Enhancing Caregiving in Traumatized Families: An Attachment-Centered Approach to Working with Parent Groups

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This paper outlines a model of attachment-centered group interventions to enhance caregiving among parents suffering from early trauma and/or social hardship. Groups are understood as an essential source of experiences that may restore traumatized adults' relational security, and enhance their parenting capacities, in face of biographical and contextual factors that compromise caregiving. The model is especially suited for intervention within social service/child protection contexts and with families that struggle to establish trusting alliances with professionals and institutions. Proposed intervention strategies are oriented toward making the group function as an attachment figure that meets parents' attachment and exploration needs and enhances parental sensitivity. Group therapists facilitate two sets of group processes: on the one hand, a sense of togetherness*, emotional containment, protection and comfort (related to attachment needs); on the other hand, the development of parental mentalization, the revision of parental representations of the child, and the consolidation of parenting competence (related to exploration needs). A theoretical rationale for working with parent groups from an attachment-centered perspective, the basic intervention principles and specific strategies of the model are presented and illustrated.*

Keywords: Attachment; Groups; Parents; Caregiving; Trauma

Fam Proc 60:1568–1583, 2021

Attachment theory can have enormous potential value for family therapists and other professionals working within a framework of family/systems theory (Brassard & Johnson, 2016; Diamond, Russon, & Levy, 2016; Kobak & Mandelbaum, 2003; Whiffen, 2003). Professionals often struggle with helping families with young children to deploy their caregiving abilities, particularly in nonclinical community settings, social services and child care system facilities.

Intervention approaches are usually based on the teaching of child-rearing techniques or developmental concepts and cognitive reframing or structure modification (Brassard & Johnson, 2016), but they frequently find a deadlock in mutual distrust (Lawick & Bom, 2008). An attachment perspective not only helps us to understand the importance of parenting in development, or the origin of caregiving difficulties in parents suffering of early trauma and social adversity. It also offers a model for understanding the importance of security for therapeutic change (Diamond et al., 2016; Hughes, 2007; Whiffen, 2003).

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Family Process, Vol. 60, No. 4, 2021 © 2021 Family Process Institute
doi: 10.1111/famp.12633

An attachment perspective provides family therapists and other professionals with a valuable continuity between a set of underlying theoretical tenets, a treatment focus, and a methodology of therapeutic work. Connection, emotion regulation and the relational processing of mental states (mentalization) are essential aspects of attachment relationships (Bowlby, 1988; Pasco Fearon & Belsky, 2018; Schore, 2015; Siegel, 1999; Slade, 2005); at the same time, they work as the three basic resources for therapeutic change in attachment-centered family interventions. Our therapeutic actions aim to consolidate a sense of connection that is inherently repairing for parents who suffer from difficult relational histories. In addition, we use the therapeutic relationship (between parent and therapist and, in our specific case, between parents within the group) as a space to regulate difficult affects, on the one hand, and help mentalize the inner world, on the other.

Brassard and Johnson (2016) have noted other important contributions that attachment theory has for family therapy. These contributions are in line with the principles of group intervention with parents that we will develop in the present paper. First, unlike other approaches that focus on boundaries and autonomy within the family, an attachment perspective promotes ways of experiencing secure dependency as the basis upon which individual resources can develop. This is especially relevant in face of trauma-related parental defenses against intimacy with their children. Second, attachment theory offers us a precise view on individual differences based on each person's relational history, and gives us clues to tailor our therapeutic strategies accordingly. In our case, detecting specific relational (attachment) styles and their synergies within the group can prevent relational ruptures and promote secure interactions between parents. Third, the therapeutic alliance is used as an essential instrument for the provision of new, reparative relational experience. Therapeutic alliances within the group and with the therapists can create a space where relational needs are met, so the parents' caregiving dispositions may be reactivated. Fourth, attachment theory gives a pivotal role to emotion and offers us therapeutic strategies for the regulation and (re) processing of difficult emotions within therapy. This is especially helpful when working with parents who, as consequence of early trauma and/or absence of social support, struggle to self-regulate and regulate their children. Fifth, attachment approaches to intervention favor the modification of internal working models of self and others among our patients. This transformation comes about as a result of secure interactions within the group and the parents' and therapist's efforts at understanding mental states and their impact upon relationships.

In the present paper, we aim to delineate a model of group attachment-centered intervention with parents of young children who struggle in the development of their caregiving, due to early trauma, social disadvantage or other sources of significant stress that impinge upon parenting. The essential aim of this intervention is to reactivate and enhance the parents' caregiving capabilities toward their children. The model is based upon essential tenets from attachment-focused family therapy (Crittenden, Dallos, Landini, & Kozlowska, 2014; Diamond et al., 2016; Hughes, 2007; Johnson & Whiffen, 2003), parent–child psychotherapies (Baradon, Biseo, Broughton, James, & Joyce, 2016; Fonagy, Sleed, & Baradon, 2016; Lieberman & Van Horn, 2008; Woodhead, Bland, & Baradon, 2006), attachment-centered intervention programs (Dozier, Meade, & Bernard, 2014; Juffer, Bakermans-Kranenburg, & Van Ijzendoorn, 2012; Powell, Cooper, Hoffman, & Marvin, 2013; Slade, 2007; Slade et al., 2005), and our clinical experience of working with underserved families (Pitillas & Berástegui, 2018).

