Attachment in children and young people

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Key messages

> Although behaviour and rituals vary across cultures, all humans share a common set of attachment needs – to have people close (primary carers) who act as a secure base and safe haven, with whom they want to spend time and separation from whom causes upset. Using carers as a safe base from which to explore captures the essence of secure attachment.

> Research since the 1960s has developed 'attachment theory' which identifies a number of 'attachment patterns'. Secure attachment and insecure (ie, avoidant or ambivalent) attachment are organised attachment patterns – each is a consistent and predictable way for children to keep carer(s) nearby. Insecure attachment is very common; although it is not optimal, and children may benefit from support and more sensitive parenting, insecure attachment is not in itself cause for alarm.

> Securely attached children are more resilient and better placed to deal with 'ups and downs' across the lifespan. Parents' own attachment patterns (established through early childhood experience) inform but do not determine their parenting capacity (Dayton et al, 2010).

> Severely disabled children often have more secure attachments than other children. However, some children with disabilities are at increased risk of abuse and neglect – this is particularly so for children with speech or language difficulties.

> Disorganised attachment behaviour is relationship-specific. The person the child turns to for security is perceived as frightening (or frightened). Children who are abused may show signs of disorganised attachment behaviour – especially 'fear without solution' when the attachment system is activated – so an indication of disorganised attachment behaviour patterns in children suggest the need for further assessment. Disorganised attachment behaviour manifests itself differently at different ages.

> Disorganised attachment behaviour can result from a child being frightened of a carer or for a carer – for example, when a parent takes drugs and becomes, untypically, emotionally unavailable: 'the lights are on ... but no one is home'.

> Disorganised attachment behaviours are not always the result of abuse or maltreatment. They may result from frightening behaviour from the parent (and there are other non-abusive pathways to the behaviour) that may be unconsciously displayed – for example, as the result of post-natal depression.

> Attachment classification cannot be considered stable before a child is one year old; however, research demonstrates that attachment patterns are evident in infant behaviour from as early as four months old (Beebe et al, 2010).

> Disorganised attachment behaviour in childhood can lead to dissociative symptoms in adolescence and early adulthood – including severe panic attacks, blanking out and difficulty remembering events, or conversely, an inability to keep intrusive thoughts/images out of one's mind.

> Children who show disorganised attachment behaviour are likely to do things to make adults reject them. Practitioners must work hard to be available, caring, sensitive and trustworthy. Practitioners must also maintain awareness of the potential for their own attachment experiences to impact on their work.

> Practitioners who work with children and carers should be alert to attachment-based behaviours, especially where there are child protection concerns. Assessing attachment is complex and different techniques are appropriate for children of different ages or stages of development. A growing range of evidence-based tools for frontline workers is available.

> Research to fully understand intergenerational transmission of abuse and disorganised attachment behaviours is still ongoing, particularly in relation to parents' unresolved trauma, which compromises their caregiving and attunement to babies' needs and feelings. Adults who experienced disorganised attachment as children are likely to find caring and supportive relationships frightening and perplexing, and hence avoid them.

> The most effective interventions aim directly to increase parental or carer sensitivity and to increase parents' capacity to mentalise – to become more accurately attuned to their child's needs and to promote synchronised and contingent behaviour.

Introduction

This research briefing is aimed at practitioners who work with children and their parents or carers. It will be of interest to social workers, family support workers, foster carers, educational welfare officers, teachers, after-school club and pupil referral unit staff, youth workers, midwives, health visitors and children's centre staff. The briefing is particularly relevant to those involved in child protection.

The briefing:

> identifies a range of attachment behaviours in children and caregivers, highlighting findings from research that are of particular significance for practitioners

> provides information about observing, supporting and assessing parents' caregiving capacity and children's attachment-seeking behaviour, with a focus on identifying signs of worrying parent-child interactions and behaviours that may require further assessment.

The briefing is divided into five sections:

1. What attachment is – and why it is important for practitioners.

2. Research on attachment behaviours and prevalence – particularly where it may indicate maltreatment.

3. The role of attachment in outcomes for children.

4. How attachment can be assessed and some of the most relevant techniques.

5. What research tells us about attachment-based interventions, focusing on what practitioners can do to support children and families.

Messages for practice are summarised at the end of each section.

Accompanying reference tool

A reference chart that summarises key signs or behaviours associated with the attachment patterns mentioned in this briefing is available to download: **www.rip.org.uk/frontline**

1. What is attachment and why is it so important?

Attachment theory and its origins

Attachment theory and research offers important messages to everyone who works with children and their parents or carers. These messages can be especially relevant within the field of child protection because they address relationships, still the most reliable compass with which to navigate the turbulent waters of child maltreatment.

The pioneers of attachment theory – John Bowlby (1969; 1973; 1979; 1980; 1988), Mary Ainsworth (Ainsworth and Eichberg, 1991; Ainsworth et al, 1974 and 1978) and Mary Main (Main and Weston, 1981; Main and Solomon, 1990; Main and Hesse, 1998) believed that human babies are inter-subjectively intertwined with their primary carers.

For example, Bowlby was intrigued by what was happening when an infant suckled from its mother's breast. At the time, most people would have replied, perhaps impatiently: *'Why, it's drinking milk! ... What else?'* But Bowlby argued that something else was indeed going on: the baby needed *comfort*, as well as food. He called this set of needs 'attachment'. When things go well these needs are reciprocated by the carer's facility to form a lasting bond.

Bowlby was familiar with Harry Harlow's experiments with Macaque monkeys that had been separated from their mothers at birth.

Harlow's monkeys

Today, Harlow's experiments with Macaque monkeys would, quite rightly, be seen as completely unethical. Presented with two surrogate but inanimate 'mothers', both made from wire (one containing an inbuilt milk bottle, the other with only a soft toweling exterior), what would the infants do? You can see for yourself if you visit:
www.youtube.com/watch?v=hsA5Sec6dAI

Understanding universal attachment behaviours

All humans share a set of attachment behaviours comprising four components:

> '*secure base*'

> '*safe haven*'

> '*proximity-seeking*'

> and '*separation-protest*'.

Hazan and Zeifman (1994) explained these components as follows:

> *'Whom do you like to spend time with?'* (proximity-seeking)

> *'Whom do you miss most during separations?'* (separation-protest)

> *'Whom do you feel you can always count on?'* (secure base)

> and *'Whom do you turn to for comfort when you're feeling down?'* (safe haven).

(Hazan and Zeifman, 1994, quoted in Feeney and Noller, 1996)

So wherever we are born and, pretty much however we are brought up, we all want to spend time with the people we love and to whom we are emotionally close (*proximity-seeking*); we become very upset if we can't see them, especially if they leave us or pass away (*separation-protest*); and when we are very frightened we usually like to contact our attachment figures (*safe haven behaviour*) because we want them to comfort us until we feel confident to face the world again. When we feel we have received comfort (or reassurance, food, warmth etc.) we use this person as a *secure base* from which to explore the world around us again.

That we experience such feelings and behaviours is universal – it's the same the world over. But how we *show* these feelings and behaviours is highly dependent on the culture in which we live – think of mourning rituals, for example, and how different they are across the world.

Understanding attachment theory

Watch a ten-minute e-learning introduction to the principles of attachment theory:
http://content.iriss.org.uk/ understandingattachmenttheory/index.html

Developments in attachment theory

Since the pioneering work of Bowlby and others in the 1960s and 70s understanding of *how* attachment patterns develop and *why* attachment is important has been expanding through research in areas such as:

> intergenerational cycles of attachment

> neurobiology and the developing brain

> how proactively relationship-seeking infants are from birth, and how parent and infant each affect the other

> the importance of 'mentalisation' or reflective functioning

> the impact of trauma on attachment

> resilience

> the importance of fathers.

Advances made in neurobiological research during the last 20 years are providing new insights into how early emotional transactions impact on the development of brain systems involved in affect (the experience of feeling or emotion) and self-regulation (the ability to appropriately control emotions and behaviour) and a growing body of evidence suggests that the attachment relationship is 'a major organiser of brain development' (Fonagy and Target, 2005, cited in Schore and Schore, 2008). Researchers see exciting potential to move beyond 'nature vs nurture' debates and build a 'mutually enriching dialogue' between biological, neurological and psychological research (Schore and Schore, 2008).

It is important to note that neurobiological understanding of the impact of trauma on human brain development is in its early stages and its application to direct work with children and families is a matter of some controversy (Brown and Ward, 2012; White and Wastell, 2013). Nevertheless, just as a carer may build a secure attachment relationship through cuddling and singing to a baby without having read or even heard of Bowlby, practitioners may confidently develop their understanding of attachment theory and its application in practice without getting too bogged down in debates about neuroscience.

Schore and Schore's article 'Modern attachment theory: The central role of affect regulation in development and treatment' (2008) is available at: http://lifespanlearn.org/documents/J.%20Schore_CSWJ.pdf

Pre-birth and early years foundations of attachment

There is a growing body of research into 'the parental caregiving system' –parental behaviour, parents' feelings toward and representations of their unborn child, and physiological (chemical, hormonal) change. Current research focuses on the parent-infant dyad and the mother-father-infant triad during pregnancy, looking at how each affects the other, sowing the seeds of attachment and future relationships.

The lifelong significance of the pre-natal parent-infant bond should not be underestimated. The instinctual trigger for the bond is the activation of the parents' caregiving systems and the urge to protect the unborn baby. For some parents, this is felt very early; for others, it comes later when they have tangible evidence of the baby – its first movements, the scan image or the bump.

While attachment patterns do often repeat from generation to generation, parents' own attachment patterns do not *determine* their parenting potential. Pregnancy can be a time of massive change, mentally, emotionally, physically and hormonally. Some parents are highly motivated *not* to repeat cycles of abuse and trauma.

