ATTACHMENT AND REFLECTIVE FUNCTIONING IN CHILD WELFARE ASSESSMENT: A MIXED METHODS STUDY

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Abstract

This thesis explores the relevance of attachment theory to child welfare assessment practice.

Concerns have been raised regarding possible misunderstandings and misuses of attachment theory in child welfare practice, but there has been limited empirical investigation of this. Study A explored the role of ideas about attachment in the thinking of social workers when conducting an initial assessment of family cases with child welfare concerns. Semi-structured interviews, including discussion of family case vignettes, were conducted with 23 UK-based child and family social workers. Findings indicated that understanding and use of attachment theory in UK child welfare assessment practice is considerably more varied than previously proposed. The findings imply that ideas from attachment theory have further potential to enhance social workers' understanding of families, and suggest changes to social work education.

Practitioners' attachment states of mind on the Adult Attachment Interview have been found to have multiple implications for professional practice, but there has been very little research on implications for child welfare practice specifically. Study B examined the relationship between practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns. The study did not find that practitioners' (N = 61) attachment states of mind predicted differences in their case risk ratings. However, the practitioners' attachment coherence of mind was found to be positively associated (r = .38) with their capacity to attend to the mental experiences of family case members (their reflective functioning).

Taken as a whole, the research suggests that attachment theory has considerable relevance to child welfare assessment practice. The theory can be applied by practitioners to inform their understanding of the children and families they work with. The theory can also help to explain some differences in the ways practitioners think about children and families.

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Author’s Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas, and contributions from the work of others.

Ethical clearance for the research presented in this thesis has been approved. Approval was sought and granted through the researcher's submission to Northumbria University's Faculty of Health and Life Sciences Research Ethics Committee on 7th June 2016.

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Chapter 1: Introduction and Background

The overarching aim of this thesis is to explore the relevance of a particular psychological theory – attachment theory – to child welfare assessment practice. This chapter commences with an overview of attachment theory and research. This will be followed by consideration of the different ways attachment theory has relevance for child welfare practice. The focus and aims of the research, and the reasons for these, will then be discussed. The chapter will end with an overview of the thesis structure.

1.1 Overview of Attachment Theory and Research

This first section provides a summary of key concepts, research findings and developments in attachment theory. The purpose is to provide background context for the rest of the thesis. In order to consider the relevance of attachment theory for child welfare practice, it is important to first examine what attachment theory comprises and proposes. This overview does not attempt to be exhaustive but instead pays particular attention to aspects of attachment theory and research relevant to child welfare practice and the empirical studies within this thesis. The understanding of attachment theory presented here was shaped by, and is indebted to, the detailed historical study of attachment theory and its concepts by Duschinsky (2020).

1.1.1 The Development of Attachment Theory

Attachment theory was initially developed by John Bowlby. Bowlby was interested in the nature of child-caregiver relationships, their immediate function and importance for the child, and their implications for later social behaviour and mental health (Cassidy, 2016).

Bowlby's training and observations as a clinician with children and families shaped the development of attachment theory. In his work at the London Child Guidance Clinic, Bowlby began to theorise that early major separations from key caregivers could predispose later behavioural issues (Bowlby, 1944). Bowlby also trained as a child analyst, and he started to develop the ideas that would become attachment theory as a response to limitations he identified in psychoanalytic theory (especially Kleinian) at that time, including what he saw as an overemphasis on the role of fantasy and imagination. Bowlby's new theory had some continuity with psychoanalytic theory,

including consideration of the implications of early experience and family relationships for later development and behaviour, the mediating role mental representations of early experience can have, and the major impact of loss of an attachment figure (Lay et al., 1995). The theory was not simply an amended psychoanalytic model however. Bowlby also drew on ethological theory to think about the functions of relational behaviour. He proposed that children are born with an instinctual predisposition to form and maintain selective attachments to key caregivers and that this predisposition evolved because of its survival value. Bowlby also combined elements of cognitive theory in order to think about how experiences come to shape mental models and expectations of caregivers and later other relationships, which in turn shape behaviour (Bowlby, 1969/1982). Bowlby's theory created a new paradigm in child development, and spawned a substantial programme of research that continues today. This research has produced many important findings for understanding close relationships, parenting, socio-emotional development, and mental health. It has also led to refinements and expansions of Bowlby's original theory, as well as the development of assessment measures and attachment-based interventions.

1.1.2 The Attachment Behavioural System, Attachment Behaviour, and its Function

Drawing on ethological ideas, Bowlby developed the idea of an attachment behavioural system. He saw this as one of a number of behavioural systems that have evolved through natural selection, with others including the exploration system, the fear system, and the caregiving system. Each behavioural system was proposed to have a species-level function as well as activating and terminating conditions for their expression. The attachment system was proposed by Bowlby as having the function of protection from harm (Bowlby, 1969/1982).

Whilst attachment theory proposes that the attachment behavioural system has been evolutionarily selected and is species-universal, children are not born with attachments or with a fully functioning attachment behavioural system. The foundations for attachment behaviours and relationships start to build over the first 6 months of a child's life and it is only by between 6-9 months of age that a child achieves clear cut attachment relationships with their key caregivers (Marvin et al., 2016).

Bowlby mainly emphasised the seeking of proximity to familiar caregivers ('attachment figures') as the set-goal of the attachment behavioural system, due to the evolutionary

advantage that proximity to an attachment figure conferred in relation to protection from predation. As time went by, he broadened this to the seeking of availability, a term that encompassed both accessibility to proximity and potential responsiveness (e.g., in Bowlby, 1973, pp.200-201). In both conceptualisations, Bowlby saw proximity as key, whether as the sole terminating condition or one essential part of a set of terminating conditions.

Whilst attachment bonds are enduring, attachment behaviours are only activated (and thus are only observable) under certain conditions. Bowlby proposed that the attachment system is activated by alarm or potential separation from familiar caregivers, which leads to the display of attachment behaviours aimed at achieving the set-goal of the attachment system (proximity to attachment figures) and is terminated by the achievement of that set-goal. The attachment figure is therefore used as a 'safe haven' in times of alarm (Bowlby, 1958b). Ainsworth would later introduce a second key use of the attachment figure, that of a 'secure base' from which a child could venture out in exploration, knowing safe haven provision is available if needed (Ainsworth & Wittig, 1969). Ainsworth (1973) described how these different uses of the attachment figure related to the interplay between different behavioural systems: with activation of the attachment and fear systems linked to safe haven use, and sufficient activation of the exploratory system to override the attachment and fear systems linked to secure base use.

Bowlby proposed that children will have different thresholds for the activation and termination of the attachment system, depending on their past experience and on their developmental stage. Likewise, which specific behaviours would be displayed to attempt to achieve the set-goal of the attachment system would depend on the current environment circumstances, past experience (with behaviours that had previously been successful in achieving the set-goal more likely to be displayed), and developmental stage (Bowlby, 1969/1982). Therefore, whilst Bowlby's theory presented the attachment behavioural system as something that is lifelong and that all humans are born with a disposition to develop, the thresholds for when it is activated as well as the observable behavioural expression of it are changeable. Consequently, attachment theory can explain diverse observable behaviours as motivated by the same underlying behavioural system.

Based on Bowlby's conceptualisation of the attachment behavioural system as serving the function of protection, attachment can be understood as one important part of the

infant-attachment figure relationship but “not an overall descriptor of the relationship between the parent and child which includes other parent-child interactions such as feeding, stimulation, play or problem solving” (Prior & Glaser, 2006, p.15). Some subsequent attachment researchers have encouraged a wider focus than Bowlby’s and have proposed additional evolutionary functions of attachment, including learning. Ainsworth introduced focus on the use of the attachment figure as a secure base for exploration, and her caregiver sensitivity concept and measure considered not only sensitivity to distress cues but also to social cues. Some attachment researchers, including Mary Dozier, have followed this wider focus, but emphasise the importance of distinguishing the distress-related and non-distress-related aspects of the relationship and acknowledge that these “are likely separable, may be predicted by different variables and may show differential effects on children’s outcomes” (Bernard et al., 2013, p.508). Other researchers have expressed concerns over what they see as broadening of the term attachment to mean the whole of the infant-parent relationship, and have argued for maintenance of a narrow focus and conceptualisation of the attachment bond as only related to the elements of the infant-parent relationship associated with protection and safe haven seeking (e.g., Goldberg et al., 1999). Different attachment researchers continue to draw different boundaries around which aspects of the infant-caregiver relationship are considered in scope as ‘attachment’ and which are not.

1.1.3 Discriminated Attachment Figures and Relationships

A key part of Bowlby’s attachment theory related to the idea of discriminated relationships, i.e., that a young child learns through experience to focus and prioritise their attachment behavioural responses towards particular individuals rather than indiscriminately to anyone. Bowlby proposed that the discrimination of these particular individuals is determined by familiarity (regular contact and interaction) and not, as was proposed by psychoanalytic and behaviourist theorising at the time, based on feeding.

Bowlby moved between broad and narrow conceptualisations of the idea of ‘attachment’ (Duschinsky, 2020). At times, especially in his early work, he used the term broadly to mean any emotionally-invested relationships. However, as his thinking developed, Bowlby used the term ‘attachment’ in a technical sense for the enduring affectional bond from infants to familial caregivers (often parents) who are discriminated and sought as a safe haven in the context of alarm. Furthermore, whilst

Bowlby wrote about attachment figures, when he gave this specific attention (e.g., Bowlby 1969/1982) he clarified that what he meant was safe haven availability.

Bowlby also considered how others beyond familial caregivers can serve a safe haven function. For instance, in line with his view of attachment as a lifelong behavioural system with maturational changes in its expression, he proposed that from adolescence onwards “groups and institutions other than the family” can be used as safe havens in times of need (Bowlby, 1969/1982, p.207). Bowlby also suggested that people treat their home as a safe haven (Bowlby, 1973, p.147). Bowlby’s view of who (or indeed what) could be an attachment figure/serve as a safe haven was therefore far more expansive than just familial caregivers. Yet despite this, even today criticism is still levelled (e.g., Garrett, 2023) at Bowlby’s attachment theory for focusing on biological mothers as attachment figures.

In some of Bowlby’s writing, especially that for popular audiences and written as he was first developing his ideas, he did emphasise the role of the mother (e.g., Bowlby, 1958a). However, this stands in contrast to his nuanced discussion of attachment figures in his academic writing. The inconsistency in Bowlby’s writings on this likely reflected an attempt to balance the demands of not only developing a detailed set of new theoretical proposals but also a desire to emphasise and promote key ways these proposals represented a new way of thinking. Making appeal to popular ideas of the time supported the ‘selling’ of this paradigm shift (Duschinsky, 2020). Bowlby was also likely influenced by his Kleinian psychoanalytic training, in which the term mother was used as a synonym for primary caregiver rather than to necessarily mean the biological mother (Hinshelwood, 1989). To take one example, in Bowlby’s (1958b) paper he carefully defined his use of the term monotropy to mean “responses … directed towards a particular individual *or group of individuals* [emphasis added] and not promiscuously towards many” (p.370), whilst titling that same paper “the nature of the child’s tie to his *mother* [emphasis added].” In the first volume of his trilogy, Bowlby (1969/1982) clearly states his position, that “many children have more than one figure towards whom they direct attachment behaviour … the role of a child’s principal attachment-figure can be filled by others than the natural mother” (p.304).

Subsequent attachment researchers have continued to recognise that child-mother attachment relationships are not the only attachment relationships possible, nor the only ones with importance for a child’s development. Research has been conducted on the child-father attachment relationship (see Lucassen et al., 2011, for a meta-analysis)

and on other attachment relationships including those between children and their child-care providers (see Ahnert et al., 2006, for a meta-analysis). Nonetheless, it is widely acknowledged that there has been insufficient attention to attachment relationships beyond those between children and mothers in research (Duschinsky et al., 2023) and attachment-based interventions (Steele & Steele, 2021) to date. It is promising therefore to see increasing appetite for focus on the wider attachment network from current attachment researchers (including a 2021 special issue on this in Child & Adolescent Development). Meta-analytic research published in this special issue reports findings that the attachment relationships with both parents are important for, and have an influence on, how likely it is that a child will develop internalising or externalising problems (Dagan et al., 2021). The special issue also contains research on how the behaviour of grandmothers can influence the infant-parent relationship (Liang et al., 2021), showing the importance of considering the wider attachment network: not only as potential additional attachment figures for children, but also as a support for primary attachment figures to children.

Guided by the idea of young children needing the protection of someone older or wiser, the emotional bond from parent to young child has typically been conceptualised by both Bowlby and subsequent attachment researchers as under the remit of a different behavioural system: the caregiving system. The function of the caregiving system is provision of protection and support. The caregiving system was proposed by Bowlby as motivating the caregiver's reciprocal response to the child's attachment system driven behaviours (Bowlby, 1969/1982). Emphasising the distinctions and differences between the attachment system and the caregiving system is helpful. However, Bowlby (1979) did also acknowledge that parents, when alarmed, may look to their own child for reassurance "more often than might be supposed" (p.157). Therefore, whilst attachment theory does not conceptualise the normative bond from a parent to infant as an attachment bond, this does not preclude the possibility that this bond can sometimes be understood in these terms.

1.1.4 The Importance of Stability of Attachment Relationships

Emphasising the importance of discriminated relationships also supported thinking within the attachment theory paradigm about the importance of the stability of attachment relationships, and the impact of major separations from attachment figures. Bowlby founded a research group focused on separation in the late 1940s and together with James Robertson, a social worker, he studied the responses of children separated

from their parents due to extended hospitalisation. Bowlby and Robertson's observations led them to theorise that children responded to their failed attempts to regain their familiar caregivers by ultimately inhibiting, at both an emotional and behavioural level, their intense and painful yearnings for their caregivers. This inhibition was theorised to lead to the avoidant, depressed, and/or disoriented behaviour the children were often observed as displaying on reunion with the caregivers. Bowlby named this 'detachment' though did not mean to imply by this that the child no longer had an attachment bond to the caregiver (Bowlby, 1960). Bowlby and Robertson's work on separation helped call into question the prevailing view at the time that when children stopped protesting a separation this was positive and a sign of 'settling in', and ultimately led to fundamental changes in hospital visitation (White et al., 2020).

Attachment theory's emphasis on the importance of discriminated relationships, and the importance in turn of familiarity for building these, also helps provide insight into why institutional care involving frequent rotation of caregivers can be so deleterious for a child's socio-emotional development (van IJzendoorn et al., 2020). Psychiatric attachment-related disorders were added to the ICD and DSM to describe behaviours first observed among children who had spent their infancy in orphanages where there was limited or no opportunity to form selective attachment relationships (Zeanah et al., 2005). Two disorders have been developed. Reactive Attachment Disorder describes withdrawn and inhibited behaviour "with no consistent displays of attachment behaviors directed to anyone" (Zeanah et al., 2016, p.992). Disinhibited Social Engagement Disorder was initially described in attachment terms, i.e., as the indiscriminate display of attachment behaviours, but more recently has been conceptualised as the indiscriminate display of social behaviours, leading Zeanah et al. (2016) to highlight that "one may reasonably question whether it is an attachment disorder at all" (p.992). Reactive Attachment Disorder and Disinhibited Social Engagement Disorder are thought to be rare, though prevalence data are not available (Allen & Schuengel, 2020). However, research in both the UK and USA has found issues with overuse of the specific term Reactive Attachment Disorder and the unspecific term 'attachment disorder' in community assessment of fostered and adopted children who in clinical assessment did not meet the diagnostic criteria (Allen & Schuengel, 2020; Woolgar & Baldock, 2015). This suggests that, while the phenomena might be rare, a desire to describe behavioural issues as disorders of attachment is less so.

Though attachment disorders and attachment theory and research share the term 'attachment', the conceptualisation of psychiatric attachment disorders has occurred

largely independently of attachment theory and research. There has also been limited overlap or dialogue between research on Reactive Attachment Disorder and Disinhibited Social Engagement Disorder on the one hand, and research in the attachment theory paradigm on the other (Duschinsky, 2020). The attachment theory paradigm has predominantly focused on studying the implications of individual differences in the quality of attachment relationships, rather than on the implications of the absence of opportunity to form full attachment relationships.

1.1.5 Infant Attachment Patterns (Classifications)

In the 1950s, Mary Ainsworth conducted ethnographic observations of mother-infant interactions in Uganda, followed by observations of families in Baltimore in the 1960s. Ainsworth noted that some children appeared to have greater confidence in their caregiver's ability to provide a safe haven and secure base. As an addition to the longitudinal home observations in the Baltimore sample of mother-infant dyads, Ainsworth developed a brief standardised laboratory observation named the 'Strange Situation' (Ainsworth et al., 1978/2015). The assessment starts with the parent and child in an unfamiliar playroom environment. The parent twice leaves the room and twice returns. During the first separation a friendly stranger is present throughout. During the second separation the child is initially left alone. The unfamiliar environment coupled with separations were expected to activate the child's attachment behavioural system, with the procedure designed to allow observation of the child's use of the caregiver as a safe haven on reunion, and as a secure base for exploration of the playroom and the toys within it once the attachment system was no longer overriding the exploratory system.

From their observations of children's responses in the Strange Situation, Ainsworth et al. (1978/2015) identified three main patterns of infant attachment behaviour. Some children showed distress on separation, displayed attachment behaviour aimed at re-achieving proximity with their caregiver, and were rapidly soothed and able to return to exploration on their caregiver's return (labelled 'B' or secure). However, some children showed little or no observable distress on separation and did not directly seek their caregiver as a safe haven on reunion (labelled 'A' or insecure-avoidant). Other children showed distress on separation but remained distressed after reunion with their caregiver and struggled to use their caregiver as a secure base from which to return to exploration (labelled 'C' or insecure-resistant). Ainsworth et al. found that the children who were classified secure had experienced different care from their caregivers in the

home to those classified insecure (see Section 1.1.9). The distribution of these patterns of attachment behaviour in the sample of 106 infants reported in Ainsworth et al. (a sample which comprised the Baltimore study plus doctoral projects) was 66% secure, 21% avoidant, and 13% resistant. A later meta-analysis by Verhage et al. (2016) found that across 2,666 infant-caregiver dyads the distribution of these classifications was 60% secure, 23% avoidant, and 17% resistant. Secure may be the most common pattern of attachment, but insecure infant attachment is far from uncommon.

Ainsworth et al.'s (1978/2015) system for coding patterns of attachment behaviour included a series of scales for measuring different sets of behaviour: proximity/contact-seeking, contact-maintaining, resistance, and avoidance. However, Ainsworth et al. ultimately chose to categorise the patterns of behaviour "as a first step toward grasping the organization of complex behavioral data" (p.55). Classification was therefore considered to be valuable for their purposes, but Ainsworth et al. also emphasised Hinde's caution about the "limitations of classificatory systems. If pressed far enough, they do not work. The categories are tools, not 'absolutes'" (p.56). In line with this caution, Ainsworth et al. proposed their classificatory system of infant attachment patterns as "a useful tool in achieving a beginning of understanding … not an end in itself" (p.57). Duschinsky (2020) highlights, however, that at other times Ainsworth did appear to treat the infant attachment patterns as reflecting 'natural kinds' and this has been further emphasised by some subsequent attachment researchers, including Main (see below). Using taxometric analysis, Fraley and Spieker (2003) examined whether the patterns are qualitatively or quantitatively different. Their findings suggested that individual differences in infant attachment would be better represented dimensionally rather than categorically. Categorical rather than dimensional measurement of infant attachment has continued to maintain dominance in subsequent attachment research to date however.

A key part of Bowlby's attachment theory was outlining the expectable functioning and expression of the attachment behavioural system and the secure pattern of behaviour Ainsworth observed matched clearly to Bowlby's description of the attachment behavioural system. The avoidant and resistant patterns did not appear to fit. But ethological theory, which had been very influential on the development of the idea of the attachment behavioural system, emphasised how there is an evolutionary survival advantage to behavioural systems containing a range of 'conditional strategies' from which individuals can draw depending on the environmental conditions (Hinde, 1982). For the attachment behavioural system, that would indicate that other strategies than

proximity-seeking might be used where proximity-seeking was not feasible or effective. Seen in this light, the avoidant and resistant patterns did not challenge Bowlby's conceptualisation of the attachment behavioural system as universal, but instead could be understood as "conditional strategies for maintaining proximity to a parent whose responsiveness is inconsistent, or otherwise limited" (Main, 2000, p.1077).

Main (1979) posited that avoidant attachment behaviour, despite ostensibly seeming to contradict the proposal that the set-goal of the attachment system is proximity, may serve the function of achieving *relative* proximity for an infant whose caregiver tends to rebuff them if they make a direct bid for proximity. Resistant behaviour may serve to retain the attachment figure. Avoidance and resistance can therefore be viewed as adaptations. Main (1980) wrote, "rather than seeing avoidance of a (rejecting) attachment figure as unhealthy or maladaptive … I see it as a highly adaptive response pattern … evidence for a healthy child's ability to adapt to the exigencies of differing styles of parenting."

At the level of mechanisms, Main conceptualised the different attachment patterns/strategies as being underpinned by differences in attentional processes, specifically where attention is directed, with "an organized shift of attention away from conditions activating attachment behavior in Group A infants, and a heightened vigilance maximizing responsiveness to even minimal clues to danger in Group C infants" (Main, 1993, p.233). Main went further in her theorising however, viewing the three attachment patterns Ainsworth had identified as representing "the three basic strategies used by all humans, whether infants or adults, for handling distress in interpersonal contexts" (Duschinsky, 2020, p.217).

The different attachment patterns can be understood as reflecting individual differences in the *form* (often termed differences in *quality* by attachment researchers, see, e.g., Forslund et al., 2022) but not the *strength* of attachment relationships. The proposal that insecure attachments are not weaker attachments was supported by research that found that infants who display avoidant behaviour in the Strange Situation (behaviour which on the surface might be thought an indication of a 'weaker' attachment bond) are experiencing similar physiological stress at the separation from their attachment figure as secure infants (Spangler & Grossmann, 1993).

The Strange Situation was "designed to elicit artificially what it might take a long period of observation in the home to notice" (Ainsworth & Marvin, 1995, p.6). But some

important clarifications were provided to this. One was that the specific attachment pattern behaviours described and operationalised in the Strange Situation did not necessarily transfer to other settings, as “the design of the strange situation activates attachment behaviour at higher intensity than is usually the case in the familiar home environment, and therefore one cannot expect behaviour there to be precisely the same as at home” (p.303). Indeed, in their home observations, Ainsworth et al. (1978/2015) found that children who showed avoidance in the Strange Situation often showed comparatively more distress and frustration with their caregivers in the home. Thus, whilst the avoidant and resistant patterns of behaviour appear very different from each other in the particular circumstances of the Strange Situation, in home settings the infants showing these two insecure patterns displayed quite similar behaviour. The Strange Situation in its original form is also designed only for use with children of 12-20 months (Granqvist et al., 2017). Other assessments of attachment patterns have been developed for use with older children, which account for development-related changes (Solomon & George, 2016).

A meta-analysis by Opie et al. (2021) found moderate (r = .28) levels of stability in attachment security/insecurity across early childhood. A meta-analysis (Pinquart et al., 2013) of longitudinal studies found no significant stability in attachment security from childhood to adulthood. Taken together, these findings provide empirical support for the idea that attachment patterns are not fixed but are responsive to changes in environmental conditions (see also Section 1.1.8).

1.1.6 Infant Disorganised Attachment

Not all infants displayed behaviour that could be classified as secure, avoidant, or resistant in the Strange Situation, and this was especially the case in samples containing infants known to be maltreated (Hesse & Main, 2000). Mary Main together with Judith Solomon reviewed infant behaviours in the Strange Situation that interrupted or did not fit well within the original three patterns from across a variety of laboratories. Based on this review, they introduced a new Strange Situation classification, ‘disorganised/disoriented’ (Main & Solomon, 1986), and developed a set of thematic indices for the various typologies of behaviour they had identified (Main & Solomon, 1990):

> (1) sequential display of contradictory behavior patterns; (2) simultaneous display of contradictory behaviour patterns; (3) undirected, misdirected,

> incomplete, and interrupted movements and expressions; (4) stereotypies, asymmetrical movements, mistimed movements, and anomalous postures; (5) freezing, stilling, and slowed movements and expressions; (6) direct indices of apprehension regarding the parent; and (7) direct indices of disorganization or disorientation (p.135).

The behaviours Main and Solomon observed and included as the first five indices of this new classification were similar to the 'conflict behaviours' that had been observed in animals when two contradictory behavioural systems were activated simultaneously (Hinde, 1970) and that were theorised to also be of relevance to humans (Bowlby, 1969/1982). The behaviours included as the final two indices suggested disruption of the attachment system (Solomon et al., 2017). Strange Situation coders do not count the number of these behaviours shown, but instead rate how certain they are that the observable behaviour of an infant indicates conflict or disruption of the attachment system (Duschinsky, 2015). A meta-analysis by Madigan et al. (2023) of more than 20,000 Strange Situations found the prevalence of disorganised attachment to be 23.5%.

Disorganised attachment behaviours are often brief interruptions, with the infant otherwise displaying one of the original three patterns (which Main came to describe as 'organised') identified by Ainsworth. Where the disorganised classification is assigned, if the infant also displays one of the underlying organised attachment patterns, this is also assigned (Hesse & Main, 2000). The disorganised classification can therefore be considered to run orthogonal to the organised attachment patterns. Thus, an infant may be classified as disorganised with a secondary classification of secure, for example. Different combinations may have different implications and an underlying secure pattern does not necessarily confer benefits. A study by Lyons-Ruth et al. (2013) reported the interesting finding that infant disorganised attachment with a secure secondary classification was uniquely predictive of recurrent suicidal thoughts or self-harm at 20 years of age. However, in general this is not an avenue that researchers have explored, even with the large, pooled data available from individual participant data meta-analysis (Verhage et al., 2020). Instead, researchers have tended to treat disorganised attachment as a discrete category for the purposes of analysis.

As children mature past infancy, disorganised attachment behaviours can develop into controlling role-inverting behaviour toward the parent, which can be controlling in an overly solicitous caregiving manner (overly solicitous) or a harshly directive punitive manner (Main & Cassidy, 1988; van IJzendoorn et al., 1999). Whilst early findings

suggested that it might be common for disorganised behaviour to develop into controlling behaviour by preschool age, a meta-analysis found the opposite: that continued behaviourally disorganised behaviour is twice as likely as controlling behaviour in preschool children (Deneault et al., 2023).

Disorganised attachment has been linked to later externalising symptoms (Fearon et al., 2010, and see Section 1.1.7), and on this basis Lyons-Ruth and Jacobvitz (2016) have argued that the disorganised attachment classification should be revalidated for diagnostic use as a measure of later psychopathology. However, Zeanah and Lieberman (2016) have explicitly argued against such an approach. A key reason that they give is that diagnosis must be of individual trait-like properties, not the dynamics particular to a specific relationship. There is no association between disorganised attachment behaviour with one caregiver and with another in the Strange Situation (van IJzendoorn et al., 1999), which indicates that the phenomenon is relationship-specific, at least in infancy. Zeanah and Lieberman therefore argue that not only is it inappropriate to press disorganised attachment into service in a diagnostic role, but that doing so would contravene the basic function of diagnosis.

1.1.7 Developmental Outcomes

Attachment researchers have hypothesised that attachment insecurity is a risk factor for lower social competence with peers and for the development of mental health symptoms. Longitudinal studies have provided some of the most insightful empirical evidence to date of the impact of early attachment experiences on later development. One such study was the Minnesota longitudinal study, which commenced in the 1970s. One of the strengths of this study was that multiple types of assessments were conducted in relation to a wide range of factors. This enabled not only the examination of the impact of attachment, but also the impact of this relative to other factors. In this study, some of the clearest links to later behaviour were from infant attachment patterns (Sroufe et al., 2005), with associations found between the infant attachment patterns and various individual characteristics as well as relationship competence. Drawing on data from this study, an association was also found between infant disorganised attachment and psychopathology in adolescence (r = .34; Carlson, 1998), dissociation in adolescence (r = .36; Carlson, 1998), and borderline personality disorder symptoms in adulthood (r = .20; Carlson et al., 2009). Whilst the Minnesota study found infant attachment assessments to be a greater predictor of later behaviour differences than any other single predictor, supporting theoretical claims of their

importance for development, Sroufe et al. (2010) cautioned for interpretive restraint, highlighting that associations were sometimes small, and that infant attachment plus other factors often predicted later developmental outcomes more strongly than infant attachment alone.

Furthermore, and as has also been found in wider psychological and scientific research, individual attachment research studies have produced research findings that have not always been replicated in subsequent studies (see van IJzendoorn & Bakermans-Kranenburg, 2021). The 'replication crisis' means that meta-analytic findings provide more dependable evidence than individual study findings, and a number of attachment-focused meta-analyses have been conducted. In a meta-analysis of 80 samples involving more than 4,000 children, Groh et al. (2014) found that attachment avoidance (r = .09), resistance (r = .14) and disorganisation (r = .12) were all related to lower social competence with non-familial peers: defined as social skills (such as ability to make friends and interpersonal awareness), peer interaction quality (such as play behaviour and helping behaviour), and social status (such as popularity and likability). In a meta-analysis of 34 studies involving more than 3,500 children, Fearon et al. (2010) found that attachment avoidance (r = .06) and disorganisation (r = .17) were significantly related to later externalising behaviour problems: defined as aggression, oppositional problems, conduct problems, and/or hostility. They found no significant relationship between resistance and later externalising problems. In a meta-analysis of 22 studies involving more than 3,000 children, Groh et al. (2012) found that attachment avoidance (r = .09) was significantly related to later internalising symptoms: defined as depression, anxiety, social withdrawal, and/or somatic complaints. They found no significant relationship between resistance or disorganisation and later internalising symptoms. In all three of these meta-analyses, the strength of the associations found did not vary with the age at which the outcomes were assessed, suggesting that, where attachment patterns are related to children's mental health and social competence, this is typically a more enduring than short-term effect. Considered together, these meta-analyses provide some support for the hypothesis that infant attachment insecurity is associated with later lower social competence and greater mental health symptoms. However, associations were not found between all the insecure attachment subtypes and mental health symptoms, and the significant associations found were sometimes quite small and at most moderate in size.

1.1.8 Developmental Processes

As seen in the previous section, some relationships have been found between infant attachment and later outcomes. However, Alan Sroufe and colleagues involved in the Minnesota study made the point that "understanding developmental processes underlying continuity and change is more important than simply understanding that early experience often predicts later behavior" (Sroufe et al., 2010, p.44).

Bowlby paved the way for not just testing the relationship between experiences and later developmental outcomes, but theorising about the processes that contribute to any such relationships. Bowlby drew on cognitive theories to conceptualise how attachment experiences may become internalised into mental representations. Bowlby termed this an 'internal working model of attachment'. He proposed that this model is a set of expectations, built up from the history of experiences of how a caregiver responds to attachment needs, which then affects interpretations and behaviour (Bowlby, 1969/1982). Internal working models are conceptualised as being actively and continuously constructed, and as having a propensity for stability but without being fixed (Main et al., 1985). More recently – and building on the advances in understanding of mental representations that have occurred in the field of cognitive psychology since the time Bowlby was developing attachment theory – Waters and Waters (2006) have proposed that script-like representations of a secure base experience are a specific and important component of mental representations of attachment.

Bowlby also considered ways that adverse childhood experiences can have developmental effects: "First they make the individual more vulnerable to later adverse experiences. Secondly they make it more likely that he or she will meet with further such experiences" (Bowlby, 1988, p.37). These ideas were reinforced by the researchers working on the Minnesota longitudinal study. Reflecting on their research findings, they proposed that early experiences lead to certain patterns of adaptation which then impact on the subsequent environment, setting in motion a chain of events, with each impacting the next. "Individuals actively participate in processes of constructing experience congruent with their relationship history by interpreting and selecting experiences and behaving in ways that are consistent with earlier experience" (Carlson et al., 2004, p.67).

Though Main stated that the patterns of adaptation seen in infant avoidant and resistant attachment are not unhealthy or maladaptive, empirical findings do suggest that they are associated with increased risk of some negative developmental outcomes, as compared to secure attachment. A way of understanding this can be to distinguish between the *immediate* functions of adaptations and potential *later* implications of them. Avoidant and resistant attachment can be seen as beneficial for ensuring an infant obtains what they can from their current attachment figures (Main, 1980), but longer term and applied to other contexts these strategies can disrupt a child's capacity to directly express their attachment needs, and potentially disrupt their ability to regulate their emotions and develop good interpersonal relationships (Slade, 2004).