THE *WHYS*: A RATIONALE FOR WORKING WITH TRAUMATIZED/SOCIALLY DISADVANTAGED PARENTS WITHIN A GROUP SETTING

Why Traumatized Families: Working with Damaged Parents from an Attachment Perspective

Attachment and caregiving are two important motivational systems that guide parent/child relationships. The caregiving system is responsible for the parent's "sensitivity" (Ainsworth, 1979) in detecting, interpreting and adequately responding to the child's attachment and exploration needs. In face of attachment needs, a secure caregiver functions as *safe haven* (Bowlby, 1988): he/she establishes physical contact with the child, provides comfort and protection, and, very importantly, contains and makes sense of affective states that the child cannot regulate on his own. In face of the exploration system, a secure caregiver functions as *secure base* (Bowlby, 1988): invites the child to play, guides exploration, supervises at a distance, and celebrates the child's achievements, among others. Caregiving also involves parental "reflective functioning" (or "mentalization"; Slade, 2005), the adult's ability to read the child's behavior in terms of underlying mental states and to sensitively interpret those states, something that has been shown to predict attachment security in the child and to protect from the intergenerational transmission of trauma (Berthelot et al., 2015; Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Slade, 2005).

Caregiving is a complex phenomenon. Parents not only must detect and adapt to the child's needs and communication patterns (which change with growth), but they also must provide care in the context of other adult relationships, in face of other demands from the environment, and under the influence of their own relational history and their internal working models of attachment (Kobak & Mandelbaum, 2003). Early interpersonal trauma and social adversity may compromise these processes in different ways.

On the one hand, parental histories of being insensitively cared for may negatively influence parents' ability to mentalize and respond sensitively. If their own subjective states were not adequately detected or tolerated, they may have trouble in reading their children's behavior and adjusting to his/her underlying subjective states (Pitillas, 2019b), because, "[h]ow can parents give availability and responsiveness to their children if they have never known either?" (Powell et al., 2013, p. 452).

On the other hand, among traumatized parents, a persistent sense of threat linked to relationships may cause the caregiving system to be overridden by other, defense-oriented motivation systems (Liotti, 2017). Parents may be assaulted by traumatic reminders (Lieberman & Van Horn, 2008; Scheeringa & Zeanah, 2001), they may be preoccupied with anticipated relational dangers (i.e., aggression, separation, abandonment), or with not being understood and taken care of (by their spouses, therapists and even their own children; see Powell et al., 2013 for a systematization of parental core fears or "sensitivities"). These threats may organize defensive styles of parenting characterized by aggression, role reversal, or a sexualization of interactions, among others (Liotti, 2017).

Current relational and social difficulties are another source of stress which (combined or not with early parental trauma) can put the caregiver–child dyad at risk. Stressful life events (i.e., job loss, economic problems, migration, single motherhood), along with lack of support, rejection, exclusion or violence within the family or the community, may reduce the caregiver's experience of safety and overwhelm his/her resources to provide relational security (Crittenden, 2016; Kobak & Mandelbaum, 2003).

Attachment-based interventions operate on the assumption that an improvement in caregiving can be achieved by the combination of two processes: conversations about attachment and parenting, and a new, reparative relational experience. By meeting the parents' needs of attachment and exploration, the intervention may repair aspects of

parental security, "accompanying the parent [. . .] from their experience of threat across the chasm of the unknown to the desired, but possibly never experienced, condition of safety" (Crittenden, 2016, p. 225). From this new "condition of safety" (Crittenden, 2016), parents may be able to acquire dispositions and train abilities that define secure parenting.

There are different ways to offer this reparative relational experience. In classic attachment-based systemic treatments, the focus is on correcting the adult attachment experience inside the family and repairing present attachment relations. In individual treatment settings, this reparative experience is provided by the therapist, who functions as a "transitional attachment figure" (Crittenden, 2016). We believe that groups are a very powerful source of the relational experiences we aim to provide parents with, since they work not only as a transitional but an alternative, permanent attachment *network*, especially for families who suffer from isolation and helplessness derived from trauma or social hardship. As will be further developed, groups can also function as a means to overcome families' distrust toward professionals and institutions, a problem that often appears in these contexts (Lawick & Bom, 2008).

Why Groups? A Rationale for Working with Families within a Group Setting

Attachment security is a systemic phenomenon: caregiver–child dyads are bi-personal, dynamic systems of interaction and meaning-making that develop within a broader ecological environment which includes family, community, institutions, and culture (Berástegui & Pitillas, in press). Kobak and Mandelbaum have spoken of a "caregiving alliance" to underline the systemic, cooperative nature of parenting:

In this line, we have used the term "chains of security" (Pitillas & Berástegui, 2018) to designate the fact that security is, in a sense, a descending phenomenon: it flows down from the wider structures of society to its constituent social networks and, ultimately, to families, child–caregiver dyads and individuals. Attachment (in)security is, to some extent, dependent upon the (in)security the caregiver is provided with in his/her relationships to partners, family, and society. For instance, child abuse and maltreatment are caused by a rich set of risk and protective factors that function across all levels of family ecology (Ciccheti & Linch, 1993).

In different ways, groups can be a very important link within the chains of security that descend toward the child. The advantages of working with families within a group setting are directly related to the particularities of our population of interest (parents who have suffered from relational trauma and/or who live under social disadvantage). We present these advantages in the following lines.

Group as a transitional attachment network for isolated families

Social exclusion strongly correlates with isolation and an absence of the supportive family environments that would normally reduce parenting stress and promote positive parenting (McConnell, Breitkreuz, & Savage, 2011; Sanders, Kirby, Tellegen, & Day, 2014). For these families, groups can be especially useful in creating continuity between therapy and community life (Sanders et al., 2014). There is a certain isomorphism between the complexities of group relating and relating within the social-communal niche where parenting takes place (neighborhood, school, formal and informal networks of care, etc.). Groups are at the interface between the micro, the exo and the macrosystems (Bonfenbrenner, 1978) that envelop parenting, and they may work as a sort of hinge between them. In this sense, groups can work a transitional space that helps parents move from isolation to a richer, more connected life in the community. Beyond this, the intervention can scaffold the transformation of the group itself into a new, real attachment network

that stays permanent. We have seen this often: after intervention, participating parents tend to stay in touch and provide each other with guidance and support.