The baby's first year

Attachment patterns develop through early parent-infant interaction (Baradon et al, 2005). Babies are pro-active in relationship seeking as soon as they are born, engaging carers in 'proto-conversations' from birth and even in utero.

Download podcasts by Professor Colwyn Trevarthen and others from IRISS's Why Attachment Matters conference in 2009:
www.iriss.org.uk/category/audio-collection/why-attachment-matters

And view a 'proto-conversation' on YouTube:
www.youtube.com/watch?v=T4Pyu-61N2g

This video on YouTube demonstrates how sensitive infants are to ruptures in communication and how hard they work to re-establish contact:

Still Face Experiment, Edward Tronick
www.youtube.com/watch?v=apzXGEbZht0

The child's experience of the attachment relationship with their primary caregiver leads to the development of an 'internal working model' (Bowlby, 1969) ie, the cognitive framework for understanding the world, the self and others. Interactions and relationships are guided by memories and expectations from this internal model.

Messages for practice

> While rituals and behaviour may differ from one culture to another, all humans share a common set of attachment needs and goals – to have people who are close (primary caregivers) who act as a secure base and safe haven, with whom they want to spend time, and separation from whom provokes upset and protest.

> The attachment-seeking system in infants and the caregiving system in parents are reciprocal aspects of the parent-child relationship. The caregiving system is activated during pregnancy and experienced as the urge to protect and care for the baby within.

> Fathers also feel protective towards their unborn children; sometimes this is expressed through protection of the mother-to-be and sometimes, though not helpfully, through anger if their partners are, for example, drinking, taking drugs and not thinking about the effect on the foetus.

> In young children, signs of secure attachment include readiness to share things with their carer, willingness to talk to new people and show them things if asked by the carer to do so, and recognising when their carer is upset. Using the carer as a safe base from which to explore captures the essence of secure attachment.

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│ Primary Carer's Behaviour   │ ◄──┐
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└─────────────────────────────┘    │
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              ▼                     │
┌─────────────────────────────┐    │
│ Child's 'Working Model'      │    │
│      of itself               │    │
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│ Secure │ │Avoidant│ │Resistant├──┘
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Figure 1.1 The child's 'internal working model'

2. What does the research on attachment tell us?

This section introduces the important concept of 'mentalisation' and looks at what research has to tell us about the different behaviour patterns that indicate secure and insecure attachments, as well as the behaviours that indicate disorganised attachment. It then discusses disorganised attachment in depth, including how behaviours change as children get older.

Mentalisation or reflective functioning

An important concept for understanding relationships is 'mentalisation', which is the imaginative mental activity of trying to make sense of the behaviour of self or others through reflecting on their thoughts, feelings, needs, beliefs and desires (their 'intentional mental states') ie, 'seeing oneself from the outside and others from the inside'.

Research has explored the links between caregivers' capacities for mentalising and attachment patterns, observing carers' abilities to 'hold the infant in mind', to attune to baby's needs and feelings and respond in a way that creates comfort, safety, regulation and a feeling of being understood (Fonagy et al, 1998). Children with secure attachments develop the capacity to mentalise through a 'good enough' experience of parents reflecting on their needs, feelings and experience and helping them regulate until they are able to do this for themselves.

Hear Peter Fonagy talk about mentalisation:
www.youtube.com/watch?v=OHw2QumRPrQ

This mentalising ability appears to develop in most children between three and four years of age. A classic experiment, Wimmer and Perner's (1983) 'false belief' task, helps us to understand the development of mentalisation capacity.

Watch a video of the false belief task:
www.youtube.com/watch?v=41jSdOQQpv0

Understanding mentalisation

Mentalising helps us navigate relationships and make sense of our own and other people's behaviour. Studies of maternal reflective functioning, ie, mentalisation within an attachment relationship, involving young mothers and their babies have shown:

> A mother's low reflective function indicates a risk of disruption to affective communication between her and her baby.

> The ability of parents to regulate an infant's affect (fear, distress) at times of heightened arousal is necessary for the development of the baby's attachment security. In so doing, the mother provides a secure base at time of fear and distress. (Slade, 2005)

Watch Dr Daniel Siegel presenting a 'hand model' of the brain:

www.youtube.com/watch?v=vESKrzvgA40

The Strange Situation Procedure and patterns of attachment behaviour

Bowlby and Ainsworth's work culminated in the Strange Situation Procedure (SSP), which is still the 'gold standard' assessment of attachment for very young children.

The 'strange situation'

What do babies and toddlers do when a stranger enters a room in which they are playing with toys with their primary carer? What do they do when the carer leaves them with the stranger – and then, briefly, on their own? And what do they do when the carer returns (the 'reunion' scenario)?

You can watch what happens at:
www.youtube.com/watch?v=s608077NtNI (See also: **www.youtube.com/watch?v=PnFKaaOSPmk**)

Bowlby and Ainsworth identified one pattern of behaviours that indicates *secure attachment,* and two that were insecure: *avoidant* and *ambivalent* attachment. (These behaviours are summarised in Table 2.1.)

All three – secure, avoidant and ambivalent – are *organised* attachment patterns and each represents a consistent and predictable way for children to work out how to keep their carer(s) nearby. Insecure attachments are very common – there's something like a 60/40 split between 'security' and 'insecurity', pretty much across the world. So although insecurely attached children may benefit from a more sensitive response or support, insecure attachment is not necessarily a cause for alarm and practitioners concerned with child protection arguably will have less cause to mention it in their reports. However, those practitioners do need to be more alert to the presence of *disorganised attachment* behaviour.

Differences between the organised attachment behaviours

> Securely attached children know they can show their needs and feelings and won't be rejected.

> Avoidantly attached children learn that bottling up feelings is what Mummy and/or Daddy seem to prefer.

> Ambivalently attached children end up unsure what to do when their attachment system is activated because, for example, they regularly get fed when their carer is hungry, not when they are.

Ambivalent children turn up their emotional volume when their attachment system is triggered – as a result of fear, hunger, separation etc. Avoidant children do the reverse: they make out they are not experiencing strong feelings, by repressing and denying them. It is only securely attached children who can effectively process and deal with their feelings.

This emphasis on explaining the different patterns of organised attachment by how individuals deal with their feelings reflects the view of contemporary attachment theorists and researchers that attachment theory is essentially about emotion (or 'affect') regulation (Schore, 2000).

Attachment theory and families

For more information about attachment theory and its applications with families see Graham Music's *Nurturing Natures: Attachment and children's emotional, sociocultural and brain development* (2010).

Disorganised attachment is best understood not as an attachment 'style' (a term that is now becoming obsolete) but as a description of the temporary and fleeting behaviours that an individual displays when their attachment system is activated.

So, for example: a toddler exhibiting disorganised attachment behaviours could freeze when a chronically abusive parent returns to a room in which the child has been left alone for a few seconds ... but only under those precise conditions. The child is temporarily experiencing 'fear without solution' because s/he is frightened of being alone but also more scared of the carer. When the fear subsides, the child's behaviour reverts to a more organised – usually insecure – attachment behaviour.

Table 2.1 (on the following page) summarises the results of the Strange Situation Procedure and compares the different attachment patterns.

Table 2.1 Attachment behaviours displayed during the Strange Situation Procedure

Secure	Insecure Avoidant	Insecure Ambivalent
Cries 'hard' when carer leaves the room.	Will cry (but sometimes less 'hard') when carer leaves the room.	Cries 'hard' when carer leaves the room.
Will not go to the 'stranger' (whether the carer is in the room or not).	Will not go to the 'stranger' (whether or not the carer is there as well).	Will not go to the 'stranger' (whether the carer is in the room or not).
Doesn't play with the toys when the carer is out of the room.	Doesn't play with the toys when the carer is out of the room.	Doesn't play with the toys when the carer is out of the room.
When the carer returns, the child is soothed and calmed relatively easily. The child wants a cuddle and receives one. The child quickly wants to continue playing with the toys.	When the carer returns, the child usually stops crying (often looking at the toys), but doesn't seek comfort or a cuddle. The parent may praise the child for *not* crying but will tend not to cuddle, reassure or soothe.	The child oscillates, quite wildly, between wanting to be picked up and wanting to get down and play with the toys. Whatever the carer does, the child quickly seems to want the opposite. This is thought to be the result of very unpredictable behaviour around ordinary caring tasks.
	Studies of cortisol levels of avoidantly attached children show them to be abnormally high, indicating that, despite the apparently calm exterior, such children are very stressed when reunited with the carer.	Cortisol levels in ambivalently attached children are also high, but their behaviour does not contradict their stress.

Disorganised attachment: a note of caution

While disorganised attachment behaviour (DAB) is strongly correlated with maltreatment – around 48 to 80 per cent of maltreated children show DAB – this does not mean that every child who shows DAB is being maltreated. (Methodologically, there may be a problem in some studies in that 'maltreatment' is assumed to be physical and/or sexual abuse but doesn't always include *emotional* neglect and/or abuse).

About 15 per cent of so called 'low-risk' samples also show DAB. This may be the result of frightening parental behaviours (which may be unconsciously displayed, for example, as the result of post-natal depression, which can be quite high in the general population of mothers). This might be thought of as '*unintended* maltreatment'.

One study (Cyr et al, 2010) showed that a **combination** of five socio-economic status (SES) factors had the same effect as maltreatment (but presumably the effect of that combination is likely to be mediated through the caregiving relationship). It is also possible that 'extensive non-parental care' and 'frequent over-night separations from the primary caregiver' may lead to D behaviours (but, again, as these events may mask high levels of emotional distress to the child).

There are a number of studies which indicate, so far, that neither temperament nor genetics play a major part in the development of DAB (but we should keep an open mind about this). One connection, however, is that some autistic children can sometimes display DAB (but if they were compared with non-autistic children, the possibility exists that the autistic children displaying DAB may also have experienced maltreatment).