Bowlby (1973) encouraged attention to the importance of 'developmental pathways', a model of developmental trajectories that he explained using the analogy of a rail system:

> A system that starts as a single main route which leaves a central metropolis in a certain direction but soon forks into a range of distinct routes. Although each of these routes diverges in some degree, initially most of them continue in a direction not very different from the original one. The further each route goes from the metropolis, however, the more branches it throws off and the greater the degree of divergence of direction that can occur. … Once a train is on any particular line, pressures are present that keep it on that line; although, provided divergence does not become too great, there remains a chance of a train taking a convergent track when the next junction is reached (p. 365).

This is a nuanced and hopeful conceptualisation of developmental trajectories, and one that can be used to help understand both continuity and discontinuity in development. In line with this, Sroufe et al. (2010) posited that early attachment experiences may have particular importance because the expectations and adaptations they create then become the starting point for subsequent transactions. Sroufe et al. concluded that "early experience can be conceptualized in terms of creating vulnerabilities or strengths with regard to later experience, including what experiences are sought and how they are interpreted, rather than as directly producing particular outcomes" (p.38). And later experience is also important. In their longitudinal study, Sroufe et al. found that the effects of earlier and later experiences were often cumulative, and that the potential impact of early experiences were sometimes transformed by later experiences. Similarly, the longitudinal NICHD study of early childcare and youth development found limited stability in attachment security from infancy to late adolescence but found that

changes in attachment security were theoretically expectable. For example, those who changed from infant attachment security to later insecurity had experienced a greater increase in negative life events and a greater decline in maternal sensitivity than those who maintained attachment security (Roisman & Booth-LaForce, 2014). Like in Bowlby's theorising, these research studies, and the picture they build of developmental processes, recognise and take into account complexity and change.

1.1.9 Caregiving Behaviour Precursors of Infant Attachment Patterns

As well as theorising and empirical research on sequelae of infant attachment patterns, there has also been theorising and research on precursors of infant attachment patterns. Mary Ainsworth highlighted that it is "the presence of the caregiving figure rather than the caregiving behavior that is essential for the attachment to develop" (Ainsworth & Marvin, 1995, p.14). This idea of the importance of presence rather than particular behaviour for who a child uses as a safe haven has been supported empirically too. Umemura et al. (2013) found that when both parents are available, a distressed 24-month-old will typically seek as a safe haven the parent who they spend the greatest amount of time, even if this is not the parent they have a secure attachment relationship with. However, this does not mean that the response of the caregiver is irrelevant. Differences in how a caregiver typically responds to their child has been found to influence the security of the attachment relationship a child forms to their caregiver. In terms of what elements of caregiving response are important, two have emerged as particularly pertinent from attachment theory and research to date: 1) sensitive caregiving behaviour and 2) alarming caregiving behaviour.

From the Baltimore longitudinal study, Ainsworth identified caregiver 'sensitivity' as important for infant attachment security. Ainsworth's definition of sensitivity focused on the caregiver's "ability to perceive and to interpret accurately the signals and communications implicit in her infant's behavior, and given this understanding, to respond to them appropriately and promptly" (Ainsworth et al., 1978/2015, p.357). Ainsworth's definition of caregiver sensitivity did not therefore refer to a general characteristic within the caregiver such as warmth, but instead to the caregiver's focus on and response to their child's specific cues. Indeed, Ainsworth emphasised that "there is a great difference between maternal warmth and maternal sensitivity" (Ainsworth & Marvin, 1995, p.11). Ainsworth developed a scale for assessing caregiver sensitivity in extended (12+ hour) naturalistic observations. This sensitivity scale has been used in, and has been extremely influential for shaping, subsequent attachment

research (Posada et al., 2021). However, the specifics of what Ainsworth meant by caregiver sensitivity have been unavailable to those outside of the research community until recently, as Ainsworth's sensitivity scale only became generally accessible in an appendix of the 2015 reprint of Patterns of Attachment.

Ainsworth et al. (1978/2015) reported an effect size of $r = .78$ for the association between mothers' sensitivity and their infants' attachment security in the Baltimore study. A later meta-analysis (De Wolff & van IJzendoorn, 1997) found an effect size of $r = .22$ and a subsequent meta-analysis (Madigan et al., in press) found an effect size of $r = .26$ for the association between maternal sensitivity and child attachment security, and $r = .21$ for paternal sensitivity and child attachment security. The meta-analytic evidence supports a robust link between sensitivity and attachment security but suggests the strength of the association is moderate. The larger association found in Ainsworth et al.'s (1978/2015) study is likely due to this also having been the development sample for the caregiver sensitivity and infant attachment measures (van IJzendoorn & Bakermans-Kranenburg, 2021) and potentially also due to caregiver sensitivity being assessed via extensive naturalistic observation rather than a brief structured observation (Posada et al., 1999). Research has found stronger associations between caregiver sensitivity and infant attachment security when sensitivity has been assessed in longer observations (Madigan et al., in press) and from multiple observations (Lindhiem et al., 2011). Research has also found stronger associations between caregiver sensitivity and child attachment security when attachment is assessed using the Attachment Q-Sort ($r = .31$) rather than the Strange Situation ($r = .24$; Madigan et al., in press). The Attachment Q-Sort (Waters, 1995) was designed to be used in observation of normal child-caregiver interaction in naturalistic settings, and is suitable for use with older children as well as infants.

Changes in caregiver sensitivity have been found to predict changes in children's attachment pattern over time (Beijersbergen et al., 2012), supporting the proposal that attachment patterns are not fixed traits within a child but developed in response to differences in caregiving sensitivity and amenable to change in response to caregiving sensitivity changes. Beijersbergen et al. suggest that attachment theory should be recognised as "a theory of sensitive parenting as much as it is a theory of attachment" (p.1281).

Research has found associations between caregivers' sensitivity and their children's developmental outcomes. A meta-analysis by Cooke et al. (2022) found an association

between insensitive caregiving and child externalising behaviour (r = .14) and a weaker but still significant association between insensitive caregiving and child internalising symptoms (r = .08). These are highly comparable to the associations found in meta-analyses between infant attachment insecurity and externalising (r = .15; Fearon et al., 2010) and between infant attachment insecurity and internalising behaviour (r = .08; Groh et al., 2012). Therefore, whilst caregiver sensitivity is only moderately associated with infant attachment security, both seem to have similar levels of notable but modest predictive power with regards to some later outcomes for children.

In parallel with the continued debate on which aspects of the child-parent relationship should be considered attachment-related (see Section 1.1.2), there is also continued debate on which aspects of caregiver behaviour are important for attachment security and for positive child development outcomes. While the current evidence base suggests that caregiver sensitivity is important, differentiating between and considering both caregiver sensitivity to distress cues and sensitivity to non-distress cues may be useful, as different combinations of sensitivity/insensitivity to these two types of cues have been found to differentially predict child attachment patterns (Leerkes & Zhou, 2018). Furthermore, Ainsworth et al. (1978/2015) did not claim that caregiver sensitivity was the only aspect of caregiving behaviour of importance, and sensitivity was just one of four aspects of caregiver behaviour for which they developed measurement scales. Ainsworth et al. also developed scales for “cooperation vs. interference with infant’s ongoing behaviour” (pp.363-368), “physical and psychological accessibility vs. ignoring and neglecting” (pp.368-373) and “acceptance vs. rejection of the infant’s needs” (pp.373-379). Bailey et al. (2015) found that these different dimensions of caregiver behaviour are differentially associated with infants’ attachment patterns. Attachment researchers continue to explore what caregiving behaviours most influence differences in children’s attachment security and how best to capture these in an assessment. As an example, initial research on one new assessment which focuses on ‘secure base provision’ suggests that this may be more predictive of infant attachment security than caregiver sensitivity (Woodhouse et al., 2020), though replication of this in other samples is still required.

1.1.10 Caregiving Behaviour Precursors of Infant Disorganised Attachment

An early indicator of some caregiver behaviours associated with infant disorganised attachment came from observation of the greater prevalence of the classification in high-risk and maltreatment samples. In an early study of disorganised attachment first reported in Carlson et al. (1989), the prevalence of infant disorganised attachment in a sample of infants known to have been abused and/or neglected was compared to prevalence in a sample of infants with no child protective services involvement. In the maltreatment group, 18 of the 22 infants (82%) were classified as disorganised, compared to four of the 21 infants (19%) in the comparison group. However, other studies have not replicated this > 80% finding. A meta-analysis on maltreatment and disorganised attachment (van IJzendoorn et al., 1999) found that, across studies, 48% of children in 'maltreatment' samples, 25% in 'poverty' samples, and 15% in 'low-risk middle-class' samples are classified as showing disorganisation in the Strange Situation. Therefore, whilst a strong association between maltreatment and disorganised attachment has been found (with a combined effect size of r = .41 in van IJzendoorn et al.'s, 1999, meta-analysis) the findings show the overlap between maltreatment and infant disorganisation is far from 1:1.

Maltreatment was not something that Bowlby had focused on in his theorising and research, but this was not due to him viewing maltreatment as unimportant in relation to attachment and later development. Bowlby disclosed that he focused on separation and loss due to these being easier to ascertain and measure than maltreatment (Duschinsky, 2020). Not giving more attention to abuse was something Bowlby later expressed regret over (Bowlby (1990/2015). An important spur for attention to maltreatment among attachment researchers was the introduction of the disorganised attachment classification and discovery of the links between disorganisation and maltreatment. Mary Main and Erik Hesse theorised that an infant frightened by their caregiver will experience an "irresolvable, disorganizing and disorienting paradox" (Hesse & Main, 1999, p.484). This is because the attachment system motivates an infant to approach their attachment figure when frightened but the fear system motivates an infant to escape from alarming stimuli. The infant therefore experiences approach-flee conflict as the caregiver is "at once the source of and the solution to its alarm" (Main & Hesse, 1990, p.163). They proposed that caregiver behaviour which could cause this conflict could include direct maltreatment, but also more subtle frightening parental behaviour resulting from the caregiver's own unresolved

experiences of loss and other trauma (Hesse & Main, 1999, 2006; Main & Hesse, 1990).

Main and Hesse developed a system for identifying dissociative, threatening, frightened, role-inverting, sexualised, or disorganised/disoriented parental behaviour ('FR behaviour') during observation of a parent in interaction with their child (see Hesse & Main, 2006, for a summary of the categories, plus illustrative examples). A later meta-analysis of six studies involving 325 infant-parent dyads found a moderate association (r = .32) between FR behaviour in the parent and disorganised attachment behaviour in the infant (Madigan et al., 2006). Lyons-Ruth and colleagues later developed the AMBIANCE system, which included Main and Hesse's FR items plus additional atypical maternal behaviours anticipated to alarm the infant (see Lyons-Ruth & Jacobvitz, 2016, for a summary). Meta-analysis of four studies involving 384 infant-parent dyads found a moderate association (r = .35) between anomalous behaviour in the parent coded using AMBIANCE and disorganised attachment behaviour in the infant (Madigan et al., 2006). The size of the association between both measures and disorganisation supports proposals that frightening and other alarming parenting behaviour can be a precursor of infant disorganised attachment, but also suggests that other factors are at play too. This is a finding Main and Hesse themselves foreshadowed when they proposed FR behaviour as "one highly specific and sufficient, *but not necessary* [emphasis added], pathway to D attachment" (Hesse & Main, 2006, p.310).

1.1.11 Wider Influences on Infant Attachment Patterns

Whilst the focus on parental caregiving behaviours as precursors to differences in infant attachment has sometimes been criticised for contributing to mother/parent-blaming discourses (e.g., White et al., 2020), Bowlby emphasised the importance of supporting parents on multiple occasions. Bowlby (1951) stated "If a community values its children it must cherish their parents" (p.84). Duschinsky (2020) also highlights how, in a 1953 book on 'The Roots of Parenthood':

> Bowlby emphasised that caregiving is dependent on the material and social resources available to a parent, which support a caregiver's energy, patience, and courage in the face of the demands of caring for a child. Without support, a caregiver may well "give up trying", no matter that "they would like to give their children all that good parents do." Bowlby condemned government inattention to "the poverty of mothers with young children" and called on his readers to "campaign unremittingly until it is remedied" (p.58).

The influence of wider family circumstances on infant attachment security has been a focus of some attachment research. Research on the impact of wider family networks (see Section 1.1.3) is one example. The impact of socioeconomic risk is another. Raikes and Thompson (2005) found that economic risks (including unemployment and single parenthood) can have an indirect effect on children's attachment security via the effect they can have on caregiving sensitivity, and that emotional risks (including domestic violence and a family member with anger problems) can have a direct effect on children's attachment security. A meta-analysis of research on the relationship between domestic violence and infant attachment insecurity found an association of r = .24 (McIntosh et al., 2021). In another meta-analysis, Cyr et al. (2010) found that children exposed to high socioeconomic risk were as likely to show disorganised attachment behaviour as maltreated children. High socioeconomic risk was defined in Cyr et al.'s meta-analysis as five of the following risk factors: low income, maternal substance misuse, ethnic minority group, single parenthood, adolescent parenthood, and low education.

Differences in the patterns of attachment shown by children do appear to be driven predominantly by environmental rather than temperamental factors. A meta-analysis examining the association between temperament and each of the infant attachment patterns found negative temperament to have a modest association with resistant attachment (Groh et al., 2017), suggesting the possibility that there might be some genetic influence on this attachment pattern. However, the findings overall suggested that temperament and attachment patterns are relatively independent.

1.1.12 Adult Attachment States of Mind

In the mid-1980s, as part of their ongoing Berkeley longitudinal study, Mary Main and colleagues developed the Adult Attachment Interview (AAI; George et al., 1985). This is a semi-structured interview in which the interviewee is asked to describe childhood experiences with attachment figures and to evaluate the effects of these experiences upon their functioning. Main et al. (1985) found that parents' responses to the AAI could be categorised into patterns that were associated with the attachment pattern their child displayed towards them. The attachment experiences the interviewee reported to have had in childhood did not seem to be the critical factor and did not determine categorisation (a feature of additional benefit considering empirical evidence of the unreliability of retrospective accounts of childhood experience, e.g., see Baldwin et al., 2019; van IJzendoorn & Bakermans-Kranenburg, 2014). Instead, the way in

which the interviewee in the present talked about and reflected on their past attachment relationships and experiences were what seemed to predict differences in their children's attachment to them (Main et al., 1985).

Some interviewees respond to the interview task in a way that is coherent (consistent and collaborative). They discuss their experiences and feelings relatively openly and objectively, acknowledge the value of attachment relationships, and support their evaluation of their childhood experiences with specific and appropriate memories. These interviewees also appear able to flexibly attend to both the interview task and their childhood memories. This pattern was ultimately termed 'secure-autonomous' (Main et al., 2003) and in the Berkeley longitudinal study the parents who responded to the interview in this way tended to have children who were securely attached to them in infancy (Main et al., 1985). Other interviewees seem remote from or unwilling to discuss feelings and attachment related relationships, thoughts, and memories. They might minimise the importance of attachment experiences, downplay the effects of difficult attachment experiences and potentially even present them as ultimately beneficial, portray their childhood relationships as positive but be unable to provide supporting evidence or provide contradictory evidence, derogate attachment figures or attachment-related feelings, and/or block questions through insistence of a lack of memory. This pattern was ultimately termed 'insecure-dismissing' (Main et al., 2003) and in the Berkeley longitudinal study the parents who responded to the interview in this way tended to have children who were avoidantly attached to them (Main et al., 1985). A third group of interviewees seem to struggle to focus on the requirements of the interview. Some express current and excessive anger towards an attachment figure, and others talk in a vague, confusing, irrelevant, or excessively long-winded way. This pattern was ultimately termed 'insecure-preoccupied' (Main et al., 2003) and in the Berkeley longitudinal study the parents who responded to the interview in this way tended to have children who were resistantly attached to them (Main et al., 1985).

Alongside these global ('organised') patterns of response to the interview, Main also identified that some interviewees displayed some disorganisation (in the form of significant contradiction, confusion, disorientation, or absorption) in their thinking and/or their discourse when discussing one or more experiences of loss or abuse. This pattern was ultimately termed 'unresolved/disorganised' (Main et al., 2003) and in the Berkeley longitudinal study the parents who responded to the interview in this way tended to have children who displayed disorganised attachment in the Strange Situation (Main & Hesse, 1990).

Prior to the development of the AAI, empirical attachment research had been focused on the behavioural level and on children. With the AAI, Main introduced a 'move to the level of representation'. Unlike the Strange Situation, the AAI does not assess security in relation to a particular relationship. Initially Main et al. (1985) drew on Bowlby's concept of internal working models of attachment alongside her own theorising about attentional differences to make sense of the different patterns of response to the AAI:

> Internal working models of relationships … provide rules for the direction and organization of attention and memory, rules that permit or limit the individual's access to certain forms of knowledge regarding the self, the attachment figure, and the relationship between the self and the attachment figure. These rules will be reflected in the organization of thought and language as it relates directly and indirectly to attachment. Many will be unconscious (p.77).

Main later proposed that what is captured by the AAI classifications is an adult's 'state of mind with respect to attachment' (Main et al., 2003). In this conceptualisation the focus is on attentional processes rather than mental representations. For Main therefore, like also theorised in relation to the avoidant and resistant infant attachment patterns, dismissing and preoccupied attachment states of mind are viewed as conditional strategies involving alterations in the focus of attention (Duschinsky, 2020). It is still uncertain, however, to what extent the different patterns of response delineated by Main et al. are capturing individual differences in attention and communication that relate solely to attachment-related information (and, if so, what precisely the boundaries would be on what constitutes attachment-related information) or extend beyond attachment-related information (and, if so, how broadly). A study by Crowell et al. (1996) involved administration of both the AAI and an interview about work-related experiences, which was coded using scales similar to Main et al.'s AAI scales. Crowell et al. found that the work-related interview discourse classifications were independent of the AAI classifications. This finding lends some support to an argument that the response patterns captured by the AAI classifications relate specifically to attachment-related information. However, more recent research has found that it is possible to reliably predict a patient's AAI classification from their discourse in a transcribed extract of a psychotherapy session even if there is not discussion of attachment-related topics within the extract (Talia et al., 2015), and from a post-treatment interview obtained outside of psychotherapy (Talia et al., 2019b). These findings potentially lend support to an argument that the AAI classifications are capturing individual differences in discourse that extend beyond attachment-related information. An alternative interpretation of Talia et al.'s (2015, 2019b) findings is that psychotherapy is an

attachment context, because safe haven and secure base dynamics are involved. Some questions remain regarding precisely what is being captured by the AAI classifications. Nonetheless, the AAI and coding system are clearly tapping something of importance, considering how differences in response to the AAI have been found to be associated with a wide range of aspects of interpersonal and emotional functioning, as discussed further below.

In their development sample, Main et al. (1985) reported an effect size of $r = .62$ for the association between mothers' attachment state of mind security and their infants' attachment security. Ainsworth and Eichberg (1991) reported an effect size of $r = .60$ for the association between mothers' unresolved loss or trauma and their infants' disorganised attachment in a second development sample, with the coding system continuing to undergo refinement. A later meta-analysis (Verhage et al., 2016) found an effect size of $r = .31$ for the relationship between mothers' attachment state of mind security and their infants' attachment security, and $r = .21$ for the relationship between mother's unresolved status and their infant's disorganised attachment. Like with the association between mothers' sensitivity and infants' attachment security, the meta-analytic evidence suggests the associations are robust, but modest. These associations have been found even when the AAI is conducted prenatally (Fonagy et al., 1991a). These associations have also been found with caregivers who are not biological parents. Significant associations have been found, for example, between adoptive mothers' attachment states of minds and their adopted children's attachment patterns (Barone & Lionetti, 2012; Lionetti, 2014). These findings all point to a form of intergenerational transmission.

A theorised, and later empirically supported, mediator in the association between a parent's attachment state of mind and their infant's attachment classification is the parent's caregiving behaviour. Parental attachment states of mind have been found to be related to caregiving sensitivity, and this is even the case when attachment states of mind are measured prenatally (Haltigan et al., 2014). Parents with an autonomous attachment state of mind have been found to be typically more sensitive than parents with an insecure attachment state of mind, with a meta-analysis of 95 samples containing nearly 5,000 parents reporting an association of $r = .20$ (Verhage et al., 2016). Verhage et al. highlighted that caregiver sensitivity only partly accounts for the transmission, and thus there is still a 'transmission gap', meaning that other as yet unidentified factors are also at play. A further link has been found between unresolved attachment states of mind and an increased likelihood of these parents displaying

frightening and other anomalous parenting behaviour: with a meta-analysis of seven samples containing over 500 parents reporting a significant association of r = .26 (Madigan et al., 2006). To narrow the transmission gap further, Verhage et al. point to contextual factors such as family functioning, the relationship between parents, and family support, and recommend such factors are considered and tested in future studies.

Associations have also been found between a person's attachment state of mind and their behaviour towards people besides their children. Hesse (2008) commented that "it is remarkable that on the basis of language alone, AAI coders are able to significantly predict how speakers will behave with others, including offspring, partners, friends, and even those to whom they have been newly introduced" (p.555). Roisman (2006) found that adults with an autonomous state of mind demonstrated more positive engagement with a stranger in a challenging puzzle-building task than those with a dismissing or preoccupied state of mind, showing that attachment states of mind are associated with differences even in initial interactions with strangers in a non-attachment-related context. In another study showing that the associations go beyond interpersonal behaviour with those already known to a person, Dykas et al. (2012) found that adolescents' attachment states of mind were associated with how positively they recalled an interaction with an unfamiliar peer. Associations have also been found between clients' attachment states of mind and their behaviour towards (Talia et al., 2014) and views about (Green et al., 2012) the professionals working with them.

In a combined non-clinical and not-at-risk sample comprising more than 4,000 AAIs, Bakermans-Kranenburg and van IJzendoorn (2009) reported an attachment state of mind classification distribution of 56% autonomous, 29% dismissing and 14% preoccupied. The prevalence of unresolved loss and/or abuse (which is assigned alongside one of the other classifications) was 16%. Like with the infant attachment patterns, autonomous may be the most common attachment state of mind classification in non-clinical samples, but the insecure classifications are far from uncommon. Bakermans-Kranenburg & van IJzendoorn also calculated the combined distribution for clinical and at-risk samples, which was 33% autonomous, 39% dismissing and 28% preoccupied. The prevalence of unresolved loss and/or abuse was 38%. In clinical samples therefore, a large majority are classified insecure.

Like with Ainsworth's infant attachment patterns, there has been debate over whether the adult attachment states of mind reflect true categories or might be better

represented dimensionally (Roisman & Booth-LaForce, 2014; van IJzendoorn & Bakermans-Kranenburg, 2014). The coherence scale from Main and colleagues' attachment state of mind coding system is commonly used "as an omnibus assessment of "security" in analyses" (Roisman & Booth-LaForce, 2014). Reviewing the arguments for categorical versus continuous measurement of attachment states of mind, van IJzendoorn and Bakermans-Kranenburg propose "the pragmatic use of both categorical and continuous measures" (p.162) due to both having heuristic value.

Other measures have also been developed to assess various facets of attachment in adulthood. Alternative methods of coding the AAI have been developed: the Adult Attachment Q-Sort (Kobak, 1993) and the Reflective Functioning (RF) Scale (see Section 1.1.13). An assessment of individual differences in secure base script knowledge (the Attachment Script Assessment; Waters & Waters, 2006) has also been developed and has been found to be associated with a parent's caregiving sensitivity and the security of their infant's attachment to them (Crowell et al., 2016). The AAI has also been adapted for adolescents: the Friends and Family Interview (Steele & Steele, 2005a) and the Child Attachment Interview (Target et al., 2003).

There is a separate body of research measuring individual differences in adult attachment styles which began with a focus on romantic attachment and utilises self-report instruments. This attachment research developed in the social psychology tradition, and there has been limited crossover between this and attachment research conducted in the developmental psychology tradition (Duschinsky, 2020). Furthermore, despite having some shared language ('adult attachment', 'secure attachment', etc), the meaning assigned to this language and the underlying constructs being examined in each tradition are different (Crowell et al., 1999; Duschinsky et al., 2021; Stein et al., 1998). One research study providing empirical support for this was conducted by Bernier and Matte-Gagné (2011). In a study using a range of different measures, they found that parents' AAI coherence but not self-report attachment style was associated with their caregiving sensitivity and their children's attachment to them, and that self-report attachment style but not AAI coherence was associated with their marital satisfaction. Furthermore, a meta-analysis by Roisman et al. (2007) found only a trivial association (r = .09) between AAI classification of security versus insecurity and self-report measures of attachment style.

1.1.13 RF and Mentalising

In the late 1980s a longitudinal study, the London Parent-Child Project, was initiated by Miriam and Howard Steele and Peter Fonagy. AAIs were conducted with expectant parents as part of this study. Whilst coding the interviews using the attachment state of mind classification system developed by Main and colleagues, the Steeles and Fonagy noticed that for parents whose interviews were coded as coherent "a defining feature of their narratives was the way they relied on language as a tool for giving meaning to experience, including the attribution of mental states (beliefs and desires)" (Steele & Steele, 2005b, p.157). This was especially noticeable in responses to the questions asking interviewees why they thought their parents behaved as they did during their childhood, and whether they thought their childhood experiences had an influence on who they are today. Though there was a draft scale within Main et al.'s classification system for 'metacognitive monitoring' (Main, 1991), this focused on the extent to which the interviewee monitored their own mental states and memories and was, by Main et al.'s (2003) own admission, "too narrow." The Steeles and Fonagy found that parents differed in their narratives in terms of "the extent to which they are able to go beyond immediately known phenomena to give an account of their own or others' actions in terms of beliefs, desires, plans and so on" (Fonagy et al., 1998, p.6). They ultimately termed this capacity 'reflective functioning' (RF), which they defined as "the mental function which organizes the experience of one's own and others' behaviour in terms of mental state constructs" (p.6). RF comprises:

> [1] Awareness of the nature of mental states … [2] the explicit effort to tease out mental states underlying behaviour … [3] recognising developmental aspects of mental states … [4] mental states in relation to the interviewer (Fonagy et al., 1998, pp.19, 20, 22, 24).

The Steeles and Fonagy developed a system for identifying and rating RF in AAIs (Fonagy et al., 1998). Further detail regarding the practicalities of coding RF is provided in Section 8.4.2. In their coding manual, Fonagy et al. positioned RF as "the psychological processes underlying the capacity to mentalize" (p.4). RF and mentalisation can thus be considered intertwined concepts. With regards to what is meant by mentalising, Duschinsky and I (Duschinsky & Foster, 2021) identified 28 distinct definitions found in Fonagy and collaborators' writings from 1989 to 2019. A synthesis of these definitions led to creation of an overall definition of mentalisation as:

> A capacity to conceive of and make available for reconsideration the thoughts and feelings implicated in motivations and intentions, in order to account for and explain the observable social behaviour and present and past perceptual experience of oneself and others (p.77).

Alongside this synthesised definition, it is useful to also highlight the definition of mentalising included in the RF coding manual, as this can be presumed to be the conceptualisation against which the scale for measuring differences in RF was developed. The coding manual states:

> Mentalising refers to the capacity to perceive and understand oneself and others in terms of mental states (feelings, beliefs, intentions and desires). It also refers to the capacity to reason about one's own and others' behaviour in terms of mental states (Fonagy et al., 1998, pp.6-7).

In the London Parent-Child Project, the Steeles and Fonagy found strong correlations between AAI coherence ratings (a key scale in Main and colleagues' attachment states of mind coding system) and AAI RF ratings: $r = .73$ for the 100 mothers in the study and $r = .64$ for the 100 fathers (Fonagy et al., 1998). Subsequent studies have also found significant associations between ratings of attachment coherence and RF from the same AAIs, though these have not generally been as strong as the associations found in the development sample. For example, Jessee et al. (2016) found an association of $r = .39$ between attachment coherence and RF in a sample of 194 expectant mothers and fathers. Crugnola et al. (2018) found an association of $r = .33$ in a sample of 41 adult mothers and an association of $r = .71$ in a sample of 44 adolescent mothers. Levy et al. (2006) found an association of $r = .48$ in a sample of 90 patients with borderline personality disorder. Maxwell et al. (2017) found an association of $r = .34$ in a sample of 202 adults, half of whom had binge-eating disorder and half did not. Talia et al. (2019a) found an association of $r = .46$ in a sample of 160 therapy clients. The size of these associations suggest that the attachment coherence scale and the RF scale are measuring related constructs.

The Steeles and Fonagy also found in the London Parent-Child Project that a parent's RF score from their AAI conducted prenatally was positively associated with their infant's later attachment security with them in the Strange Situation: $r = .51$ for mothers and $r = .36$ for fathers (Fonagy et al., 1991b). Furthermore, parental RF predicted infant attachment security more strongly than did parental attachment coherence, which had no association with infant security once RF was controlled. They concluded that "coherence may be a measure of reflectiveness, and it is the latter attribute of the

caregivers that has direct implications for their relationship to the infant" (Fonagy et al., 1991b, p.215).

In the AAI where the focus is on a person's experiences in childhood, the RF 'task' is to reflect upon your own and your caregivers' mental states. Slade highlighted that an assessment of RF capacity in the AAI is therefore not a direct assessment of a parent's RF in relation to their child. An addendum to the RF manual was developed by Slade et al. (2004) for use with the Parent Development Interview. The Parent Development Interview (Aber et al., 1985) focuses on asking a parent about their child, their interactions with them, and their feelings as a parent. In the first study of Parental RF in the Parent Development Interview, Slade et al. (2005) found that mothers who were classified as autonomous in the AAI had significantly higher RF scores in the Parent Development Interview, conducted 12 months later, than mothers who were classified insecure. Slade et al. also found that higher maternal RF was associated with infant attachment security in the Strange Situation 4 months later. Like in the Fonagy et al. (1991b) study, Slade et al. found that parental attachment state of mind had no association with infant security once the effect of RF was factored in. A later study by Stacks et al. (2014) found an association of $r = .30$ between the mothers' RF in the Parent Development Interview and their infants' attachment security in the Strange Situation.

A review by Camoirano (2017) highlighted that no published studies to that point had examined the association between a person's RF assessed on the AAI and their RF assessed on the Parent Development Interview, thus leaving open the question of whether the capacity to mentalise your own childhood attachment experiences and the capacity to mentalise your child and your relationship with them are equivalent. Flykt et al. (2022) subsequently examined this in a sample of 24 mothers with substance use disorder and reported an association of $r = .56$ between RF assessed prenatally on the AAI and RF assessed on the Parent Development Interview when their infant was 4 months old. A study with 88 mothers (Ensink et al., 2019) found a similar strength association of $r = .51$ between RF assessed prenatally on the AAI and RF assessed on the Mini-Parent RF Interview (a 15-minute interview developed to assess parent's mentalisation about their child) when their infant was 6 months old. These findings provide some support for mentalising capacity having both some relationship-specific and some cross-relational aspects.

A parent's RF capacity, rather than their caregiving sensitivity, has been proposed by Fonagy and Slade as the key for explaining individual differences in children's attachment security. A meta-analysis by Zeegers et al. (2017) assessed the relative contributions of parental mentalisation and caregiver sensitivity on children's attachment security. With the effect of sensitivity controlled for, the association between parental mentalisation and infant attachment security was r = .24. With the effect of parental mentalisation controlled for, the association between caregiving sensitivity and infant attachment security was r = .19. The authors highlight that their findings suggest that both parental mentalisation and caregiving sensitivity are relevant and play complementary roles in explaining attachment security. RF has also been found to be associated with other caregiving behaviour known to be relevant to infant attachment: Grienenberger et al. (2005) found a negative association of r = .48 between maternal RF and frightening and atypical maternal behaviour assessed using the AMBIANCE measure. A recent systematic narrative review by Stuhrmann et al. (2022) concluded that parental RF is generally associated with positive parenting behaviours, but that the associations vary dependent on contextual factors and appear to be more robust in more emotional challenging and lower socio-economic family situations.

RF and mentalisation have also been proposed by Fonagy and colleagues as of primary importance for explaining the associations found between early attachment security and aspects of later interpersonal and emotional functioning. They theorise that secure attachments facilitate a child's developing capacity for mentalising and it is this capacity for mentalising, rather than expectations about attachment relationships, that drives the associations that have been found in attachment research (Fonagy & Target, 2002).