Groups also can be helpful sources of an alternative attachment experience in the face of relational pain suffered by families. Some family configurations (e.g., single mothers, migrant families that have been split) or intrafamilial conflicts (e.g., domestic violence) make it very difficult for the family to benefit from systemic approaches. Within these configurations, the primary caregiver may lack the support from other attachment figures (a spouse, or extended family). A group approach, which favors the enactment of attachment dynamics within a network of horizontal relationships, is especially relevant for this type of cases.

Group as a source of recognition for "invisible" parents

Across very diverse cultures, the community not only offers physical resources to the parent and the child to survive, protects the dyad from external threats, or offers multiple "hands" to take care of the child when the caregiver cannot (Lancy, 2017; Mesman et al., 2018). It also gives *meaning* to the parent's experience of parenthood through a series of rites, which may be formal and prescribed (e.g., a christening) or informal (e.g., grandmother witnesses how mother bathes her baby and guides and reinforces mother). The community recognizes and legitimizes the child–caregiver relationships.

For many of the parents, we work with, caregiving takes place under conditions of relational invisibility: they feel unaccompanied by spouses or their extended family; they lack access to social interactions; their parenting-related stress makes them feel incapable or even illegitimate as attachment figures (as if they did not have what it takes to raise their child); etc.

A process of social (re)validation of the parent–child relationship can be pursued within attachment-centered group interventions with parents. With facilitation from the therapists, groups can become accessible and magnified versions of the community that *sees* parents and helps them see themselves as legitimate caregivers (see below for more details).

Groups as a source of epistemic trust for "distrustful" parents

"Epistemic trust" is an individual's willingness to consider new knowledge as trustworthy and relevant, and use it as a guide to change behavior and one's identity (Fonagy & Allison, 2014). Trauma can jeopardize parents' abilities to rely on cues communicated by their children and, more generally, on transmitted social knowledge about parenting. Their (traumatic) learning is that social information can be misleading or hide malevolent intentions. The resulting "epistemic petrification" (Fonagy & Allison, 2014) may involve inflexible thinking, and a difficulty to learn from interactions with children and the social environment. It may reduce parents' openness to novel information coming from figures that represent authority or care, thus hindering the establishment and maintenance of a therapeutic alliance.

Contrary to what happens in more traditional settings, therapists who work with parent groups can recede into the background, and enable the group to become the main source of therapeutic processes. A group approach favors the exchange of relevant information within a framework of horizontal relationships and safety, thus fostering the repair of epistemic trust. Safety makes communication reliable, a potential source of new experiences and learning. The opportunity to transmit knowledge that is valuable to others may restore the value of communication and social learning for parents who had problems with epistemic trust. This becomes especially true when traumatized parents find themselves providing information to other parents (in the form of advice, validation, a different perspective on things, guidance, etc.), something that rarely takes place when

parents are receptors of valuable, change-inducing information (instead of providing it) by a single therapist.

Group as an accelerator of change

Groups offer a sort of "fast track" to achieving significant attachment experiences, since they multiply the number of interactions where connection, regulation and mentalization take place.

Within the groups, parents help other parents by providing support, sharing alternative perspectives to long-lasting problems, inviting and supporting exploration, etc. These dynamics of mutual, symmetrical care between parents may be especially effective in circumventing resistances with regards to other approaches where the patient/family-therapist relationship is in the forefront. Moreover, reciprocity of support becomes an accelerator of change because each member receives a restorative experience and at the same time contributes to offering that experience to others, something that increases their sense of effectiveness and enhances the training of parenting skills. The parent that, say, helps another parent in mentalizing their child, is also training himself in parental mentalization: "Reciprocity enables people to influence the treatment; that is, instead of "receiving" the treatment, they participate in creating it. It becomes their own and reflects their agency in the context of relationships [. . .]" (Crittenden, 2016, p. 23). In this way, groups multiply the effects of therapeutic actions that otherwise would need more time and effort to have an impact.

THE *HOW*: A MODEL OF PRINCIPLES AND STRATEGIES FOR GROUP WORK TO ENHANCE PARENTAL CAREGIVING

What do therapists need to do so groups may work as a source of restored security for parents? How do we use groups to help parents become better caregivers?

In this section, we develop the specifics of our parent group intervention model. These include a consideration of the general intervention process, as well as specific principles and strategies for increasing caregiving through group work.

Some Notes on Process

There is no single way to conduct parent groups for attachment-centered intervention, as shown by the large array of attachment-centered therapeutic programs for parents and young children (Brisch, 2012; James & Newbury, 2010; Pitillas & Berástegui, 2018; Powell et al., 2013; Woodhead & James, 2018). Using different techniques, these programs provide useful information about early development and parenting to families and, most importantly, they enhance essential caregiving capabilities, such as parental sensitivity and mentalization (Berlin, Zeanah, & Lieberman, 2016; Pitillas, 2019a). Research shows that these approaches, despite their diversity, are effective in enhancing caregiver sensitivity, changing parental states of mind and moving the child with insecure/disorganized attachment to secure/organized attachment patterns (Fonagy et al., 2016; Hoffman, Marvin, Cooper, & Powell, 2006).

Our model (Pitillas & Berástegui, 2018) tries to facilitate a process that is congruent with the characteristics of the population and the context in which we intervene, both of which require time-limited, focused interventions, with a balanced load of emotional depth and training of specific abilities. Specifically, our program works with groups of 6–8 parents of children between 1 and 6 years of age in social risk contexts. It is a time-limited (8 weeks of intervention), strength-based, and attachment-focused program. Its main tools

to enhance parenting are psychoeducation, video-feedback and the facilitation of a very specific relational experience within the group (see below for details).