One way to rationalise these findings is to think of three different 'pathways' to disorganised attachment behaviour:

> *Abusive parental behaviour* experiences, such as physical or sexual abuse and some kinds of emotional abuse or neglect.

> *Unintentional parental maltreatment*, comprising caregiving which is inadvertently frightening to the child, extensive unplanned care, frequent overnight separations, the combined effect of socio-economic risk factors, gene-environment interaction, etc.

> *Pathways involving no maltreatment*, such as some children with autism (but as yet it isn't clear precisely what the mechanism is that produces D behaviours).

At the root of D behaviour appears to be prior experience which is felt by a child as *traumatic*, even if not caused or intended by a carer (in the case of a child with autism, as a 'neuro-diverse' child s/he may simply have a much lower threshold of what constitutes trauma than a 'neuro-typical' child).

What the family will often need is help to understand and then stabilise (ie, 'un-disorganise') the child's attachment system. Ignoring D behaviours is likely to lead to developmental problems later on.

Thus, DAB must not be viewed as 'magic bullets': they are 'amber lights' which then need to be considered alongside other mechanisms of maltreatment, and then with other more familiar risk factors such as substance abuse, domestic abuse, etc. But if a child is regularly exposed to very stressful experiences, for which there is no immediate prospect of comfort or respite, then help and support will be needed.

Finally, it important not to repeat the Strange Situation Procedure, or create too much distress within it, as this can elevate disorganised attachment behaviours, but not as a result of maltreatment (see Granqvist et al, 2016).

Older children seek to gain control of their caregiver(s) in two distinct, and opposing, ways:

1) Controlling through excessive role-reversed caregiving to the adult: *controlling-caregiving* children tend to be excessively (but superficially) bubbly, polite or helpful to the caregiver, but not necessarily to others.

2) Controlling by becoming hostile and punitive: the *controlling-punitive* child will speak harshly to a caregiver and threaten them verbally or physically, but they will not necessarily behave this way towards others (see Main and Cassidy, 1988; Moss et al, 2004).

Younger children can also show disorganised attachment behaviours in situations when they are frightened *for* their carer (as distinct from being frightened *of* the carer). This can happen if a carer who is normally attentive and emotionally available suddenly becomes emotionally unavailable, for example as a result of a florid paranoid episode or drug taking. It is the wild oscillation and unpredictability that can lead to the experience of 'fear without solution' for some younger children.

The developing brain and maltreatment

Marinus van IJzendoorn and Marian Bakermans-Kranenburg at Leiden University concluded that:

... parental maltreatment is probably one of the most frightening behaviours a child may be exposed to. **(van IJzendoorn and Bakermans-Kranenburg, 2009)**

EEG maps comparing maltreated and non-maltreated children (who have been shown photos of angry, happy and neutral faces) now begin to suggest that maltreated children process the images in a different part of the brain to non-maltreated children. Furthermore, maltreated children experience considerably heightened neural activity *whatever* the emotion.

Of most concern is the finding that the attachment systems of maltreated children stay on 'red alert' long after those of non-maltreated children have returned to a steady state (again, whatever the emotion).

McCrory et al (2010) offer the best summary of neurobiological and biochemical findings to date, and illustrate how maltreatment and, by implication, given their association, behaviour seen within disorganised attachment, can affect the structure of the brain. Maltreated children may have smaller cranial and cerebral volume, as well as reduced 'white matter' in key parts of the brain. The amygdala, hypothalamus and hippocampus are also affected, which can result in losses of dendritic branching. There may also be biochemical consequences of disorganised attachment, especially in the way the body deals with stress. (Shemmings, 2014)

Early brain development and maltreatment

For more information about the impact of neglect and maltreatment on brain development, see the briefing produced by Research in Practice at:
http://fosteringandadoption.rip.org.uk/topics/early-brain-development

Predictors of maltreatment

A comprehensive review of research into disorganised attachment behaviour, which includes findings from across the fields of social psychology, anthropology and neurochemistry (Shemmings and Shemmings, 2011), analysed the key intervening variables that operate between 'carer characteristics' and maltreatment. This knowledge base informs Shemmings' Attachment and Relationship-based Practice programme. The programme (formerly the Assessment of Disorganised Attachment and Maltreatment or ADAM project) began in 2009 with the aim of helping practitioners gain a deeper and more theoretically informed understanding of human relationships and equipping them with the knowledge and skills to make a difference in the lives of children and their families. A key component of the programme is its Pathway Model of Child Maltreatment (see page 23 in Section 4 for a diagram), which can be used by child protection practitioners to help guide them through complex situations and help them feel more confident when assessing why some so-called 'high-risk' parents abuse their children, while others do not.

The Pathway Model of Child Maltreatment identifies three possible predictors of maltreatment that may be signalled by parental behaviour (Shemmings and Shemmings, 2011). The three parental predictors of maltreatment ('explanatory mechanisms') are shown in the box on the right.

Parental behaviour which may lead to disorganised attachment

1. *Unresolved loss and trauma* (see Lyons-Ruth, 2003). This refers to significantly repressed or denied interpersonal losses that can re-emerge in situations where a parent is reminded of their own vulnerability – for example, when caring for an infant or toddler.

For example, a mother's history of abuse and/or trauma may well affect her internal working models of caregiving and the ways in which she begins to think about her unborn child (Malone et al 2010). A groundbreaking study *Ghosts in the Nursery* (Fraiberg et al, 1975) showed how a baby can become confused in the parent's mind with a figure or figures from the parent's past. A parent can unknowingly project onto their baby repressed experiences and feelings, or aspects of their personalities that they need to disown. It is important to pay attention to the 'ghosts' that a father or other men in the home bring to family relationships (Barrows, 2004).

Someone trained in assessing this might look for the following when an individual is invited to think and then speak about painful memories:

> Marked lapses in the ability to 'think about thinking' and a very illogical narrative.

> The parent oscillates (almost simultaneously) between two insecure organisations – so at one point, they will be excessively emotional and the next become very cold and dismissive of emotion (this is unusual, as the two behaviours represent polar opposite ways of dealing with emotion).

> The parent shifts rapidly between being hostile about someone to becoming very helpless when speaking about them, but not explaining the discord (they may do this in a cold or in a very emotional way – as above, these two 'styles' may become intertwined and temporarily confused).

There are a number of factors that promote resilience in the face of abuse and trauma (Hart et al, 2007). One important factor is the presence and support of a significant adult who recognises abuse and trauma, even if they can't stop it. When working with trauma it is essential to offer hope and to build upon the 'angels in the nursery' (Lieberman et al, 2005) as well as addressing the abuse.

2. Disconnected and extremely insensitive parenting (see Out et al, 2009a). Disconnected parenting may include sudden and frightening changes in behaviour that aren't accompanied by explanatory gestures, vocalisations or signs of affection. These are likely to be the result of unresolved loss or trauma. Extremely insensitive parenting may be excessively withdrawn and neglectful – or conversely, it may be expressed through caregiving that is over-intrusive or aggressive.

Someone trained in assessing this might look for:

> *Dimension 1. Disconnected behaviour* (adapted from Main and Hesse, 1998)

  - frightening/threatening parental behaviours – eg, attacking or threatening to attack

  - frightened parental behaviours – eg, parent suddenly retreats from the child or startles in response to the child's behaviour

  - dissociative parental behaviours – eg, 'stilling', freezing, voice alterations, sudden shifts in mood

  - deferential and romantic/sexualised behaviours – eg, handling the child or interacting with the child in a timid, submissive and/or deferential manner, spousal/romantic and sexualised behaviours

  - disorganised/disoriented parental behaviours – eg, anomalous movements and postures.

> *Dimension 2. Extreme insensitivity* (adapted from Bronfman et al, 2004)

  - parental withdrawal and neglect – eg, failure to initiate responsive behaviour to the child, actively creating physical distance from the child, a worrying lack of interaction between parent and child

  - intrusive, negative, aggressive or otherwise harsh parental behaviours.

3. Low mentalising capacity (see Allen et al, 2008). This refers to a significantly reduced ability to appreciate that others have feelings and intentions that are different to one's own – for example, the mother who couldn't see why, on a cold winter's morning, she should put shoes and socks on her one-year-old baby because her own feet were 'like toast'.

Someone trained in assessing this might look for:

> *Mentalisation failures*: The adult cannot make much sense of what happened to them as children; often, in addition, they show no interest or curiosity. For example:

  - Q: '*Why do you think your parents behaved as they did when you were a child?*'
    A: '*How should I know; you are the social worker!*' (Here, the parent is not simply being uncooperative!)

  - Q. '*Do you think your childhood experiences have influenced you in any way?*'
    A. '*I can't think of anything ... nothing I can think of at the moment.*' (Lack of curiosity)

> *Low mentalisation*: For example:

  - '*He's stupid*', '*She's cute*' (but no elaboration).

  - '*She's clingy, but there's nothing wrong with her.*'

  - '*She's horrible and that's the way she is.*'

We will return to the pivotal concept of *mentalisation* later in the briefing (in Section 5) when we consider how practitioners can intervene to increase security among abused and maltreated children, suggesting the need for a rediscovery of the *importance of empathy*.

Importance of empathy

In Section 5, we will also discuss the relationship between mentalisation and empathy. In essence, *empathy* could be said to be about the facility to appreciate the probable feelings another person is experiencing, whereas *mentalisation* includes thoughts and feelings, as well as intentions. This rebirth of a 'dormant' (and arguably, a neglected) relationship skill has been accelerated by Simon Baron-Cohen's book (2011) *Zero Degrees of Empathy: A new theory of human cruelty*.

A note about attachment disorders

From time to time, practitioners are likely to hear the term 'attachment disorder'. Some non-medical practitioners may misuse the term 'attachment disorder' as an incorrect descriptor for a child's attachment difficulties.

An attachment disorder is in fact a formal psychiatric diagnosis described in the two diagnostic manuals used by psychiatrists: DSM-5 and ICD-10. It is fair to say that psychiatrists make diagnoses of attachment disorders only rarely.