The RF scale does not just measure the degree to which a person displays indicators of RF. Score of 4 and above can be considered to do so, but scores below a 4 capture different forms of 'impoverished' RF. In their coding manual, the Steeles and Fonagy highlight that "when reflective functioning is absent or ineffectual, quite distinct, readily classifiable, patterns of responses tend to emerge" (Fonagy et al., 1998, p.27). They provide a tentative typology of impoverished forms of RF. More than one category from this typology is assigned to each negative to limited RF scale point, meaning that two interviewees could show very different forms of impoverished RF but be assigned the same score. For example, naïve-simplistic RF (where mental states are mentioned but in only a superficial, simplistic way) and hyperactive RF (where mental states are

elaborated in depth but in an unconvincing way) are both assigned a score of 3 on the RF scale. This led Choi-Kain and Gunderson (2008) to argue that assessing a multi-dimensional capacity using a unidimensional score means “there are limitations in interpreting the meaning of a given RF score” (p.1133). Naïve-simplistic RF can be considered a form of ‘not mentalising’ (where mentalising is neither active or blocked) and hyperactive RF a form of ‘non-mentalising’ (where mentalising is specifically blocked), and these may have distinct qualities that would be beneficial to distinguish (Duschinsky & Foster, 2021) but which are currently hidden from view within a single score.

Another potentially important distinction which is obscured within the unidimensional score is if an individual is good at reflecting on their own mental states but not those of others, or vice versa. Fonagy and colleagues have debated whether this is an important distinction. At times they have argued that the capacity to mentalise self and others come together into a unitary process during development (e.g., Fonagy & Target, 1997) though more recently this has been refined to an argument that they *generally* come together (Fonagy & Luyten, 2009). Whether one has primacy and is required for development of the other has also been subject to varied theorising by Fonagy and colleagues. Fonagy and Luyten proposed that the capacity to mentalise the self is secondary and requires the capacity to mentalise others. Yet the opposite proposition, that “to mentalize others requires the capacity to mentalize the self” has also been made (Bateman et al., 2019, p.347). Viewing the capacity to mentalise the self and the other as mutually reinforcing cycles in normal development (Fonagy & Allison, 2018) may supplant debates on whether (and which) one is primary. However, the possibility that development of the capacity to mentalise self and others do not always come together and develop to the same degree seems open. This is something Fonagy and colleagues have acknowledged, for example, by drawing attention to the possibility that individuals may have a better understanding of others than themselves (Fonagy & Luyten, 2009). It has also been proposed that mentalising the self could at times contradict rather than complement the capacity to mentalise others. Rizq and Target (2010a) suggested that “where high levels of RF tip over into anxious and depressive ruminations, they may unhelpfully sustain a preoccupation with the self, rather than with another’s experience and needs” (p.475). Some researchers (e.g., Bizzi et al., 2019; Ensink et al., 2015; Suchman et al., 2010) have begun to separate out the measurement of RF in relation to the self (RF-S) and RF in relation to others (RF-O), a practice that will be useful for examining the extent to which these capacities

tend to converge or diverge, factors that increase the likelihood that they converge or diverge, and any distinct correlates.

An association between RF and psychopathology has also been theorised and empirically tested. In AAIs conducted with a sample of 82 psychiatric patients plus 85 matched non-clinical participants (Fonagy et al., 1996), the mean RF score for the psychiatric group was 3.7 compared to a mean score of 5.2 for the non-clinical group. Within the psychiatric group, the mean score for the 36 patients with borderline personality disorder was lower still (2.7). Fischer-Kern et al. (2010) also found a mean RF score of 2.7 in a sample of 92 borderline personality disorder patients. Fonagy has proposed that borderline personality disorder can be understood as an inhibition of mentalising capacity in response to childhood abuse (Fonagy & Target, 2000). In a narrative synthesis of RF studies, Katznelson (2014) highlighted that while research has typically found lower levels of RF in clinical rather than non-clinical populations, this “seems most related to more severe forms of psychopathology, with less severe forms approaching more normal levels of mentalization, suggesting that impaired mentalizing capacities … cannot be thought of as a general core deficit in psychopathology” (p.115).

RF capacity is amenable to change. Levy et al. (2006) found that RF levels significantly increased over a year of Transference-Focused Psychotherapy. The mean RF score for patients with borderline personality disorder in this study rose from 2.86 pre-treatment to 4.11 after treatment. Trowell et al. (2008) found that RF scores for mental health professionals who undertook a 2-year training programme on coping with the emotional stress of practice increased from a mean of 3.56 pre-training to a mean of 4.81 after training.

1.2 The Potential Relevance of Attachment Theory for Child Welfare Practice

Attachment theory has potential relevance for a wide range of different practice settings. As seen in Section 1.1.1, Bowlby's development of attachment theory was intrinsically linked to child and family practice. His focus and ideas were in part inspired by his practice observations, and one of his goals for the theory was its use in child and family clinical practice. Practice relevance is therefore built into the DNA of attachment theory and the theory has been applied to clinical work with children (see, e.g.,

Oppenheim & Goldsmith, 2007). With the development of the AAI, and the discovery of links between certain patterns of response to this and various forms of psychopathology and trauma, the relevance and application of the theory to adult clinical practice also blossomed (see, e.g., Steele & Steele, 2008b).

Beyond clinical practice, the theory is also drawn on in childcare and education settings, and in fostering and adoption. Another area of practice where the theory has potential relevance is child welfare practice. However, particular applications of the theory within this practice context have been the focus of concern and criticism (e.g., Forslund et al., 2022; Granqvist et al., 2017; White et al., 2020) and this will be discussed further in Part A of the thesis.

There are several ways in which attachment theory has potential relevance to child welfare practice. Firstly, practitioners can formally train in and use attachment-based interventions. A range of manualised attachment-informed interventions have been developed to support children across all age ranges and their parents (see Steele & Steele, 2017). One example is Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer et al., 2017). This is a short intervention typically delivered over six sessions. In a meta-analysis of the first 25 randomised controlled trials of VIPP-SD, the intervention was found to have a substantial effect on increasing sensitive parenting and reducing rates of child attachment insecurity including disorganised attachment (van IJzendoorn et al., 2023). A second example is the Attachment and Biobehavioral Catch-Up (ABC) model. This home-based 10-session intervention has also been found in randomised controlled trials to increase sensitive parenting and reduce rates of child attachment insecurity/disorganisation (Dozier & Bernard, 2017). Another example is the Group Attachment-Based Intervention (GABI), which has been found in a randomised controlled trial to decrease maternal hostility and increase dyadic reciprocity (Steele et al., 2019). Whilst GABI runs for 26 weeks, and thus is a longer intervention than VIPP-SD or ABC, its group format helps to make it cost effective. However, uptake of any evidence-based attachment interventions is limited in the UK currently. In survey research with UK practitioners providing interventions to improve child attachment, Wright et al. (2023) found that the commonly used interventions had a limited evidence base and the interventions with a strong evidence base were much less commonly used. In this survey VIPP was reportedly used by only 4.2% of respondents, ABC by only 1.6% of respondents, and GABI by none.

A second aspect of potential relevance to child welfare practice is attachment-based assessments. Attachment researchers generally agree that attachment assessments such as the Strange Situation and AAI can provide useful information to inform case formulation and supportive intervention (e.g., Forslund et al., 2022; Granqvist et al., 2017; Slade, 2004; Steele & Steele, 2008b), though their use in child welfare decision making is contentious (see Section 2.1.3). Furthermore, the Strange Situation and AAI are time consuming to conduct and code, limiting their practical value for child welfare practice. Some attachment researchers are in the process of developing and testing attachment-based assessments that could ultimately prove beneficial for use in practice. Attachment-based parenting capacity assessments are one example, and initial findings regarding their potential value in child protection decision-making are promising (Cyr et al., 2022). Madigan and colleagues have identified a reduced set of atypical parenting behaviours central to AMBIANCE (Cooke et al., 2020; Haltigan et al., 2019) and work is underway to examine the feasibility of use of this AMBIANCE-brief assessment in child welfare practice (Madigan et al., 2021). Other shortened measures are also currently being developed and tested for validation, including a briefer version of the Attachment Q-Sort (Cadman et al., 2018).

Thirdly, child welfare practitioners can draw on ideas from attachment theory and research in a free-form way to inform their routine practice. Unlike the formal use of specific interventions and assessments, where the translation of attachment theory and research into a way of working has already been carried out by attachment researchers, and where training and model fidelity or reliability tests can be used to ensure consistent application, there is potential for great variation in how individual practitioners make sense of and use ideas and findings from attachment theory to inform their routine practice.

As well as how practitioners draw on attachment theory, a fourth important area of consideration is how their practice may be shaped by attachment-related processes. Unlike the previous three ways the theory may have relevance, which relate to ways practitioners interact with and use the theory in their practice, here attachment theory may potentially explain individual variations in child welfare practice that do not involve application of attachment theory by practitioners.

This thesis explores facets of the third and fourth of these, i.e., how individual practitioners *apply* ideas from attachment theory to child welfare practice, and how attachment theory *applies to* the way practitioners work.

1.3 Research Aims and Thesis Structure

The overarching aim of this thesis is to explore the relevance of attachment theory to child welfare assessment practice. In this thesis assessment practice is conceptualised broadly and considered one of the two core processes of social work, the other being intervention. Whilst there is no single agreed definition of social work assessment (Crisp et al., 2005), a relevant broad definition is that assessment "involves collecting and analysing information about people with the aim of understanding their situation and determining recommendations for any further professional intervention" (Crisp et al., 2003, p 3).

The focus is on assessment for three reasons. The first is that, as can be seen in the definition above, assessment precedes any intervention and so any influences on assessment practice arguably influence the full course of social work involvement with a family. The second reason is that assessment is the dominant focus in UK child protection social work practice. The independent review of children's social care (MacAlister, 2022) highlighted that systems and resources are currently focused on assessing families rather than supporting them. MacAlister's review presents Department for Education figures which show that assessments following a referral increased by 14% between 2014/15 and 2020/21 while spending on non-safeguarding children's services decreased by 38% between 2012/13 and 2020/21. The third reason is that (as is discussed further in Section 2.1.3) use of attachment theory in child welfare assessment practice is an area that has been particularly subject to conflicting recommendations and concerns regarding inappropriate use.

The specific aspect of practice focused on in this research is initial assessment of family cases with child welfare concerns. This aspect was chosen because important decisions can be made by practitioners at this point, such as whether to make or accept a safeguarding referral. It is also a time when there is particular scope for practitioners to fill in the gaps in what they know about a family with their own assumptions.

The overarching thesis aim was underpinned by two research objectives:

- **Research Objective 1:** To explore the role of ideas about attachment in the thinking of social workers when conducting an initial assessment of family cases with child welfare concerns.

- **Research Objective 2:** To examine the relationship between practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns.

The research objectives were addressed in two distinct strands of research. Research Objective 1 was explored via a qualitative strand of research and is reported in Part A of the thesis. Research Objective 2 was examined via a quantitative strand of research and is reported in Part B of the thesis.

As well as making links back to the overview of attachment theory and research contained in this chapter, Part A and Part B each contain a review of literature specific to the research objective for that strand. Part A opens with a literature review of recommendations for the use of attachment theory in child welfare practice and research findings regarding how it is understood and used (Chapter 2). Part B opens with a systematic narrative review of how the attachment states of mind and RF levels of helping professionals compare to non-clinical norms and relate to their professional practice (Chapter 7).

It was possible to design and conduct a single research study to collect the data required for both strands of research. There was some overlap but also some divergence in which parts of the sample and collected interview data were drawn on for each strand of the research, and the analysis approach was distinct for each. Parts A and B of the thesis each contain a methodology chapter (Chapters 3 and 8) where key detail on the elements of the methodology specifically relevant for that strand of research is provided. Appendix A details the methodology as a whole.

After the reporting of primary research findings (Chapters 4, 5, and 9), each part of the thesis contains a discussion chapter specific to that strand of the research (Chapters 6 and 10). The thesis ends with an overarching conclusions chapter (Chapter 11).

A note on style: This thesis conforms to APA Style (2020), except where the Northumbria University requirements for thesis presentation specify a different approach or layout. The terms used to describe attachment theory concepts, and meaning assigned to those terms, align with those in the glossary presented by SEAS (2021). At times in this thesis content is written in the third person, at times in the first person. This switch is deliberate. Third person is common in research conducted within the quantitative paradigm, but first person is common in research conducted within the

qualitative paradigm. In order to avoid a distracting level of switching between the two, the standard position in this thesis is use of the third person. At times, however, there is a temporary move to first person where this is considered particularly useful. For example, when reporting findings from my own previous work (in Section 1.1.13), reflecting on my influence on the qualitative analysis (in Section 3.4.3), and explaining which specific elements of data collection and coding were conducted by me and which were conducted by others (in Appendix A.1).

PART A

SOCIAL WORKERS' CONCEPTUALISATION AND PRACTICE APPLICATION OF ATTACHMENT THEORY

Chapter 2: Literature Review

As stated in Chapter 1, the overarching aim of this thesis – to explore the relevance of attachment theory to child welfare assessment practice – was underpinned by two research objectives. Research Objective 1 was to explore the role of ideas about attachment in the thinking of social workers when conducting an initial assessment of family cases with child welfare concerns. Addressing Research Objective 1 is the focus in this part of the thesis (Part A).

This chapter opens by reviewing expectations about what UK social workers should know about attachment theory. Different portrayals of social workers' understanding of attachment theory are then summarised, and an overview is provided of debates regarding whether and how attachment theory and research should be used in child welfare practice. This is followed by presentation and discussion of what is known from existing empirical research about the understanding and use of attachment theory in child welfare assessment practice.

2.1 Background

2.1.1 Is Attachment Theory Considered Fundamental Knowledge for UK Child and Family Social Workers?

In an online survey of 642 professionals involved in improving Children in Need's educational outcomes in the UK (Department for Education, 2018), attachment theory was the most mentioned theory in response to a question about what theories or research are relied on to inform a plan of how to support a child. However, attachment theory was still only mentioned by 11% of respondents, suggesting there was not a pervasive reliance on attachment theory. It was also not clear from the report what participants meant by relying on a theory. Furthermore, the majority (86%) of the respondents were from the education sector. Only approximately 9% of the respondents were from social care, and the report stated that "other theories were discussed by non-educational professionals. Social workers discussed systemic theory" (p.15). The report did not specify whether this was in addition to, or instead of, attachment theory. Therefore, whilst this report provides some evidence for greater popularity of attachment theory than any other single named theory amongst education professionals, the theory was still not mentioned by the vast majority (89%) of

respondents, and the popularity of attachment theory among social workers remained unclear.

The Munro Review of Child Protection in England proposed that the minimum capabilities for child and family social work must include “knowledge of child development and attachment and how to use this knowledge to assess a child’s current developmental state” (Munro, 2011, p.96). A review of serious case reviews (Brandon et al., 2011) found that where there were failures to recognise problems, issues were often framed in practical terms and there was a lack of curiosity about attachment, emotional development, and the parent-child relationship. Brandon et al. recommended that “practitioners need to be aware of the parents’ reactions to their child, and to specifically observe and reflect on the child’s responses to his or her caregivers. These are the foundations of emotional development and of attachment behaviour” (p.8). In a review of the education of child and family social workers in England, Narey (2014) named attachment theory as one of seven things that he felt newly qualified child and family social workers should have a comprehensive understanding of at graduation.

The Professional Capabilities Framework (PCF; BASW, 2018), introduced in 2012 and refreshed in 2018, outlines the generic capabilities that are expected of social workers in England. In the version of the PCF for social workers in the early stages of their career, the knowledge domain includes the following:

> Acknowledge the centrality of relationships for people and the key concepts of attachment, separation, loss, change and resilience …
>
> Demonstrate a critical knowledge of the range of theories and models for social work intervention …
>
> Recognise the contribution and use research … to inform and develop my practice (pp.7-8).

Theory and research are therefore identified as important in the PCF, though with theory only mentioned in relation to intervention and not assessment. Attachment is specifically mentioned but framed as a ‘concept’. Social workers are expected to draw on theory and research, but which theories and research is not specified.

Social Work England became the new regulatory body for social workers in 2019. In their published social work professional standards, they state that a social worker needs to "use research, theories and frameworks to inform my practice and my

professional judgement" (Social Work England, 2019, p.10). This is the only mention of theory in the standards. Like with the PCF, no specific theories are mentioned in the professional standards or in the guidance on the professional standards. Social Work England (2022) acknowledged that "we do not currently make explicit the specific knowledge … required of courses to ready students to meet the professional standards. As a result, we are seeing differing interpretations of how to translate the professional standards into course content." At the current time there is no clear stance within the professional standards on whether attachment theory is considered fundamental knowledge for social workers, or the relative weight that should be given to this in pre-qualifying education compared to other theories and research.

Furthermore, there is no common curriculum for pre-qualifying social work education in the UK (Narey, 2014). This, coupled with the lack of specificity in the professions' capability framework and professional standards, means there is scope for great variation in what is covered by universities on their pre-qualifying social work programmes. Variation may exist not only in relation to the relative weight given to attachment theory, but also which aspects of the theory are covered. These decisions are currently made by individual social work academics and/or programme teams. Furthermore, there is also scope for variation in the recommendations that are provided during pre-qualifying education regarding how attachment theory and research should be applied to social work practice.

2.1.2 How are Social Workers Thought to Conceptualise and Understand Attachment Theory?

Section 2.3 presents what is known from the available empirical evidence about social workers' understanding of attachment theory. Also of interest, however, are the concerns that have been raised by commentators about whether social workers' understanding aligns with the research evidence. Three statements of concern regarding social workers' understanding of attachment theory are discussed here, each generated from a different perspective. The first comes from Granqvist et al. (2017) and Forslund et al. (2022). Most of the authors of these two papers are attachment researchers. The second is from Duschinsky et al. (2021). The authors of this paper (of which I am one) belong to a research group which has close ties to both the academic attachment field and practice but are not fully situated in one or the other. The third comes from White et al. (2020), who are social work academics.

The first depiction presented here is from two consensus statements that have been produced by attachment researchers with a goal of countering misunderstandings and misuses of attachment theory and encouraging appropriate practice use of the theory. In a consensus statement by Granqvist et al. (2017), the focus is on a particular aspect of attachment theory: infant disorganised attachment. Granqvist et al. highlight some "erroneous assumptions" about disorganised attachment that are proposed to have "accrued in recent years" (p.536). The misunderstandings highlighted are that:

> 1) attachment measures can be used as definitive assessments of the individual in forensic/child protection settings and that disorganized attachment (2) reliably indicates child maltreatment, (3) is a strong predictor of pathology, and (4) represents a fixed or static "trait" of the child (i.e., is not altered by development or changes in available family support) (p.536).

In a consensus statement by Forslund et al. (2022) the focus is not on a particular aspect of attachment theory but on an area of practice where attachment theory may be applied: family courts, including child protection decision-making, Forslund et al. outline a series of misunderstandings, which are described as "common" and "widespread" (p.7). The misunderstandings listed and discussed (other than one which is divorce/custody specific only) are as follows:

> *Misunderstandings regarding the nature of attachment.*
>
> Attachment equals attachment quality.
>
> Children's attachment quality equals caregiver sensitivity.
>
> Attachment quality equals relationship quality.
>
> Single behaviours reveal attachment security.
>
> Children are born attached.
>
> Attachment quality equals strength of attachment.
>
> *Misunderstandings regarding the interaction between multiple attachment relationships.*
>
> An attachment relationship with one person is at the expense of other attachment relationships.
>
> *Misunderstandings regarding the implications of classifications of attachment quality.*
>
> Attachment classifications provide reliable and valid information about individual children's caregiving history and developmental prospects.
>
> Secure attachment equals psychosocial health, forecasts individual-level psychosocial health, and provides an index of a child's best interests.

> Organised insecure attachment implies harm and pathology.
>
> Insecure-disorganised attachment invariably implies harm and psychopathology.
>
> Insecure or disorganised attachment signifies attachment disorder (pp.7-20).

Discussion of practice-based understanding of attachment theory in these two consensus statements (Forslund et al., 2022; Granqvist et al., 2017) remains focused on potential misunderstandings. Whilst these are thought to be widespread, the authors acknowledge that the extent to which these misunderstandings are held by social workers is an empirical question, and currently largely unknown.

A second depiction of social workers' understanding of attachment theory comes from Duschinsky et al. (2021), where we identify and describe divergent forms of attachment discourse that have developed in different domains in response to the needs and priorities of each particular context. We propose that the specific demands each context makes on the type of knowledge that is desired about attachment has produced barely overlapping discourses, and different strengths for each discourse. As well as two academic attachment discourses (one in developmental psychology, focused around individual differences research with the Strange Situation and the Adult Attachment Interview (AAI); and one in social psychology, focused around individual differences research with adults using self-report measures), we also identify four other distinct attachment discourses:

- A psychiatric diagnosis attachment discourse: focused on attachment disorders.
- A therapeutic attachment discourse: focused on insecurity as the mechanism of mental pathology.
- A child welfare attachment discourse: focused on attachment categories as a potential signifier of children's welfare.
- A popular attachment discourse: predominantly focused on the parent-child relationship and simplified, sometimes inaccurate, portrayals of attachment pattern classifications.

In Duschinsky et al. (2021) we highlight how the child welfare discourse draws on concepts from academic, psychiatric, therapeutic, and popular discourses. We propose that these different discourses are drawn on "without particular distinction" (p.367), though systematic research has not yet investigated whether some social workers are

aware of the distinctions between different attachment discourses and which they are drawing on at different times.

In Duschinsky et al. (2021) we also highlight that the links between academic attachment research and child welfare practice are weak. Social workers' understanding of attachment is rarely gained from reading original research articles and is instead generally gained via texts written for social workers by non-attachment researchers. Duschinsky (2020) found that these texts tend to focus on categories of child attachment and early attachment research, and can be extremely inaccurate (see, e.g., Pearce, 2016). There are multiple potential drivers of this. Despite attachment theory having both normative and individual difference components, most academic attachment research has been focused on individual differences (Granqvist, 2021). Ainsworth's Strange Situation assessment of individual differences in infant attachment has "continued and even hegemonic importance" in attachment research (Spies & Duschinsky, 2021, p.6). In addition, the subtle and complex theory underpinning these individual differences is embedded within the coding system, which is hidden from public view (Spies & Duschinsky, 2021), and the focus in published research is often on amalgamated overarching categories (e.g., secure/insecure) with subcategories and scales unexplored (Duschinsky et al., 2021). These factors could increase the likelihood of attachment research being perceived by social workers (and by non-attachment researchers writing texts for social workers) as solely concerned with individual differences in children's attachment, represented at the level of a few crude all-encompassing classifications (Slade, 2004).

In Duschinsky et al. (2021) we also show how the existence of multiple attachment discourses means that many attachment concepts and terms have multiple, sometimes quite contradictory, meanings. Compounding this, many terms used in attachment theory have been ascribed technical meanings that are quite different from the ordinary language meanings of the terms (Duschinsky et al., 2021; see also Verhage et al., 2023). Duschinsky (2020) highlights how the use of everyday terms in attachment theory has contributed to the theory's appeal and popularity, but also to a lack of recognition of when oversimplified versions of the theoretical ideas are being drawn upon:

> Bowlby's appeals to ordinary language and cultural stereotypes in writing for popular forums helped set his theory alight; it glowed to widespread visibility, even as its qualifications and technical subtlety burned away as fuel. The manner of Bowlby's popular writings helped create what Bourdieu termed

> ‘allodoxia’, a ‘light’, commodified version of a more complex cultural form, appealing to a wider base of constituents without the tools or means to access the original. … What characterises allodoxia in psychology is the circulation of a simplified account of the human mind as if it had the same meaning as the technical account of empirical researchers. … The cut-price popular discourse of attachment was evocative and underdetermined, as well as having the appearance of scientific credibility. This gave it flexibility, urgency, and reach for these diverse constituents concerned with speaking about the nature of family relationships and child development (pp.103-104).

The multiple discourses and multiple meanings for attachment terms increase the likelihood of conceptual confusion and the risk of people talking past each other without realising they are doing so, due to use of what appear to be common terms. What is not considered in Duschinsky et al. (2021) is that this is not necessarily only an issue for communication *between* domains but potentially also a particular issue *within* the child welfare domain, due to the attachment discourse within this domain drawing on concepts from multiple other discourses.

A third depiction of social workers’ understanding of attachment theory comes from White et al.’s (2020) book, which presents an analysis of how attachment theory is used in child welfare practice. There are many overlaps between the portrayal from White et al. and the portrayals outlined above. White et al. argue that a simplified version of the classifications and their implications have been adopted into child welfare practice knowledge, with secure attachment viewed as “one of the child’s most basic needs” (p.vii), insecure attachment “a sign of inadequate parenting and a marker for future problems” (p.30), and disorganised attachment “the risk factor to trump all others” (p.132).

White et al. (2020) draw on the work of Fleck (1979) to show how tentative, provisional attachment ‘journal science’ is simplified into ‘handbook science’, then simplified further still into ‘popular science’. White et al. highlight how complexities and contradictions are lost in the simplification, and the status of the knowledge becomes more ‘certain’ the further it is from the original journal science. This process could help to explain how some of the misunderstandings (highlighted by Granqvist et al., 2017 and Forslund et al., 2022) could occur.

White et al. (2020) argue that attachment theory, outside of academia, functions as a myth. By myth, White et al. mean the presentation of a cultural artefact as if it is an “undisputed ‘fact of life’” (p.24). White et al. also argue that ideas from attachment

theory have permeated into cultural discourses and norms, and these can influence the informal theories (derived from experience and the ideas circulating in society) that social workers have. Payne (2005) distinguishes between formal and informal theories, and White et al. argue that attachment operates as both:

> Attachment theory is thus used in, and influences, practice at different levels. As a formal theory it can be applied deductively, applying the theoretical ideas to specific situations. As a foundation for people's informal theories, however, it can be manifest in practice without explicit reference to the theory (p.67).

This has overlaps with Duschinsky et al.'s (2021) argument that child welfare practice draws on both academic attachment discourses and popular attachment discourses. The extent to which attachment ideas influence practice via practitioners' informal theories (and the extent to which social workers are aware of this) is not fully clear however.

2.1.3 Differing Perspectives on Whether and How Attachment Theory and Research Should be Used in Child Welfare Assessment Practice

There has been some promotion of the application of attachment theory to child welfare assessment practice, some considered cautions, and some strident criticism.

Attachment theory features as one of the core theories presented in general texts aimed at social workers and social work students (e.g., Teater, 2019; Webb, 2018). In the UK, social work academic David Howe has written a corpus of books for social workers focused on how ideas from attachment theory can be drawn on in child protection practice (Howe, 1995, 2005, 2011; Howe et al., 1999). Several other authors have also recommended the use of attachment theory in child protection practice (e.g., Mennen & O'Keefe, 2005; O'Gorman, 2013, Turney & Tanner, 2001). There has been some encouragement of the use of attachment theory to understand the behaviour and needs of parents, though this has received much less attention than use of the theory to understand the behaviour and needs of children (Bunting & Lazenbatt, 2016).

There has also been some promotion of the practice use of attachment assessments. NICE (2015) recommended that social workers for children in care or at high risk of going into care should be trained to assess 'attachment difficulties'. NICE define 'attachment difficulties' as insecure or disorganised attachment or diagnosed attachment disorders (p.17). For NICE, attachment assessment is recommended for

the purpose of identifying children who require intervention support, and it is recommended that formal validated attachment assessment tools are used. The academic research community has likewise recommended that the value of attachment assessments in applied practice lies in "targeting and directing supportive interventions" (Forslund et al., 2022, p.3).

However, some UK social work academics have enthusiastically promoted practice assessment of attachment classifications, especially disorganised attachment, to identify welfare concerns. For example, Wilkins (2012) argued that "disorganised attachment is not just associated with child maltreatment but is indicative of it" (p.16) and, on this basis, recommended that social workers use the disorganised attachment concept as part of their risk assessments. Wilkins was a PhD student of social work academic David Shemmings. Shemmings (2011) had developed an 'Assessment of Disorganised Attachment and Maltreatment' (ADAM) training programme, which encouraged social workers to look for disorganised attachment behaviours in naturalistic settings as an indicator of maltreatment. Social workers at multiple UK local authorities undertook this training. The attachment research community (Granqvist et al., 2016, 2017) highlighted the substantial issues with using disorganised attachment in this way, including – but not limited to – the insufficient sensitivity and specificity of the disorganised attachment classification for indicating maltreatment. Taking on board the issues highlighted by the research community, Wilkins (2021) withdrew the recommendations of his 2012 article. Articles and books which suggest to social workers that disorganised attachment indicates maltreatment are still in publication however. Shemmings' training may also have influenced social work understanding and practice in the UK beyond the local authorities directly involved in the training, for example, as social workers move between local authorities, taking ideas and practices with them.

There has also been debate and disagreement regarding the use of attachment assessments and classifications as evidence in child protection court decision making. The Granqvist et al. (2017) consensus statement argued that it is not appropriate to use the disorganised attachment classification in case-specific child protection practice. Spieker and Crittenden (2018) cited this claim to argue that assessments from their Dynamic-Maturation Model of Attachment and Adaptation (DMM) could be used instead. In response, van IJzendoorn et al. (2018) criticised use of the consensus statement to promote "another approach that is more than likely to repeat past mistakes" (p.644) and concluded that it was "scholarly and ethically irresponsible to

promote the DMM measures for court use" (p.645). A second consensus statement on the use of attachment theory and research in court (Forslund et al., 2022) highlighted issues with use of attachment assessments (including, but not limited to, assessments of disorganised attachment) as court evidence. However, it was acknowledged that some dissensus existed among the 70 authors of this statement regarding whether attachment assessments should never be used as case-specific evidence in court, or whether it may sometimes be appropriate to use them, provided this is done "responsibly" and as part of "a larger assessment battery" (p.31).

White et al. (2020) are also critical of the use of attachment categories to "diagnose" perceived issues, and they argue that use of attachment theory in this way is a "prominent, and often dominant, perspective" in social work practice (p.33). However, like Granqvist et al. (2017) and Forslund et al. (2022), White et al. distinguish between different applications of attachment theory and do not disregard the potential value of attachment theory for practice. White et al.'s overall argument is that there is a need to change how the theory is utilised in social work practice, rather than a need to move away from use of the theory altogether:

> At its best, attachment research has produced ideas that practitioners can use to understand the quality of child-carer relationships when the child is anxious, scared or upset, and to guide them in their work to improve familial relationships. … In other situations, attachment is used with a mixture of excessive credulity and zealotry, a cavalier heavy handedness and unsophisticated reductionism. … These are aspects and consequences of the theory about which the thoughtful, humane practitioner should be very wary indeed. They need instead to understand the theory properly and engage with its aspirations, limitations and moral dimensions (p.124).

In contrast, some authors have taken an outright critical stance regarding the use of attachment theory in child welfare practice. For example, Smith et al. (2017) argue that attachment theory has a dominance in child and family social work practice that "may inhibit consideration of other, complementary or alternative ideas" (p.1607). Smith et al. view attachment theory as contributing to a biologising and deterministic discourse. Garrett (2023) also proposes that attachment operates as a received (dominant) idea within social work. Garrett argues that social workers are insufficiently critical of Bowlby's "relentless focus" (p.13) on the biological mother. As seen in Chapter 1, attachment theory and research does not support a view of early attachment experiences as having deterministic outcomes (see Sections 1.1.7 and 1.1.8) nor of biological mothers as the sole attachment figures (see Section 1.1.3). Nevertheless,

what Smith et al. and Garrett's papers usefully highlight is that such conceptualisations of attachment theory exist for these authors and thus may exist for some practitioners too. Even though these conceptualisations of the theory do not align with a thorough understanding of the theory, if these conceptualisations are held by some practitioners, it is these conceptualisations that will inform whether and how they use ideas about 'attachment' in practice.

As seen above, there are a range of perspectives regarding which aspects of attachment theory should be drawn on in child protection practice and how these aspects should be applied. Some strong disagreements about what are and are not appropriate applications of attachment theory to child welfare practice can be found, especially in relation to individual difference attachment typologies and their assessment. However, the extent to which the various recommendations are being seen by practitioners, the ability of practitioners to assess the variable empirical soundness of the recommendations, and whether and how they are influencing practice is as yet unknown.

2.2 Literature Review Aims and Focus

The introduction to this chapter highlighted that social work education and professional standards in the UK draw attention to the importance of attachment but do not specify what social workers need to know about attachment theory, nor how the theory should (and should not) be utilised in practice, leading to potential for substantial variation. The introduction also traced how concerns have been raised about misunderstandings of the theory that social workers may hold, and that social workers may be drawing on different attachment discourses (including ones divorced from academic discourses). Finally, the introduction identified how a range of different – sometimes contradictory – recommendations have been made about if and how social workers should draw on attachment in child welfare assessment practice.