Even though the intervention follows a pathway of pre-established steps (each step focused on specific aspects of the children's and the parents' emotional lives), it is based on an individualized family assessment process. Therefore, despite addressing themselves to the group, therapists intervene with each parent (their history, struggles and strengths) in mind, making the intervention develop within a creative tension between universality and individuality. On the one hand, group discussions create a shared knowledge about universal children's needs and parenting. On the other hand, we adjust the nature and intensity of interventions to each of the parent's relational style. An assessment of each parent's attachment-related anxiety and avoidance tendencies (Mikulincer & Shaver, 2003), and/or their core sensitivities (Powell et al., 2013) guides interventions so that, to some degree, each parent may find their specific needs met. For example, a mother with high levels of attachment anxiety would clearly benefit from direct, emotionally attuned responses from the group to her affective experience. Conversely, a highly avoidant father would feel threatened by this kind of high-intensity interventions, and may benefit more from group dynamics where he can be a source of support for others and experience vicarious mentalization by exploring other member's mental states. Therapists are expected to facilitate tailored interactions, within a framework of universality (regarding concepts and caregiving principles).

Recruitment and the construction of a therapeutic alliance constitute two important aspects of the intervention process with these families. For recruitment, we collaborate with NGOs and family support agencies that serve these families with other important needs (legal, health, work) and that select those families that may need therapeutic help in parenting. After selection and recruitment, intervention always takes place in a semi-natural context for the families (NGO facilities, public spaces in the neighborhood, the school, etc.).

The time-limited nature and the intervention's early focus on strengths facilitate the establishment of a working alliance that, progressively and with the exchange of sensitive responses in the group (see below for details), can become a genuine *therapeutic* alliance. The detection and repair of interactive ruptures (Beebe & Lachmann, 2014) in the group constitutes a fundamental factor in maintaining this alliance between the parents of the group, as well as between the group and the therapists.

Two therapists conduct the intervention. The diversity of relational styles within the group and the complexity of interactions require distributed attention from the therapist and the maintenance of their own mentalization in the face of complex, emotionally challenging material. This is made possible by intervening within a co-therapy framework.

Caregiving is a relational process. This requires that interventions *bring the child* into the session, thus creating the opportunity to work with lived, emotionally significant relational episodes, and to facilitate change that goes beyond theoretical learning. Video-feedback is the fundamental strategy with which we achieve this. By jointly analyzing videotaped parent–child interactions, the parents of the group can re-expose themselves to the relationship with their children in a regulated, secure context, while maintaining their mentalization. For the population we work with, the "real" presence of the child in the sessions could introduce important technical challenges. Under the stress of current interactions with the child, parents may find their reflective capacity overshadowed by automatic responses and the need to defend themselves. Video-feedback allows us to bring the child into the session, to think about and speak for the child, while maintaining a reflective and collaborative stance that accelerates change and favors the development of skills.

Our experience indicates that change happens across four levels. First, there is change in the caregiving alliance: parents who have felt isolated and helpless as caregivers, now

find themselves in a holding environment that provides security and supports their parenting with containment, guidance, and advice. Second, there is change within parents' internal working models of attachment: when their attachment and exploration needs are systematically met within the group, more secure relational scripts are built; these new scripts may compete with older, danger-related expectations (Stern, 1995). Third, the group facilitates a reactivation of epistemic trust (Fonagy & Alison, 2014): as an effect of secure, sensitive interactions within the group, parents may start to see human communication as a reliable source of information and a guide to adjust one's behavior. This increase in epistemic trust contributes to the improvement of caregiving in the long-term, because parents are more open to process the child's signals and flexibly change their responses according to that input. Fourth, the former changes improve the quality of parental responses and enhance security within parent–child dyads.

How are these changes achieved? How do we create a sense of connection among parents? How do we achieve regulation and enhance parents' mentalizing abilities? These and other important questions are approached along the following lines. Our responses to these questions are organized around two axes that are complementary and that constantly influence each other, in a kind of double helix: making the group function as *safe haven* (toward attachment) and making the group function as *secure base* (for exploration). Therapists need to detect shifts from one system to the other (among group members as well as in the group), and to facilitate sensitive responses, in order to guarantee the (re)construction of relational safety that will allow for a reactivation of parental caregiving.

The Group as Safe Haven Toward Attachment

Interactive and communicative dynamics related to attachment are frequent within therapeutic parent groups. Participants express anxiety, confusion, or helplessness regarding parenting. As the intervention progresses, participants learn to use the group as a safe haven where they can be heard, understood, comforted or supported. These experiences are equivalent to those that a child has within a secure attachment relationship, where the caregiver detects, interprets and responds sensitively to the child's signals of distress.

Some strategies that can be used to make the group function as safe haven for its participants are described followingly.

Connection, cohesion, and the creation of a sense of togetherness

The experience of belonging, being with and feeling with others may be one of the most basic manifestations of human attachment. Interventions that build a sense of *togetherness* within the group are useful in face of social invisibility and the absence of agency that stem from social exclusion, early relational trauma, and from the traumatized person's identification with parental rejection (Stern, 2019).

Togetherness starts by therapists having *the group in mind*. This involves having a mental image of each member as well as of the whole group; being aware of the group's rhythms, worries and feelings as the intervention progresses; believing in the reparative force of the group and being ready to promote those processes at all times.

Another way of creating a sense of togetherness in the group involves what James has described as "reinforcing a culture of the group as an attachment object" (James & Newbury, 2010, p. 135). Using a language that highlights the shared nature of experience is useful toward this end:

Therapists may also promote a sense of object constancy and presence-within-absence through interventions that include absent members of the group, or that mark reunions:

> We don't have Alex with us today, but I remember how last week he told us about some experiences that resemble the ones we are exploring today.
>
> Last week we spoke about how difficult it is sometimes to get what children are feeling inside, and we remembered what you had told us some weeks before.