In DSM-IV, attachment disorders were divided into two separate categories – *inhibited* and *disinhibited*:

Youngsters who had the first subtype [inhibited] were described as displaying internalizing behaviours such as fear, avoidance, and withdrawal whereas youngsters who had the second type [disinhibited] were described as displaying externalizing behaviours such as indiscriminate, superficial sociability. (Leveille, 2014)

These two subtypes were replaced in DSM-5 (APA, 2013) by two separate and distinct disorders: Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED). Both disorders 'essentially result from social neglect and/or other situations that limit a child's opportunity to form selective attachments' (Black and Grant, 2014). RAD involves 'the lack of, or incompletely formed preferred attachments to, care-giving adults'; DESD is 'a pattern of behavior that involves inappropriate and overly familiar behavior with unfamiliar adults or relative strangers, thus violating the social boundaries of the culture' (Black and Grant, 2014). And whereas RAD involves the lack of or incomplete attachment to caregivers, DESD occurs in 'children who lack attachments, children who have established attachments, and even children with secure attachments' (Black and Grant, 2014). (For a full discussion of these changes see Black and Grant, 2014; Shemmings, 2014; and Leveille, 2014.)

From a child protection perspective, the crucial point for practitioners is that disorganised attachment is the more reliable *indicator* of abuse and neglect. Different editions of DSM have consistently made clear that disorders related to attachment are 'rare' and suggest they are seen most often in children who have been living in deprived institutional settings (Leveille, 2014). DSM-5 notes that fewer than 10 per cent of children who have been severely neglected develop RAD (Leveille, 2014); however, prevalence rates for disorganised attachment among maltreated children are very high.

Attachment disorders and disorganised attachment behaviours

For more on the differences between attachment disorders and disorganised attachment behaviours, see the special issue of the journal *Attachment & Human Development* (Volume 5, Issue 3, 2003):
www.tandfonline.com/toc/rahd20/5/3

Inter-generational cycles of attachment

Parents' own attachment patterns are an important indicator of how they may interact with their children and their future parenting behaviours (Dayton et al, 2010). The following are considered to be significant pre-birth indicators:

> The parents' representations of the baby: the way mothers conceptualise their relationship with their unborn child has been associated with important outcomes including mental health and wellbeing, parent-infant interaction and child disorganised attachment behaviour (Walsh et al, 2014).

> The mother's representation of herself as a mother, and of the father as a father (and vice versa) – and of them both as a parental couple (Slade, 2008).

> The mother's capacity for reflective functioning or mentalisation.

> The mother's behaviour and ability/ willingness to provide the best possible physical environment for foetal growth.

> The mother's support system, especially with regards to the risk of perinatal depression and anxiety. (Brandon et al, 2009)

Practice questions:

> To what extent are the mother and father-to-be able to think about the baby *both* as a separate person to them with a developing mind (mentalising), and at the same time dependent upon them and in need of their care and protection?

> Do their responses suggest they are able to make the transition from frightened attachment-seeking child to protective caregiver at times of stress?

> Are they able to regulate the powerful emotions stirred up during pregnancy, separately and as a couple?

> Do they have good enough support and people who they turn to for help (proximity seeking, safe haven)?

Fathers

It is important not to forget the impact (positive, negative or ambivalent) that fathers have on their infants and young children. Fathers are often marginalised or problematised, for instance as perpetrators of domestic abuse; however, fathers can be an important asset and a protective factor. Children can develop different attachment patterns toward their mother and father and a father's involvement can make a meaningful difference in their children's lives. Consistent contact with biological fathers (through financial support, periodic access visits, or child care) is associated with fewer behavioural problems and better educational attainment (Mountain, 2010).

However, rather than the individual role of the father, it is the nature of the parental couple, which creates the 'emotional climate' into which an infant is born, that is likely to be more critical for the future mental health of the developing infant.

Messages for practice

> Secure attachment and insecure (avoidant or ambivalent) attachment are all organised attachment patterns – that is to say, each is a consistent and predictable way for children to keep their carer(s) nearby.

> Insecure attachment (avoidant or ambivalent) is very common – there's something like a 60/40 split between 'securely' and 'insecurely' attached people across the world. So while insecure attachment is not optimal and children may benefit from support and more sensitive parenting, it is not in itself cause for alarm.

> Disorganised attachment behaviour tends to be relationship-specific in toddlers. Children who are abused are likely to show signs of disorganised attachment, so an indication of disorganised attachment behaviour patterns in children or caregivers can suggesting the need for further assessment.

> Although strongly correlated with abuse, caregiver characteristics – such as serious substance misuse or parental mental health problems – are not reliable predictors of maltreatment.

> Disorganised attachment manifests itself differently at different ages. By early adolescence, children showing disorganised attachment behaviour will seek to gain control of their carer(s) in two distinct, and opposing, ways: (i) by being excessively (but superficially) bubbly, polite or helpful, but not necessarily to others; or (ii) by becoming hostile and punitive – speaking harshly to the carer(s) (but not necessarily towards others), or even threatening them physically.

> Neurobiological research now begins to show that maltreated children experience significantly heightened neural activity whenever any emotion is aroused. Their attachment systems also stay on 'red alert' long after those of other children have steadied. This can adversely affect the areas of the brain responsible for the development of empathy and impulse control.

> A parent's 'caregiving system' and protective urges are activated during pregnancy and post-birth, as a reciprocal system to the baby's 'attachment-seeking system' and their complete dependency. For health practitioners, social workers and other professionals it is a cause for alarm if this caregiving/protective urge is not evident: help is needed!

3. Attachment and outcomes

This section considers the outcomes associated with secure and insecure attachments. It looks at the importance of secure attachment in the development of resilience, attachment processes for children with disabilities, and the relationship between disorganised attachment behaviour and mental health problems.

Secure attachment and resilience

Children are protected from most of the inevitable 'ups and downs' of life when they know that they are loved *no matter what* (provided that such love and affection is not cloying or over-indulgent). Combined with certain predisposing factors, such children are more likely to be resilient and to 'bounce back' when the going gets tough.

Contemporary attachment-based research tells us that children who are securely attached are fortunate in other ways too. Securely attached children benefit in a number of different ways:

> They tend to have high self-esteem and are able to empathise with others because their carers were, more often than not, accurately attuned to them as children.

> This leads to a high capacity for mentalisation – they appreciate that others have different thoughts, feelings and experiences than their own. Such a facility is strongly correlated with emotional intelligence, itself a predictor of success in roles dependent upon relational skills.

> They can deal with stress effectively, as measured by lower cortisol levels (not just by self-report or even observable behaviour).

> Securely attached children have faster memory recall, which means they are likely to achieve their cognitive and intellectual potential.

> They have much higher impulse control than insecurely attached children (and children with disorganised attachment in particular). This means they can defer gratification, leaving them less likely to become prone to addictive behaviour.

> Securely attached children can integrate negative experiences – for example, experiences during which they have been let down – within a coherent narrative because they see relationships from an 'I'm OK, you're OK' position.

> They are likely to be popular with others, because they are reliable and 'giving'.

Secure children are not necessarily dealt a 'good hand' at birth; rather, they are given those cards by their primary carers. Does this mean, however, that insecurely attached children are destined to a life of unhappiness, addiction and stress? The answer is certainly not – although 'avoidant' people often find relationships troubling and fragile, and 'ambivalent' individuals find them exciting *and* troubling.

The close relationships of insecurely attached people can become strained and fractured because they find it difficult to trust others and so may place them under considerable and sometimes relentless pressure; other people will also find *them* hard to fathom at times. Unfortunately, children who have experienced abuse or neglect and prolonged bouts of parenting that lead to disorganised attachment behaviour are very likely to find caring and supportive relationships frightening and perplexing – and so will tend to avoid them.

Attachment and children with disabilities

For children with disabilities, attachment processes operate pretty much as they do with non-disabled children: disabled children don't like being separated from a non-abusive carer, they protest when a sensitive parent leaves the room, and they are more likely to explore their immediate environment if a primary caregiver offers them a 'safe haven'.

However, things become more complicated when maltreatment enters the equation. Table 3.1 (on the following page) shows the relative rates of risk for maltreatment for disabled children, compared to non-disabled children – for example, the risk of a child with a learning disability experiencing physical abuse is twice that of a non-disabled child. (The table is from an article written by David Howe in 2006, based on research conducted by Sullivan and Knutson, 2000.)

Table 3.1 Relative rates of risk for maltreatment for disabled children, compared to non-disabled children

(*Figures below show relative increases in the risk of maltreatment for disabled children, when compared to children without a disability. So for example, the risk of a visually impaired child experiencing neglect is one and a half times greater than it is for a non-disabled child.*)

1 Neglect: autism 1.3; visual impairment 1.5; physical disabilities 1.8; learning disability 2.0; hearing impairment 2.3; health impairment 3.4; speech/language difficulties 4.7

2 Physical abuse: autism and visual impairment showed no increased risk; physical impairment 1.2; learning disability 2.0; health impairment 3.3; hearing impairment and 'low intelligence' 3.8; speech/language difficulties 4.7

3 Emotional abuse: autism showed no increased risk; visual and hearing impairments and learning disability 2.0; health impairment 3.4; 'low intelligence' 3.8; speech/language difficulties 6.6

4 Excluding those with behaviour disorders, the groups most at risk of being *sexually abused* were: children with speech/language difficulties 2.9; and 'low intelligence' 4.0 (Howe, 2006)

The figures in Table 3.1 setting out the relative risk of maltreatment for disabled children show that children with speech, language and hearing difficulties are far more likely to be abused than children with other disabilities, including children with physical disabilities.