The core aim of the literature review that follows is to ascertain what the available research evidence indicates about how attachment theory is viewed, understood, and used by social workers in child welfare assessment practice. To identify relevant literature, database searches were conducted, the reference lists of relevant empirical and commentary papers were reviewed, and other researchers with an interest in this topic were consulted. Although child protection social work was considered the core of

child welfare practice, social work practice with looked after children was also considered part of child welfare. Studies did not need to have a core focus on views, understandings and/or use of attachment theory by social workers in child welfare practice to be included: any studies which reported some findings relevant to this were included. While relevant detail was therefore limited in some of the studies, drawing on this wider literature was considered useful because of the limited research that has directly examined the topic. The focus in this literature review remains on child welfare assessment practice however, with the reader interested in research on understandings of attachment theory in UK child mental health clinical practice directed to Beckwith (2021) and Beckwith et al. (2022), and the reader interested in research on routinely used interventions to improve attachment in the UK directed to Wright et al. (2023).

2.3 Empirical Research Findings

A total of 23 studies were found which contained some relevant findings. However, exploring understanding and/or use of attachment theory was an aim at the design and data collection stage for just five of these studies, though it was a key theme in the findings or focus of analysis for a further six studies too. Some of the other studies contained only limited findings and insights regarding how attachment theory is viewed, understood, and used by social workers in child welfare assessment practice. Table 2.1 provides a summary of the 23 studies included in this review.

Table 2.1 *Summary of the 23 Empirical Studies Included in the Review*

Study	Country	Aspect of child welfare practice	Methodology	Participants	Study focused on attachment understanding and use?
Alexius & Hollander, 2014	Sweden	Child protection court practice	Document analysis of investigation reports and court judgements	Documents only	No (but some relevant findings)
Bjerre et al., 2023	Denmark	Child protection	Qualitative practice observation	42 hours of observation of the meetings of three social work teams	No (though was the focus of this particular analysis of the data)
Boswell & Cudmore, 2017	UK (England)	Fostering and adoption	Qualitative interviews	Various, including unspecified number of social workers, but social worker interviews not directly analysed/ included	No (and reporting of relevant findings very limited)
Botes & Ryke, 2011	South Africa	Fostering	Quantitative survey	17 social workers	Yes
Brown et al., 2015	UK (England)	Child protection court practice	Qualitative interviews & focus groups and predominantly quantitative survey	Various, including 22 social workers	No (and reporting of relevant findings very limited)
Furnivall et al., 2012	UK (Scotland)	Child protection	Qualitative interviews	Various, including unspecified number of social workers	Yes (but reporting limited)
Hammarlund et al., 2022	Sweden	Child protection	Quantitative survey	191 social workers	Yes

Study	Country	Aspect of child welfare practice	Methodology	Participants	Study focused on attachment understanding and use?
Hollin & Larkin, 2011	UK (England)	Fostering	Qualitative focus group	5 social workers	No (though was a key theme in the analysis of the data)
Keddell, 2017	New Zealand	Child protection	Qualitative interviews	22 social workers	No (though was a key theme in the analysis of the data)
Lesch et al., 2013	South Africa	Fostering	Qualitative interviews	20 social workers	Yes
McLean et al., 2013	Australia	Residential care	Qualitative interviews	Various, including 19 social workers, but not reported separately	No (though was the focus of this particular analysis of the data)
McMurray et al., 2008	UK (England)	Child protection	Qualitative interviews	19 social workers	No (and reporting of relevant findings very limited)
Menzies & Grace, 2022	Australia	Child protection	Predominantly quantitative survey	55 social workers	No (and reporting of relevant findings very limited)
Morison et al., 2020	UK (Scotland)	Residential care	Qualitative interviews	20 workers, unclear if/how many were social workers	Yes
North, 2019	UK (England)	Child protection court practice	Qualitative interviews & focus groups	9 social workers	No (though was a key theme in the analysis of the data)
O'Reilly, 2021	Ireland	Child protection and fostering	Selected case studies	3 social workers	Yes (though focus was on use of a particular attachment model rather

Study	Country	Aspect of child welfare practice	Methodology	Participants	Study focused on attachment understanding and use?
					than attachment theory in general)
Skivenes & Skramstad, 2015	UK (England), Norway, USA (California)	Child protection	Vignettes with qualitative interviews	93 social workers	No (but some relevant findings)
Skivenes & Tefre, 2012	UK (England), Norway, USA (California)	Child protection	Vignettes with fixed-choice & open ended questions	299 social workers	No (and reporting of relevant findings very limited)
Ward et al., 2010	UK (England)	Child protection	Qualitative interviews	Various, including unspecified number of social workers	No (and reporting of relevant findings very limited)
Gibson (reported in White et al., 2020)	UK (England)	Child protection	Qualitative interviews, practice observation, review of practice reports	19 social workers for interviews, 250 hours of observation of two social work teams	No (though was the focus of this particular analysis of the data)
Wilkins, 2015, 2017	UK (England)	Child protection	Q-sort and qualitative interviews	24 social workers: 20 for Q-sort and 11 of these plus four more for interviews	Yes (though focus was on use of a particular attachment model rather than attachment theory in general)
Wisso & Johansson, 2018	Sweden	Child protection court practice	Document analysis of court decisions	Documents only	No (but some relevant findings)
Woolgar & Baldock, 2015	UK (England)	Fostering and adoption	Document analysis of referrals to specialist CAMHS	Referral documents only, 1/3 from social services, but not reported separately	Yes (though focus was on attachment disorders rather than attachment theory)

Relevant findings from the studies are reported below, grouped by the aspect of child welfare practice addressed (child protection, court practice, fostering and adoption). Within each section, findings from studies conducted in the UK are presented before international studies. Study aims and methodologies are highlighted, as are the potential implications of the individual studies and the questions they raise. Some direct quotes from qualitative studies are included, particularly where these highlight insights or unanswered questions beyond those identified by study authors regarding how attachment theory is understood and used.

2.3.1 Findings on Understanding and Use of Attachment in Child Protection Practice

There are some UK research findings that point to limitations in understanding of attachment theory among child protection social workers. In a research study on child protection decision making, which included interviews with child protection social workers from 10 UK local authorities, Ward et al. (2010) reported that "some professionals showed little understanding of infant attachments" (p.4). There was no detail provided of how this limited understanding manifested however. In a 'mapping exercise' which included interviews with an unspecified number of social work practitioners and managers in Scotland, Furnivall et al. (2012) likewise reported concerns regarding the "overall inability of many social workers to articulate or use attachment theory in their work with children and families" (p.24). Furnivall et al. highlighted a lack of shared language about attachment between practitioners, including different opinions about whether it was helpful to specifically use the word 'attachment'. They also identified "a considerable amount of inaccuracy about the concept of attachment" and "a sense that professionals knew the word but not the underlying theory" (p.29). One example given was the conflation of attachment and the whole of the relationship between a child and their primary caregivers. Furnivall et al. reported that experienced social work managers and practitioners in their research reported concerns about the lack of attachment understanding displayed in many social work assessments where permanent placement for a child was being sought. However, the particular nature of these concerns – whether regarding perceived misuse or missed use of attachment theory – was not reported, nor were the views from these managers and practitioners regarding what they perceived to be an appropriate use of attachment in assessments. A further example of inaccurate understanding came from an interview study with 19 UK social workers by McMurray et al. (2008). The focus in this study was on understanding of resilience rather than attachment, but McMurray et

al. found that some social workers held a deterministic view that “negative attachment” in infancy would inevitably lead to later mental health issues.

Another UK study found an interesting difference between the extent to which attachment featured in practice discussions versus written documentation. In research in an English children’s services department, Gibson (reported in White et al., 2020) interviewed 19 social workers, asking them to describe a time they felt they had done good work. Gibson found that none of the social workers made any explicit mention of attachment theory in their descriptions of work that had gone well. Neither did Gibson observe attachment theory (or any other theory) being explicitly mentioned during the nearly 250 hours of social work team observation he undertook (though whether the social workers’ discussions suggested implicit use of theory was not reported). Gibson did, however, find frequent explicit references to attachment theory in the documents the social workers produced, with these references functioning to explain situations and predict later outcomes. For example:

> [The health visitor] has identified that there is no bond and attachment between [the mother] and [the child] which has also been observed by the social worker during visits to the home, [the social worker] has witnessed [the child] yearning for eye contact with [her mother] which is not undertaken (White et al., 2020, p.73).

Discussing the unpublished findings from Gibson’s study, White et al. (2020) reported that attachment concepts were often used imprecisely, including references to positive and good attachments, and lack of attachment as seen in the example above. Furthermore, the links between case information and the references to attachment were often underspecified. The sole local authority involved in Gibson’s research had received an inspection rating of inadequate prior to the research taking place. In response, the inspectors and senior local authority managers required social workers to demonstrate that their work was theory informed, as one perceived marker of high-quality practice. It is unknown the extent to which this specific organisational context shaped the social workers’ behaviour, and whether they would have explicitly referred to attachment in their written documentation without this expectation.

Skivenes and colleagues conducted cross-country vignette studies with child welfare practitioners from England, Norway and California. In a study with 299 practitioners using a vignette of a 3-year-old boy who was wanted for adoption by his foster papers who had cared for him since he was 5 months old, Skivenes and Tefre (2012) found

that 31% of the English practitioners, 37% of the American practitioners and 57% of the Norwegian practitioners mentioned the child's attachment to his foster parents as part of their justification for adoption. However, it is unclear from the detail provided in the article whether the practitioners used the word attachment and were consciously drawing on attachment theory to think about this, or whether any references to the long-term relationship/bond between child and foster parents were interpreted as references to the concept of attachment by the study authors. In a second study with 93 child welfare workers, examining responses to emotional risk factors in a different vignette, Skivenes and Skramstad (2015) found that the English child protection workers made more references than Norwegian or American workers to attachment theory when discussing the mother's failure to meet her child's emotional needs. Two examples of English child protection workers' references to attachment were:

> If her emotional needs aren't being met…potential sort of attachment issues, which are going to have a huge impact on Beatrice for the rest of her life really. (p.817).

> I think that the attachment bit, I think from a young child upwards it's vitally important because there's different types of attachment. What you aim for is a secure attachment between a child and adult, and if there is a secure attachment, then that child will grow up to feel confident in themselves and also be able to go out to the world and undertake education and other things quite happily. So, yes, that's something that I would want the worker to consider when they're doing their assessment (p.819).

Possible reasons why attachment was more commonly referenced by Norwegian practitioners in one of these studies and by English practitioners in another were not explored by the authors. It may be that attachment as a concept is more commonly considered by Norwegian practitioners but attachment theory is more often discussed by English practitioners, or it may be that practitioners in different countries are more likely to draw on attachment ideas for different purposes and in different contexts. There was insufficient detail available in the articles to consider the likelihood of these or other explanations. Furthermore, the language used by the child protection workers in the above quotes implies that they held a view of differences in attachment quality as having a definite rather than possible impact on later development. There was also some indication from the second quote that attachment quality may be considered an important factor in assessments. However, as this study was not focused on examining the practitioner's understanding and use of attachment theory, further information on attachment theory understanding and use was not available.

In Sweden, Hammarlund et al. (2022) conducted online survey research with 191 child protection workers. Hammarlund et al. found that the majority of the participants reported that they "form an opinion about a child's attachment pattern" in most or all of their child protection investigations. The younger the age of the child involved in the investigation, the more likely participants were to form an opinion about their attachment pattern: 85% said they did so in most or all of their investigations involving children younger than one, compared to 77% in investigations involving children ages 1–12 years, and 57% in investigations involving children aged 13–18 years. Forming opinions about the attachment patterns of parents was less common, with 27% of participants reporting that they did so in most or all of the child protection investigations. Hammarlund et al. found that their participants reported predominantly forming these opinions through observations, interviews, and information from other professionals and prior investigations. 19% of the practitioners said they used systematic assessment instruments to form opinions about child attachment patterns, but the instruments they named were generally not attachment assessments and included instruments such as the risk assessment tool Signs of Safety. A small number of the practitioners named attachment assessments, but only ones developed for use with adults and not well-validated ones.

The participants' views on the purpose of forming an opinion about a child's attachment pattern were also sought in Hammarlund et al.'s (2022) survey. A large majority agreed with statements that the child's attachment pattern provides information about the child's care experiences to date, their current wellbeing, their future development, and the parents' current caregiving capacity. A smaller majority agreed completely or to a large extent that child attachment quality provides information on which placement decisions could be based. Using questions with only yes or no answers permitted, Hammarlund et al. also found that 86% of participants agreed with the statement "if a child has insecure attachment, it signals deficits in the parents' caregiving capacity" and 37% agreed with the statement "if a child has disorganised attachment, this speaks in favour of moving the child away from the parents."

Hammarlund et al. (2022) propose that their findings indicate widespread, overconfident use of attachment classifications in child protection investigations in Sweden. While this might be the case, the nature of the online fixed answer survey method used means that these findings leave open a number of questions and possible alternative interpretations. The most fundamental unknown is how each participant interpreted the meaning of "forming an opinion about a child's attachment

pattern" and thus what practice they were reporting. This could have ranged from confidently ascribing an attachment pattern classification to a child without having undertaken a formal attachment assessment, through to forming a tentative hypothesis that all might not be well in the relationship between a child and their parents. It is also unknown how much information each participant felt a child's attachment pattern provided, from all the information they needed to just one small part. It is unknown whether some participants held nuanced and/or uncertain views about the relationship between insecure attachment and caregiving capacity, and between disorganised attachment and parental suitability, but were unable to express this nuance or uncertainty due to the yes/no answer format. It is also unknown how the opinions participants formed about a child's attachment pattern were integrated into their investigations, and the weight given to these opinions by them and others in child protection decision making.

Bjerre et al. (2023) conducted observations of Danish child protection social work team meetings where specific family cases were discussed. The research aimed to explore how knowledge and representations of children's development were socially constructed by social workers, and this article focused specifically on findings relating to how attachment was used. Bjierre et al. found that the social workers had a shared sense of attachment as being critically important for children's development, but struggled to describe what attachment is. In one example, where the social workers were discussing how to explain a child's need for attachment to a family, the social workers showed awareness of their struggles to describe attachment, referring to "the knowledge we cannot even explain" (p.58). These social workers ultimately abandoned attempts to define what attachment is and instead moved on to emphasising implications for development:

> Social worker 1: If she does not – then it gets the consequence, that she will be permanently damaged, concerning her –
>
> Social worker 2: Her social and psychological development.
>
> Social worker 3: It is serious damage to her development generally (p.58).

This extract shows that the social workers held a view of attachment as having a strong and deterministic influence on later development. A second finding from Bjerre et al. (2023) was that multiple interpretations of attachment were held by social workers, and these were not anchored to attachment theory. In an illustration of this, Bjerre et al. presented an extract from a social work team discussion of a case where a 5-week-old

boy is to be placed in foster care and the team are considering the most appropriate contact with the biological parents:

> New co-worker: We have to leave the foster parents alone with the baby, so they have peace, so he can establish an attachment to the foster mother. The parents really should not come in the beginning. I would say a fortnight without contact. After that once a week. That is the need of the child, if you want it to form attachment. The child gets confused, he has been at home with mom and dad, and then they come by three times a week. He gets confused.
>
> Team leader: But he has to be detached first. The child is attached to his biological parents. Especially this boy he has been at home for three weeks. … Will you just say, 'cut'?
>
> New co-worker: But the newest research shows that they can be moved, if they have learned attachment.
>
> Social worker: He has not learned attachment, which is the reason we are removing him from home (p.59).

This extract shows that different members of the team have very different interpretations of what attachment is, when it forms and how to proceed. All the team members use references to attachment with authority, yet none of the understandings of attachment presented in this extract are aligned with attachment theory and research. Bjerre et al. (2023) concluded that:

> The empirical examples show a lack of theoretical knowledge, but at the same time a shared certainty of the importance of the phenomenon of attachment. This discrepancy demonstrates that the way the theory is used is not with theoretical nuances, but based in a normative cultural form (p.60).

Keddell (2017) conducted a qualitative study of child welfare decision-making discourses, which involved interviews with 22 social workers from a child and family welfare service in New Zealand. Keddell found that the social workers often used discourses based on versions of attachment theory to conceptualise the emotional needs of children. However, Keddell also found that the use of attachment discourses was not straightforward. She found that the social workers preferred maintaining the continuity of existing caregiving relationships with biological parents or long-term foster carers, and that attachment was often invoked in support of this. Attachment ideas that did not support placement stability tended to be rejected by the social workers. This suggests that attachment theory was being used to justify already-made decisions rather than support the act of decision-making. Furthermore, whilst Keddell was explicit that her study was not an analysis of whether attachment theory was being used accurately and thus did not comment on this, it could be seen from the direct quotes in

the paper that the social workers were sometimes referencing attachment in ways that did not align with attachment theory and research. For example, quotes from three social workers showed them making judgements about “strength” of attachment. The nature and meaning of different patterns of attachment also did not appear to be understood by at least some of the social workers. For example, one social worker could be seen to be interpreting potential signs of resistant attachment as strong attachment:

> The soiling was associated with his anxiety that was around his uncertainty about how he was going to be with his mother … and so that was an indication of how important it was to this child to be with his mother, he had a strong attachment to her (p.334).

Another social worker could be seen to be interpreting potential signs of avoidant attachment as resilience and a lack of attachment:

> They were so resilient and they would go from foster parent to mum and there were no tears, there was – they were just happy fitting in anywhere which isn’t necessarily a good thing because it may show a lack of attachment to mum (p.334).

In survey research with 55 child protection practitioners in Australia, Menzies and Grace (2022) found that attachment was the theory most commonly identified as guiding their child protection practice. A total of 73% of the child protection workers stated that they used attachment theory in their day-to-day practice. Attachment theory was one of three theories given as examples in the survey though, and it is unknown if – and to what extent – this may have inflated the response rate. How the social workers used attachment theory to guide their practice is also unknown. A further interesting finding was that far fewer (33%) of the child protection workers stated that they used attachment theory in practice with Aboriginal families, suggesting some real or perceived limitations in the theory’s cross-cultural value.

Considered altogether, these studies suggest limitations and inaccuracies in the understanding of attachment theory held by child protection social workers across countries. Quantitative studies in Sweden and Australia (Hammarlund et al., 2022; Menzies & Grace, 2022) seem to suggest high levels of use of attachment theory in child protection practice but leave unanswered questions regarding how the theory is being used. Qualitative studies suggest that attachment theory may be being drawn on in some aspects of practice but not others (Keddell, 2017; Gibson, reported in White et

al., 2020), or that attachment theory might not be being drawn on at all, but instead a lay understanding of a phenomenon referred to as 'attachment' (Bjierre et al., 2023). Cross-country studies (Skivenes & Skramstad, 2015; Skivenes & Tefre, 2012) also suggest there may be some between-country differences.

2.3.2 Findings on Understanding and Use of Attachment in Family Court

As part of broader research on how law and policy may support social work practice in relation to emotional abuse, North (2019) highlighted challenges identified by UK social workers in relation to using attachment theory to help evidence the presence of emotional abuse for court cases. North reported that the social workers in her study almost uniformly stated a view that attachment theory is useful for identifying problematic parent-child relationships, and that they routinely described using it for such identification (though details of how they used the theory for this were not provided). However, North also reported that the social workers were cautious about using attachment theory in court. In a direct quote included to illustrate this point, a social worker highlighted a lack of qualification as a barrier to stating a child's attachment pattern:

> As a social worker, I guess, I find it difficult because I guess we're not like a trained psychologist. And although you can see things there, you have to stay within your remit. And I think I get a bit concerned I guess about how we're not getting psychological reports any more because I think that could back up quite often our, although they just write what we have written, [draws in breath and laughs slightly] sometimes they would have the clout to say, "Well, actually this child's attachment style is like 'this' and that's as a result of 'this'": Whereas although we can say we have concerns about the attachment, I don't feel we're qualified enough to say, you know [softly], "They've got an attachment issue, you know, they've got a dis– organised [almost inaudible] attachment or whatever" (p.313).

The quote suggests that this social worker might make informal and tentative references to attachment in court (mentioning "concerns about the attachment"), but viewed formal assessments of attachment patterns as valuable for court yet as something only psychologists can undertake. Whether this pattern of not using formal attachment terms but making informal references to attachment was specific to this social worker or seen across social workers in the study was not discussed. North reported that social workers in her study "often want to be more proficient in their application of attachment theory and in how they describe their utilisation of it in assessments" (p.314). It is unclear from the paper whether the social workers wished

to be trained in and use formal attachment assessments and felt these would add value to their practice assessments, or whether some or all held a different view of what would be an appropriate way to draw on attachment theory in assessments used in court.

In research on the use of commissioned experts in family law cases in the UK, Brown et al. (2015) reported that many of their participants – a group which included social workers, psychologists, and lawyers – believed that assessment of attachment needed to be carried out by a psychologist. It is unclear from the report whether participants thought all psychologists are qualified to assess attachment, or whether participants were aware that additional specialist training is required to undertake attachment assessments but viewed this specialist training as only available to psychologists. Brown et al. also reported that some participants, especially psychologists, said that "local authority social workers 'don't know what they don't know' and were sometimes being asked to assess issues outside of their areas of expertise" (p.24). Brown et al. reported that the judges involved in their research did not share these concerns. It is unclear from Brown et al.'s report what their participants meant by an attachment assessment: assessment of children's attachment patterns, and/or parent's attachment representations, and/or attachment disorders, and/or something else.

Alexius and Hollander (2014) studied social services child welfare investigation reports and subsequent court judgements in relation to 16 families in Sweden where at least one parent had a learning disability and there were concerns about neglect. Their focus was on analysing how parenting and children's care needs were assessed in these cases. They found that there was mention of concerns about attachment in the majority of the child welfare investigation reports, including "lack of attachment" (p.299), but that none of the reports specified how the alleged concerns with attachment had been assessed. They found that arguments based on attachment were described by social services as if "accepted reality" (p.306) and that courts did not question any arguments based on attachment theory. They also found that, despite an apparent focus on attachment, the possible harm caused by separating a child from their primary caregiver was not considered in any of the cases. The extent to which the references to attachment contributed to court decisions for forced removal of children, as compared to other information, is not clear however.

Wisso and Johansson (2018) also conducted a document review of Swedish court judgements. The focus in this study was the reasons given for 32 district court

decisions regarding whether children who had been in foster care for 3 years should have their custody transferred from the birth parents to the foster carers. Wisso and Johansson reported that 'attachment to foster parents' was a factor mentioned in 11 of the court orders. A number of other factors potentially also had overlap with core ideas from attachment theory: 'duration of placement' which was mentioned in 17 of the cases, 'family belonging' mentioned in 13 cases, 'avoiding disruption of care' mentioned in seven cases, and 'foster parents provide good care' mentioned in seven cases. The article does not present detail of which of these factors were combined in different cases, and there was little detail of what these factors meant to those making the decisions. Two extracts from verdicts provided in the article provide some insights of relevance to the current review questions of how attachment is understood and used:

> The child is said to have become rooted in the foster home and to feel such stability and connection that it sees the home as its own. It is therefore important to assess the child's attachment to the foster home (Verdict 4, p.330).

> (The child) is seen as part of the family and relates to (the foster parents) as its obvious (?) carers and is securely attached to them (Verdict 17, p.329).

The first quote suggests a focus on the universal aspects of attachment relationships (relating to the importance of continuity), the second quote suggests a focus on the individual differences aspects of attachment relationships (relating to the importance of the quality of the attachment relationship formed). There was insufficient detail in Wisso and Johansson (2018)'s paper to ascertain whether different courts were focused on different aspects of attachment. It is also unclear what, if any, formal attachment assessments were being recommended in verdict 4 and had been carried out to ascertain the secure attachment in verdict 17. It is also unknown to what extent explicit references to attachment in these court decisions were precipitated by explicit references to attachment in the social workers' reports feeding into the courts.

Only studies from the UK and Sweden addressed use of attachment by social workers in the court context. The UK studies can be seen to draw attention to a lack of confidence and qualification in relation to assessing attachment for court (Brown et al., 2015; North, 2019). The Swedish studies (Alexius & Hollander, 2014; Wisso & Johansson, 2018) suggest that attachment is often mentioned in court reports and judgements. There may be cross-country differences in the extent to which social workers reference attachment in court. However, the differences may have been

exaggerated by the different methodologies and foci. For example, it is possible that tentative references made by social workers to “concerns about attachment” (reported by North, 2019) might be interpreted as evidence by judges (who view social workers as having the expertise to conduct assessments according to Brown et al., 2015), thus potentially leading to attachment being included in court reports and judgements in the UK too. Whether this is the case is currently unknown.

2.3.3 Findings on Understanding and Use of Attachment by Social Workers in Fostering, Residential Care, and Adoption

There has been some research on the understanding and use of attachment theory by social workers in the fostering, residential care, and adoption arena. The focus and context of this work is different to child protection practice, but social workers undertake the same pre-qualifying education and may move in and out of different areas of work post-qualification, and thus there is likely to be crossover in the understandings of attachment theory. Furthermore, there is movement of children between the child protection and the looked after arena.

Woolgar and Baldock (2015) reviewed 100 consecutive referrals of fostered and adopted children experiencing severe and/or complex problems to a specialist Child and Adolescent Mental Health Service (CAMHS) in the UK. The findings of this study are relevant to this review because nearly one third of the referrals came from social services. Attachment was commonly mentioned by referrers: in 31 of the 100 referrals. There were five references to Reactive Attachment Disorder, 11 references to an unspecified ‘attachment disorder’, and 26 more general references to ‘attachment problems’. Woolgar and Baldock found that the references to attachment were not accompanied by supporting symptom descriptions. Furthermore, the specialist CAMHS assessed very few of these children as having Reactive Attachment Disorder. These findings suggest that community-based practitioners working with fostered and adopted children tend to frame behaviour problems in attachment terms and are drawn to a broader conceptualisation of ‘attachment problems’ than those constituting the diagnostic category of Reactive Attachment Disorder. The use of more generic references to attachment than Reactive Attachment Disorder in many of the referrals may indicate that the referring practitioners were aware that they were appealing to a broader conceptualisation. However, the data did not enable exploration of the referrers’ thinking, and thus it is unknown whether this was a deliberate shift in terminology to signal a broader concept and, if so, what the precise nature and bounds

of their broader concept of attachment were. Furthermore, it is unknown whether social workers' references to attachment differed from those of the other community-based practitioners in this study, as reporting this separately was beyond the scope of Woolgar and Baldock's paper.

Hollin and Larkin (2011) studied the discourse of five UK social workers during a focus group about foster care provision. They proposed that the social workers used a discourse based on attachment theory to understand foster children's behavioural issues, the negative impact of placement breakdown (particularly where the child has been in the placement for a longer period of time), and the positive impact that having a consistent social worker in a foster child's life can have (and conversely, the loss that can be experienced when there is a change in social worker). The extent to which the social workers viewed themselves as drawing on attachment theory is unknown however. Furthermore, whilst not discussed by the authors, it could be seen from the direct quotes in the paper that social workers were sometimes using language such as "good attachment" (p.2201) that is not aligned with the terminology of attachment theory.

Boswell and Cudmore (2017) investigated the transition from foster care into adoption in the UK. They carried out an audit of adoption agency policies on the speed of transitions and contact with foster carers post-adoption, and found that attachment was being cited to support contradictory recommendations regarding continued contact with foster carers:

> Some agencies told us that older children with a deeper attachment to their foster carer needed slightly earlier contact; others cited a strong attachment to the foster carer as a reason to avoid contact after the move for fear of unsettling the child (p.245).

Here again we see use of terms that are not used in attachment theory: "deeper" and "strong" attachment. Boswell and Cudmore (2017) also conducted a qualitative study of the transition of four children/sibling groups from foster care into adoption. Boswell and Cudmore reported that social workers often stated a view that children could attach more quickly to adopters if they had previously had a stable attachment to a foster carer, but that it was better to avoid continued contact with foster carers post-adoption in order to help children forget those attachments quickly and form new ones to their adoptive parents. There appeared therefore to be a disconnect between proposals from attachment theory and the social workers' perceptions of the children's needs

during this transition. The interviews with social workers were only used as a "background reference" (p.246) in analysis and so there was limited detail of the content from their interviews. It is unknown whether the social workers were directly referencing attachment and were under the impression that they were working in an attachment-theory-informed way or not.

Morison et al. (2020) undertook a qualitative interview study with 20 practitioners working with looked after children in residential care in Scotland, with an aim of identifying how the practitioners conceptualised and used attachment theory. It was unclear if this group of practitioners included any social workers. Morison et al. found that practitioners typically did not perceive their practice to be explicitly based on attachment theory or any other specific formal theory. The practitioners had awareness of attachment theory but described it as being in the background: "it's there, it's on the back-burner, you are aware of it" (p.11). Some said they would draw on attachment theory more explicitly when they found their natural approach was not working, and others said they used elements of attachment theory, but struggled to articulate how. Morison et al. highlighted that whilst staff rarely spoke about attachment theory without being prompted, they viewed the building of relationships as core to their work, and some used the terms 'relationship' and 'attachment' interchangeably. Morison et al. suggested that the participants in their study were often working in attachment-aligned ways, but without explicit links to attachment theory research. As a result, Morison et al. warned that "theory could become rhetoric or risk being misused, creating a disconnection from the evidence base" (p.19).

McLean et al. (2013) conducted qualitative research in Australia with a range of practitioners, including social workers, and found that the challenging behaviour of looked after children in residential care was often explained using references to attachment but in ways not aligned with attachment theory (a finding aligned with Woolgar & Baldock, 2015). Children who did not overtly signal a need for attachment were seen as having less desire or need for attachments, suggesting a lack of understanding of the universal nature of attachment needs and the avoidant pattern of attachment. Only close, trusting (likely secure) attachment relationships were seen as attachment relationships, leading to other forms of attachment relationship potentially being overlooked. In a parallel to Boswell and Cudmore's (2017) findings, McLean et al. also found that attachment was viewed as a skill that could be learnt and then transferred from relationship to relationship, and that attachment was viewed as a capacity that is limited, meaning that it could be helpful for residential home staff or

foster carers to remove themselves from a child's life in order to 'free them up' to form new attachments. McLean et al. propose that "many of the apparent misapplications of attachment theory identified here may serve as rationalizations for systemic issues, which mean that children's needs become secondary to system constraints" (p.249).

Quantitative survey research by Botes and Ryke (2011) explored 17 South African fostering social workers' perceptions of their knowledge and use of attachment theory. The generalisability of the study is limited by its small sample size and recruitment of social workers from a single organisation. The reporting of the survey also provided limited detail. Nonetheless, there were some interesting findings. The Strange Situation had only 1% reported use, yet the specific insecure attachment patterns each had a reported use of 16% or more, and 65% of the participating social workers agreed with the statement "I am able to identify the attachment pattern of a child ." Considering the limited reported use of the Strange Situation, the researchers concluded that the social workers "may be able to determine in generic terms whether the attachment between a foster parent and child is good or bad, but do not actually assess the attachment in terms of the parameters and concepts of attachment theory" (p.44). This interpretation of the findings, that social workers may be using attachment classification *terms/concepts* divorced from the attachment assessments they were developed from, does seem feasible, though insufficient detail was provided to fully discount the possibility that the social workers were using formal attachment assessments other than the Strange Situation. Botes and Ryke concluded that the social workers in their study had:

> A "common sense" approach to understanding and addressing attachment-related issues, but lacked the theoretical knowledge to underpin their efforts to address the attachment between the foster parent and the child. … It seemed that they were largely under a false impression of their actual ability to deal with attachment-related issues (p.47).

Lesch et al. (2013) also found limited knowledge of attachment theory amongst 20 South African fostering social workers in a qualitative interview study. The social workers reported that attachment theory was not a prominent feature of their pre-qualifying education, and they did not use formal measures of attachment in their practice assessments. Despite limited knowledge of the theory, Lesch et al. reported that most of the social workers did consider attachment an important factor in foster care cases and assessments, and the quotes included in the article show that many made explicit references to attachment. These references often related to a lay

understanding of attachment that was not aligned with attachment theory however, as the following quote illustrates:

> I think the child's behaviour is definitely something that shows you if this child is attached or not. Because if you attach, you will listen to what you are told and you will do things together (p.1105).

Lesch et al. (2013) highlighted that all the participants recognised the attachments that children had with their biological mothers at the time of removal and beyond, and the importance of these attachments, but few of them were aware that the quality of those attachments could be differentiated. Lesch et al. concluded that whilst “general attachment theory ideas were implicit in our participants' accounts, formal attachment theory knowledge and applications did not seem to explicitly and consciously inform their foster care work” (p.1108).