Many of the parents we work with believe that their parenting-related stress is unique, something that enhances a sense of stigma or shame. Rage toward the child, feelings of inefficacy, doubts about oneself as caregiver, among other feelings, are difficult to accept and communicate. A powerful reparative experience achieved by group work is the discovery of "not being the only one" who struggles with parenting (Woodhead & James, 2018). With their interventions, therapists may promote and enhance these dynamics of identification that help regulate difficult, shame-inducing feelings:

Generally, these interventions are helpful in consolidating a sense of belonging and the emergence of a caregiving alliance within the group. As stated above, this alliance is a fundamental dimension of caregiving that links parenting to the social and community networks where parents are supported and guided.

Tolerating and containing difficult affects

Attachment security has much to do with the way that emotions are regulated within the relationship (Brassard & Johnson, 2016). The shared management of difficult affects among parents who were traumatized is another of the basic ingredients that make groups a potential safe heaven toward attachment needs.

Parent–infant therapists found out that child abuse often stems from the parents' need of externalizing intolerable trauma-related affects (rage, fear, helplessness, shame) that are re-experienced when interacting with the child (Fraiberg, Adelson, & Shapiro, 1975; Seligman, 2017). These authors advise us to remove the child from such projective circuit by redirecting these affects on to a containing figure: the therapist (within an individual therapy setting) or the group (within a group setting).

Containment may take the form of the group mirroring the emotions of its members, in formats that combine affective resonance/identification with differentiation. This balance is an essential part of normal parental mirroring: in face of the child's emotional states, caregivers deploy expressions that are congruent with such states and, at the same time, differentiated ("marked"), so as to avoid confusion and to help the child move to new, more tolerable states of mind (Fonagy, Gergerly, Jurist, & Target, 2002). With help from therapists that modulate affective intensity and model this balance, groups can emulate this process. Consider the following extract from a group session, where Julia, a teenage mother, complains about her one-year-old son's crying.

Julia	He won't stop. When he cries, he looks at me as if saying: "I will not let you have a moment to rest". You know what I mean?
Therapist	This is so painful, both for you and Mauro
Julia	I think he hates me. [negative parental projections: child as aggressor]
Therapist	I wonder what the group is feeling after listening to this
Mother 1	I know what you're saying. Sometimes, it is too much
Julia	So much!
Mother 2	You have to do so much for your child, and people are not helpful [processing and mirroring of Julia's negative experience: feeling overwhelmed and unsupported]
Julia	Exactly. My parents make it so much harder. It is as if I am always under scrutiny with them. [interruption of parental projections: aggression and criticism, formerly located in the child, are now perceived as coming from parents]

Therapist And it seems that those feelings are very present now, when you interact with Mauro. As if his crying and demanding might remind you of those criticisms and disappointments. [with this interpretation, the therapist invites Julia and the group to move to a more exploratory state of mind]

As seen in this vignette, mirroring processes within parent groups help participants articulate their experiences. They take place in a cyclical form that goes from the unfolding of raw, unarticulated affects to the collaborative processing of those affects within the group, and back again. Security among parents is enhanced, and this leaves the group very close to the possibility of changing from an attachment to an exploration mode of functioning. As Crittenden (2016) argues, mirroring can enable insight:

Group regulation of negative affects may be instrumental in re-ordering the functional organization of motivational systems in parents. As stated above, trauma can make the caregiving system to be overridden by defense-oriented motivational systems (Liotti, 2017). When a parent feels sad, threatened, lonely or helpless, these systems will likely motivate aggressive or fearful parenting, role reversal, etc. (Powell et al., 2013). The child's inability to assuage any of these needs makes it likely that parental responses become more rigid and defensive, thus contributing to vicious cycles of insecurity and trauma within the relationship (Lieberman & Van Horn, 2008; Liotti, 2017). Containment of negative parental emotions in the group may reduce parental stress, thus helping the caregiving system to get back to the fore.

As stated above, attachment is a precondition and a facilitator of exploration dynamics across development. Therapists need to keep this premise in mind, so as to avoid the danger of pushing parents toward exploration before attachment needs have been responded to. Consider a father that feels helpless in face of his three-year-old daughter's temper tantrums: "When she gets like that, it is as if every effort that I've been making to be kind to her wasn't enough. She makes me feel like a failure, and then everything turns black and I just want to be far from her". Here, a therapist can detect parental distortions and defenses that deactivate caregiving and stimulate negative responses: the father seems to interpret that his child intends to make him feel a failure; consequently, an avoidant defense ("staying away from her") is put into motion. In a more traditional, cognitive-oriented approach, we might want to stimulate a revision of the distortions that are guiding this father's response, maybe an exercise in perspective-taking. This would be aimed at stimulating the father's exploration of new ways of thinking and doing. Nevertheless, such exploration will not be possible (and, in fact, it may be counterproductive) if the feelings of distress and helplessness have not been regulated. Thus, an attachment-oriented therapist may use the group as a container of the father's strong, negative emotions, and make sure that these affects have been recognized and regulated before inviting him to explore new ways of seeing and doing.

The Group as a Secure Base for Exploration

When attachment needs are adequately met, it becomes possible for the group to work as a *secure base* for the exploration of alternative ways of seeing and doing. In the secure context of the caregiving alliance, parents may gain a better understanding and new constructive perspectives about their children and their parenting (Kobak & Mandelbaum, 2003). This venture into the unknown will likely reactivate attachment needs among members of the group (a reemergence of uncertainty, anxiety, shame, etc.), inviting us to flexibly work back and forth between attachment and exploration.

Two exploration-oriented therapeutic actions are essential in our model.

(Re)activating and consolidating parental reflective functioning

As stated above, trauma can compromise parental reflective functioning (Berthelot et al., 2015; Grienenberger, Kelly, & Slade, 2005; Luyten, Nijssens, Fonagy, & Mayes, 2017; Slade et al., 2005). Distorted attributions about the child's intentions, dismissal of the child's emotions underlying behavior, or simulated, emotionally disconnected interpretations of the child's affective states are some of the "mistakes" that we see among parents who were not mentalized by their own caregivers or suffer from current stress. Groups can work as a very powerful space where reflective functioning can be (re)activated and trained.