But why might this be so? David Howe, an expert on attachment and child maltreatment, offers the following explanation:

Increased severity of a child's disability does not predict increased risk of insecurity. Indeed, children with more severe disabilities show higher rates of security. One explanation is that when a child's disability is unquestionably present, parental recognition, understanding and acceptance increase, and expectations are therefore more realistic. Second, infants with developmental delays display facial, postural and vocal behaviour that make it more difficult for carers to read their signals and needs. This was thought to lead to less sensitive and less responsive care-giving, increasing further children's anxiety and distress. (Howe, 2006)

Disorganised attachment behaviour and subsequent mental health problems

A large meta-analysis published in 1999 concluded that disorganised attachment is 'an early sign of psychopathology' (van IJzendoorn and Sagi). High levels of 'externalising' behaviour such as marked aggression (as assessed by parents, teachers or observers) were found among children experiencing disorganised attachment behaviour in a more recent meta-analysis (Fearon et al, 2010).

We must be careful, however, *not* to think attachment theory explains everything. Writing in the *Handbook of Attachment*, Michelle DeKlyen and Mark Greenberg (2008) describe their evidence-based review of the links between early attachment and the development of mental health disorders later in childhood. Refreshingly, they note that the 'enthusiasm to utilise attachment theory has at times led to over-interpretation of findings and a fruitless search for a "Holy Grail" of psychopathology'. Nevertheless, while they conclude by questioning whether 'attachment insecurity alone' would lead to mental health disorders, they are in little doubt that it is 'the absence of a coherent strategy (ie, disorganisation) rather than insecurity *per se* that is linked to maladaptation'.

Similarly, Mary Dozier and colleagues (in Chapter 30 of the same *Handbook*) contend that 'the only clear connections between infant attachment and adult psychopathology are between disorganised attachment and dissociative symptoms in adolescence and early adulthood' (Dozier et al, 2008). In other words, disorganised attachment behaviour in childhood can lead directly to individuals later on experiencing severe panic attacks, fainting, blanking out and difficulty remembering events and experiences that (consciously or unconsciously) remind them of an earlier trauma. Alternatively, they may experience the opposite: an inability to keep intrusive and unwanted thoughts and images out of their mind.

Attachment difficulties in childhood tend to be associated with, and are sometimes predictive of, conditions such as borderline personality disorder and antisocial personality disorder (so-called 'conduct disorders' in older children) but not with depression, schizophrenia or anxiety disorders (eg, eating disorders) (Dozier et al, 2008).

Messages for practice

> When children are securely attached to their caregivers, they are more resilient and better placed to deal with 'ups and downs' across the lifespan.

> Adults who experienced disorganised attachment behaviour as children are likely to find caring and supportive relationships frightening and perplexing, and hence avoid them.

> Although severely disabled children often have more secure attachments than other children, some children with disabilities are at increased risk of abuse and neglect. This is particularly so for children with speech or language difficulties.

> Assessment and intervention to support parents pre-birth and during babies' first year can potentially improve outcomes for children at 12 months (SSP). The brain's plasticity enables change facilitated by positive attachment/ relationship experiences.

4. Assessing attachment

We saw in Section 2 how different patterns of attachment behaviour in toddlers can be observed using the Strange Situation Procedure (SSP). We saw also how attachment behaviours become more complex as children get older. This is especially so for behaviours indicative of *disorganised attachment*. For example, young adolescents experiencing disorganised attachment behaviour may seek to gain control of the carer(s) through controlling caregiving or controlling-punitive behaviours. This means different assessment techniques are needed as children grow older.

Research supports the drive for assessment and intervention early in infants' lives (Barlow and Schrader McMillan, 2010) and new models of pre-birth assessment are being developed.

Pre-birth assessment model

Watch the Research in Practice webinars (October 2014 and October 2015) on the NSPCC and Warwick University pre-birth assessment model at: **www.rip.org.uk/events-and-online-learning/webinars**

In this section we look at tools, measures and training available to help practitioners assess attachment pre-birth, in infants, younger children and adolescents, as well as attachment and related parenting behaviours in adult caregivers.

Pre-birth risk assessments

Pre-birth risk assessments are usually only undertaken when there is a high degree of concern about the potential risk of significant harm to an unborn child.

Working Together (HM Government, 2015), the statutory guidance for undertaking assessments, includes little specific information on pre-birth assessments and the tools and measures it contains are not particularly helpful for assessment of the potential care-giving relationship.

During the pre-birth period the assessment of parenting capacity in relation to the unborn child (as opposed to any existing children) can be assessed by using a range of tools that are associated with later parenting practices, including, for example, the developing relationship with the baby and parental willingness to put the needs of the foetus/baby before their own.

It is also possible to support parents to develop an ability to be reflective by adopting a mentalising stance during the assessment – for example, asking such questions as 'I wonder whether being pregnant is how you thought it would be, or whether there are things you hadn't expected?' and 'I wonder what you (and your partner) think your baby will be like as a person?'

The practitioner can encourage expectant parents to engage with the unborn baby by encouraging them to stoke mother's stomach, talk or sing to the baby and imagine what the baby might be like and might be feeling.

Getting to know your baby

A number of resources are now available for parents, including an app that can be downloaded onto a phone showing women talking and singing to their babies.
Go to: www.your-baby.org.uk

Baby Bumps is a free pregnancy app and social network for expecting parents:
https://babybumpapp.com/babybump/home
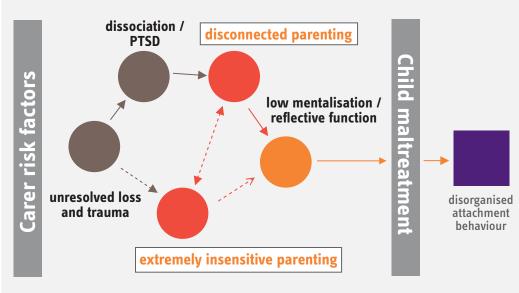
Attachment assessment measures and tools

Attachment assessment tools for pre-birth and infancy

Parent Development Interview (revised)	An interview to assess parents' representations of their relationships with their child. Parents are asked to describe their experience of the child, their relationship with the child, their own internal experience of parenting and the child's reactions to normal separations, routine upsets, and parental unavailability. Go to: **http://pditraininginstitute.com/parent-development-interview/**
Parent-Infant Relational Assessment Tool (PIRAT)	A pre-classification tool developed by the Parent Infant Psychotherapy team at the Anna Freud Centre. Alerts to concerning behaviour in the infant, the mother and the relationship between the two. Go to: **http://annafreud.org**

The Pathway Model of Child Maltreatment (Shemmings and Shemmings, 2011) can be used by child protection practitioners to guide them through complex situations and help them feel more confident when assessing why some so-called 'high-risk' parents abuse their children, while others do not. The model shown at Figure 4.1 illustrates how dimensions of caregivers' behaviour are thought to interact and form a pathway to child maltreatment. It will help practitioners focus on the critical dimensions of parenting for carrying out assessments with carers. Go to: **http://arpractice.org.uk/about.html**

Figure 4.1 Pathway Model of Child Maltreatment (Shemmings and Shemmings, 2011)

Maltreatment Pathway Model

Carer risk factors

dissociation / PTSD

disconnected parenting

low mentalisation / reflective function

unresolved loss and trauma

extremely insensitive parenting

Child maltreatment

disorganised attachment behaviour

Assessment measures and tools for children

Table 4.1 lists evidence-informed assessment measures and techniques that practitioners can use in their work with children and families.

Table 4.1 Evidence-informed assessment measures		
Age group	**Measure**	**Description and link to further information**
Toddlers	Strange Situation Procedure Coding for 'DA' behaviours.	Assessment tool developed by Mary Ainsworth (1965) to classify infant attachment security/insecurity at 12 to 18 months. Mary Main developed the additional classification of disorganised attachment to describe parents who are frightened or frightening to their children and infants. Administered in a clinic setting using a specified sequence of interactions of caregivers and strangers entering and leaving the room in order to activate the infant's attachment behaviour.
1 to 5-year-olds	Attachment Q Sort (AQS)	Based on observation of children in the home environment, the AQS consists of a set of 90 cards with a specific behavioural characteristic described on each card. The cards are used as a vocabulary to describe the behaviour of a child, with an emphasis on secure-base behaviour. The Q-set provides a score along a continuum of secure to insecure and is a strong predictor of later developmental outcomes.
4 to 9-year-olds	Story Stem Completion (Hodges et al, 2003)	When presented with the opening or 'stem' of a story that begins with a mild level of stress, children displaying disorganised attachment will end their stories in ways that are markedly different to those of children who are either securely or insecurely attached. Doll-based representational techniques require training in their use. www.annafreud.org/training-research/
9 to 13-year-olds	Child Attachment Interview (CAI) (Target et al, 2003)	The CAI assesses children's perceptions of their attachment figures' availability and responsiveness. The child is asked to reflect on the relationship they have with their main carer and to 'think out loud' about separation and loss and how they obtain comfort when they need it, along with their memories of any traumatic experiences. www.annafreud.org/training-research/
Assessing caregiver behaviours and representations		
Related parenting dimension(s)	**Measure**	**Description and link to further information**
Unresolved loss AND mentalisation	Adult Attachment Interview (AAI)	A standardised measure for assessing adults' mental representations of their childhood attachment experiences and their influence (as perceived by the interviewee). Interviewees are also asked about the loss of loved ones and other traumatic experiences. Download the AAI Protocol (George et al, 1985) at: www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf
Dissociation	Dissociative Experiences Scale	A 28-item self-report questionnaire for measuring the frequency of dissociative experiences. Go to: http://serene.me.uk/tests/des.pdf
Disconnected / insensitive	Disconnected and Extremely Insensitive Parenting (DIP) Measure	The DIP coding system (Out et al, 2009b) assesses two dimensions of parental behaviour: (i) the 'disconnected behaviour' dimension includes parental behaviours (eg, 'frightening' or 'frightened') that may indicate a dissociative state; (ii) the 'extreme insensitivity' dimension includes parental withdrawal and neglect, as well as intrusive, negative, aggressive or harsh behaviours. Go to: http://media.leidenuniv.nl/legacy/dipcodingsystem091207version3leidenuniversity.pdf
Mentalisation	Working Model of the Child Interview	An interview to assess a parent's internal representations, or working model, of their relationship to a child. Its purpose is to have the parent reveal, in a narrative account, as much as possible of their perceptions, feelings, motives, and interpretations of a particular child and their relationship with them (The Working Model of the Child Interview (WMCI): Zeanah et al, 1996).