Considered altogether, these studies – like those with child protection social workers – suggest limitations and inaccuracies in the understanding of attachment theory held by workers. There were also indications of variation in practice use of attachment. Some studies found that social workers were making explicit references to attachment but practicing in ways that are counter to the proposals of attachment theory (e.g., McLean et al., 2013) whereas other studies found that social workers were drawing on attachment theory ideas to inform their practice (Hollin & Larkin, 2011) or were working in attachment aligned ways without making explicit links to attachment theory (e.g., Morison et al., 2020). It is unclear if these findings indicate substantial variations in practice, or whether the apparent differences are at least in part an artefact of the different methodologies, different researchers' perceptions of what constitutes 'attachment aligned’, and/or a distinction between references to attachment as a phenomena and references to attachment theory.

2.3.4 Findings on Use of Attachment-Related Assessment-Focused Training in Child Welfare Practice

Two studies were found which examined social workers’ perspectives on the application of attachment-related assessment-focused training in child welfare practice. These findings have been separated out from the reporting of findings on understandings and use of attachment in various areas of child welfare practice above. Whereas the sections above consider the ways in which social workers individually

negotiate with and apply ideas from attachment theory to practice, the studies reported here consider social workers' views on their attempts to apply specific attachment-related ideas provided from training sessions to their assessment practice.

Wilkins (2015, 2017) used Q-methodology to explore views on the relevance of disorganised attachment for practice from a sample of 20 UK-based child protection social workers. The social workers had all taken part in the Assessment of Disorganised Attachment and Maltreatment (ADAM) four-day training programme devised by David Shemmings and "were selected on the basis that they self-reported using the theory and research related to disorganised attachment in practice" (2015, p.128). The ADAM training focuses on "assessment techniques adapted for use pragmatically by busy child protection practitioners" (Shemmings, 2011). The research assessments which formed the inspiration for the techniques presented in the training included Adult and Child Attachment Interviews, Story Stems, Guided Parenting Tasks, and the Strange Situation. As seen in Section 2.1.3 above, the attachment research community has expressed significant concern about some of the proposals and tools from the ADAM project not being well aligned with the concepts, research findings, and research tools they are purportedly based upon.

Wilkins' (2015, 2017) found four distinctive perspectives among his participants regarding the use of disorganised attachment theory and research in child protection assessment practice, and thus found that social workers were using it in a variety of ways. Taken altogether, the ways social workers said they used theory and research knowledge related to disorganised attachment were to gain a deeper understanding of children and their families, to support and help carers, and to improve assessments. The social workers in the study were positive about practice use of attachment theory and research, though this is unsurprising considering the nature of the sample. Wilkins (2015) found that the concept of mentalisation was felt to be particularly useful, and social workers provided specific examples of how they had used the concept of mentalisation in their direct work with caregivers. Other key caregiver characteristics covered in the ADAM training (the concepts of unresolved loss and trauma and extremely insensitive caregiving behaviour) were not directly mentioned. The research also found that the social workers appreciated the greater depth gained from using methods such as the AAI and story stems rather than standard question and answer sessions. The social workers valued being provided with specific skills and techniques, underpinned by theory and research, that they could use in practice. Wilkins also found that social workers saw the theory and research knowledge introduced in the ADAM

training as complementing and enhancing (rather than replacing) their existing practice. They also saw it as workable to draw on attachment theory and other theories together.

There were some interesting areas of dissensus in Wilkins' (2015, 2017) research, and this was more noteworthy considering all the participants had undertaken the same training programme and thus been exposed to the same messages and recommendations. Some of the statements which were strongly agreed with by some social workers and strongly disagreed with by others included "Using the theory and research knowledge related to disorganised attachment helps social workers distinguish between abused and non-abused children" and "Knowing and understanding the theory and research knowledge related to disorganised attachment enhances child protection social workers' assessments of children." Wilkins' Q-sorts were conducted in 2012-2013 but how much earlier the ADAM training was undertaken was not specified. This is unfortunate as it would have been useful context for interpreting responses to statements such as "Social workers should be concerned about being cross examined in court regarding their use of the theory and research knowledge related to disorganised attachment." This statement received moderately strong disagreement from some through to moderately strong agreement from others. It is unknown whether some of the social workers had included reference to disorganised attachment in any court reports and were basing their response on their experience of that, or if the training had been completed too recently for their opinions on this to be based on anything but speculation.

Wilkins (2015) also conducted interviews with 15 social workers (11 of whom had also completed the Q-sort) to extend understanding of the Q-sort findings. Based on these interviews, Wilkins reported that the social workers found it helpful for their use of attachment theory and research knowledge to be mediated through already-developed methods and techniques, rather than having to individually interpret how the attachment concepts and findings could or should affect their practice. Yet there was an interesting negative case example from one social worker in the study who had been trained and validated as a coder of attachment story stems by the Anna Freud centre, and thus had a more expert level of training than many of the other participants in Wilkins' study. This social worker felt that analysing children's story stem responses was difficult, and said she would not attempt to undertake such analyses on her own in practice. Whilst it is important not to overinterpret a single case, this participant's response could indicate that those with greater levels of training are more aware of the complexity and subjectivity of attachment assessments and thus are perhaps more

cautious about using them in practice than those who have been introduced to more simplified versions of the assessments.

O'Reilly (2021) studied Irish child protection and fostering social workers' experiences of implementing the 'Child Attachment Relationship (CAR) Guide'. The CAR Guide, developed by O'Reilly, aims to enhance social workers' understanding of attachment relationships. Whilst 34 social workers undertook training in the CAR Guide and 26 returned written assessments of their experiences of using it over the 4 months following training, just two case studies are reported by O'Reilly. It is unclear whether these are representative of responses or chosen as positive cases. The case examples demonstrated that these social workers appreciated being provided with guidance on how to explain a child's attachment needs to caregivers. One of the social workers reported that previously she had been "explaining the theory in a complex and fragmented way" (p.10). The examples also showed the potential for social workers to use attachment theory ideas to gain additional insights into the strengths and concerns within child-caregiver relationships and to share these insights with caregivers in a way that supports them to recognise and respond appropriately to their children's need to feel safe, secure, and protected.

2.4 Discussion

Multiple studies included in this review stated in their introductions that attachment theory is commonly used and very influential in child protection social work practice (e.g., North, 2019; White et al., 2020). Yet a review of the available empirical evidence suggests that this assertion might be premature. Whilst attachment theory does appear to be cited as one of the more common theoretical influences, the research also seems to suggest that many social workers do not draw on attachment theory. The reasons why some use the theory and others do not are currently underexplored.

What was meant by using or being influenced by attachment theory was also not always clear. Different studies appeared to draw the boundaries in different places and appeared to be operating with different definitions of 'use of attachment', and these were not always clarified. Findings from qualitative studies seem to indicate that practice use of a lay understanding of attachment may be much more common than practice use of attachment theory. This appeared to be the case both in child protection practice (Bjerre et al., 2023; Gibson, reported in White et al., 2020) and fostering,

residential care, and adoption (Lesch et al., 2013; McLean et al., 2013; Morison et al., 2020). However, many of the qualitative studies (e.g., Boswell & Cudmore, 2017; Hollin & Larkin, 2011; Keddell, 2017; North, 2019; Skievenes & Skramstad, 2015) did not distinguish between social workers' use of a concept of attachment (which may or may not be aligned with the way attachment theory defines the concept) and use of specific ideas, proposals, and research findings from attachment theory. Thus, whilst some signs of misalignment were evident from direct quotes within these papers, the extent of the misalignment was unclear. With quantitative survey research (Botes & Ryke, 2011; Hammarlund et al., 2022; Menzies & Grace, 2022) it was unclear what conceptualisation of attachment respondents had in mind when answering questions, making it difficult to confidently interpret the meaning of the findings.

A common finding across studies was that there are limitations and inaccuracies in the understanding of attachment theory held by social workers. Yet the implications of these limitations and inaccuracies for whether and how social workers then use attachment theory are less clear. Different studies have to date found quite disparate things, ranging from what appears to be overconfident use (Hammarlund et al., 2022) to what is presented as underconfident use (North, 2019). This leaves important unanswered questions regarding whether there are significant differences in understanding and use in different contexts and/or countries, whether different methodologies are exaggerating differences, and/or whether other factors (such as whether practitioners are aware of the limits in their understanding of the theory) affect whether and how the theory is then drawn on.

Two research studies included in this review involved observation of practice (Bjierre et al., 2023; Gibson, reported in White et al., 2020). These studies did not set out to examine attachment, but nonetheless produced findings which were relevant to the question of how child protection social workers understand and apply attachment. A strength of these studies is that they provided a more naturalistic examination of aspects of social work practice. However, the lack of direct focus on attachment meant that examination and/or reporting of how attachment was understood and used in practice was quite restricted in these studies.

Several studies involved mixed groups of practitioners which included but were not limited to social workers, and the majority of these studies (e.g., McLean et al., 2013; Woolgar & Baldock, 2015) did not separate out the social worker understandings and use of attachment from those of other professionals. It is thus not fully clear in some of

the papers the extent to which the findings presented reflect the social worker participants specifically.

International research provides some interesting insights, but the extent to which these findings translate to the UK context is not known. The two available cross-country studies (Skivenes & Skramstad, 2015; Skivenes & Tefre, 2012) suggested between-country differences exist. Research findings on UK social workers' understanding and use of attachment theory in child welfare assessment practice are very limited to date, as the findings are predominantly from studies which had a different primary focus. Whilst Wilkins (2015, 2017) was one exception, he solely recruited social workers who had undertaken an attachment training programme exhorting a very particular application of attachment concepts to social work practice. Wilkins' findings therefore provide insights into the application of this training, rather than attachment theory in general. The other exception, Furnivall et al. (2012), was very limited in its reporting. Further research focused on exploring how UK social workers conceptualise and use attachment theory in child and family assessment practice would therefore be useful.

Chapter 3: Methodology

This chapter provides key detail of the methodology for this qualitative strand of research. Appendix A provides detail of the methodology as a whole.

3.1 Study Aims and Research Questions

Chapter 2 presented concerns that have been raised by attachment researchers regarding possible misunderstandings and misuses of attachment theory in child welfare practice (Forslund et al., 2022; Granqvist et al., 2017). Chapter 2 also highlighted proposals that links between academic attachment research and child welfare practice are weak (Duschinsky et al., 2021). Furthermore, Chapter 2 showed how multiple, sometimes conflicting, recommendations have been made about if and how social workers should draw on attachment theory in child welfare assessment practice (see Section 2.1.3). However, a review of existing research identified that findings on social workers' understanding and use of attachment theory in UK child welfare assessment practice are very limited to date (see Sections 2.3 and 2.4). This study therefore aimed to help address this gap in knowledge by providing detailed insights into how a sample of UK child and family social workers conceptualise and use attachment theory when thinking about families where there are child welfare concerns.

The research questions were as follows:

- How do child and family social workers conceptualise and understand attachment theory and research?
- How does the conceptualisation and understanding of attachment theory and research by child and family social workers compare to the published academic account?
- How do child and family social workers use attachment theory and research in their thinking about vignettes representing family cases with child welfare concerns?
- How do child and family social workers describe using attachment theory and research in their day-to-day practice with families where there are child welfare concerns?

To answer the research questions, this strand of research utilised a qualitative methodology as the goal was to explore complexity and context-dependent meaning (Creswell & Creswell, 2023).

3.2 Participants

3.2.1 Sample Focus and Size

The current study draws solely on the social worker subsample (23 participants) from the overall study. The overall study sample size (61 participants) was as large as viably possible, to meet the needs of the quantitative study reported in Part B. However, unlike in quantitative research where bigger is usually better, too large a sample in qualitative research can prevent the depth of individual participant case-oriented analysis that is central to achieving the goals of this type of research (Sandelowski, 1995). Whilst appropriate sample size in qualitative studies is affected by various factors, qualitative interview-based research utilising thematic analysis often has a sample size of between 15 and 30 participants (Braun & Clarke, 2013).

There is considerable debate in the literature regarding whether it is appropriate to decide sample size in qualitative research a priori (Sim et al., 2018). Unlike in quantitative research where statistical power can be calculated in advance of data collection, an important factor in qualitative research is the quality and richness of the data. The more useable (relevant and rich) the data obtained from each participant, the fewer the number of participants needed (Morse, 2000). However, how useable the data will be from each participant can be predicted but not fully known before the data are collected. Some authors therefore argue that sample size should not be decided in advance in qualitative research, and that ‘saturation’ should be adopted: continuing to recruit and collect data until no new relevant insights are being generated (Charmaz, 2006). However, saturation was originally proposed as part of the qualitative methodology Grounded Theory and, whilst the concept is often invoked by researchers utilising other qualitative methods (Vasileiou et al., 2018), O’Reilly and Parker (2013) and Braun and Clarke (2019) argue that saturation is not appropriate for all qualitative research designs.

As an exploratory study, the current research aimed to offer “new insights that contribute substantially to or challenge current understandings” rather than “a complete

description of all aspects of the phenomenon" as would be the goal in Grounded Theory (Malterud et al., 2016, p.1759), and thus saturation was not considered relevant. Instead, the question of whether the data collected held sufficient 'information power' to offer new insights (Malterud et al., 2016) was used to support sample size decisions in the current study. As data were not being solely generated for this qualitative study, the decision was not when to stop recruiting participants and collecting data, but rather how much of the overall dataset to include in this qualitative strand of the research, and how broadly or narrowly to focus the research questions in relation to the research aim.

Patton (2015) proposes that in qualitative research design there are always "trade-offs involved between depth and breadth" (pp.258-259). The overall sample comprised not only child and family social workers, but also clinical psychologists and general practitioners (GPs). Social workers were considered of core importance to include in the qualitative research as they have the responsibility of leading on child protection assessments (HM Government, 2018) and child protection is an area of work where particular concerns have been raised about misunderstandings and misuses of attachment theory in general (see Forslund et al., 2022) and disorganised attachment specifically (see Granqvist et al., 2017). It would have been possible to broaden the qualitative research questions to consider the other two professional groups alongside the social workers and, had the data from individual participants been quite shallow, this would have been a way of increasing the information power of the dataset. However, review of the data collected led to the conclusion that the social worker interviews had generated very rich information relevant to the research questions. Broadening the research focus and questions, and qualitatively analysing a larger set of data, was therefore considered not only unnecessary but likely to lead to an inappropriate forfeiting of depth.

3.2.2 Recruitment

The social workers were recruited from two English local authorities. Sampling was purposeful (Patton, 2015); participants were sought who had completed qualifying social work education, worked directly with children and families, and had a minimum of 1 year of child protection social work practice experience.

The study was described to prospective participants as being focused on professionals' perspectives on relationships and their thinking when conducting child and families

assessments. No mention was made of attachment or any related terms in the research recruitment materials or process, to avoid introducing self-selection bias towards social workers with particular views on attachment theory (and also to avoid priming, as discussed further in Section 3.3.2). Further details of recruitment permissions and processes can be found in Appendix A.1 and A.2, and the study recruitment materials can be found in Appendix D.

3.2.3 Participants

The study participants were 23 child and family social workers: 11 from one local authority, 10 from another. Most of the social workers were based in either initial assessment (nine social workers) or longer-term safeguarding (eight social workers) teams. A further three of the social workers were involved in delivering a support programme to families where children are on a child protection plan or child in need plan. The remaining three were based in fostering, adoption, or child disability teams respectively, but all had prior experience of working in initial assessment and/or longer-term safeguarding.

Professional experience ranged from 1–22 years (with 7 years the average length of experience), and age ranged from 25–58 (with 37 the average age). The participating social workers were predominantly female (91%) which is broadly reflective of the workforce gender split for the profession: statistics published at the time of data collection reported that 82% of registered social workers in England were female (HCPC, 2018).

3.3 Data Collection

3.3.1 Procedure

This strand of the research drew on the practice-related interviews only, which were the first of two interviews conducted with each participant (the second being the Adult Attachment Interview [AAI], used in the other strand of research). The interviews were carried out face-to-face from October 2017 to May 2018. They ranged in length from 44–88 minutes and lasted an average of 67 minutes. The interviews involved collection of some background and demographic information, then discussion of two family case vignettes developed specifically for this study (see Section 3.3.2). The vignettes were

presented and discussed one at a time, and in the same order for all participants. Though they are described as vignettes here following conventional research terminology, when discussing them with the participating practitioners they were described as ‘cases’ as this term is more practice relevant. The participants were given as long as they wanted to read each vignette prior to discussing it, and still had the vignette to hand during discussion of it. After discussion of both case vignettes, a series of semi-structured follow-on questions were asked to further explore their understanding and views of attachment theory and assessments.

3.3.2 Research Materials

Vignettes are “short hypothetical accounts reflecting real-world situations” (Tremblay et al., 2022, p.1) which participants are asked to respond to. Their use in qualitative research supports the generation of complex data (Wilks, 2004) which can be explored in situational context (Barter & Renold, 1999). The two vignettes developed for this study (see Appendix B) were family cases containing child welfare concerns. The vignettes were designed to be an analogue to family cases the social workers receive in their day-to-day practice, and the social workers were asked to respond to them from their professional perspective. Whilst vignettes can be presented in a range of formats (Tremblay et al., 2022), written narratives were chosen as the format of the vignettes developed for this study as initial child safeguarding referrals are often received in written form. Questions were predominantly semi-structured and were developed to support detailed discussion of the vignettes (see Appendix C, Section B). Questions were first asked about the practitioners’ perception of the level of risk and what they saw as the key features of the family cases. Questions were then asked about the behaviour of different family members, and finally about intervention and outcomes.

Serious Case Reviews were used as the basis of the vignettes, to increase their authenticity. Serious Case Reviews are conducted when a child is seriously harmed, fatally or otherwise, because of abuse or neglect. Each review contains detail of the family circumstances and the events that occurred, as well as analysis and recommendations. The two Serious Case Reviews that formed the basis of the vignettes were chosen as they reported family situations with relevance to social workers, clinical psychologists, and GPs (the three professional groups within the overall research sample) and pointed to a lack of focus on phenomena that attachment theory could have drawn attention to. The review used as the basis for the first vignette (Trench & Griffiths, 2014) identified how a focus on neglect in relation to poor home

conditions and/or a focus on a label such as ADHD could detract attention away from issues in parent-child relationships. The review used as the basis for the second vignette (Connelly-Webster & Jennings, 2014) identified a failure to recognise the possible impact of childhood difficulties on the children's mother and her parenting. The process of developing and refining the vignettes involved checks and feedback from my academic supervisors as well as practitioners from all three professions involved in the wider research, and formal piloting with additional practitioners (see Appendix A.3 for further details). A further check of the validity of the vignettes was made by asking each research participant how familiar the family cases felt to them. The feedback from the research participants across all three professions confirmed that the vignettes felt authentic and relevant to them. All 23 participating social workers said the vignettes felt very familiar. Comments included "that could be half my cases", "sounds like one of my referrals", and "I think you've got this from our case files."

Use of vignettes increased the possibility of eliciting the social workers' 'theory-in-use' as opposed to 'espoused theory' (Osmond et al., 2008). Argyris et al. (1985) explain that "espoused theories are those that an individual claims to follow. Theories-in-use are those that can be inferred from action" (p.82). By asking the social workers to think about and discuss their response to case vignettes, it was possible to observe whether and how ideas from attachment theory entered into their thinking.

A further benefit to using vignettes was being able to control what content was contained within the family cases discussed, to ensure discussion of the cases would be maximally relevant to the research questions. The vignettes were designed to contain sufficient welfare concerns with relevance to attachment that drawing on attachment theory would be meaningful to help understand them, whilst not being designed such that they could only be understood by drawing on attachment theory. There was deliberate avoidance of mention of attachment in the first vignette (and during recruitment to the study), thus allowing for exploration of whether the social workers explicitly used attachment terms and/or drew implicitly on ideas and findings from attachment theory to make sense of a family case when there was no clear prompt or demand characteristic to do so.

The second vignette included explicit mention of disorganised attachment, thus enabling exploration of how the social workers responded to this specific attachment concept which Granqvist et al. (2017, pp.536-537) claim has been subject to "widespread interest" but also "misconceptions and misapplications." This information

was contained at the end of the case vignette, where it stated: “both children have been assessed as having a disorganised attachment.” The attachment assessment information was provided after a lot of other information regarding family circumstances, behaviour, and specific events. It was therefore something that the social workers could choose to draw on or not when discussing the case vignette, and it was possible to observe the relative weight the social workers placed on the disorganised attachment reference as compared to other information in the case. Once discussion of the case vignette was complete, the social workers were asked follow-up questions on whether and why the disorganised attachment assessment information did or did not feed into their thinking about the case.

Use of case vignettes also ensured that rich data were generated from all participants. If the interviews had solely contained abstract questions about whether attachment theory is drawn on in practice, interviews with social workers who declared they do not draw on the theory would only have been able to provide insight into their reasons for not drawing on the theory. However, inclusion of case vignette discussions meant that the case vignette responses of such interviewees could be examined to consider whether any ideas from attachment theory were implicitly informing their thinking, and whether the cases were thought about differently if attachment theory was not drawn on. Furthermore, and in recognition that social workers who do not themselves draw on attachment ideas may still potentially be influenced by references to attachment made by others, the second case vignette also enabled examination of how all the social workers responded to an attachment assessment.

Some follow-on practice-related questions were asked after the questions about the two vignettes (see Appendix C, Section C). The purpose of these was to explore some of the factors that may have influenced the role that attachment theory did or did not have in the social workers’ thinking when discussing the vignettes. The follow-on questions explored the social workers’ perceptions of what they drew on when working through the vignettes, their knowledge and practice use of attachment theory, and their views on attachment theory. Inclusion of these questions enabled examination of practitioners’ own reflections on their understanding and application of attachment theory. This provided useful context for how the social workers responded to the case vignettes as well as insights into how attachment theory features in their day-to-day practice thinking.

3.4 Data Analysis

3.4.1 Data Analysis Process

The data were analysed using thematic analysis: a descriptive method of qualitative analysis where the researcher "stays close to the data" (Creswell & Creswell, 2023, p.196). The process for thematic analysis outlined by Braun and Clarke (2006, 2013) was followed.

Analysis began with familiarisation with the data. Once all 23 social worker interviews were complete and transcribed, I read through them all. The first time I listened to the interview recordings while I read them, to check transcription accuracy. The second time I read through them more slowly, making an initial note of things of interest at the individual participant interview level. I read through them all a third time, making an initial note of things of interest at the cross-interview comparison level.

I then moved to the coding phase, working through each printed interview line by line, noting initial codes in the margin and highlighting interview text that illustrated the codes. Everything in the data of relevance to the research questions was allocated a code. Initial codes were free-generated and were often short phrases, for example, "attachment mentioned but not elaborated" and "attachment-aligned idea but no explicit mention." The next phase of analysis involved moving from initial codes to broader themes. Codes were grouped, based on their relationship to each other, into an initial set of themes and sub-themes. The themes and sub-themes were partly theoretically driven by the research questions and the researcher's analytic interests, and partly inductively driven by the data. For example, it was anticipated – based on the literature reviewed in Chapter 2 – that there would be a theme or themes relating to how formal attachment assessments and the related classification terms are used in practice, but the precise nature of this theme and its sub-themes were determined by the data. Furthermore, some themes (such as "turning away from attachment theory due to how it was conceptualised") were not anticipated in advance and were identified inductively.

The next phase of analysis involved review of the themes. The coded data extracts from the individual interviews were collated under the initial themes and sub-themes. All the data extracts collated under each theme and sub-theme were read through to see how well they fit together. This led to some data extracts being moved from one

theme to another, and some sub-themes being moved to other themes. As an example, it was at this stage that it became apparent that there would be value in exploring understanding of attachment theory separately from exploring practice application of attachment theory. Prior to this decision, all the sub-themes relating to disorganised attachment were grouped under a single theme, but following this the sub-themes relating to understanding of disorganised attachment were separated from the sub-themes relating to whether and how the disorganised attachment assessment informed the practitioners thinking about the case vignette.

The individual interview transcripts were then revisited and read through again, alongside the list of themes and sub-themes, to check the fit of the themes with each individual interview and to check that everything of relevance from the interviews was adequately captured within the current themes. The final phase of analysis involved writing up each of the themes and sub-themes. This involved summarising the collated data extracts within each theme, choosing which illustrative direct quotes to retain, and adding analytic narrative.

3.4.2 Data Analysis Principles

Thematic analysis is a flexible method (Braun & Clarke, 2006) and, as such, there are choices to be made. These choices, which became principles informing the analysis and write up, are made explicit here.

Whilst cross-interview (cross-case) analysis is a key feature of thematic analysis, analysis of this dataset also followed the recommendation of Sandelowski (1996) to recognise and value the individual participant case-oriented basis of qualitative research:

> Qualitative analysts are obliged, first and foremost, to make sense of individual cases. … Each individual sampling unit in a qualitative project is the basis from which researchers may move to cross-case comparisons … or other aggregations, syntheses, or interpretations of data that originate from and remain faithful to individual cases (pp.526-527).

Analysis therefore started with careful focus on each individual social worker's interview and the themes were later checked against each individual interview. Furthermore, when conducting cross-interview comparison an important guiding principle was to be as alert to differences across interviews as commonalities. The

approach to recruitment (deliberately not mentioning attachment and not selecting participants with a particular view and level of use of attachment ideas in their practice) had led to a sample with diverse understanding, views, and use of attachment theory. This diversity was a core feature of the sample and data, and it was felt that better understanding this diversity could make a substantial contribution to understanding practice uses of attachment. A stated advantage of thematic analysis is that it can be used to identify similarities *and* differences across a dataset (Braun & Clarke, 2006) but it has been noted that the act of searching for patterns across data to generate themes can sometimes lead to the ironing out of contradictions in the data (Phoenix & Orr, 2017). Emphasising commonality over differences when developing the themes in the current study would have obscured meaningful diversity in the data and the insights this could generate, and would also have resulted in the data not being well represented.

To support an appropriate balance during analysis between individual participant case-orientation *and* cross-interview comparison, and between the identification of similarities *and* differences, somewhat different criteria were set for themes versus sub-themes. Both themes and sub-themes needed to meet the criteria of salience: capturing something important about the data in relation to the research questions. Themes had an additional criterion of prevalence: the theme did not necessarily need to be present in every interview within the dataset, but it needed to be present across several of them. This ensured that all the themes contained an element of cross-interview comparison. Sub-themes, however, did not have the criterion of prevalence. As a result of these principles, whilst some sub-themes did draw across interviews, it was considered appropriate to include some sub-themes containing findings found in a single interview, provided these findings provided important insights in relation to the research questions. This approach ensured that important individual participant case-oriented findings could be reported as appropriate, and prevented a need to force comparative comments where that comparison would be arbitrary at best or misleading at worst.

There is some debate as to whether numbers should be reported in qualitative research, and both some potential benefits and pitfalls to their inclusion (Maxwell, 2010). In the current study, a deliberate choice was made to not present as standard the number of participants who provided a particular response, following general convention in qualitative research. As a qualitative study, the purpose was exploration of variability, not quantification of variability. The study was not designed with a goal of

nomothetic generalisation, and it was felt that reporting the specific number of social workers taking different approaches in the sample would encourage focus on a feature of the data that was of limited value and could be misleading. Stating that one view was held by 10 social workers in the sample and another view by six social workers could lead to a focus on one of these views being more common than the other, detracting from the more relevant insights provided from the detail of the different views (Sandelowski, 2001). Furthermore, in another sample or the wider workforce the balance might be different and what was the more common view in this sample may be a minority view there. Therefore, deliberately non-specific terms such as “some”, “several”, and “a number” were used to indicate findings that were observed in multiple interviews (e.g., “some social workers held view *x*, a number of other social workers held view *y*”) and there was generally no signalling of how common findings were. At times, however, it felt useful to provide the reader with a sense of whether something was common or uncommon within this sample. Where a finding was based on a single interview, this was clearly noted (“one social worker…”). Furthermore, in a few instances, a clearly dominant perspective or finding was identified in the dataset and not noting this would have meant withholding relevant and important information (Maxwell, 2010). In such instances numbers were still avoided for the reasons already outlined, but a descriptive indication of predominance was provided (e.g., “many”, “most”, “all”), with “none”, “just one”, or “a few” used as appropriate to describe the exceptions.

A substantial number of verbatim participant quotes are included in the presentation of the findings. This is standard practice in qualitative research and provides several benefits including offering the reader greater depth of understanding of the findings (Corden & Sainsbury, 2006). In their criteria for reporting qualitative research, Tong et al. (2007) recommend that participant quotations are included to illustrate findings, and further recommend that each quotation is identified with a participant code or pseudonym, and that quotes are included from different participants to add trustworthiness and transparency. These recommendations were followed. Quotations were chosen from all the collated data extracts that formed the basis of each sub-theme, and the direct quotes chosen were those which were felt to best illustrate the content of the sub-theme that had been developed from all the relevant interview material. Selecting quotations after theme development, rather than during, provided reassurance that themes were based on thorough review of all the data, rather than based around stand-out individual remarks cherry-picked from the dataset (Eldh et al., 2020).

In line with most contemporary research, anonymity was regarded as ethically important and agreed with participants (though see Edwards, 2020, for a discussion about the assumptions and power underpinning decisions to anonymise participants). Whilst the interviews were assigned codes, these were substituted for pseudonyms when writing up the findings. This was a pragmatic decision: it was felt that references to names would fit the flow of sentences better and be easier for a reader to hold in mind. Plant/flower names were used as the pseudonyms as these were considered more neutral than a researcher generated list of names which could inappropriately reflect particular cultural, socio-economic, or generational naming influences.

3.4.3 The Position of the Researcher and Reflexivity

The active and subjective role of the researcher is not only acknowledged as inevitable but "positively valued" as a research tool in qualitative research (Braun & Clarke, 2013, p. 36). However, it is important to make visible and critically reflect on how the background and stance of the researcher shapes the knowledge produced (Braun & Clarke, 2019). This can be done through reflexivity: "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p.220).

I conducted this qualitative research from the position of a critical friend to both the academic attachment field and social work practice. Costa and Kallick (1993) define a critical friend as "a trusted person who … offers critiques of a person's work as a friend … [and] advocate for the success of that work" (p.50). Previous research and writing on the relationship between attachment theory and social work practice has predominantly been produced by either those 'inside' the attachment field, or those 'inside' social work practice and 'outside' the attachment field. In contrast I occupy a somewhat liminal space between the two. My academic discipline is psychology. I have undertaken training in key attachment assessments (the AAI, reflective functioning [RF], and the Strange Situation); I have attended attachment conferences and collaborated with attachment researchers; and I have undertaken some research from a 'within attachment' perspective (such as the research reported in Part B of this thesis looking at the relationship between practitioners' attachment states of mind and their practice-related RF). However, I am not based directly within an attachment research group, and instead am part of a research group (led by Duschinsky, a sociologist and historian) that has studied attachment theory from a critical friend perspective

(Duschinsky, 2019). With regards to practice, I am not a social worker myself, and do not have any direct practice experience of child welfare or related fields. However, I am an educator of social workers: I am a lecturer within a university social work department, and in that role deliver teaching on attachment theory and research to pre-qualified social work students and post-qualified social workers. I am also the convener of an 'Attachment Special Interest Group' for child and family practitioners in my region who are interested in exploring the potential relevance of attachment concepts and findings for practice. I have therefore developed insight into, and deep respect for, both attachment research and social work practice, and I do not feel an allegiance to just one, which could lead to a prioritisation or legitimisation of one over the other.

One of my aims was to compare social workers' conceptualisation and understanding of attachment theory and research to the 'published academic account'. It felt important to make explicit what published academic account was in scope (and this was done in Chapter 1), as I recognise that different researchers would draw the boundaries in different places and emphasise different elements. The boundaries I chose (e.g., choosing to include mentalising/RF but exclude self-report adult attachment styles and attachment disorders except for brief mention) were shaped by the attachment training I have undertaken and the developmental psychology focus of the attachment academics I have collaborated with. The first attachment training I attended was an AAI institute and alongside this I immersed myself in Main and Hesse's conceptual literature on attachment states of mind, research literature on intergenerational transmission of attachment, and writing on clinical applications of the AAI (most notably the edited book by Steele & Steele, 2008b). I have also undertaken RF training and worked with my supervisor Robbie Duschinsky on a book about mentalising and the wider work of Fonagy and his collaborators (Duschinsky & Foster, 2021). Starting my training with a focus on the level of representation, adults, and intergenerational transmission made me particularly attuned to noticing social work colleagues and practitioners who held a conceptualisation of attachment theory as being focused solely on children and categories. I also noticed however, particularly through discussions with practitioners attending the Attachment Special Interest Group, that some practitioners have very deep, nuanced conceptualisations and understandings of attachment theory. This therefore shaped my decision to not only examine how social workers use attachment theory but also how they conceptualise it. My informal observations suggested this might provide some important insights, and it also felt important to examine this systematically in my study so that I could replace my anecdotal impressions with empirical findings.