This process may start with invitations to enrich parental narratives about daily interactions with children. It is likely that, under the influence of trauma and/or stress, parents develop poor descriptions of their relational episodes: "We went on a trip last weekend. She was being defiant, crying and shouting all the time. I ended up snapping at her". This narrative is almost a purely behavioral, very limited account of the interaction. There is a lack of reference to the context in which it took place; the sequence that led to this result; or the thoughts and feelings experienced by parent and child. The therapist may invite parents and the group to explore richer, more nuanced relational narratives and, progressively, to go beyond behavioral descriptions into the subjective dimension of these episodes.

Narrative work may feel threatening, because telling better stories is equivalent to feeling things more intensely and to revising previous modes of seeing and doing. Therefore, therapists can use the group as *co-narrator*: "Clara tells us that her weekend was hard for her and her child. It is not always easy to know what one feels, or what exactly has happened, when things turn hard. Can anyone guess how this experience may have been for Clara and her daughter, what happened and how they may have felt?"

The group's effort to build richer narratives sets the stage for a significant movement: exploring the child's perspective, or, *speaking for the child*. By means of "reflective dialogue" (Powell et al., 2013) parents can explore their children's inner states and their way of cuing such states. The development of a child-centered sensitivity may culminate in first-person accounts of such experiences (e.g., "Dad, it is hard for me to understand why sometimes you disappear even though your body is close to me, and to know when you're going to be back"). This kind of insight into the child's subjective world is a very powerful resource for reframing child symptoms in relational terms:

A final strategy to promote perspective-taking among parents in the group is "developmental guidance" (Lieberman & Van Horn, 2018). Participants and therapists share information about child development to correct distortions and support richer, more realistic interpretations of the child's states and intentions. The selective provision of developmental information may reduce parental distortions. A father used to complain that, since her first anniversary, her daughter had started playing with food whenever he tried to feed her. The child enjoyed averting her gaze when her dad brought the spoon close to her mouth, putting her hands on the plate, and throwing food in several directions. This was new: in the previous months, she had fed gently. This father was worried that this was a sign of defiance and a loss of the child's affection. Some mothers in the group, having had similar experiences, reframed the child's behavior in terms of exploration (instead of defiance): now that her motor skills were finer, she was beginning to play (even with food!).

Even though mentalization is a focus of other frameworks of intervention (individual, systemic), the group, by its very nature (a reunion of different minds) can accelerate perspective-taking among participants. Besides, parents who are sensitized to threats and criticism coming from authority figures may be more receptive to confrontations coming from peers. The therapist should use this in favor of participants (e.g., "Lidia feels that,

when her son is playing by himself, it's as if he was saying: 'I don't want to be close to you now, you're on your own'. Does anyone think there may be other ways to interpret this behavior?").

Consolidating a sense of competency

Secure base dynamics that take place within attachment relationships not only include the caregiver's promotion and respect of the child's autonomy, but also the caregiver's *celebration* and enjoinment of the child's explorations and achievements. This logic is directly incorporated into the group work. We want groups to mark the learnings and strengths of its members.

Many traumatized parents have negative representations of themselves as caregivers: they see themselves as incapable, destructive, unable to love the child, etc. Under the benevolent gaze of the therapist (and the group, in the case at hand), parents may acquire new, more balanced views of themselves. These new representations of self as caregiver, based on self-efficacy and legitimacy, may compete with negative self-images stemming from trauma (Stern, 1995). They may also create a sort of ·"breathing space" for the parent to see the child and "reclaim" (Baradon et al., 2016) his/her role as caregiver. An approach that is sensitive to parents' resources is instrumental toward this goal, and helps consolidate the caregiving alliance between parents.

As has been proposed within infant–parent psychotherapies (Baradon et al., 2016) and in other domains of intervention (Fosha, 2005), the *metaprocessing* of positive changes should be an essential part of any treatment. By metaprocessing changes in the group, these become more accessible, more solid and more integrated in the self. This therapeutic principle can lead to a diversity of strategies. First, reflecting back sensitive parent–child interactions. Some of these interactions may be microscopic (e.g., a change of body posture that "welcomes" the child; visual connection during a moment of stress) and very short in time. Video-feedback techniques (Pitillas & Berástegui, 2018; Powell et al., 2013; Schechter et al., 2006; Steele et al., 2014) or the presence of children to some of the sessions (Brisch, 2012; James & Newbury, 2010) help us detect and discuss these interactions. Second, reflecting back the cues by which the child shows his attachment to the parent, his "use" of the parent as a secure base and/or safe haven (e.g., the child follows the caregiver visually or physically; the child looks at the caregiver in moments of uncertainty; the child tries to share exciting aspects of exploration with the parent, etc.). This technique is intended to counteract parental fantasies that the child is indifferent toward the parent, that other adults are more important or referential to the child, etc. The caregiving system may be reactivated when parents start feeling that they are important for their children. Third, exploring experiences of adequate care within the personal histories of parents. Lieberman used the term "angels in the nursery" (Lieberman, Padron, Van Horn, & Harris, 2005) to refer to the benevolent aspects of parents' relational history, which work as a powerful countermeasure to the negative impact of the "ghosts in the nursery" (Fraiberg et al., 1975) stemming from parental trauma. The active exploration and integration of angels in the nursery into the parent's self-representation provides a consistent basis for caregiving, an *inner model* that may guide new, sensitive parental responses. Fourth, recapitulation and celebration of participant and group explorations, learnings and achievements (Baradon et al., 2016). This strategy may consolidate changes, enhance the therapeutic alliance within the group and between the group and the therapist and, finally, it may push the group toward new explorations.

