to feel rejected—but also did not want to destroy our relationship. I clearly explained how I felt: that I would miss her but I was not offended because it did not feel like a rejection, but rather, a healthy goodbye and evidence of her growth.

At our last session, Anna gave me a painting that Danny had made at school and a drawing that she said she made. The drawing was a picture of herself, Danny, and a giraffe. At the top of the picture, she wrote a message, which began: "And it all started with a giraffe." As I read it aloud, Anna explained that she remembered the first time I had played with Danny and the toy giraffes. She held this moment in her memory because, she explained, it was the first moment she felt connected to me and felt that she could trust me. It was also perhaps the first time she had seen someone play with her child so tenderly and without fear. This was also a moment that she was able to see Danny as gentle in his play with the giraffe, as opposed to his earlier angry play with the lions.

I encouraged Anna to return to GABI© with Danny when she could, and to reach out when and if she felt like it, to assure her that I would remain a constant, even if we were not continuing to meet. For the first 2 weeks, she sent text messages that she described as "check-ins," as if to make sure I was still there. These texts stopped completely after two weeks. I sent Anna a message when Christmas gifts arrived to our clinic that had been donated for each of our families, letting her know that Danny's gifts had arrived. She made sure to come in on a day when I would be at the clinic, and she waited for me to finish up a session so that she could give me a small gift and thanked me "for everything." This simple moment conveyed a really important and positive outcome of the therapy. In the time that had lapsed since our termination and the independence she had achieved from me, Anna had held me and the other therapists at our clinic in mind as good, nurturing objects. She proudly reported that Danny was doing well and was learning a lot in school, informing me that she was looking forward to bringing him to GABI© when he would be on summer vacation.

3 | CLINICAL PRACTICES AND SUMMARY

In GABI©, Anna learned how to watch her son and pay attention to his signals and try to understand the intentions and emotions behind his difficult behaviors. Her ability to tolerate his behaviors and reflect on them, however, was dependent on her own emotional stability. With more intensive individual psychotherapy, Anna seemed to develop the psychological energy to better meet her son's emotional needs. Anna's commitment to improving her own mental health as well as her commitment to her son's emotional wellbeing was evident in her ability to organize herself well enough to follow through with the referrals given to her and recognize the importance of this level of support.

Anna and Danny came to GABI© because of concerns regarding Danny's development and his aggressive behaviors. Anna was not receiving any mental health treatment of her own at the time. At the time of referral, Anna was motivated to engage in the parent–child therapy and was eager to relate and connect to other parents. The added support and connection of a trusting relationship with an individual therapist helped Anna explore her own mental states and behaviors and their effects on her son. With a strong rapport established through several ruptures and repairs, Anna grew increasingly secure in our relationship, and she felt supported and validated by me as I made new recommendations for more intensive treatment for her and her son. Although Anna did not want to let go of me at the end of our treatment, she was able to do so without destroying the relationship and without fear of loss. Her ability to remain connected to me without feeling dependent on me or rejected by me was a major indication of progress. She used me

as a "secure base" as she willingly explored new therapeutic settings, and she held on to me as a "safe haven" as she began this daunting transition. Once she felt safe enough to be independent, she said goodbye to me with a surprising sense of object constancy.

This case represents a comprehensive and ongoing treatment for an extremely vulnerable parent and child with disorganized attachment patterns and maladaptive ways of relating to others. Anna also represents an individual who fell through the cracks many times before when she had dropped out of treatment due to substance abuse relapse, repressed anger, feelings of rejection or dismissal, and so on. With a group practice model in GABI©, multiple therapists were involved in her and Danny's treatment, making it more difficult for her to disappear. Additionally, when she defended against uncomfortable feelings about herself by *splitting* members of our team, we continued to collaborate and function as a team, making it more difficult for her to engage this primitive defense.

An essential aspect of this treatment outcome and prognosis is the thoughtful treatment planning that went into this case. Anna learned a lot about herself and her relationship to her son in GABI© and this served as an important entry point for continued intensive mental health treatment. Having felt accepted and respected in a therapeutic environment with her son, Anna was more capable of seeking out help in new settings and trusting that she might be taken seriously and understood.

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