Another of my aims was to explore how social workers use attachment theory in their practice. This is a topic I have had to develop a stance on in my role as a social work educator. In that role I support students to develop an understanding of attachment concepts and research, but the limited time available to cover the topic – compared to the vastness of attachment theory and research – means that I have had to make decisions about which concepts and research to prioritise and focus on. I also need to support students to not only gain knowledge of attachment but to reflect on appropriate ways to apply that knowledge in practice. These are therefore core concerns of mine in my educator role, and ones I revisit regularly. I have used new insights from reading, this research, and interactions with social workers and my pre-qualifying students to further refine my stance and my teaching materials. For example, I have been influenced by pre-qualifying students' responses to the theory and by seeing – through their questions and when marking their assignments – which aspects of the theory tend to be well understood and less well understood, and what they see as the relevance of the theory for practice.

My stance has also been shaped by discussions with attachment researchers on this topic, including at the Disorganised Attachment Conference in Berkeley in 2017 and at the International Attachment Conferences in London in 2017 and in Vancouver in 2019. I also fed my experiences and views into the consensus statements on disorganised attachment (Granqvist et al., 2017) and attachment in court practice (Forslund et al., 2022) and my thinking was in turn shaped further by these papers.

It is important therefore to acknowledge that I am not neutral on this topic: I commenced this research with existing impressions of how social workers understand attachment theory, and with existing views on what I consider to be 'valuable' and 'less valuable' ways of using attachment theory ideas in practice. To ensure these impressions and views did not shape the research inappropriately, I paid careful attention to the interview questions I asked to ensure they were open, were not skewed to a focus on content which confirmed my prior assumptions, and were not value laden. I also sought to attend to my assumptions, values, and perspectives when analysing and reporting the findings, and to be explicit about which points were based on the views of research participants and which points were based on my views. Use of research supervision was helpful here.

Chapter 4: Findings on Conceptualisation and Understanding

This chapter reports findings from interviews with 23 UK-based child and family social workers, exploring how they conceptualised and understood attachment theory and research, and how their understanding compared to the academic account represented in the published work discussed in Chapter 1. The themes and sub-themes identified were as follows:

Themes	Sub-themes
'Attachment' often conceptualised broadly but 'attachment theory' narrowly	Attachment seen as applying to a range of emotionally-invested relationships
	Conceptualisations of attachment theory dominated by early work on individual differences in children's attachment
Substantial variation in depth and breadth of understanding	Varied depth and breadth of understanding of attachment theory and research in general
	Varied understanding of disorganised attachment
	Varied perceptions of what disorganised attachment might indicate about a child's experiences of care
	Varied perceptions of the longer-term implications of disorganised attachment
Turning away from attachment theory due to how it was conceptualised	Turning away due to perceived flaws in attachment theory
	Limiting use due to seeing attachment theory as having limited practice value
	Limiting use due to seeing attachment theory as promoting existing attachment relationships even if they are harmful

4.1 'Attachment' Often Conceptualised Broadly but 'Attachment Theory' Narrowly

Overall 'attachment' tended to be viewed by the social workers as a broad, diffuse concept, sometimes leading to it being applied to a broader range of phenomena and issues than in attachment research. In contrast, the social workers' views on what 'attachment theory' comprised were often narrowly based around a simplified, fuzzy

picture of early work on individual differences in infant attachment, leading to the theory often being viewed as far narrower in scope than it is.

4.1.1 Attachment Seen as Applying to a Range of Emotionally-Invested Relationships

When discussing who attachment bonds are formed with, many of the social workers talked about the bond formed between a child and their primary caregivers. Some focused on the bond from children to "parents", others talked about "caregivers", and some both. Several also explicitly stated that attachment bonds can be formed to a wider range of people than just primary caregivers. For example, Jasmine said, "I think primarily we talk about infant and parent, but … I think it can be applied to any number of relationships." A number showed awareness of the idea and value of secondary attachment figures and wider attachment networks (see Section 1.1.3). For example, Rose discussed the value of children having "a consistent figure within their lives to go to for reassurance, comfort, help, support … a safe person … in your life. And that … doesn't always have to be your main caregiver, which is redeeming." Cassia, when discussing the children in the second case vignette, speculated that "they might have an attachment to granny or an aunty or a neighbour or somebody" and discussed how such relationships might potentially help offset the impact of issues in primary attachment relationships. Overall, the social workers in the sample demonstrated an awareness that attachment bonds are formed to particular individuals and that the role of an attachment figure is not limited to mothers, which is in line with the academic account (see Section 1.1.3).

However, the social workers did not always limit their use of the word attachment to bonds formed from children to people who are older or wiser. A number of participants also used the word attachment to describe the emotional bond a parent was typically expected to form with their child. Here the concept of attachment was being stretched to refer to the affective components of the caregiving system, rather than being used to describe the potential for some parents to attempt to use their child as an attachment figure. 'Attachment' from parent to child was referenced when highlighting potential difficulties parents were experiencing in being able to emotionally invest in their children, and the language used framed this 'attachment' as something that could be limited or lacking. For example, in relation to the first case vignette, Fern asked about the mother, "Does she have postnatal depression that meant that she struggled to attach and relate to the children when they were born?" A few social workers also

described the relationship between similar aged siblings as an attachment. In these cases, social workers were using the word attachment to denote any important (typically familial) bonds, rather than solely bonds with the specific function of seeking protection and support. For some social workers therefore, a broader range of bonds and relationships were conceptualised in attachment terms than in attachment research, though this broader application of the word does align with the broader usage seen in some of Bowlby's earlier writing (see Section 1.1.3).

Whilst there was variation in what relationships were considered attachment relationships, the social workers did all reserve the term attachment for enduring emotionally-invested relationships. In other words, they were aware that not all relationships are attachments. However, the social workers did not make the obverse distinction: that attachment is one important part of the relationship between a child and their attachment figure but not an overall descriptor of this relationship (see Section 1.1.2). It was not that the social workers did not recognise that there was a range of important aspects to the child-parent relationship, but the word attachment was often used to refer to the child-parent relationship as a whole. Attachment figures were seen as 'discriminated individuals with whom you have an emotionally-invested relationship', and not as 'discriminated individuals who are sought as a safe haven in the context of alarm'.

4.1.2 Conceptualisations of Attachment Theory Dominated by Early Work on Individual Differences in Children's Attachment

Views on what attachment theory comprised were often narrowly based around a simplified, fuzzy picture of Ainsworth's patterns of infant attachment (see Section 1.1.5) and sometimes, though not always, Main and Solomon's addition of disorganised attachment (see Section 1.1.6).

Although the infant attachment patterns/classifications were seen as the sum of the theory for many, and as a core part of it for the rest, the detail of the patterns/classifications was often not known. This extended even to the names of the classifications. For example, Cassia said, "if you would ask us, tell us the different attachments, I wouldn't know off the top of my head, I would have to go and read a book." Fern said, "I get some of my ones confused, there's like four categories or whatever, isn't there. … I can't remember them all off the top of my head." Poppy said, "I can't even remember. … I couldn't even name the different types of attachments

now, I just kind of think of them as secure or insecure", showing that she was aware that attachment theory had a concern with individual differences in security, though the detail of the classifications had not been retained.

The social workers in the sample tended to view individual differences in attachment quality as being firmly categorical, but with the categories often reduced to secure versus insecure. This was seen in the language used to refer to potential individual differences in attachment when discussing the case vignettes, and also in the descriptions of how they use attachment theory in their practice. For example, Daisy said, "you would be observing how the kids are with their parents, and trying to make an assessment on whether you think that they feel secure or they don't." Attachment was often seen as secure or not, a binary option, and no participants used language that indicated they were thinking about security as differing by degree.

None of the social workers in the sample were trained to conduct formal attachment assessments, and their knowledge of how the different attachment patterns manifest and are identified within the various attachment research measures was very limited. Some still thought it useful to draw on a concept of individual differences in attachment security however. For these social workers, secure (also sometimes called "good", or "positive", or "healthy") attachment as a concept was benchmarked against a general idea of a 'good enough' child-caregiver relationship rather than against specific attachment assessment criteria, and insecure attachment in turn was equated with 'a child-caregiver relationship we find concerning from a social work practice perspective'. For example, Fern said:

> I know what a secure attachment is and what a secure attachment looks like and how important that is, and if I'm not, if I'm seeing behaviours that suggest that that's not happening and there's an insecure attachment there then that's enough to make me feel a bit worried and want to do work around that.

Individual differences in children's attachment security were seen as being related to differences in caregiver behaviour. Aspects of caregiving behaviour linked by the social workers to differences in child attachment security included some relatively more proximate to Ainsworth's idea of sensitivity (see Section 1.1.9): a caregiver's "availability and ability to meet the needs of a child" (Heather), "responsiveness" (Iris), "reliability" and "stability" (Jasmine), and ability to be "sensitive" and "emotionally available" (Lilac). Other participants emphasised other aspects of caregiving such as "stimulation, care, promoting developmental milestones" (Ash). Looking across the

participants' responses, a wide range of positive caregiving behaviours were viewed as associated with secure attachment and a wide range of less positive caregiving behaviours were viewed as associated with insecure attachment. The conceptualisation of which types of caregiver behaviour were relevant was only sometimes aligned with empirical findings from attachment research, and none of the social workers made explicit links to Ainsworth's concept of sensitivity or research findings.

4.2 Substantial Variation in Depth and Breadth of Understanding

Whilst some general trends in understanding could be identified across the social worker sample as a whole, and were presented in the previous theme, there was substantial variation between individual social workers regarding the depth and breadth of their understanding of attachment concepts and findings. This was both the case regarding attachment theory and research in general and regarding the disorganised attachment classification specifically.

4.2.1 Varied Depth and Breadth of Understanding of Attachment Theory and Research in General

The sample provided evidence that some social workers have a very limited understanding of attachment theory. At times this presented in the form of a very shallow conceptualisation of attachment that appeared to be based on ordinary language definitions of the word attachment rather than attachment theory. For instance, Primrose (who elsewhere in her interview stated that she does not tend to draw on formal theories) said that attachment "means that you've got that very seriously close link to your mum." For others this presented in the form of misunderstanding. One misunderstanding, held by a number of social workers in the sample, was that attachment to a primary caregiver can be lacking. Hazel, for instance, speculated that a reason for the children's challenging behaviour in the first case vignette could be that "they haven't actually got attachment with parents." The information in the case made it clear that the children had enduring relationships with their parents, so such comments imply that not all the social workers had a clear understanding of a core attachment theory proposal: that with sufficient familiarity all

children form attachments to their caregivers, regardless of how those caregivers respond to them (see Section 1.1.9).

As seen in the previous theme, many of the social workers in the sample saw attachment theory as about different patterns of infant attachment, formed due to differences in caregiver behaviour. However, the depth of this understanding varied considerably. Some saw the patterns as straightforward sets of behaviours and seemed unaware of the complexity beneath and beyond this. For example, Cassia revealed such a view when discussing what she saw as differences between attachment theory and systems theory:

> I think I understood the concept of attachment theory much more. … I think it's very simple in terms of when you know the different domains and the different aspects of it, it is what it is, there's not really much fluctuation on that. … But with systems theory it's so comp-, it's so broad, and people have different perspectives on it, and how you apply it can be very different. … Whereas you could resonate the attachment theory with, a person has this and it might display itself like this.

However, while less common, a few of the social workers did think about the processes underpinning the different attachment patterns. Iris, for instance, discussed attachment patterns as adaptations with the function of getting needs met, and said attachment theory "doesn't necessarily give easy answers but it helps to understand." Furthermore, whilst many of the social workers in the sample saw individual differences in child attachment security as the sum of attachment theory, a few of the social workers saw this as one core aspect of the theory but were aware that the theory was broader. For example, Violet said:

> I think it [attachment theory] means a lot more than we talk about in this context about young children and their caregivers and things, but it's something that is much bigger than that and it can be seen in … all of your relationships throughout your life.

Violet and a small number of other social workers in the sample were aware that attachment theory extended to thinking about internal models, parents' states of mind, and intergenerational transmission. There was a notable lack of awareness of these aspects of attachment theory and research among the majority of the social workers in the sample however.

Some of the participants themselves highlighted substantial variation among social workers with regards to depth and breadth of understanding of attachment theory and research. For example, Laurel commented “I don’t think everybody understands it [attachment theory] enough. I think there are some [social] workers who read it, get it, and then are passionate about it … and there are others that don’t.”

The social workers’ level of understanding of attachment theory and their perception of their level of understanding were not always aligned, and this was not all in one direction. Whilst there were some examples of overconfidence in understanding of attachment theory and research, such as the example from Cassia earlier in this theme, there were also corresponding examples of underconfidence from a number of social workers who had a quite deep and nuanced understanding of attachment theory. There were also a considerable number who had limited knowledge of the theory but were aware of this.

4.2.2 Varied Understanding of Disorganised Attachment

The second case vignette included explicit mention that the children had been assessed as having a disorganised attachment, thus allowing for examination of how the social workers made sense of this specific attachment concept. A few of the social workers openly disclosed a lack of knowledge of disorganised attachment and did not attempt to speculate on what that assessment might indicate or predict. Primrose, for example, said she would need to research to see what it means. Dahlia likewise stated she was not clear what disorganised attachment was and said that she would like further information about the definition and the impact it would have on the children.

Despite disorganised attachment not being a diagnosis (see Section 1.1.6), some of the social workers implied that they viewed disorganised attachment as a diagnosis when they stated that they “can’t diagnose disorganised attachment” themselves. However, it was unclear whether it was disorganised attachment that these social workers specifically viewed as a diagnosis, or whether such statements were a consequence of a more general conflation of attachment assessments and diagnosis and/or insecure attachment classifications and attachment disorders. Furthermore, not all mistook disorganised attachment for a diagnosis. Rose said, “the attachment … has been *termed* disorganised.” Hazel corrected her own initial reference to disorganised attachment as a diagnosis, saying “they’ve been diagnosed, sorry, both been assessed as having disorganised attachments.” Similarly, Cassia said, “to think that they would

be diagnosed with having dis–, not diagnosed, sorry, but that they've got a disorganised attachment." Cassia explained at another point in her interview that she does not tend to see reference to disorganised attachment in reports but does see reference to attachment disorders in adoption work. This may mean that a discourse of attachment diagnosis is more familiar to her, which could explain her initial slip.

No participant asked whether an alternate organised attachment pattern had also been assessed for the children and, if so, which it was. This suggests that either they were not aware that disorganised attachment is typically assigned alongside another pattern (see Section 1.1.6), or they did not see this as important information. Limited awareness of the specifics and practicalities of how disorganised attachment is assessed was also revealed by the surprise expressed by a few of the social workers that an 18-month-old would have been classified as having a disorganised attachment. As one example, Zinnia said, "I think it's really early for them to be saying that Jack's got a disorganised attachment because I don't know that that's normally decided at that age." This is despite the disorganised attachment classification being developed specifically for use in observations of children of this age (see Section 1.1.6). This highlights that at least some of the social workers were unaware of the age range that the disorganised attachment coding system (and possibly the Strange Situation in its entirety) was developed for.

4.2.3 Varied Perceptions of What Disorganised Attachment Might Indicate About a Child's Experiences of Care

There was variation in what experiences of care the social workers anticipated would be associated with disorganised attachment. Some were aware that disorganised attachment can be associated with alarming caregiver behaviour and foregrounded the image of the 'frightening' caregiver (see Section 1.1.10). For example, Ivy said that the assessment indicated that "obviously the kids have found their caregivers frightening" and Iris said it is "usually indicative of the attachment figure being also a frightening figure." The social workers in the sample who mentioned frightening caregiving as a precursor to disorganised attachment were aware that this did not necessarily mean the caregivers were abusive however. They showed awareness that there are multiple possible reasons why children might experience one or both of their caregivers as frightening. For instance, the domestic violence described in the case was identified by some as a possible contributory factor to a disorganised attachment relationship, a view which aligns with theory and research findings (see Section 1.1.11).

Furthermore, many social workers thought that there were multiple possible pathways to disorganised attachment. For example, Violet said that the main things she had come to understand can contribute to a disorganised attachment were witnessing abuse, neglect, and unpredictable parenting. The interview with Iris illustrates the nuanced and exploratory thinking shown by some participants, with Iris considering the possible interplay between the domestic violence and caregiving behaviours, and leaving multiple possibilities open:

> Whether that could be just down to Chris and therefore if he does stay out then that's a massive safety … but … how has that come about? What's Amy's role been in parenting and that coming about? …If her problematic parental responses that's resulted in this disorganised attachment has been … almost solely influenced by the domestic violence and her high state of alert then … there could be quite a good chance of the children coming back to her care.

Several social workers thought that the disorganised attachment assessment indicated something about the parenting that the children had received but did not think it could tell them what specific behaviour. For instance, Poppy said, "I think the disorganised attachment certainly tells us that there's a lack of stability in their caregiver. That lack of stability could be anything." Rose said, "the attachment with mum has been termed disorganised, so … we would be looking at what sort of parenting she's implemented to have that disorganised attachment situation going on with her children." Here we see Rose identifying the disorganised attachment as a noteworthy feature, and viewing it as related to the care received, but wanting to investigate what parenting behaviour had led to that, rather than assuming the attachment assessment could tell her. Rowan said:

> It mentions at the end that both children have been assessed as having a disorganised attachment. So that, well I think that is tied up in the experiences that they've had of being parented by mum. … I'm trying to refresh my memory now of attachment training, attachment theory, but from what I recall … it's not as simple as good parenting, bad parenting or good childhood experience or bad childhood experience, but I think in this scenario, knowing everything there that's going on it does seem to be sort of indicative of the care of the children not being as good as what you'd want it to be.

Like Rose, Rowan viewed the disorganised attachment as an indicator of the type of care received and showed awareness that it was not a simple indicator of one single type of caregiving behaviour. Rowan therefore did not provide an overconfident or oversimplified portrayal of disorganised attachment. However, Rowan struggled to provide any clear indication of types of caregiving behaviour that can lead to

disorganised attachment, and ultimately returned to drawing on other information in the case to make sense of what it might indicate.

There was also variation in whether the social workers thought the disorganised attachment assessment provided them with information on how long the children had been experiencing problematic parenting. Many did not mention this; however a few thought the assessment indicated a long-term pattern of problematic parenting. For example, Camellia said the assessment indicated that, “It hasn’t been good enough. Consistently hasn’t been good enough. … I think that indicates strongly that this has all been going on throughout their lives.” A similar point was made by Azaela, though a little less definitively:

> That suggested to me that this is probably quite chronic and long-standing, for them to be displaying disorganised attachment behaviours. … If they’re showing us that they’ve got disorganised attachment that suggests that this is how they’ve been parented. … So to me that would be suggesting … that this wasn’t a one-off and that this has been long-standing, and … whatever they’ve been experiencing has been significant and chaotic and to the point that they haven’t had that consistent care.

While not common, a small number of social workers in the sample considered not only possible parenting behaviours that could contribute to the disorganised attachment, but also separation from their primary caregiver. For example, Heather said:

> They’ve been assessed as having a disorganised attachment, was that before they were removed from mum’s care? Because if it was after, even if it was a normal attachment before, they might have a disorganised attachment because they’ve been removed from their primary caregiver.

Considered as a whole, none of the social workers mistook disorganised attachment as a clear indicator of maltreatment, but neither did any draw directly on insights from the FR or AMBIANCE systems when considering possible alarming parenting behaviours (see Section 1.1.10), nor did they discuss unresolved loss or abuse states of mind that might underlie alarming parenting behaviours (see Section 1.1.12). Focus was predominantly on parenting behaviours as a cause of disorganised attachment, with some acknowledgement of the potential role of domestic violence and the current separation in the case vignette too. None of the social workers considered the role of socio-economic risk factors, lack of social support, or other contextual factors as possible contributors to the disorganised attachment (see Section 1.1.11).

4.2.4 Varied Perceptions of the Longer-Term Implications of Disorganised Attachment

Disorganised attachment was perceived to have a potential impact on a range of aspects of longer-term development. The most mentioned areas of potential impact were difficulty building new positive relationships and trust in relationships. For example, Violet said, “they might have difficulty forming attachments with new carers or trusting carers” and Hazel said, “I think they would struggle to have positive relationships with any caregiver.” Only one social worker in this sample, Cassia, mentioned the possibility of an impact on the “mental health aspect of things”, but this was not expanded on. None of the social workers drew explicitly, or appeared to draw implicitly, on research findings (see Section 1.1.7) to shape their consideration of what areas of development might be affected by the disorganised attachment.

Some of the social workers in the sample discussed what disorganised attachment could predict in a way that showed they were aware it had a probabilistic not deterministic, and only small to moderate association, with later outcomes (see Section 1.1.7), by using language such as “*might* have difficulty.” However, it was more common in this sample for social workers to view some form of problematic impact/outcomes as “very likely” or even “inevitable” without intervention. Yet these social workers did not hold a view of a particular level of impact as very likely or inevitable. For example, when asked how likely it was for there to be long-term implications, Iris said, “quite likely but obviously that’s recognising there’s a massive range from quite small problems to really huge ones, and different problems at different life stages." Thus, views on this had some nuance.

Furthermore, many of the social workers showed awareness that disorganised attachment is not fixed. For example, Jasmine said, “it’s never unchangeable” and Camellia likewise said, “it can change.” Ivy also showed recognition that disorganised attachment patterns can change, though thought they might be easier to change for younger children and “more difficult” for older children as the patterns will be “more established.” A number also talked about the likelihood or possibility of limiting negative effects from disorganised attachment with intervention. For example, Cassia said, “it could impact on these children life-long *if* they don’t get the right therapeutic support.” These views align with research evidence of the effects of some attachment-based interventions on reducing disorganised attachment (see Section 1.2), though none of the social workers referred to either research or specific evidence-based interventions.

Some social workers expressed views on disorganised attachment that aligned with the idea that early attachment experiences can be transformed but may nevertheless create underlying vulnerabilities which are not entirely erased and could continue to have influence on later outcomes (see Section 1.1.8). For example, Rose said, “there would be some impact, but hopefully if the situation could be improved … [and] with the right emotional support the effects could be limited.” Zinnia said, “it is influential right throughout their lives, and yes you can definitely make changes … don’t know if you can eradicate it, but you can certainly minimise the trauma.”

Though less common, there were nonetheless examples of social workers in the sample who viewed disorganised attachment as fixed. Azalea said, “it’ll be there forever, with kids with that kind of attachment” and Daisy said, “when you have been assessed with a disorganised attachment that doesn’t go away, that’s with you into adulthood.” This is not supported by the research evidence, which has highlighted that attachment classifications have only modest stability and are impacted in predictable ways by changes in circumstances (see Section 1.1.8).

4.3 Turning Away From Attachment Theory Due to How it Was Conceptualised

How attachment theory was understood and conceptualised appeared to be an important influencing factor for how relevant and helpful it was thought to be for practice. A few of the social workers in the sample were drawn to particular theories and ways of practicing – especially systems theories – for reasons that suggested attachment theory had the potential to feel attractive to them, but this attraction to attachment theory was not felt because of what they perceived the theory to be. Instead, turning away from or limiting use of attachment theory was observed. In all these cases a narrow and simplified version of attachment theory, which had little resemblance to the academic account, was held and repelled. Yet these social workers did not all conceptualise attachment theory in the same way, indicating that more than one simplified version of attachment theory is in circulation and can be viewed as unattractive and/or unhelpful for practice. To avoid obscuring this variation, the examples of this phenomenon seen in the sample are presented at individual-case level below.

4.3.1 Turning Away Due to Perceived Flaws in Attachment Theory

One social worker in the sample viewed attachment theory as having limited value, not only for social work practice but as a theory in general, due to perceived theoretical flaws. This social worker, Willow, said she found systemic practice helpful due to it being about "relationship building" and "family history and background." She also appreciated narrative therapy for providing "a story of people's lives and how that can inform the pattern" of their interactions with others. By contrast, Willow reported that she had turned away from attachment theory because she perceived it as being mother-blaming and not culturally inclusive. She also believed it was outdated, implying that she saw the theory as being solely Bowlby's and Ainsworth's work rather than a living theory and body of research that continues to be revised and added to:

> I did do a bit more reading about it [attachment theory] and then found out feminist critiques of it, and …when it was devised and the context at that time, and how things have changed, and then it doesn't, culturally there's differences, so … I didn't like it. … I felt like it blamed mothers for things going wrong.

Willow articulated a view of there being value in thinking about attachment as a *phenomenon* but did not equate this to attachment *theory* due to her conceptualisation of what the theory comprises and the flaws she perceived the theory to have. For example, in answer to a question of whether there are any theories that she would like more training on, Willow replied "attachment, but I think not just focus on attachment theory but … the impact of relationships on children, how their early experiences … impact on their development and their wellbeing." Willow's response suggested that she saw the phenomenon of attachment as important to understand but at the same time did not see attachment theory as something that could help her to understand this phenomenon.

Although Willow had consciously turned away from attachment theory and did not perceive herself to be drawing on it, there was evidence that Willow's thinking was nonetheless influenced by some ideas from attachment theory. For instance, Willow stated that "how you've been parented yourself impacts on your own attachment style and … that could influence how a parent interacts with a child." Furthermore, when discussing whether she thought a person's early experiences with their parents influence their longer-term development, Willow said she thought this was "a really strong influence" and went on to explain her thinking:

> I think because that's the base for how you interact with the world, so that internal working model … what you expect … how you experience the world … how that then influences … how you interact … so when you get to school how confident, and trusting people and how you interact with people socially.

The points Willow raised fit with ideas and research findings from attachment theory: Bowlby's concept of the internal working model (see Section 1.1.8) is named explicitly, and the influence that differences in early attachment experiences/patterns can have on later social competence aligns with findings from longitudinal studies such as the Minnesota study (see Section 1.1.7). Yet Willow did not see herself as liking, using, or knowing much about attachment theory. Where she drew on ideas from attachment theory and research, the source of these ideas appeared not to be recognised.

4.3.2 Limiting Use Due to Seeing Attachment Theory as Having Limited Practice Value

Another social worker in this sample, Heather, viewed attachment theory as having limited value for social work practice due to perceiving the theory as solely about the classification of infant attachment patterns, and due to viewing such classification as blaming and deterministic:

> I think attachment's a lot to do with blame. And I think … it doesn't leave a lot of hope really, you know, because once you've got a disorganised attachment where do you go from there? … Attachment is … fixed.

Heather did not appear to be aware of Bowlby's idea of developmental pathways (see Section 1.1.8) nor research evidence showing that attachment classifications are amenable to change (see Section 1.1.8).

This conceptualisation of attachment theory had not led Heather to turn fully away from the theory but had led her to limit her use of it in her practice and to focus more on using systems theory. Heather valued systems theory due to finding it useful to think about intergenerational cycles with parents:

> With systems theory … I find it really useful because I tend to find that families find it useful. So if you are able to work with parents in a … way where you're saying … 'Look this is what's happened up here with these relationships and how that's impacted down here', that's what I tend to find families like, because it's less stigmatising, it's less blame-focused. And so … I would work with that theory quite overtly I think, rather than attachment.

Heather was seemingly unaware of the specific focus in attachment research on parents' states of mind and intergenerational patterns since the mid-1980s (see Sections 1.1.12 and 1.1.13).

4.3.3 Limiting Use Due to Seeing Attachment Theory as Promoting Existing Attachment Relationships Even if They Are Harmful

One social worker in the sample viewed attachment theory as having limited value for social work practice due to a perception that the theory proposes that existing attachment relationships should never be severed. This social worker, Azalea, talked about the professional challenges for social workers of balancing the importance of continuity of primary attachment relationships with a duty of care where those relationships do not provide sufficient safety. Azalea conceptualised attachment theory as promoting primary attachment relationships over all else and, as a result, believed there was a limit to the extent that attachment theory could support her child protection practice. She thought that relying on the theory to inform decisions could, at times, be harmful:

> It's their first and main relationship and … you acknowledge the importance of it, but then you have to balance it with, is it just being harmful now? … Is it helpful to maintain, to try and promote that attachment all the time or actually is it really damaging? … Are you doing it just because it's an attachment? … Attachment theory is a fantastic theory, but actually over-relying on it can be more harmful for children. … You bring in the element of resilience and you think, actually children, they'll cope with bereavement in terms of attachments getting severed, and they do cope with going into care.

Azalea's awareness of attachment theory's identification of the importance of stability of attachment relationships (see Section 1.1.4) did not appear to be coupled with an awareness of attachment theory and research on individual differences in attachment quality and the implication of these differences for developmental outcomes (see Section 1.1.7). Azalea also did not seem aware of attachment theory and research on the value of stable and secure attachment relationships with foster or adoptive parents (see Section 1.1.12). Like Heather, this had not led Azalea to turn fully away from practice use of attachment theory but had led her to limit her use of it.

Chapter 5: Findings on Practice Use

This chapter reports findings from interviews with 23 UK-based child and family social workers, exploring the role attachment theory played in their thinking about family case vignettes and in their day-to-day social work practice, and some factors shaping whether and how attachment theory was used. The themes and sub-themes identified were as follows:

Themes	Sub-themes
Variation in whether attachment theory is drawn on in practice	Variation in use of formal theories in general
	Variation in emphasis on attachment theory versus other formal theories
	Variation in whether and how attachment fed into thinking about a case containing no explicit references to attachment
Limited practice use of formal attachment assessments and the related classification terms	Variation in whether and how a disorganised attachment assessment fed into thinking about a case
	Assessment of attachment classifications and use of classification terms viewed as outside the expertise of the social work profession
	Fear of court challenge is one driver for avoiding attachment terminology in reports
	Formal attachment assessments seen to have some potential value for child welfare practice
	Use of attachment classification terms can be unhelpful in child welfare practice
	References to formal attachment assessment terms rare
Variation in whether attachment theory was used to support understanding	Use of attachment theory to support social workers' understanding of children
	Use of attachment theory to support social workers' understanding of parents
	Use of attachment theory to support parents' understanding of their children and themselves
	Alternative, non-attachment-related, ways of understanding families
Communicating attachment-related ideas	A lack of clarity and consistency in meanings and synonyms for the word attachment
	Substantial variation in how individual differences in attachment were communicated
	Talking to families about attachment without using the word attachment

5.1 Variation in Whether Attachment Theory is Drawn on in Practice

There was substantial variation in this social worker sample with regards to whether participants drew on attachment theory when responding to the case vignettes, and whether they reported using attachment theory in their day-to-day social work practice. This was underpinned by variation in views on the practice value of formal theories in general and attachment theory specifically.

5.1.1 Variation in Use of Formal Theories in General

When reflecting on what they drew on to make sense of the case vignettes, most social workers highlighted the central role of their practice experience. A little over half of the social workers in the sample also mentioned theory.

For a number of social workers, formal theories were something they did not think played a role in their assessment of the case vignettes or in their day-to-day social work practice. A few described feeling quite daunted by theory: with it seen as something they "struggle with" (Lily) and are "rubbish at" (Poppy). This was despite both Lily and Poppy discussing how they find it helpful to draw on research, indicating that at least some social workers see theory and research as quite distinct. Some described theory as something that had faded from view over time in practice. For example, Holly said, "when I started … you go back to the theory that you've learnt at university, but the more you do it you rely more on your experience of working with families." A view of theory as something separate from the primary social work task was also revealed by Primrose's statement that "in practice we don't use that much theory, and as social workers visiting the family we're focusing on the task in hand."

For another group of social workers there was a sense that they viewed theory as something that had the potential to be helpful, but thought that reading or thinking about theory after qualification was challenging in the face of the demands of professional practice. Violet said that "when I have space and the time … you can bring in theory. But I think on a day-to-day level there isn't really the space to do that." Similarly, Rowan said that he thought theory could be helpful but that "thinking about cases theoretically is, sometimes there isn't time for that." The idea that there is insufficient time to draw on theory suggests that these social workers viewed theory as

something that would need adding on to what they are already doing, rather than as something that could be embedded and subsumed into thinking and practice.