DISCUSSION

You can only change a relationship by providing a relational experience. That essential premise guides the model of therapeutic parent groups presented in this paper. Experiences of sensitive responding and mentalizing must be provided to parents if we want to enhance their sensitivity and their reflective functioning toward their children. This is most important in cases where parents come from a traumatic past and/or are exposed to high levels of social stress in the present. Changing the parent–child relationship *from within* (Powell et al., 2013) entails going beyond traditional parenting approaches (based on the teaching of child-rearing techniques), parental psychoeducation (based on the teaching of developmental concepts), and even some traditional systemic interventions (e.g., restructuring, boundary-setting).

Apart from their obvious resource-related advantage, groups are powerful accelerators of the relational processes we want to provide parents with. A group can be an attachment network that keeps the participants in mind, mirrors their experience, cares for them and leads them to explore and test better versions of themselves. Within groups, essential experiences of connection and togetherness may crystalize rapidly; difficult affects can be expressed and contained; reflective dialogue and creative confrontations can enrich parents' perspective about their children and themselves as caregivers; achievements are celebrated and consolidated; etc. Finally, groups are a valuable transitional or alternative space between therapy and community life. The experience in a group is a facilitator and a rehearsal of social support, recognition and trust, something that may be especially helpful for the families that are most socially vulnerable.

To achieve these goals, therapists are expected to play a facilitating role in which they: have a mental image of both the group and its members (to promote continuity); detect and discriminate moments of attachment and moments of exploration; stimulate interactions that may adjust to each parent's relational style; and invite the group to flexibly respond to emergent needs among its members.

The model we have presented builds upon brilliant work by previous authors who have used groups to enhance parent–child attachments (Dozier et al., 2014; Juffer et al., 2012; Powell et al., 2013; Slade, 2007; Slade et al., 2005), and adds what we believe are new important contributions. We have framed group work within a logic of "chains of security" (Pitillas & Berástegui, 2018), which envisions the child's attachment security as the endpoint of an arc where security is transmitted across several layers of caregiving. We have delved into very specific ways by which parent groups can facilitate change among traumatized parents and enhance their caregiving. We have provided a set interventions that integrate a focus on both attachment and exploration systems, so security among parents can be repaired and the caregiving system is reactivated.

Due to space and time constraints, important considerations for group work with parents have not been addressed here. Beginnings and endings, working with resistances, and the potential (dis)advantages of including children in some (or all) of the group sessions are some questions that need to be dealt with in future works. Also, research should look into the differences between individual and group attachment-centered interventions in terms of results and dimensions of change.

An attachment framework reminds us that, in order to change a child's development trajectory, his/her contexts of care must be changed. Attachment-based therapy with groups of parents may be an effective way to achieve this change:

> Danger is the problem, and that is what the professionals should address. Change the danger, not the child. Create an environment in which infants do not feel anxious and attachment will take care of itself. (Crittenden, 2016 , p. 33)

REFERENCES

Ainsworth, M. S. (1979). Infant–mother attachment. *American Psychologist*, *34*(10), 932–937.

Baradon, T., Biseo, M., Broughton, C., James, J., & Joyce, A. (2016). *The practice of psychoanalytic parent-infant psychotherapy: Claiming the baby*. New York, NY: Routledge.

Beebe, B., & Lachmann, F. M. (2014). *The origins of attachment: Infant research and adult treatment*. New York, NY: Routledge.

Berástegui, A., & Pitillas, C. (in press). What does it take for early relationships to remain secure in the face of adversity? Attachment as a unit of resilience. In M. Ungar (Ed.). *Multisystemic resilience: Adaptation and transformation in contexts of change*. New York, NY: Oxford University Press.

Berlin, L. J., Zeanah, C. H., & Lieberman, A. F. (2016). Prevention and intervention programs to support early attachment security: A move to the level of the community. In J. Cassidy, & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 739–758). New York, NY: Guilford Press.

Berthelot, N., Ensink, K., Bernazzani, O., Normandin, L., Luyten, P., & Fonagy, P. (2015). Intergenerational transmission of attachment in abused and neglected mothers: The role of trauma-specific reflective functioning. *Infant Mental Health Journal*, *36*(2), 200–212.

Bowlby, J. (1988). *A secure base*. New York, NY: Routledge.

Brassard, A., & Johnson, S. M. (2016). Couple and family therapy: An attachment perspective. In J. Cassidy, & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (3rd ed., pp. 805–824). New York, NY: Guilford Press.

Brisch, K. H. (2012). *Treating attachment disorders: From theory to therapy*. New York, NY: Guilford Press.

Bronfenbrenner, U. (1978). Who needs parent education? *Teachers College Report*, *79*(4), 767–787.

Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry*, *56*(1), 96–118.

Crittenden, P. M. (2016). *Raising parents: Attachment, parenting and child safety*. New York, NY: Routledge.

Crittenden, P. M., Dallos, R., Landini, A., & Kozlowska, K. (2014). *Attachment and systemic family therapy*. Berkshire: McGraw-Hill Education.

Diamond, G., Russon, J., & Levy, S. (2016). Attachment-based family therapy: A review of the empirical support. *Family Process*, *55*(3), 595–610.

Dozier, M., Meade, E., & Bernard, K. (2014). Attachment and biobehavioral catch-up: An intervention for parents at risk of maltreating their infants and toddlers. In S. Timmer, & A. J. Urquiza (Eds.), *Evidence-based approaches for the treatment of maltreated children* (pp. 43–59). New York, NY: Springer.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372.

Fonagy, P. G., Gergerly, G., Jurist, G., & Target, E. M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., Sleed, M., & Baradon, T. (2016). Randomized controlled trial of parent–infant psychotherapy for parents with mental health problems and young infants. *Infant Mental Health Journal*, *37*(2), 97–114.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3), 201–218.