Messages for practice

> It is useful for those who work with children and their parents or carers to be aware of and alert to attachment-based behaviours and responses, especially when there may be child protection concerns. However, assessing attachment is complex and requires training in appropriate techniques.

> Different techniques are appropriate for children of different ages or stages of development – and for assessing caregiver behaviours and mental representations of their own childhood attachment and experiences of their current relationship to a child.

5 Interventions

It's all about relationships. We are talking about dealing with people with problems, with painful stuff. You have to know someone ... trust them. They must be reliable and be there for you, if you are going to be able to talk about the things you don't want to. The things that scare you.

(Parent: Office of the Children's Commissioner, 2010)

Social work and community health practice are developing away from approaches focused on correcting parenting behaviour and towards reflective practice and direct work (Munro, 2011). Aspects of this shift include recognition of the relational nature of children and young people's identities, understanding parents' underlying mental states and issues such as trauma, motivation and capacity to change. Direct work includes the provision of early help, targeted family support and social work that focuses on engaging families in meaningful relationship-based practice and work to improve the relationships between various family members.

This section summarises evidence for effective intervention with families where children display disorganised attachment behaviour. It suggests the approach practitioners should take when working with children. It stresses the importance of professionals maintaining self-awareness about the emotional impact of working with these children and the potential influence of their own attachment experiences. Finally, it looks at how to work with and support adult caregivers to encourage sensitive parenting and mentalisation, and promote secure attachment for their children.

What works: a brief overview of research findings

Two major reviews into the relationship between interventions on the one hand and organised and disorganised attachment on the other were undertaken by Marian Bakermans-Kranenburg and colleagues at Leiden University. Each review involved meta-analyses of previous studies.

1 *'Less is More: Meta-analyses of sensitivity and attachment interventions in early childhood'* (Bakermans-Kranenburg et al, 2003)

This review analysed 70 published studies, including 88 intervention effects on sensitivity (n=7,636) and attachment (n=1,503). Interventions were coded as aiming to:

i) *increase carer sensitivity*: help the parent become more attuned to their child – for example, through initiating positive interactions with the infant by responding to the child's vocalisations, voice tone and by showing more interest

ii) *change the carer's representations of early relationships*: encourage the carer to explore and, hopefully, change their working models of attachment relationships in general, but specifically to their children

iii) *provide social support*: offer practical help and advice through relationship-based interventions using Rogerian, trust-building principles with family members

iv) combine any of these approaches.

The results showed that:

...interventions can enhance (parental) sensitivity and infant attachment security, but infant attachment security to a lesser extent than (parental) sensitivity. In particular, interventions that only focused on sensitive (parental) behaviour were successful in improving insensitive parenting as well as infant attachment security.

(Bakermans-Kranenburg and van IJzendoorn, 2007)

Very specific and clear interventions were far more effective than 'broad-band interventions'. Interestingly, family characteristics counted for little in determining outcomes.

2 *'Disorganised Infant Attachment and Preventive Interventions: A review and meta-analysis'* (Bakermans-Kranenburg et al, 2005)

Ten studies with 15 interventions were analysed, but this time the aim was to review specifically whether the interventions could be related directly to disorganised attachment behaviour. The types of intervention varied in both the 2003 and 2005 reviews, but all were connected by the 'golden thread' of being 'attachment-based' (rather than approaches based around 'parenting education', say). Approaches were sub-divided into those that were 'sensitivity-based' (aimed at increasing synchronised behaviours, reflecting reasonably accurately a child's needs) and 'representationally-based' (aimed at encouraging the parent to understand, review and reconsider their own early childhood experiences).

The second review included more narrative detail about the approaches analysed, but the results are remarkably similar to the first study: the most effective interventions occurred when a *sensitivity-based* approach was deployed.

The findings imply that parenting programmes should only be deployed after a careful assessment of what's going on in the family and that different approaches will be effective with different families, and possibly with the same family at different times.

Both reviews conclusively recommend that interventions for people with mentalisation difficulties should be very focused and aimed specifically at altering parenting behaviours directly, rather than try to affect carers' views of relationships more generally.

More recently, in November 2015, the National Institute for Health and Care Excellence (NICE) commissioned guidelines on attachment in children and young people in care, adopted from care or at high risk of going into care. See: www.nice.org.uk/guidance/ng26

In *Safeguarding Children from Emotional Maltreatment: What works*, Barlow and Schrader McMillan (2010) undertook a literature review of research on interventions directed at emotionally abusive parenting.

Key findings underlined that:

> A 'one-approach-fits-all' to the complex issues underlying emotional abuse is unlikely to lead to sustained change.

> A number of attachment-based interventions (including video-interaction guidance and parent-infant psychotherapy) improved maternal sensitivity and infant attachment security.

> The limited evidence suggests that some forms of emotionally abusive parenting may respond to cognitive behavioural therapy. Parent-infant/child psychotherapy also appears to hold promise.

> The Family Nurse Partnership is effective in reducing serious injury, abuse and neglect (see, for example, a recent randomised control trial at http://fnp.nhs.uk/evidence/randomised-control-trial) and is underpinned by a theoretical model, which targets parent-child attachment and parental sensitivity. Such an approach may also reduce emotional abuse.

> Similarly, interventions underpinned by models of working that target aspects of emotionally abusive parenting (eg, misattributions and excessive anger) may prove effective in treating emotional abuse.

> The evidence points to the value of implementing both population-based and targeted interventions to prevent the occurrence of child emotional maltreatment, alongside therapeutic-based interventions aimed at preventing its recurrence.

> Absence of evidence does not equal absence of efficacy. Practitioners and commissioners of services should acknowledge the importance of research to practice.

> There is a need for multi-level interventions that target not only parenting practices but also aetiological factors affecting the parent.

> The effective reduction of child emotional maltreatment requires that staff working at all service levels have the necessary skills to work more 'therapeutically' with families.

Examples of early attachment-based interventions

Pre-birth and infant assessment offers valuable opportunities for early help with vulnerable families.

Parent Infant Psychotherapy (Anna Freud Centre)

The Parent-Infant Relational Assessment Tool (PIRAT) is an observational measure designed to assess the quality of parent-infant interactions in a variety of settings. PIRAT is grounded in clinical practice, psychoanalytical thinking on the primary parent-infant relationship and infancy research, and aims to reflect the needs of health-care professionals working with parents and infants in their workplace settings. It was developed specifically for use by a range of health professionals with or without a clinical training and in a variety of work settings (eg, clinic, home, nursery).

PIRAT focuses on the dyadic quality of interactions between mothers/fathers/caregivers and infants/toddlers and provides global ratings of parent-infant and infant-parent interactions (affects and behaviours).

Often the signs of disturbed interactions are quite subtle and even interactions that do not immediately provoke anxiety in the observer can be precursors of later social and emotional difficulties. PIRAT enables the user to codify his or her observations and set them within a validated assessment framework of the parent-infant relationship observed in interactions.

PIRAT is adapted for infants and toddlers from 0 to 24 months, and can be applied to 'live' or videotaped observation of ten minutes' free play, with or without toys. Go to: **http://annafreud.org**

Family Nurse Partnership

The Family Nurse Partnership is a voluntary home-visiting programme for first-time young mums aged 19 or under (and dads). A specially trained family nurse visits regularly, from early in pregnancy until the child is two years old. For more information see: **http://fnp.nhs.uk**

What can practitioners do? How to approach your work with children

Practitioners can do a lot to build positive relationships. However, as we have seen, much of the research focuses on understanding the *state of mind* of insecure children – especially those indicating disorganised attachment behaviour and 'fear without solution' experiences – and how it operates. When a child is terrified of their caregiver, or is being abused by them, they develop an 'internal working model' of relationships that basically tells them: '*I'm rubbish, I don't matter, I'm unlovable.*' This is how their brain makes sense of what is happening. It's a way of coping with relationships in the short term, but not in the long term.

Practitioners should bear in mind that the more they try to reach out to and care for a child who has developed this internal model, the more likely it is that the child will reject them. Children who show very marked attachment disorganisation are likely (albeit unconsciously) to do things to *make* adults reject them. Practitioners are then lassoed into confirming this poor self-image.

Experienced child protection practitioners will immediately recognise this process. The effect is likely to make the practitioner feel incompetent and so respond with inappropriate levity, superficial humour or even hostility towards the child. (The same applies, of course, to working with parents and caregivers.)

So what can practitioners do to interrupt this vicious circle? When working with children (and carers) who have been abused, neglected and maltreated – and so who experience great difficulty organising their attachment system – always try to be:

> available, loving, caring

> interested, responsive

> sensitive, accessible

> co-operative and trustworthy.

Above all, aim never to be:

> unavailable, unloving

> uninterested, unresponsive

> neglectful, hostile

> rejecting, inaccessible

> ignoring or untrustworthy.

Try to avoid 'big gestures' or 'empty' statements, especially at the beginning of your work with a child (or carer), such as: *'I'll always be there for you', 'I won't let you down', 'You're a really nice kid.'*

So how *do* you show a child that you care and that you won't let them down?

> Be on time. If you're late, explain to the child why you're late (otherwise they automatically think it's because you don't care).

> Discuss and clarify what's going to happen … and then make sure it does. If for some reason it doesn't, explain why (but try and make sure that it does). The aim is to create predictability, which is the bedrock of relationship security.