In contrast, for a third group of social workers, theory was viewed as subsumed into their thinking and practice. There was variation in the extent to which these social workers could trace theoretical ideas back to source and the extent to which they chose to make explicit references to theory however. At one end of the spectrum, Heather was aware which theories were informing her thinking but chose not to refer to them explicitly in her day-to-day practice: “There’s some theory … there’s a few different ones that I would be thinking of, but … I wouldn’t say it, I would only be thinking it.” For others, drawing on theory was described as something they are not always aware of at the time, but can bring awareness to. For example, Jasmine said, “I think you draw on elements of lots of things, and sometimes it’s not until you sit and reflect afterwards … that you recognise that.” At the other end of the spectrum were social workers who believed their thinking aligned with theory they had been taught during qualification but were not sure which. For example, Camellia said, “I’m sure it would fit in some box somewhere but it’s so long since I’ve been a student … those days are gone, it just comes instinctively now.”

Views on the practice value of formal theory in general were an important influencing factor. Not all those who were advocates of formal theory in general were advocates of attachment theory, but a view that formal theory was not something of value for practice served as a clear barrier to further exploring attachment theory and its potential relevance.

5.1.2 Variation in Emphasis on Attachment Theory Versus Other Formal Theories

For those who drew on formal theories in their social work practice, some had fully or partially turned away from attachment theory: drawing only on other theories, or drawing predominantly on other theories but with some limited use of attachment theory. Other social workers described attachment theory as being one of a number of theories in their “toolbox.” In this sample, the social workers who drew on attachment theory when responding to the case vignettes typically did so alongside other theories. Systems theory was identified as one of the other theories drawn on for almost all the social workers who used theory. There was just one social worker in the sample who stated that she drew on attachment theory but no other formal theories.

Variation in emphasis on attachment theory aligned with variation in how much attachment theory was thought to be able to explain, as can be seen from the following two quotes:

> I think it's helpful in terms of something to think about and something to consider. … I don't think it's the be all and end all. I think it's one aspect of everything that you take into consideration and you look at when you're assessing. (Fern)

> I've always said for a long time, attachment is the root of everything, and I think a lot of the reasons why the parents we work with struggle to parent is because of attachment difficulties. … I don't know if sometimes I just say, 'Oh … it's attachment', and you don't look for anything else. But I always do think it's at the heart of everything. (Laurel)

In these quotes we see variation in views on how much can be understood through reference to attachment theory. Fern saw attachment theory as something that can provide part of the picture, Laurel saw attachment theory as core to understanding the situation of families. Some of the social workers themselves described variation among their colleagues regarding the level of emphasis placed on attachment. For example, Iris proposed that attachment theory is "really important … for our work" yet emphasised the need to also draw on other theories, and contrasted her own stance to that of some of her colleagues who "would say that attachment theory explains all, [laughs] all of human behaviour."

5.1.3 Variation in Whether and How Attachment Fed into Thinking About a Case Containing No Explicit References to Attachment

Attachment was not mentioned during recruitment, and the first case vignette made no explicit mention of attachment. A little under half the social workers in this sample made explicit reference to attachment in their discussion of this first case vignette. Where they did, this took one of three forms.

A first was reference to attachment as a synonym for the parent-child relationship or the general emotional bond from child to parent or parent to child. For example, Zinnia said about the mother in the case, "if she's got postnatal depression now, did she have it when the kids … were younger and she's never formed an attachment to them?" These references were not to the concept of attachment as defined by attachment theory or to ideas within attachment theory, but to everyday meanings of the word

attachment. However, the use of the term ‘attachment’ to serve this function, rather than alternatives such as relationship or bond, suggest that the term is part of the social work professional vocabulary.

A second was reference to attachment to mark and label something problematic in the child-caregiver relationship. For example, Camellia said, “even though Sam has been diagnosed with ADHD and receives medication, it’s unlikely, I would say it’s more likely to be attachment stuff.” Camellia also said, “mum probably has difficulties with her own attachments.” As another example, Lily said, “mum’s depression may … have affected her emotional availability and attachment issues.” These references to attachment were made in the service of noting a potential problem in the child-caregiver relationship, but not also as a springboard for further exploration of these potential problems. References to attachment such as these were not explained and expanded on further: the loose ascription of the problem to attachment was treated as sufficient, perhaps with implied reference to attachment theory as a body of scientific knowledge concerned with difficulties in the child-caregiver relationship.

A third was reference to attachment as a factor worthy of further consideration and exploration. For example, Laurel questioned “if she [the mother] hasn’t been emotionally available to them [the children], what’s their attachment like?” As another example, Heather said:

> She was on a child protection plan from 16 months to two, and then she’s placed in foster care, so I suppose those months of development during that time are really pivotal for a child to establish their secure base … and develop a good attachment system. So I suppose I’d be thinking, what was going on, why did she end up in a child protection plan, could that have impacted on that? How did the transfer to foster care, and being in foster care impact on her and her relationships? And whether she suffered any harm and what impacts that’s all having now on what she’s learnt and what she thinks is normal parenting.

In such instances, ideas from attachment theory were being drawn on, and references to attachment were being made as part of a process of hypothesising and being curious about the case. References to attachment were not seen as the end point, but were explained and expanded upon.

In a little over half the interviews attachment was not explicitly mentioned by the social workers in their responses to the first case vignette. For many of these social workers implicit use of attachment ideas were not observed in their discussion of the case, nor

did these social workers later identify attachment theory as something they had been drawing on to support their thinking about the case. However, a few social workers could be seen to be drawing on ideas from attachment theory in their discussion of the first case, but without use of any explicit references to attachment. For example, Iris highlighted how the mother's "experiences as a child isn't necessarily going to set her up well for being emotionally available and also meeting the needs of her children" and went on to clarify "it's not really just about modelling but she probably hasn't had … her needs met in a way that allows her to in turn meet her children's needs." These social workers later confirmed that they had been drawing on attachment theory ideas to support their thinking about the case, and that their avoidance of use of attachment terminology had been deliberate (see also Section 5.4). Though different in that attachment was not explicitly mentioned, these social workers were using attachment theory in a very similar way to those referencing it explicitly in the service of hypothesising.

There was great variation seen, therefore, in relation to whether and how attachment fed into thinking about a case containing no explicit references to attachment. Some of the social workers did not draw on attachment theory explicitly or implicitly. Some who drew on attachment theory referred to the word attachment, but others deliberately did not. And some who referred to the word attachment did not draw on the theory. Furthermore, references to attachment were used in the service of very different types of thinking: labelling and exploring/hypothesising.

5.2 Limited Practice Use of Formal Attachment Assessments and the Related Classification Terms

This theme focuses on findings related to the social workers' engagement with a particular aspect of attachment theory: attachment assessments and the related classification terms. In this social worker sample, there was no evidence of use of formal attachment assessments, very little use of formal attachment classification terms unmoored from formal assessments, and varied but overall quite moderate reactions to a case reference to disorganised attachment.

5.2.1 Variation in Whether and How a Disorganised Attachment Assessment Fed Into Thinking About a Case

The second case vignette included explicit mention that the children had been assessed as having a disorganised attachment, thus allowing for exploration of how the practitioners responded to this specific attachment classification. Many of the social workers referred to the disorganised attachment assessments as part of their discussion of the case. How soon they referenced this, and the extent to which it fed into their thinking about the case varied.

Some of the social workers thought the disorganised attachment assessment provided them with additional insights beyond those provided by the other information in the case. For a few of these social workers, the disorganised attachment information was a key piece of information from the case that they drew on when thinking about the level of risk. For example, Iris said, “the reason I say high [risk] in the short-term is noting that the children have been assessed as having a disorganised attachment which is, it’s quite a major thing.” A few participants also believed that the disorganised attachment information indicated that the issues in the child-caregiver relationship had been going on for a while, which fed into their risk assessment.

For other social workers, the disorganised attachment assessment information generated additional questions about what might be going on in the case. For example, Ivy stated that the disorganised attachment assessment information confirmed her thinking about the behavioural presentation of the boy in the case, but made her wonder more about the experiences of the girl in the case:

> When he lies prone on the floor, barely moving, glazed, and then reports seeing father’s angry face in Jack’s features, I think that kind of made me think, yeah, attachment isn’t quite right there. And then when you came to … disorganised attachment, I thought, yeah, it sounds about right, frightening parent. … It wasn’t a surprise … but I think the fact both children I was like, oh that’s a little bit more interesting, so it makes me think, what’s been going on with Ellie?

Iris, likewise, indicated that the disorganised attachment assessment generated additional hypotheses. Iris drew on the assessment information to question whether the family’s problems all stemmed from the father, and to question whether the family were facing a one-off crisis event. She argued that “the assessment of disorganised attachment … perhaps would challenge a version of events where you’re just

interpreting that Amy's been fine and Chris has been violent." These were presented as tentative ideas that would require investigation rather than definitive conclusions.

Several of the social workers drew on the disorganised attachment assessment to think about what support the children might need. Willow used it to hypothesise about "if there's any specialist therapeutic support that we'd need to put in." Poppy said that the "children have been diagnosed as having a disorganised attachment so they're going to need some referrals into [the local child mental health service] … because I'm not really quite sure what work would be done around the disorganised attachment." Poppy's comments reveal that, whilst she was unsure of what support is needed for disorganised attachment, she saw this support as something that is a matter for mental health services rather than social services.

Others stated that the disorganised attachment information fed into their thinking, but that it did not lead to any new conclusions and instead just confirmed thoughts they were already having about other information in the case. Ash explained this by saying "I wouldn't say that it affected what I was thinking about the case as much as it kind of affirmed what I had been thinking." Ash went on to clarify that the attachment "diagnosis" abstracted away from an understanding of the actual disorganised behaviours shown by the child towards their caregiver, which he thought would be the useful information to know:

> That [disorganised attachment assessment] doesn't really tell us anything more than the rest of the scenario did, we don't know about what the impact is, we don't know about what those disorganised behaviours looked like. I'm not sure it's massively helpful to just be a stand-alone. It's a diagnosis that doesn't really say anything.

Thus, whilst the disorganised attachment information was viewed by Ash as having some confirmatory value when provided alongside details of behaviour and events, he was also clear that the disorganised attachment information would not have been a useful substitute for the other information in the case. He also thought that disorganisation as a category subsumed and, in doing so, lost track of important information about the specific behaviours shown by the child towards their caregiver.

Several social workers did not mention the disorganised attachment assessments at all and confirmed afterwards that it had not fed into their thinking. Two distinct reasons for this were found. The first reason related to a view that the descriptive information in the

case vignette concerning events and the children's behaviour was sufficient to inform their practice thinking, and the attachment assessment information could only offer a less effective, and potentially reifying, index of the same information. This perspective had some overlap with the perspective illustrated by Ash above, but differed in that the disorganised attachment information was not even seen to have confirmatory value. For example, Fern said:

> Looking at some of their behaviours you can tell that there's difficulties with the attachment and their needs not being met and all of that. I try not to put labels on, this child is suffering disorganised or ambivalent attachment. … It's focusing more on the behaviours and what the behaviours will be telling you as opposed to sticking a label, an attachment theory label on it. Because it's just words, we need to understand what that means for these children and what we're actually seeing.

The second reason for not drawing on the disorganised attachment information stemmed from a lack of knowledge of the classification and any sense (grounded in understanding or misunderstanding) of its potential ramifications. Dahlia, who elsewhere in her interview identified that she did not draw on any formal theories, stated that she did make a note of the disorganised attachment assessment but would need to know more about what this was for it to feed into her thinking about the case. Primrose, who had a very limited understanding of attachment theory in general and did not draw on any aspects of the theory explicitly or implicitly when discussing either case, did not register the disorganised attachment assessment information when reading the case. When asked specifically if it fed into her thinking, Primrose replied, "no it didn't. … I've actually just noticed that." Primrose went on to explain that she was "focusing more on how she [the mother] was caring for the kids, as opposed to how they were dealing with it." The implication was that even with her attention drawn to the disorganised attachment information, it would not have fed into her thinking about the case. Primrose appeared to have assumed that an assessment of disorganised attachment related only to the individual child, rather than being an assessment of the dyadic relationship and suggestive of the child's history of care in that relationship.

The extent to which the disorganised attachment assessments were noted and weighted by the social workers in this sample could be seen to vary substantially. However, it was rare in the sample for the assessment of disorganised attachment to lead to additional conclusions beyond those the social workers were already making based on the other case information.

5.2.2 Assessment of Attachment Classifications and Use of Classification Terms Viewed as Outside the Expertise of the Social Work Profession

Most of the social workers in the sample emphasised that they were not qualified to formally assess attachment. However, the reason for not being qualified was not explained in terms of qualification requiring completion of specialist training and reliability tests. Instead, qualification was often presented as profession specific. Assessment of attachment was seen as within the remit and expertise of mental health professionals such as clinical psychologists or psychiatrists. In turn the social workers did not feel they had the professional legitimacy to be, or become, experts in attachment. For example, Rose said, “we as a professional group wouldn’t be considered an expert on those things”. Jasmine said, “as social workers we’re made aware that we are not experts in this.” Willow said, “I’m sort of aware of like different types of attachment but I don’t think I know enough … because I’m not a trained psychologist.” Thus, most of the social workers seemed to be unaware that specialist training in attachment assessments is both something that is available to them as social workers and not something that clinical psychologists automatically train in. It was unclear to what extent the perception of attachment assessment as being within the purview of mental health professionals was due to a misperception of the classifications as having the status of diagnoses. A number of the social workers used the language of not being qualified to diagnose, suggesting that this was at least part of the reasoning for some.

The terms ‘secure’, ‘insecure’, ‘avoidant’, ‘resistant/ambivalent’, and ‘disorganised’ were generally seen as tied to, and indicative of, formal assessment of attachment. In response to this, these terms were described by all but one (see Section 5.2.6) of the social workers in the sample as terms they could not use in their practice assessments, unless they were referencing an assessment already conducted by a qualified assessor. For example, Azalea explained how “in my assessments … I won’t say they’ve got a secure attachment because I’m not a professional.” Camellia, when asked if she used the term disorganised attachment in her assessments, said, “we aren’t qualified. … I couldn’t say, ‘This child has a disorganised attachment.’ You would need psychological assessment.” None of the social workers in the sample used any formal attachment assessment classification terms when discussing the first case vignette, nor any when discussing the second case vignette beyond referring to the disorganised attachment assessment already included in the case.

5.2.3 Fear of Court Challenge is One Driver for Avoiding Attachment Terminology in Reports

Some of the social workers raised court challenge as a reason they avoid using attachment assessment terms. Heather explained: “I wouldn’t say, this is a disorganised attachment. … It could be for court, in which case they’d be like, how do you know?” Furthermore, a fear of court challenge was not always limited to use of formal attachment classification terms. For several social workers, there was also hesitancy to make more general references to attachment in reports. For example, Rose said:

> I think we’ve been stung in the past. … So all social work reports if necessary need to go to court. Say for example … we’ve made some general comment upon attachment, they would be saying, how on this witness stand are you qualified to make that comment with regard to attachment? And I think social workers have then shied away from that because that can be a really difficult place to be.

Similarly, Cassia said:

> I’ve worked with managers before who’ve said, don’t do it, because if you get to court and you’re giving evidence and you’ve quoted attachment theory you could be hauled over in terms of, well you’re not an expert on that.

From the comments made by the social workers, a picture emerged of how a perception of not having professional legitimacy to be experts in attachment assessment, combined with limited knowledge of the classifications and a view that these are the crux of the theory, could lead to a view of attachment theory in general being something they are not and cannot be experts in, and thus should avoid mentioning.

However, an alternative account of potential drivers for the hesitancy to mention attachment theory in court was raised by one of the social workers in the sample. Iris initially raised the same issue of court challenge as other social workers in the sample, but then began to question whether this is necessarily the real reason for the reticence:

> It almost becomes a slightly mythical thing, and I don’t think we are actually regularly warned against putting, quoting research in court reports, but it’s a sense that it’s something that one doesn’t do because it’s easy to get, then for people to pick on you quite specifically about that. I mean I don’t know whether I

> think that's true, and I think most of us just probably haven't, feel like we haven't got time to go and carefully fish out all the references and put them in.

In this account, social workers as a professional group are not delegitimised and prevented from drawing on attachment theory and research. The suggestion here is that a key barrier might instead be social workers not having the time and/or knowledge to refer to attachment theory appropriately. Iris's account acknowledges the possibility that social workers can develop greater knowledge of attachment theory and be expert in it: the barrier is one that may be difficult to overcome but is nonetheless one that could be overcome. Yet this was a minority account of the situation in the sample.

5.2.4 Formal Attachment Assessments Seen to Have Some Potential Value for Child Welfare Practice

For some social workers, formal attachment assessments were viewed as an aspect of attachment theory that could offer useful information for child welfare practice. Whilst direct use of them was seen as out of their reach, formal attachment assessments were still seen as valuable where it was possible to get someone suitably qualified to carry them out. This view was expressed through a number of comments. For example, Ivy suggested that it was a missed opportunity that attachment assessments were not carried out more often in child protection cases: "I certainly have only read about one happening … which is wrong." Rose described how she would draw on attachment theory to tentatively explore elements of a parent-child relationship, but viewed the value of this as being the starting point for more formal assessment: "we could then pass that on to another professional like, well we've noticed x, y and z, our professional opinion is there's probably some difficulties as far as attachment's concerned, can you look into that?'" Similarly, Violet said, "I could recognise generalised behaviour related to different types of attachment and offer advice on how to deal with that, but I wouldn't feel able to diagnose a certain attachment style … that's where we would then bring in another professional."

Rose and Violet's points also highlight an additional implication of viewing formal attachment assessments as the most valuable aspect of attachment theory for practice. Social workers who were using ideas from attachment theory to inform their thinking in curious, exploratory, tentative ways sometimes undervalued this use of the theory. Using attachment theory in a tentative way was at times framed primarily as a

response to being unable to formally assess attachment, rather than as a potentially more beneficial way of drawing on attachment theory in practice.

Other social workers saw benefits to having a formal attachment assessment, but also potential drawbacks. For example, Heather identified that assessments can sometimes facilitate access to support and understanding, but also raised concerns that they can oversimplify:

> Is it helpful or is it not? In a sense it is because if they've assessed as having a disorganised attachment then things can be put in place to try and address that, so they might be able to access services, and different therapies, and if they were going into long-term foster care, adoption, whatever, then that would help perhaps the future carers to be able to manage the behaviours, and understand them. But I think it's not as simple as all that and there's a lot more to it.

Lilac articulated a nuanced view of formal attachment assessments having the potential to be helpful or harmful in social work practice, depending on what information was provided from the assessment and how that information was used:

> I think it's helpful in terms of if you have that information … [of] what does that mean for that family. I'd be wary of it being used in terms of … that parent can't parent because of that. … To inform decisions that may not be favourable for families, that's what I would be concerned about.

Here we see Lilac raising concerns about the potential for attachment assessments to be used in a deterministic and/or punitive way. Yet Lilac also articulated a view that formal assessments could generate useful knowledge for practice if there is also detail of what the assessment means.

What was in scope as an 'attachment assessment' for the social workers who talked about the practice value of such assessments was not always entirely clear. For some this seemed to extend beyond assessments of attachment security/insecurity and disorganisation to 'attachment disorders' too, though what they meant by 'attachment disorders' was also not clear. What was evident, however, was that the 'attachment assessments' being discussed and valued by these social workers were assessments of children's attachment behaviour, conducted and coded by a psychological professional. The potential practice value of formal attachment-informed assessments of caregiving behaviour, caregivers' attachment states of mind, or caregivers' reflective functioning were not discussed.

5.2.5 Use of Attachment Classification Terms Can Be Unhelpful in Child Welfare Practice

Some of the social workers identified specific problems with the use of attachment classification terms in child welfare practice. A first issue raised was that the classifications can become sticky labels, implying a fixed property of the child. For example, Violet said:

> People become, can become pathologised by labels and I think attachment is getting kind of moving towards that a little bit … people getting that label and then is that something that professionals and other people perceive stays with them forever? Do people know that that can change?

Lily mentioned how even if attachment classification terms are presented tentatively, over time the qualifications can fade: "What'll happen is … somewhere along the line … there's a suspicion … to then … definite this, and you're thinking, where did that come from? … And it's just words have been changed through time." Similarly, Jasmine said:

> I think it can be unhelpful in terms of a professional capacity, because it sometimes becomes fixed and it becomes a characteristic of that child or family that is accepted from one document to another without any further enquiry as to, is it still the case, was that an accurate description? You know, it's just if someone writes it down then it's there … follow them from assessment to assessment. Even if it changes to, 'When they were accommodated they were assessed as having …' it's always there and it's always going to be applied to them, and I think that can be unhelpful sometimes.

A second issue identified was that attachment classification terms can be reductionistic and insufficient for capturing complexity. This was seen as particularly problematic where use of classification terms are provided in the place of behavioural descriptions, rather than alongside them. Laurel was critical of this practice:

> I think you have to be really careful with that sort of language. Because I think sometimes we throw those sorts of labels around and I think unless you've got a really good understanding of attachment I don't, I don't know if it's helpful, I think seeing the behaviours is more helpful.

A third issue raised was that attachment classifications can be used as an over-encompassing explanation. For instance, Violet said:

> I think that it's important not to get bogged down into 'they're in that box now' as a way of explaining behaviours and as a way of supporting them. … I think that overuse of it can lead to lazy thinking and lazy practice.

A fourth issue highlighted was that attachment classification terms alone were thought to have limited value for informing the next steps for practitioners. For example, Laurel said, "ok, so they've got that, what do I do with it?" Violet said, "it's like, well what next now you've said that's that attachment, what happens next?"

A fifth issue identified was that attachment classification terms can be unintelligible for families, in part perhaps due to the attribution of technical meanings to terms from ordinary language like 'secure' or 'disorganised'. For instance, Ash said, "I think about the audience of my assessments … this is written for a family, and what does that mean to them? So when we … have the term disorganised attachment, what does that mean to the family?"

These five issues were sometimes raised by social workers who had nonetheless expressed a view of there being value in formal attachment assessments, indicating that some of the social workers were somewhat ambivalent about the practice value of the classifications aspect of the theory. For other social workers however, there was a clear distinction made between use of the attachment classification terms (seen as pointless at best and sometimes problematic by these social workers) and use of knowledge of individual differences in attachment security for helping them to decide whether to intervene (seen as helpful). Fern encapsulated this perspective when she said:

> Knowing what a secure and an insecure attachment is and how important they are to the child kind of feels enough to give me a direction on how I'd intervene, rather than having to label it as a specific one because these behaviours fit into this category. What does that even mean? Like just it's about what you do with it and how you work with the family.

5.2.6 References to Formal Attachment Assessment Terms Rare

Most of the social workers in the sample said that they had never, or only very rarely, seen reference to a formal assessment of disorganised attachment in real cases they had been involved in. None of the social workers in this sample were trained to assess disorganised attachment (and, as seen in Section 5.2.2, were generally not aware that this training was available to their profession). Thus, formal attachment assessments

and formal identification of disorganised attachment seemed rare in the practice experience of these social workers. A few social workers said that whilst they had never seen a formal assessment of disorganised attachment, they had heard the term spoken about informally. However, none of the social workers in the sample said they would use the term disorganised attachment themselves, and informal use of the term by others was not viewed as helpful.

Only one social worker in this sample described having used a formal attachment classification term (in this case ambivalent attachment) in their social work practice without having undertaken attachment assessment training and without conducting formal assessments. During discussion of a real case she had worked on, Holly said:

> I had three children, and we ended up splitting them in separate placements because even their sibling attachment was assessed as being an ambivalent attachment. And with mum really there was no attachment at all. And … despite dad being the perpetrator they seemed to have a good attachment with dad during contact compared to mum, and my assessment of that was because dad was not the one providing the care to them. Although he was abusive to mum but he wasn't really there for them, whereas mum was the one who was with them on a regular basis, so they were still craving that father figure. … Mum spent quite a lot of time with them but she couldn't really care for them effectively because she was massively affected with the domestic violence and she suffered from mental health as a result of that and was misusing alcohol … she couldn't really form a strong attachment with each child because she wasn't just functioning herself.

Within Holly's account of this case there are numerous statements made that do not align with the academic account of attachment. Sibling relationships have been assessed as attachment relationships despite not clearly being older siblings providing a safe haven for younger siblings. What *may* have been indications of an avoidant attachment pattern with the mother has been interpreted as a lack of attachment. An apparent craving for attention from an often absent and domestically violent father has been interpreted as good attachment. What is meant by good attachment, a term not used in the theory, is not specified. Parents are seen as attaching (or not) to children.

Holly revealed that she had drawn these conclusions from her observations of contact and confirmed that she had used attachment classification terms in her report relating to the case, saying "I've put the words there and described in words exactly why I think that's ambivalent." Whilst we do not have access to the records of this case, and so do not know how definitive or tentative the references made to attachment were, nor to what extent the references to attachment played a role in decisions on where to place

the children, what was clear from the interview was that Holly felt comfortable and confident about making some authoritative claims about attachment that were unmoored from the underpinning academic theory and research. However, Holly did not attempt to relate the case vignette children's behaviour to attachment classifications, nor did she draw on the reference to disorganised attachment assessments to inform her thinking about the second case. This suggests that reaching for and drawing strong conclusions from attachment classifications might not be a pervasive part of her social work practice.

5.3 Variation in Whether Attachment Theory was Used to Support Understanding

Attachment theory is much broader than just assessment and classification of children's attachment behaviour. Though not common within the sample, a few of the social workers drew on ideas of attachment processes, adult attachment states of mind, and intergenerational patterns to support understanding of, and by, families. Here again there was variation though, both in terms of whether social workers attempted to draw on attachment theory to support understanding and, for those who did, whether they found success in their attempts to use attachment theory in this way.

5.3.1 Use of Attachment Theory to Support Social Workers' Understanding of Children

Some of the social workers described finding attachment theory valuable for deepening their understanding of the children they worked with. These social workers identified, and demonstrated in their discussion of the case vignettes, how they used ideas from attachment theory to help them to explore and ask questions about relationships and children's needs and behaviour. Lilac, for instance, said:

> In terms of understanding family dynamics and relationships, that's where I would be thinking about that [attachment theory]. And knowing, if people have periods of unsettled lives how that might have affected them, I'd be mindful of how are they now forming relationships or how is that impacting on their behaviour? … And [for a] child … if there is particular behaviours if it's because they're not feeling safe? That would be the thing I'd be thinking … is it because of what's happened in the family that they haven't got that safe place to be?

A number of social workers stated that they found ideas from attachment theory helpful to inform their thinking about potential reasons for children's behaviour. For example, Hazel said, "when children have difficulties, I think attachment really helps you understand why they would behave in a particular way." And Fern said, "when you're seeing certain behaviours it can be helpful to think about it in terms of what that would mean from the attachment theory perspective." Azalea stated that she used attachment theory to make sense of why children will "still be loyal to parents even when parents aren't doing the right thing."

Yet invoking attachment as an explanation did not automatically lead to expanded understanding of children's needs and behaviour. For example, Primrose said:

> If a child's behaving, or the mother and her child are just clashing for whatever reason, the child feels a bit sad, and I know that's all about attachment. You can ask as many questions as you want with the parent and the kid, but sometimes I will look at the attachment theory and think, ah, well that's there because, ah, that's why they [laughs].

Primrose identified aspects of a family situation that attachment theory could be used to help understand (child behaviour, parent-child interaction, child emotions) but there was no clear identification of specific concepts and ideas from attachment theory that might be relevant, and no use of attachment concepts and ideas to generate additional insights or hypotheses. There was also a sense of the theory being used as an over-encompassing explanation. Here surface-level references to attachment were made in the place of understanding, rather than use of attachment-related ideas to support understanding.

Where social workers did use attachment theory to inform their understanding of children, this tended to be in relation to their needs within a particular relationship and the implications of the nature of this relationship for their behaviour. Only a very small number of the social workers in the sample used ideas from the theory to inform their understanding of the significance of separating children from a caregiver. Azalea was one who did. She said, "the influence the caregiver has on the kid is absolutely massive, and … you've got to consider that all of the time when kids go into care, how huge that is for them."

5.3.2 Use of Attachment Theory to Support Social Workers' Understanding of Parents

For a small number of the social workers who used attachment theory to support understanding, there was recognition that the theory can provide insights into the behaviour of parents too. With regards to working with parents, Camellia said:

> It helps you to understand almost any behaviour or reaction to a situation. … And if you can understand, or try to understand why people behave like they do, you're in a far better position to be able to help them to either change that or to overcome that or to learn to cope with that. … If you can start to just take back layers and look at the history, the family history, what's gone before, it helps.

Iris also described how she found drawing on the theory helpful for understanding challenging behaviour from parents:

> Usually if you think of it from an attachment perspective, I think it often helps you to understand why that is and that kind of sense of adapting to circumstances and self-preservation and getting your needs met. … I think it's helpful for understanding why people act as they do. I don't think I've worked with many parents who … I can't kind of understand to some, where it's come from, how they are as parents.

Iris went on to contrast this with the blame focused thinking that she believed can happen when attachment theory is not drawn on:

> I think we can probably forget that sometimes. … Falling back to thinking that … we might all have done before we learned about attachment. … Sometimes it's easiest to kind of blame someone for, you know, what they've done to their child … if that's something you can't kind of understand where it comes from.

This perspective is quite contrary to the conceptualisation and critique of attachment theory as 'mother blaming' (raised by Willow and Heather and discussed in Sections 4.3.1, 4.3.2, and 5.3.3). It is perhaps noteworthy that the social workers who found attachment theory helpful for avoiding blame were aware of, and drawing on, intergenerational patterns insights from the theory. For those who focus on attachment as just relating to children's needs, parent blaming may be more likely, but for those who focus on attachment as a cyclical process, there may be greater likelihood of considering and understanding the needs and behaviour of parents too.

5.3.3 Use of Attachment Theory to Support Parents' Understanding of Their Children and Themselves

A few of the social workers described using and sharing ideas from attachment theory with parents to help the parents themselves better understand their children's needs and behaviour. For example, Ivy talked about how she used ideas from the theory to help parents to understand their children's emotional needs and to help encourage parents to recognise the importance of these and not just their children's physical needs. Lilac gave an example of a case where she had introduced ideas from attachment theory to help a parent to understand her son's behaviour:

> There was one actually I was talking to about, her son had just come to live with her, he'd been away for a year, and I said … "Has anyone talked to you about attachments and that?" and said, "Now he's back he's going to be needing to feel secure again, and by some of those behaviours he's testing that out." So then I talked about him feeling safe with her, he's now having to understand that she is now that safe person, that he'd previously not known that.

Laurel described a case where she had shared ideas from the theory with a mother to support the mother's understanding not only of her children's needs but also her own parenting responses:

> I'm working with a family that's very similar to this and what I did was talk to mum about how attachments are formed, and we looked at what was happening with her and her life at the important times of attachment. … Help her have a better understanding of what her children need, but help her to understand, I suppose lots of mums in this just think of themselves as being bad parents, so it might give her an understanding of why she hasn't been able to do things and help her to then see what she can do to plug those gaps.

Lilac also described using attachment theory concepts to help parents to think about possible underpinning drivers for their addiction:

> Working with families who have got addictions … looking at when people are talking about their use of drugs or alcohol that have become their kind of safe base, and unpicking that for families … well that's the place you go to that makes you feel safe, because of the things that are around you are no longer there.

This research cannot speak to how helpful or not the parents found these attachment theory ideas, but from the perspective of the social workers, use of the theory in these ways was perceived to be valuable. Yet not all the social workers who had attempted to

use attachment theory ideas with parents had found this successful. Heather gave an example from one of her cases:

> Within that family there was two boys and all the issues I am sure were stemming from her care of them. … And this mother, I really wanted her to be able to see the attachment side of things, and she wouldn't. So she would refuse to talk about anything that had happened while the children were in her care when they were younger, and I always, for about a year having this case I focused so much on trying to get her to see the attachment, and to understand their behaviours, but actually what I needed to actually conclude was she didn't want to, she felt there was a lot of blame, guilt, etc, and then I had to really change. And the only way that I could work with that mother, because she wouldn't work under attachment, that sort of framework, was by having basically like a strengths-focused approach. So rather than talking about anything in the past, only talking about the future. … So that case really showed me that as much as it might make sense to me to understand attachment, to be able to have insight and reflect on it, the reality is that it's not helpful in that respect. … I think I still find it useful to understand and process and … unpick what's gone on, but I think families, it hasn't worked well … because of the blame thing.