Fosha, D. (2005). Emotion, true self, true other, core state: Toward a clinical theory of affective change process. *The Psychoanalytic Review*, *92*(4), 513–551.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421.

Grienenberger, J. F., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother–infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development*, *7*(3), 299–311.

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security intervention. *Journal of Consulting and Clinical Psychology*, *74*(6), 1017.

Hughes, D. A. (2007). *Attachment-focused family therapy*. New York, NY: W.W. Norton & Company.

James, J., & Newbury, J. (2010). Infants, relational trauma and hopelessness: Therapeutic possibilities through a hostel baby clinic group and research evaluation. In T. Baradon (Ed.), *Relational trauma in infancy: Psychoanalytic, attachment and neuropsychological contributions to parent–infant psychotherapy* (pp. 19–47). New York, NY: Routledge/Taylor & Francis.

Johnson, S. M., & V. E. Whiffen (Eds.) (2003). *Attachment processes in couple and family therapy*. New York, NY: Guilford Press.

Juffer, F., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (Eds.) (2012). *Promoting positive parenting: An attachment-based intervention*. New York, NY: Routledge.

Kobak, R., & Mandelbaum, T. (2003). Caring for the caregiver. In S. M. Johnson, & V. E. Whiffen (Eds.), *Attachment processes in couple and family therapy* (pp. 144–164). New York, NY: Guilford Press.

Lancy, D. F. (2017). *Raising children: Surprising insights from other cultures*. Cambridge: Cambridge University Press.

Lawick, J., & Bom, H. (2008). Building bridges: home visits to multi-stressed families where professional help reached a deadlock. *Journal of Family Therapy*, *30*, 504–516.

Lieberman, A. F., Padron, E., Van Horn, P., & Harris, W. W. (2005). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal*, *26*(6), 504–520.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford Press.

Liotti, G. (2017). Conflicts between motivational systems related to attachment trauma: Key to understanding the intra-family relationship between abused children and their abusers. *Journal of Trauma & Dissociation*, *18*(3), 304–318.

Luyten, P., Nijssens, L., Fonagy, P., & Mayes, L. C. (2017). Parental reflective functioning: Theory, research, and clinical applications. *The Psychoanalytic Study of the Child*, *70*(1), 174–199.

McConnell, D., Breitkreuz, R., & Savage, A. (2011). From financial hardship to child difficulties: Main and moderating effects of perceived social support. *Child: Care, Health and Development*, *37*(5), 679–691.

Mesman, J., Minter, T., Angnged, A., Cissé, I. A., Salali, G. D., & Migliano, A. B. (2018). Universality without uniformity: A culturally inclusive approach to sensitive responsiveness in infant caregiving. *Child Development*, *89*(3), 837–850.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. *35*, pp. 53–152). New York, NY: Elsevier Academic Press.

Pasco Fearon, R., & Belsky, J. (2018). Precursors of attachment security. In J. Cassidy, & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 291–313). New York, NY: Guilford Press.

Pitillas, C. (2019a). Common therapeutic elements of interventions aimed at enhancing parent–child early relationships. *Psychoanalytic Psychology*, *37*(1), 28–36.

Pitillas, C. (2019b). Back to the origins: Early interpersonal trauma and the intergenerational transmission of violence within the context of urban poverty. In H. Gaisbauer, & G. Schweiger (Eds.). *Absolute poverty in Europe: Interdisciplinary perspectives on a hidden phenomenon* (pp. 183–212). Bristol: Policy Press.

Pitillas, C., & Beráastegui, A. (2018). *Primera Alianza: Fortalecer y reparar los vínculos tempranos*. Barcelona: Gedisa.

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). *The circle of security intervention: Enhancing attachment in early parent-child relationships*. New York, NY: Guilford Press.

Sanders, M. R., Kirby, J. N., Tellegen, C. L., & Day, J. J. (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review*, *34* (4), 337–357.

Schechter, D. S., Myers, M. M., Brunelli, S. A., Coates, S. W., Zeanah Jr., C. H., Davies, M. et al. (2006). Traumatized mothers can change their minds about their toddlers: Understanding how a novel use of videofeedback supports positive change of maternal attributions. *Infant Mental Health Journal*, *27*(5), 429–447.

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress*, *14*(4), 799–815.

Schore, A. N. (2015). *Affect regulation and the origin of the self: The neurobiology of emotional development*. New York, NY: Routledge.

Seligman, S. (2017). *Relationships in development: Infancy, intersubjectivity, and attachment*. Routledge.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Publications.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, *7*(3), 269–281.

Slade, A. (2007). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry*, *26*(4), 640–657.

Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005). Minding the baby: A reflective parenting program. *The Psychoanalytic Study of the Child*, *60*(1), 74–100.

Steele, M., Steele, H., Bate, J., Knafo, H., Kinsey, M., Bonuck, K. et al. (2014). Looking from the outside in: The use of video in attachment-based interventions. *Attachment & Human Development*, *16*, 402–415.

Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. London, UK: Karnak Books.

Stern, S. (2019). Airless worlds: The traumatic sequelae of identification with parental negation. *Psychoanalytic Dialogues*, *29*(4), 435–450.

Whiffen, V. E. (2003). What attachment theory can offer marital and family therapists. In S. M. Johnson, & V. E. Whiffen (Eds.). *Attachment processes in couple and family therapy* (pp. 389–398). New York, NY: Guilford Press.

Woodhead, J., Bland, K., & Baradon, T. (2006). Focusing the lens: The use of digital video in the practice and evaluation of parent–infant psychotherapy. *Infant Observation*, *9*(2), 139–150.

Woodhead, J., & James, J. (2018). Transformational process in parent-infant psychotherapy: provision in community drop-in groups. In M. P. Monzo & B. Tydeman (Eds.), *Innovations in parent-infant psychotherapy* (pp. 117–133). New York, NY: Routledge.