> Early on, praise the child's *behaviour* rather than the child *per se.* Say, 'I really liked the way you coloured in the sea and the grass,' rather than, 'You're fantastic at art'.

> Try and avoid 'big treats' as they are likely to go wrong. Because the child finds it very hard or impossible to tolerate 'nice things' happening to them, they will often sabotage 'nice things'.

> Instead, perhaps try a visit to the park or bake a cake together; do something more personal and 'slow'. Speak in a calm and reassuring voice; don't get too animated, as it can frighten abused children.

> Remember: it's *what you do and how you are* that make a child feel secure, not what you *say*. But also bear in mind that when you do this, the child is likely to test you a great deal: *'Is this person for real? I need someone like her/him, but I don't yet believe s/he's as s/he seems.'*

The principles of PACE

Dan Hughes (2009) suggests that when practitioners are working with children and families, they should try and adopt the principles of PACE:

> *Playfulness*

> *Attunement*

> *Curiosity*

> *Empathy*.

Hughes recommends a useful approach for working with children, which puts these principles into practice. For example:

'The girl in your picture looks very angry. Look how strong she is, fighting the men; do you think she is very frightened? I bet she could use some help, even though she is so strong.'

OR:

'That baby calf looks very frightened because he can't find his mummy. Do you think he needs some help to get back to her?'

Notice how this type of talking does not focus directly on a child's own experience.

Read an interview with Dan Hughes at: **www.jkp.com/blog/2012/03/interview-kim-golding-daniel-hughes-creating-loving-attachments**

David Howe points out:

'Sensitive care-giving helps children learn about and understand how their bodies and senses work.' **(Howe, 2005)**

It is helpful at times to explain gently and calmly a child's feelings 'back to them'. For example:

> *'Your tummy's full; that's probably why you feel sleepy.'*

> *'You're cold, that's why you're shivering and feeling unhappy, so I'm going to put on your nice, warm jacket and then you'll feel better.'*

Helping children develop empathy

In her book *Inside I'm Hurting* (2007), Louise Bombèr offers advice on how to help children develop empathy. In the box below are a few examples. All these suggestions assume that you know the child fairly well, so that at least they believe you're not dangerous. The aim is, gently, to let the child know you 'hold them in mind'. (But take great care if the child has been sexually abused, as s/he may significantly mis-read what you say).

Supporting children to develop empathy

> In order for a child to develop empathy, they first need to have had a positive experience of being kept in mind by another. Unless an adult is right in front of them and focusing on them directly, many children with attachment difficulties believe they are not being held in mind. This is terrifying for the child – they feel abandoned.

> Try something like: *'Isn't it good to know that even when you are not right in front of me, that I think about you? I have you in mind in my photo, in my heart and in my mind.'*

> Very young children find transitional objects helpful, such as: a small cuddly toy, a hankie with scent of on it, a key ring with photo, a note in their lunchbox, perfume or scent on their collar. (This applies to many older children also, but you have to respect their peer relationships.) (Bombèr, 2007)

Maintaining professional self-awareness and insight

Resources for developing attachment-based techniques

You will find plenty of other ideas for developing attachment-based techniques in the following resources:

> *Chatter Matters* – a DVD presented by Dr Tanya Byron **http://icancharity.org.uk/resources/chatter-matters**

> *Toddler Talk* – an activity pack http://icancharity.org.uk/resources/toddler-talk

> *Talk Together* – an illustrated eight-page booklet which can be bought (in printed form) or downloaded (for free) in a number of languages **http://icancharity.org.uk/resources/talk-together**

Visit the online shop at **www.ican.org.uk** to view a range of other resources.

Children who are abused or neglected and who demonstrate disorganised attachment behaviour can be very demanding emotionally. This means practitioners need to be aware of their own behaviour, because their own attachment systems will be regularly activated. After all, it's very painful for a practitioner who can't find the right family for a child or can't stop the child's unhappiness. It's especially hard if you're pretty sure a child is being harmed but feel you can't do anything about it. At such times our own memories of rejection, some of them unconscious, are churned up.

We might also revisit the concept of projection here. Sometimes, when a child feels bad s/he might cope with the bad feelings by trying to make someone else feel bad as well. This is an essentially unconscious process, of course. Professionals often then feel useless, de-skilled, not liked etc. – much like the children do.

One very experienced practitioner remembers vividly how, when a judge had overruled the local authority's request for a care order, she had to take the child back home again afterwards. The boy looked at her and asked her to promise she wouldn't take him back to his parents. But that's exactly what she was about to do: she had no choice. Finding a way of dealing with this without becoming hard, cynical and brittle is an important task for practitioners. (Good supervision is key to this; see the Research in Practice resources (2016) on reflective supervision: **www.rip.org.uk/ resources/publications/recent-publications**).

Practitioners can use attachment theory and research in their work with children and families by reflecting on their own attachment behaviour. For example, child protection practitioners should be aware that if they are avoidantly attached, they might unconsciously minimise the feelings of others – perhaps through inappropriate levity, superficiality or humour. In contrast, ambivalently attached practitioners are likely to be unpredictable and rejecting, precisely at the point when they are needed most.

Understand your own attachment 'style'

To get an idea of your own attachment 'style', try Chris Fraley's self-report measure – the revised Experiences in Close Relationships (ECR-R) questionnaire: **http://internal. psychology.illinois.edu/~rcfraley/measures/ ecrr.htm**

In her book *Nurturing Attachments: Supporting children who are fostered and adopted*, clinical psychologist Kim Golding reminds us that:

You will know that empathy is low when you find yourself responding to your child with: anger; despair that you are not understanding or helping your child; feelings that you cannot continue to provide a home for your child; feelings that your child is selfish and ungrateful; frustration that your child is not taking responsibility for her behaviour.

(Golding, 2008)

Supporting mentalisation: working with adults likely to have experienced unremitting stress as children

... The heart of good mentalising is not so much the capacity to always accurately read one's own or another's inner states, but rather a way of approaching relationships that reflects an expectation that one's own thinking and feeling may be enlightened, enriched and changed by learning about the mental states of other people. In this respect, mentalising is more like an attitude than a skill, an attitude that is inquiring and respectful of other people's mental states, aware of the limits of one's knowledge of others, and reflects the view that understanding the feelings of others is important for maintaining healthy and mutually rewarding relationships.

(Fearon et al, 2006)

For most parents who abuse or neglect children, interventions that aim specifically to increase the carer's capacity to *mentalise* – ie, to appreciate and show curiosity about others' intentions, hopes, fears and feelings – are likely to be the most effective. This is especially so when they are augmented with approaches to resolve early traumatic losses and trauma and to attune parents more to the needs of their children.

Peter Fonagy lists the key elements of what he calls 'the mentalising stance' (the opposite of which, therefore, imply *low mentalisation*):

> greater inquisitiveness, curiosity and open-mindedness

> the ability to live with a degree of uncertainty

> concentrating more specially on the mind of another person (Allen et al, 2008).

Working to increase a caregiver's mentalising capacity requires two conditions:

> firstly, the professional needs to focus the person's mind onto *someone else's mind* – often the *professional's*

> secondly, the carer needs regularly to receive mentalised experiences *from* the professional.

So, for example, a minimally *empathic* response might include something along the lines of '*When I did/said [X], this makes you angry because ...*' However, a *mentalised* response would look more like this:

'I'm finding it really difficult to hear what you are saying at the moment – but I very much want to. Can I ask that you try and stop shouting as I can't concentrate and I know I'm likely to be a bit defensive.'

Then, assuming they *do* stop, or at least calm down sufficiently, you can follow this up:

'If I've done something to upset you, I'd really like to know what it is, because I may be able to explain myself better or stop doing what's upsetting you.'

Mentalised responses therefore might be thought of as 'empathy plus'. And remember too that mentalisation is a two-way, reciprocal process: it's about 'seeing oneself from the outside and others from the inside'.

Using a mentalised approach: an example

The following example is taken from Shemmings and Shemmings (2011) and illustrates how a social worker used a *mentalised response* to encourage a mother's mentalising capacity.

A social worker visited a mother (Jean) who quickly became angry with her, but not, so it seemed, about anything specific. Jean admits that she 'can often fly off the handle at nothing'. All of a sudden, and apparently out of the blue, Jean railed against the worker, along these lines:

'Who do you think you are? You get on my nerves, coming here in your brand new green car. You have no idea what it's like for me living on this estate. It's a dump.'

In fact, the mother had become very close to the social worker and had already said she could talk to her about aspects of her life that she'd never discussed before. The social worker asked the mother (gently but firmly, and without any hint of annoyance) if she could try and stop shouting, and offered to make her a cup of tea and find her favourite chocolate biscuits.

When a sufficient amount of calm had ensued, the social worker said:

'I'm really sorry if I've said or done something to upset you, Jean. I'd like you to try and tell me what it was but could you explain one thing first please. Am I correct in thinking that you believe that I am kind of rubbing your nose in it when I pull up in my new car?'

If Jean apologises, they can then both reflect on what happened and how it might relate to any patterns around anger expression. If, on the other hand, Jean holds her ground and continues with the point about the car, then the social worker will need to explore this non-defensively (*'How and when did this develop?'* etc.).

The key question that the social worker and Jean need to discuss, however, is:

'What does Jean think is in the social worker's mind, when the social worker drives up in her new car?'

Provided that the social worker can explore this openly (as it is possible that she *is* unwittingly giving this impression) it is likely to reveal problems with mentalisation. The point of this approach is to encourage Jean to mentalise with the social worker, not for the worker *solely* to empathise with Jean.

The social worker encourages Jean to consider that 'the same behaviour may be experienced differently and thought about differently by different minds' (Allen et al, 2008). The aim is not necessarily to raise insight about *why* they hold a particular view of the worker, but rather to engender curiosity as to '*why, given the ambiguity of interpersonal situations, they choose and stick to a particular version*' (Allen et al, 2008).

In wondering why a parent might be doing this, we help them give up 'the rigid, schematic ... mode of interpreting their subjectivity and others' behaviour' (Allen et al, 2008). The individual progressively moves out of their mind into another's by being gently nudged to consider questions such as: '*What do you think might have been in her mind for her to do that?*' and '*What indications did you see to make you think she was thinking this way?*'

Lois Sadler and colleagues at Yale University, who worked on the *Minding the Baby* project (a home-visiting programme for young at-risk urban families learning to care for their first child), came to a rather sobering conclusion:

Understanding that the baby has feelings and desires is an achievement for most [participants]. **(Sadler et al, 2006)**

The authors continue:

*One mother, for example, began to tease her child when he cried after catching his finger in the door. 'You're a faker' she exclaimed, mocking him. The home visitor gently spoke for the baby: 'Ooh that hurt. You're kinda scared and want Mommy to make it feel better.' Thus, she was first trying to help the mother to perceive **accurately** the child's intention.'* **(Sadler et al, 2006 – original emphasis)**

The video-based interventions (see box on page 34) all adhere to some extent to a mentalisation-based approach. For child protection practitioners, an additional attraction is that all explicitly use strengths-oriented methods.

Three video-based intervention tools

The Video-feedback Intervention to Promote Positive Parenting (VIPP)

VIPP is a preventive intervention that aims to increase sensitivity in parents and improve their discipline strategies, thereby improving parent-child interaction, the parent-child relationship and reducing behavioural problems in young children. VIPP has been developed by the Centre for Child and Family Studies at Leiden University, which offers training packages for practitioners.

Go to:
www.leidenattachmentresearchprogram.eu/vipp/en

Marte Meo (Latin: 'On one's own strength')

MARTE MEO training programmes cover different areas of child development (as well as other areas of human interaction) and enable practitioners to use video as a critical tool ('a behavioural microscope') to work with parents and carers in analysing and learning from everyday interactions with their children.

Go to:
www.martemeo.com/en/About-Marte-meo/FAQs

Video Interaction Guidance (VIG)

VIG is a technique that can be used with parents, carers and families to improve communication and relationships. It involves participants viewing and then discussing short recordings of their successful interactions.

Go to: **www.videointeractionguidance.net**

Working with children who display traumatised behaviour

As we have seen, the research on interventions is clear that a practitioner's focus needs to centre on *states of minds*: of the child *and* of the carer. To make sense of an individual's behaviour, we need to get a good idea of what's going on in their head. But this doesn't mean you need to learn to be clairvoyant or a mind-reader – powerful insights into the way a child's mind is working can be gained from well-honed observational skills and from techniques aimed at gaining an insight into a child's *state of mind with regard to attachment*.

On page 35 we signpost and describe some tools and techniques, including the *Three Houses* tool and the *Three Islands*, for you to use when communicating with children who display disorganised attachment.

Signs of Safety and the 'Three Houses' technique

Signs of Safety (Turnell and Edwards) includes the use of a number of child-friendly tools, such as the Three Houses tool, the Fairy/Wizard tool, and the Safety House tool. These support children to reveal some of their hopes, wishes and fears in ways that are often easier to express for a child who indicates disorganised attachment. (The Three Houses technique is described in Eileen Munro's review of child protection: Munro, 2011, pp 30-31). You can watch Yvonne Shemmings demonstrating the Three Houses technique at:
http://player.vimeo.com/video/45905899

The Signs of Safety website includes videos in which practitioners describe how they have used the approach in practice. Go to:
www.signsofsafety.net

And you can read more about the tools in the NSPCC-commissioned evaluation of Signs of Safety in England (Bunn, 2013) at:
**www.nspcc.org.uk/services-and-resources/
research-and-resources/2013/signs-of-safety-
model-england**

Three Islands

The Three Islands technique was developed by Kate Iwi from the West London Alliance's Advanced Child Protection Programme. Three Islands helps the practitioner gain insight into a child's life without the use of question and answer interviews, which some children find intimidating.

The practitioner draws three islands, one at a time, and then addresses features of one island at a time before moving on to the next one.

1. One island is where the child lives.
2. Another island is joined to the child's island by a gated bridge. This is where potential visitors to the child's island live. But the child has the only key to the gate – and so the child controls who visits and when.
3. There is a third island further away which is not joined to the child's island.

Ask the child to put who and what they want onto their island – and to decide who might be able to visit sometimes (ie, they put these people on the visitors' island). When will they be allowed to visit the child's island? Who lives on the island far away? What is in the water? (See Figure 5.1 for an example of a child's three islands.)

Children can use colours and/or pictures to draw these people. The practitioner should ask open questions about what the colours and pictures and positions of different people mean to the child.

Read more about the Three Islands technique (as well as the Three Houses tool and the Faces technique) here: **www.communitycare.
co.uk/2011/11/07/social-work-tools-for-direct-
work-with-children-drawing**

Figure 5.1 An example of the Three Islands technique

Observations and the use of techniques on their own are of little use without understanding the theoretical principles underpinning them. As Marian Brandon and colleagues at the University of East Anglia put it, after analysing all 350 Serious Case Reviews between 2003 and 2007:

Theoretically informed explanations are able to accommodate and make sense of what might otherwise appear to be a simple accumulation of facts ... They guide observations. They sponsor curiosity and new lines of enquiry. They offer a framework and a language that enable different professional groups to communicate.
(Brandon et al, 2008)

Learning at the Anna Freud Centre

The strapline for the Anna Freud Centre is '*Caring for young minds*'. As well as providing training in the use of many of the assessment measures listed in Section 4, the Anna Freud Centre also runs training courses in the theory and practice of mentalisation-based interventions for children and families.

Go to: **www.annafreud.org/training-research/ training-and-conferences-overview**

Teachers have more contact with children than most other practitioners and classroom teachers have also developed attachment-based practice for vulnerable children in their charge. Two excellent examples of evidence-informed interventions that can be used with groups of children are **Roots of Empathy** groups and **Nurture Groups**. Both have been shown to increase children's 'secure base' experiences (see box).

Attachment-based practice in groups

Roots of Empathy is an evidence-based classroom programme that has shown significant effect in reducing levels of aggression among schoolchildren while raising social/emotional competence and increasing empathy. As well as increasing knowledge of human development, learning, and infant safety, it aims to foster the development of empathy, develop emotional literacy, reduce levels of bullying and violence, and promote children's pro-social behaviours. Go to: **www.rootsofempathy.org**

Nurture Groups are grounded in attachment theory and work in primary schools and other settings to help build children's emotional resilience and social skills, help them engage with their peers and communities, and form secure and happy relationships. Go to: **http://nurturegroups.org**

Messages for practice

> The most effective interventions are those that aim directly to increase parental or carer sensitivity and parents' capacity to mentalise – in other words, to promote synchronous behaviour and to support parents in becoming more accurately attuned to their child's needs. These have been shown to be successful in improving insensitive parenting as well as infant attachment security.

> Children who show disorganised attachment behaviour are likely to do things to make adults reject them. Practitioners must work hard to be available, caring, sensitive and trustworthy. As their own attachment systems will be activated, practitioners must also maintain awareness of the potential for their own attachment experiences to impact on their work.

> For most parents who abuse or neglect children, interventions that aim specifically to increase their capacity to mentalise are likely to be most effective. This is especially so when augmented with approaches to resolve early traumatic losses and traumas.

> Practitioners should aim to adopt a mentalised approach when working with adults likely to have shown disorganised attachment behaviour as children. Video-based interventions can be particularly helpful in supporting work with parents and carers. With children, a range of tools is available to help practitioners gain insight into a child's state of mind with regard to attachment.

> For a child to develop empathy, they must first have positive experiences of being held in mind by someone else. Children who show disorganised attachment behaviour are likely to believe they are not kept in mind unless an adult is in front of them and focusing directly on them. For these children, practitioners can use mentalisation-based strategies and techniques to strengthen attachment.

Conclusion

Attachment to a parent or carer is a foundation for a child's experience of the world. It is about relationships and so is subtle and complex. All humans share a common set of attachment needs and goals – to have people who are close (primary caregivers) who act as a secure base and safe haven.

When children are securely attached to their caregivers, they are more resilient and better placed to deal with 'ups and downs' across their lifespan. Typically, about 60 per cent of people will have enjoyed secure attachment relationships.

A large proportion of people – around 40 per cent of the population – will show signs of insecure attachment, either avoidance or ambivalence. They may benefit from a practitioner's awareness and sensitive response to this, but unless the signs or behaviours are severe, insecure attachment behaviour is not in itself reason for alarm. Assessments by trained practitioners can help to identify severe attachment problems, which can have a physical cause or involve gene-environment interaction and so may or may not be the result of maltreatment.

Disorganised attachment behaviours can be triggered by the child's dilemma of experiencing anxiety for *themselves* or *for their carer* conflicting with a fear of the carer. There are a number of assessment techniques that trained practitioners can use to assess the child and the parent or carer.

Research also suggests that the most effective interventions aim directly to increase parental or carer sensitivity and the capacity to mentalise or envision their child's needs and respond more accurately to them. A number of techniques and exercises can help practitioners work with adults or carers likely to have shown disorganised attachment behaviours as children (as well as with children who are currently showing such behaviours). These often focus on greater sensitivity, insight and response to what is going on in someone else's head.

Attachment theory and evidence-informed approaches to putting this knowledge into practice in direct work can be valuable in supporting children, young people and families throughout the life course. Pregnancy is a time of huge change for parents who are often very motivated not to repeat family patterns. Engaging parents pre-birth and working with parent-infant relationships from birth offers opportunities to improve outcomes for children. Techniques for direct work with children and adolescents can support building relationships of trust and positive attachment experiences. Understanding adult attachment patterns and their implications for parenting will be enormously valuable in partnership work with parents.

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