For Heather, attachment theory was conceptualised as solely about, and relevant to, thinking about children's behaviours. Heather was unaware of the adult-related aspects of the theory. In seeing attachment theory as focused only on what children need, parents were framed solely in terms of meeting or failing to meet these needs, rather than as people who are also affected by the attachment experiences they have had. Heather also appeared to perceive work under an attachment framework as necessitating a focus on the past and asking parents to directly confront how their parenting behaviour may have contributed to their children's behaviour. Yet some attachment-informed interventions, such as the ABC model (see Section 1.2), focus more on the present and on reinforcing and encouraging positive behaviours from parents, which is what Heather ultimately found worked in this case but did not view as work under an attachment framework.

5.3.4 Alternative Non-Attachment-Related Ways of Understanding Families

Examination of how the social workers made sense of the case vignettes highlighted that a number of social workers did not draw on attachment theory ideas explicitly or implicitly. For these social workers, there was often a dominance of social learning explanations, with behaviour understood as likely copied or mimicked. Zinnia, for example, when talking about why the boys in the first case vignette might be behaving violently, speculated "it could be just mirrored behaviour." A view of aggressive behaviour as only being possible if it had been directly observed, i.e., use of this as the

sole possible explanation, was rare amongst the social workers but was observed. This led to particular conclusions being drawn about what children had experienced, and feasible alternatives discounted.

Lack of stimulation, lack of boundaries, and attention-seeking were other common possible explanations that were mentioned for the children's behaviour in the first case vignette. Correspondingly, parenting was discussed in terms of providing stimulation, setting boundaries, providing advice and guidance, and meeting physical needs. Such factors were often considered alongside emotional factors by those drawing on attachment ideas. Yet for some of those who did not draw explicitly or implicitly on attachment ideas, children's and parents' behaviour was solely considered in practical and non-emotional terms.

Intergenerational cycles were often mentioned by social workers when thinking about the behaviour of the parents in the case vignettes. However, the focus was typically on how parents learn parenting practices and norms through observing and replicating the parenting practices they were exposed to in their childhood. For example, Primrose discussed how "it's like a vicious cycle … it's copy-cat behaviour from when they were children, and they may see that it's the norm of parenting." Poppy speculated that "maybe her [the mother's] own experiences of being parented haven't been great and she hasn't had a role model who's helped her learn what children should expect in their lives." Hazel proposed that "for people who've had a difficult upbringing … it's very difficult for them to understand normal family life … to know what to do and what's acceptable and what's not." For the majority of the social workers in the sample, their understanding of intergenerational patterns was not influenced explicitly or implicitly by insights from attachment theory.

5.4 Communicating Attachment-Related Ideas

Across the sample, attachment-related ideas were communicated in a range of different ways. The interviews highlighted three challenges in relation to communicating attachment-related ideas. A first related to a lack of clarity and consistency in use of the word attachment. A second related to the conflict created by wanting to discuss individual differences in attachment but not feeling able to use the formal terminology from attachment theory to do so. A third related to concerns that the language of attachment was not accessible for families. The social workers in the sample showed

varied levels of awareness of these challenges. Some highlighted the potential for practitioners to talk past one another and sought methods of communicating attachment ideas that might offset this issue. Others seemed to assume a greater level of shared understanding of the meaning of formal and informal attachment terms than existed.

5.4.1 A Lack of Clarity and Consistency in Meanings and Synonyms for the Word Attachment

Those who used the word attachment and/or said they draw on attachment theory were asked at the end of the interview 'what does the term attachment mean to you?' It was striking not only how many of the social workers struggled to answer this question, but also how some seemed surprised by how much difficulty they had articulating what they meant by attachment. For example, Daisy replied:

> It's a, it's a bond, isn't it, it's an interaction, it's, a bond, like an emotional attachment to someone. Attachment, it's hard to describe actually. Something that attaches you to someone else, like how you interact with someone else, I'd describe that. I don't know [laughs].

For some of the social workers, difficulty clarifying the meaning of the term attachment seemed to be underpinned by a fuzzy and limited understanding of the term. For other social workers, difficulty clarifying the meaning of the term attachment seemed instead to be underpinned by a sense of the many levels at which the term can be used, and finding it difficult to reduce this down into one clear definition. Iris indicated this latter challenge when she began her answer to the question by saying:

> What does attachment mean? In, I suppose it's that [Pause] [Sighs] How do you, how can I explain it? That, I, I don't know whether, I don't know how to start the, which way to come at it from really.

Iris went on to highlight:

> One of the reasons I don't like using that word [attachment] too much is because I think it's widely kind of used in, if not, it might be harsh to say it's misused but it's used in lots of different ways and so you can't really be confident that you're talking about the same thing when you talk to people.

Thus, some of the social workers in the sample acknowledged the lack of clarity and consistency in what meaning was ascribed to the term attachment, and the implications of this for potential miscommunication and misunderstanding. In an attempt to address this, several social workers said they limited or avoided use of the term attachment. A number of these social workers stated that they used the terms ‘relationships’ or ‘emotional bonds’ in place of the term attachment, suggesting that they saw these terms as having the same meaning.

Other social workers in the sample were seen to explicitly use the word attachment, but in ways that were in line with the ordinary language meaning of attachment rather than the attachment theory meaning. There were examples of social workers using the term attachment (rather than relationship) to describe the whole of the relationship between a child and their key caregiver and not specifically the child’s use of the caregiver as a safe haven. There were also examples of social workers discussing a parent’s attachment (rather than emotional bond) to their children and how the parent might have struggled to form this.

A lack of clarity and consistency was not only raised by some of the social workers therefore, but was also observed across the interviews when looking at whether the word attachment was explicitly used, what meaning was applied to it, and what terms were seen as appropriate synonyms for it.

5.4.2 Substantial Variation in How Individual Differences in Attachment Were Communicated

When it came to describing individual differences in children’s attachment, most of the social workers in the sample held that it would be inappropriate for them to use formal classification terms from the theory in their social work practice. However, they responded to this conclusion in different ways.

Some social workers used informal terms that still included reference to attachment. “Attachment difficulties” was commonly used, “attachment issues” was also used by some, and “poor attachment” was used by one. There were also indications that these informal terms would at least sometimes be included in reports. For example, Violet said, “you might say attachment difficulties or something in a report.” The interviews revealed that these social workers were consciously and proactively choosing to use these informal attachment terms as a response to recognition that they were not

qualified to use the formal terms. However, what was meant by terms such as ‘attachment difficulties’, and what assumptions and implications were included within these terms, were not explained and were unclear.

Other social workers avoided all reference to different kinds of attachment and described attachment-related behaviours instead. For these social workers, this was seen as more helpful than using attachment classificatory terms. These social workers demonstrated awareness that the meaning and implications of formal or informal attachment terms was not obvious, and thus argued that more explanation was useful. As an example, Daisy said, “I think it’s sometimes a bit more helpful to describe exactly what you’re seeing and what you’re worried about rather than just name it. Because that might not mean something to everyone.” Ash, likewise, raised concerns about use of undefined informal attachment terms in social work practice:

> I think it can be vague and I think it can be overused by people, or not always used appropriately. So I sometimes read reports or I hear professionals talking about bad attachment and good attachment, and … I don’t think it really explains anything.

These social workers gave examples of how they would use ideas from the individual differences aspect of attachment theory to inform their observations but would avoid mention of the word attachment when discussing and reporting the observations. For example, Willow said, “I’d say, ‘I’ve got concerns about how they interact in the relationship.’” Heather said, “I would say, ‘It’s likely that … mother had been very distracted with her parenting due to the violence and this really prevented her from responding to Jack.’” Lily said she would say “I have concerns about the relationship between x and y, because when I observe contact x behaves like this towards y.” Ash described how “in reports I use it [attachment theory] quite implicitly. … I’m more drawing on what their behaviours are, why I think that’s the case, what the impact is on the children based on how the parents have interacted with them.”

5.4.3 Talking to Families About Attachment Without Using the Word Attachment

The social workers in this sample who shared attachment-related ideas with families said they tended to avoid using the word attachment when doing so. They highlighted how they would deliberately substitute the word attachment for other terms thought to be more understandable. For example, Lilac said that when talking with families “I find

myself talking about the emotional bond you have … [and] when you're looking at a person's history about how were they with their own parents. I probably wouldn't use the particular word attachment." Laurel said:

> I would use relationships, bonds … because I think the times that I had talked about attachments they [families] would go, "Do you mean the bond we have?" and I'd go, "Yeah, that's it." So it's then just using words they're familiar with, are comfortable with.

Ivy described how she had found using the term attachment with families unhelpful:

> There's something about that word [attachment], and people have heard it or they're not quite sure what it is, they're aware that it can be shit, and, or they misconstrue it with the word love. … I think I've learnt this as I've gone on, that if you talk about attachment or attachment theory or what it is … it's just a very convoluted concept. I find talking about it is … ambiguous.

Ivy explained that what she had instead found helpful with families was "talking in terms of responsivity and care and that two-way thing, and sometimes the foundations. People can kind of access that in a more realistic way." Thus, these social workers were not avoiding discussion of attachment-related ideas with families but were avoiding use of some attachment language. There was a sense here of how a social worker can play an important translation role: presenting relevant ideas from attachment theory to families in a way that may be more accessible for them.

Chapter 6: Discussion

This study aimed to provide detailed insights into how child and family social workers conceptualise and use attachment theory when thinking about families where there are child welfare concerns. This was examined through analysis of whether and how a sample of UK social workers drew on attachment ideas to make sense of two family case vignettes, as well as through direct discussion of their understanding of attachment theory and their use of it in day-to-day practice. This study was the first to observe if and how attachment ideas were applied in practice-related thinking alongside gathering the practitioners' own views and reports on attachment theory and its application. As a result, the study allowed for a deeper and more holistic exploration of the topic. The findings from the current study show that there are multiple conceptualisations of attachment and applications of attachment theory ideas in child welfare practice, with some considered more valuable than others by social workers. The findings also provide a new perspective on apparently contradictory findings in prior research. This chapter discusses the current study findings in relation to the previous literature, considers the methodological strengths and limitations of the study, provides suggestions for future research, and considers implications of the findings for social work practice and social worker guidance and training.

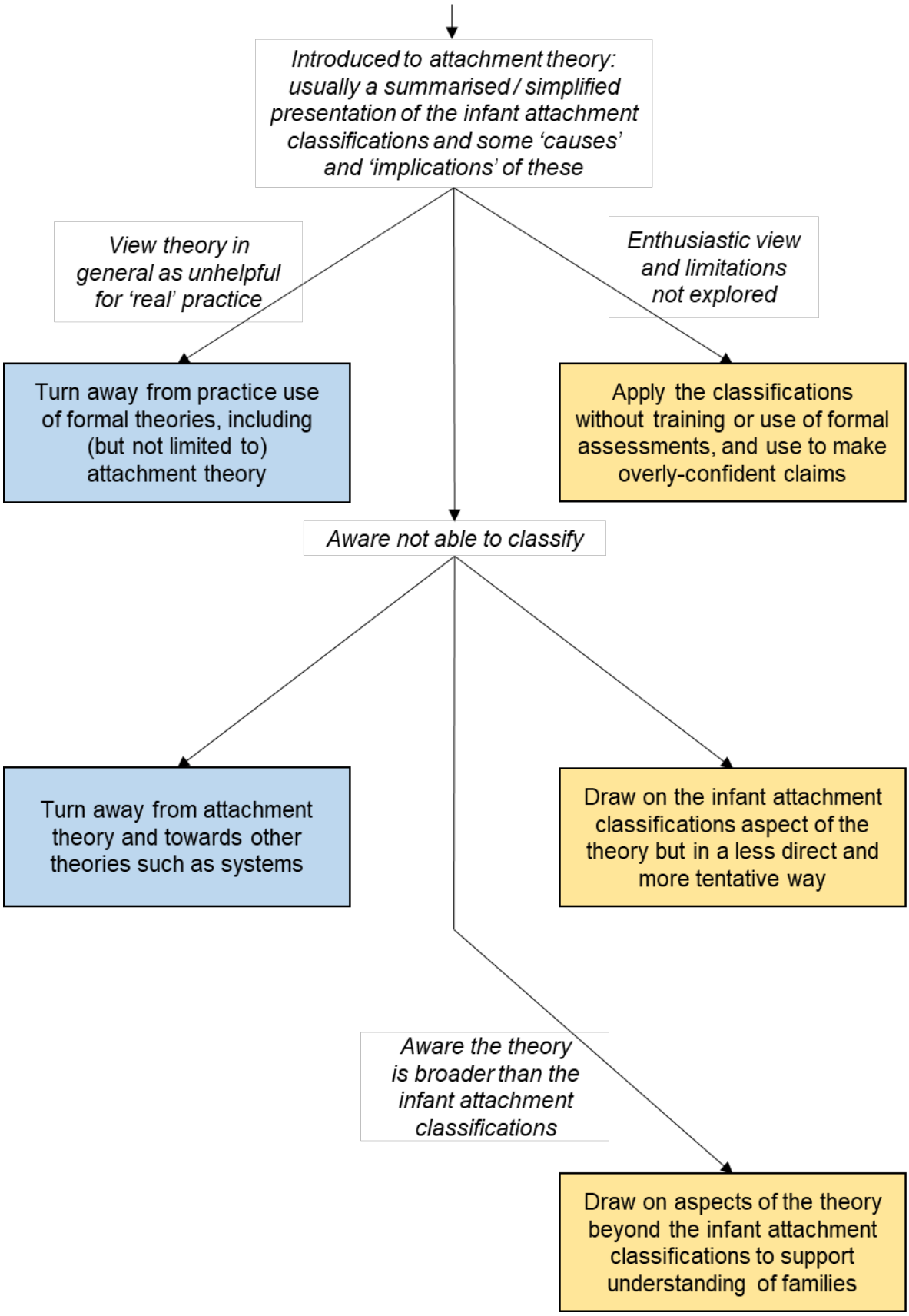
6.1 Discussion of Findings

6.1.1 Varied Understandings and Practice Applications of Attachment Theory

In contrast to a number of statements on the uptake of attachment ideas in practice which have implied or claimed uniformity (e.g., Forslund et al., 2022; White et al., 2020), a key finding of this study was variation: in relation to how attachment theory was conceptualised and understood, whether it was drawn on at all, and – if it was – the ways it was drawn on. This variation was all the more noteworthy considering the small and relatively homogenous sample: 23 participants from a single professional group (social workers), working in the same area of practice (child and family social work), in a single geographic region of one country (England), and employed at two local authorities.

The study found that differences in what the social workers understood attachment theory to comprise, combined with their views on the value of theory for practice, led to differences in whether and how attachment theory was drawn on in their vignette responses and their day-to-day practice. These different practice applications are presented in Figure 6.1 and discussed further in subsequent sections of this chapter.

Figure 6.1 *A Summary Model of Attachment Theory Understanding and Practice Application in a Sample of UK Child and Family Social Workers*



6.1.2 Understanding and Misunderstanding of Attachment Theory

The social workers in the current study were all aware of attachment theory, and their descriptions of what attachment theory comprised indicated that they had all been introduced to the infant attachment classifications. Possibly the dominance of the Strange Situation in attachment research had translated to a focus on this aspect of attachment theory in pre-qualifying education and texts summarising the theory for social workers (Duschinsky, 2020). Although the social workers had awareness that attachment theory included the delineation of individual differences in children's attachment, knowledge of the specifics of the infant attachment classifications was often very limited. Limited understanding of attachment amongst some social workers has also been briefly referenced in previous empirical studies (e.g., Ward et al., 2010). The current study adds confidence to this prior finding as it both solicited the social workers' own appraisal of their understanding and examined their understanding directly. A small number of the social workers were aware of – and recognised the value in thinking about – the processes underpinning the classifications (something which has been encouraged by Slade, 2004), but this was not common in the sample.

Furthermore, many aspects of attachment theory and research besides the Strange Situation classifications appeared to be outside the awareness of many of the social workers. Although there were some noteworthy exceptions, most social workers in this sample were not aware of concepts and research from attachment theory focused on adults/parents including attachment states of mind and reflective functioning (RF) and their influence on caregiving behaviour. It was not that these aspects of attachment theory were known about but in limited depth; these aspects of attachment theory and research were entirely outside of awareness for many. This finding aligns with Bunting and Lazenbatt's (2016) assertion that use of attachment theory to understand the behaviour and needs of parents has received much less attention than its use to understand children. The current study also found that many of the proposals from Bowlby's theorising, such as the ideas of safe haven and developmental pathways, were not known. Furthermore, empirical research on attachment after Ainsworth's original Strange Situation study was not engaged with at all. The findings therefore provide support for the proposal by Duschinsky et al. (2021) that the links between academic attachment research and child welfare practice are weak.

While an absence of knowledge may lead to missed opportunities to draw on knowledge that could be valuable for practice, misunderstandings are also an important

consideration. The holding of inaccurate knowledge could lead to inaccurate, overconfident self-appraisal of understanding and in turn to inaccurate, overconfident application of the theory in practice. The consensus statements written by attachment researchers (Forslund et al., 2022; Granqvist et al., 2017) raised concerns regarding several misunderstandings about attachment theory that may be held by practitioners.

One set of misunderstandings raised by Forslund et al. (2022) related to the *nature of attachment*, and in the current study some, but not all, social workers had errors in their understanding of this. The misunderstanding most often observed in this sample was a conflation of attachment and relationship, a finding also noted by Furnivall et al. (2012) and Morison et al. (2020). Forslund et al. propose a risk of such conflation is that there might be a reduction in attention given to other important aspects of relationships outside of the attachment-related aspects. The current study highlighted the opposite risk: that conflating attachment and the whole of the parent-child relationship could lead to a reduction in attention given specifically to the attachment-related aspects of the relationship, and to overlooking the benefits of paying attention to potential differences between the attachment-related aspects of the relationship and other aspects of the relationship. Research has found that these different aspects of the relationship can have differential effects on children's outcomes (see, e.g., Bernard et al., 2013; Leerkes & Zhou, 2018). Another misunderstanding about the nature of attachment raised by Forslund et al. that was held by some of the social workers in the current study was that attachment to a primary enduring caregiver can be lacking. This is a misunderstanding that has also been found in some previous studies (Alexius & Hollander, 2014; Keddell , 2017; Gibson, reported in White et al., 2020).

A second set of misunderstandings highlighted by Forslund et al. (2022) and Granqvist et al. (2017) related to implications of *classifications of attachment quality*. However, many of these misunderstandings were not observed in the current study. Forslund et al. proposed that the replicated finding of an association between caregiver sensitivity and children's attachment quality is often misunderstood to mean that a parent's sensitivity can be inferred from their child's attachment quality. This was not a misunderstanding held by any of the social workers in this sample. Instead, the social workers had a more general and fuzzy awareness that attachment quality was related to differences in caregiver behaviour. Forslund et al. and Granqvist et al. (as well as White et al., 2020) also raised concerns that disorganised attachment is misunderstood as indicating maltreatment. Reassuringly, none of the social workers in this sample demonstrated this misunderstanding. This suggests that training and articles by UK

social work academics that promote disorganised attachment as an indicator of maltreatment (see Shemmings, 2011; Wilkins, 2012) have not led to this becoming an all-pervasive view among UK social workers. Forslund et al. and Granqvist et al. also raised concerns that disorganised attachment is viewed as an invariable predictor of pathology. Again, this misunderstanding was not found in the current study, though perceptions of the longer-term implications of disorganised attachment did vary, and there was misunderstanding from some that disorganised attachment is a diagnosis. Overall however, the current study found more evidence of social workers with limited knowledge about the attachment classifications and their implications than inaccurate knowledge.

The social workers also did not hold misunderstandings that the role of attachment figure is limited to mothers or limited to a single person. Garrett (2023) proposed that social workers are insufficiently critical of Bowlby's focus on the biological mother. Yet while Garrett's claim reveals Garrett's own misunderstanding of Bowlby's overall stance, the vast majority of the social workers in this sample did not share Garrett's misunderstanding. None of the social workers invoked attachment theory to support an emphasis on biological mothers above all other caregivers. Furthermore, the one social worker in this sample who did perceive attachment theory to have an emphasis on mothers was critical of such an emphasis. Garrett's proposal was not empirically based, and the current study raises questions about the relevance of his claim.

6.1.3 The Reception of Attachment Theory in Child Welfare Practice

Forslund et al. (2022) state that "attachment theory and research have … become very influential" (p.3) and that there are "frequent references to attachment theory and research … to inform decision-making concerning child protection" (p.6). A number of other commentators have also suggested that attachment theory is a "prominent, and often dominant, perspective" in social work practice (White et al., 2020, p.33, see also Garrett, 2023, and Smith et al., 2017). However, a review of the previous research (see Sections 2.3 and 2.4) found that empirical evidence of whether attachment theory is dominant was limited and inconclusive.

The current study found widespread awareness of attachment theory, likely stemming from its inclusion in pre-qualifying social work education in the UK, but did not find that this translated into attachment theory being a dominant perspective. Some social workers in this study had an anti-theoretical orientation, viewing formal theories in

general as having limited value for their day-to-day practice. As a result, these social workers did not tend to explicitly draw on any formal theories including (but not limited to) attachment theory. Hostility towards any academically-grounded theories in UK social work has been found in some previous studies (see Hicks, 2016, for a review).

Other social workers saw value in the use of theory in their practice, but this was not always associated with use of attachment theory. In this sample, systems theory was a more commonly cited theoretical influence, with attachment theory – where drawn on – typically used alongside systems theory. This finding opposes Smith et al.'s (2017) argument that use of attachment theory may inhibit consideration of other ideas. In cases where systems theory and attachment theory were both seen as valuable and drawn on, the social workers had a reasonably broad and deep understanding of what attachment theory covered and proposed, and felt that systems theory and attachment theory could complement each other. In cases where systems theory was seen as valuable and drawn on but attachment theory was not, the social workers held a narrow and simplified conceptualisation of what attachment theory covered and proposed. A Department for Education (2018) online survey also found that social workers reported systems theory as a key theory for their practice. The current study supports this finding and extends it by providing insights into reasons why social workers are sometimes drawn to systems theory but not attachment theory.

Some previous commentators have argued that attachment theory ideas have permeated into cultural discourses and therefore can influence social workers' informal theories and practice even if the social workers do not deliberately and consciously draw on attachment theory in their practice (Garrett, 2023; Smith et al., 2017; White et al., 2020). A benefit of including case vignette discussions in the current study was that it was possible to observe if attachment theory ideas were or were not influencing practice thinking in this way. The current study found that, for some social workers, their understanding of the case vignettes was not influenced by or aligned with an attachment theory perspective, thus countering previous suggestions that attachment theory ideas are pervasive. An alternative discourse used to explain children's behaviour was to regard it as observed and copied. Social workers drawing on this alternative discourse were not deliberately and consciously drawing on social learning theory, but ideas from social learning theory appeared to be influencing their informal theories and practice understanding. The current study did therefore find that formal theoretical ideas could influence social workers' informal theories, but attachment theory did not have dominance in this process.

A further theme across previous commentaries on use of attachment theory in social work practice is that social workers are insufficiently critical either about the theory itself (Garrett, 2023; White et al., 2020) or about whether it is being applied to practice in appropriate ways (Forslund et al., 2022; Granqvist et al., 2017). In contrast with this depiction, the current study found evidence that some social workers are engaging critically with attachment theory and its practice applications. However, the nature of the critique interacted with the conceptualisation of attachment theory that was the target of the critique, leading to different outcomes. Some social workers had read polemical critiques of attachment theory that take issue with the validity of attachment theory as a whole whilst solely focusing on work by Bowlby and Ainsworth. Garrett (2023) is one illustration of such a critique, another is Vicedo (2017). Elsewhere, we (Duschinsky et al., 2020) have highlighted the flaws in such critiques. However, where social workers had a narrow and limited understanding of attachment theory, focused around early work on the infant attachment patterns, there was indication that these critiques could be successful in convincing the social workers that attachment theory was weak.

Other social workers were found to be thinking critically about the implications of different practice uses of attachment theory. These critiques centred around the attachment classifications. In clear contrast to White et al.'s (2020) argument that the classifications provide social workers with "a degree of comfort", "a handy vocabulary" (p.viii) and are widely and enthusiastically adopted, most social workers in the current study were either ambivalent or very critical about the use of attachment classifications in practice. The social workers' stance was thus in line with the stance of attachment researchers in the consensus papers (Forslund et al., 2022; Granqvist et al., 2017). However, the reasoning that had led to this shared stance differed. Forslund et al. and Granqvist et al. highlight that the formal attachment assessments which generate the classifications are validated at group-level only, and not as individual-level assessments. None of the practitioners raised this point or seemed aware of it. Instead, the practitioners raised concerns based on insights gathered from practice experience: that use of attachment classification terms in child welfare practice can be pathologising, reductionistic, over-encompassing, and unintelligible for families. Here too, these critiques interacted with conceptualisations of attachment theory to determine the implications for practice. Where social workers raised these concerns and believed the attachment classifications to be the sum of attachment theory, the result was sometimes to turn away from attachment theory and sometimes to draw on the attachment classifications aspect of the theory but in a less direct and more

tentative way. Where social workers raised these concerns and were aware that the attachment classifications were only one aspect of attachment theory, the result was a turning towards use of other aspects of attachment theory (attachment processes, adult attachment states of mind, and intergenerational patterns) with a goal of supporting the social workers' understanding of families.

6.1.4 A Distinction Between Attachment and Attachment Theory

The current study found that a distinction was drawn by some social workers between 'attachment' and 'attachment theory'. Where this distinction was drawn, attachment was conceptualised broadly and without reference to attachment theory: as a synonym for enduring emotionally-invested relationships, especially parent-child relationships. Attachment theory was seen as a theory that provided one means of understanding this phenomenon.

This is not an unreasonable distinction. As previously highlighted (Duschinsky et al., 2021; Verhage et al., 2023), many terms used in attachment theory – including the word attachment itself – were already in ordinary use when Bowlby was developing the theory but were given a specific technical meaning when used within attachment theory. The word attachment thus precedes attachment theory and continues to exist and have meaning and usage outside of attachment theory. The ordinary language meaning of attachment is very different from the attachment theory meaning of attachment. The Oxford Online Learners Dictionary, for example, defines attachment as "a feeling of love for somebody/something" and provides the illustrative sentence "a child's strong attachment to its parents."

Whilst previous commentators have highlighted the circulation of multiple versions of attachment theory (Duschinsky et al., 2021; White et al., 2020) these are portrayed as all originating from attachment theory, even if some of them now bear limited resemblance to the theory. What the current study found is that, alongside these multiple discourses/versions of attachment theory, some social workers are also using the word attachment purely in its ordinary language sense, with no link (accurate or otherwise) to attachment theory.

A number of the social workers showed clear awareness that they were making this distinction. In such instances therefore, appeals to attachment were not a form of allodoxia (Duschinsky, 2020): the term attachment was not being used with a

misapprehension that it had the same meaning and scientific credibility as when used by attachment researchers. Yet the switch between use of the word attachment in an ordinary language sense and references to attachment theory ideas was not always obvious and clear. At times, especially when social workers were referring to ‘attachment difficulties/issues’, it was unclear whether they meant ‘general difficulties/issues in the parent-child relationship' and were not attempting to make any links to attachment theory, or whether they were trying to indicate that they had suspicions that a child might have an insecure attachment to the parent in the attachment theory sense. Even if the social workers themselves were clear about which of these they meant, this was not clear to the listener, leading to risk of misunderstanding and misinterpretation, especially given the potential for listeners to regard attachment theory as pertinent to a child welfare context.

Identifying that social workers were both using the word attachment in an ordinary language sense and in an attachment theory sense helped to explain an apparent paradox within the data: that social workers could reveal a sense of feeling both legitimised and delegitimised to discuss attachment. Closer examination of the data highlighted that this was due to participants feeling qualified to discuss the phenomenon of parent-child relationships (a phenomenon which was sometimes framed as attachment based on the ordinary language use of the term), but not qualified to discuss attachment theory and use the related formal attachment classification terms.

6.1.5 Attachment Assessments and Child Protection Social Work Practice

Concerns have been raised by attachment researchers (Forslund et al., 2022; Granqvist et al., 2017) that the infant attachment classifications are being misused in case-specific child protection practice and as court evidence: to make claims that the evidence base does not support, and with the classifications assigned without formal assessment. Hammarlund et al.’s (2022) quantitative survey-based study in Sweden appeared to provide empirical evidence of this occurring. Yet all but one of the social workers in the current study were very clear that they could not and would not use formal attachment classifications terms in their reports or court. This aligns with a finding from North’s (2019) study with UK social workers, and thus the current study adds to the evidence base by showing that this finding extends beyond North’s sample.

In the current study, just one social worker described a real case example that indicated some inappropriate application of the classifications without training or formal assessment. Furthermore, there were indications that using attachment theory in this way was not necessarily a common occurrence even for this social worker, as she did not draw on attachment classifications in her discussion of the case vignettes. Thus, in this sample of UK social workers, there was no evidence of widespread overconfident use of attachment classifications.

There are a number of possible reasons for the difference between the current study findings (supported by North, 2019) and Hammarlund et al.'s (2022) findings, and these are not mutually exclusive. One reason could be between-country differences in use of attachment theory in social work practice. Different countries have differences in pre-qualifying social work education, social work practice guidance, and court practices. Previous cross-country studies (Skivenes & Skramstad, 2015; Skivenes & Tefre, 2012) lend support to the possibility of between-country differences. A second possible reason is that sampling differences could have exaggerated the differences in attachment classification use. Hammarlund et al.'s survey was described to potential participants as "a survey on how people think about attachment-related issues and assessments in investigations of children's needs." This could have skewed their sample to those who felt they had something to say on this, leading to an overrepresentation of those who drew on attachment. In contrast, neither the current study nor North's study mentioned attachment during recruitment. A third possibility is that Hammarlund et al.'s findings might not necessarily indicate inappropriate use of formal attachment classifications by some or all of their respondents after all. Findings from the current study suggest that an alternative reading and interpretation of Hammarlund et al. is possible. It may be that some of the social workers in Hammarlund et al.'s study, like some in the current study, had a broad conceptualisation of attachment as a synonym for the child-parent relationship. If so, the answers they gave in the survey could have indicated that they 'form opinions about the nature of the child-parent relationship' in investigations, rather than that they attempt to 'form opinions about attachment classifications as delineated by Ainsworth and Main'. This reading would help to explain why some social workers in Hammarlund et al.'s survey cited use of non-attachment-related social work assessments of the child-parent relationship (such as Signs of Safety) as their means of forming opinions about attachment. I have discussed this interpretation with Hammarlund and colleagues, and they regard it as fully plausible.

Hammarlund et al. (2022) raised concerns that their findings "suggest that misinformed perceptions about attachment quality may mislead CP [child protection] investigations" (p.724). Similar concerns were made in the consensus statements (Forslund et al., 2022; Granqvist et al., 2017). The implication is that practitioners think they can ascertain and assign formal attachment pattern classifications without use of validated attachment theory-based attachment assessments, and then make overly certain inferences about what these classifications indicate. In the current study this was not occurring. The social workers in the current study were aware that formal attachment assessments existed but did not see these as something they could use. Social workers who saw the terms 'attachment' and 'child-parent relationship' as synonymous viewed the assessments of child-parent relationships that they carried out as part of their routine practice as a kind of attachment assessment. However, these social workers did not see their assessments of child-parent relationships as equivalent to the formal attachment assessments used in academic research, and did not try to present their assessments as such. Attempts were made by the social workers to signal the distinction to their listener/reader by avoiding use of attachment assessment classification terms such as secure and insecure attachment, and instead deliberately choosing language that is not part of the formal terminology of attachment theory.

What is currently unknown, however, is whether audiences can successfully understand and interpret this use of alternative, sometimes hazy, language. For instance, at times the alternative language used was 'attachment difficulties/issues'. It is unknown whether courts, for instance, recognise that mention of 'attachment difficulties' in a social worker's report does not carry – and was not intended to carry – the weight of a formal attachment assessment. It may be that allodoxia becomes an issue at the point of interpreting initial informal references to 'attachment'.

6.1.6 Attachment Theory Used in the Service of Different Forms of Thinking

Whilst the current study found that attachment theory was not dominant and social workers were not using the formal attachment classification terms, the study did find that some social workers were drawing on attachment theory ideas. Two broad approaches to using attachment theory were identified from the social workers' responses to the vignettes as well as from their descriptions of how they use the theory in their day-to-day practice. These are presented in Figure 6.2.

Figure 6.2 *A Dichotomous Typology of What Attachment Theory is Used to Do*

Attachment theory used in the service of labelling	Attachment theory used in the service of exploration
Tends to involve: ● Drawing on surface-level classifications from the theory. ● Using the theory in a more explicit way. ● Using the theory in a fixed way. ● Using the theory in a way that seeks to reduce uncertainty. ● Using the theory to restrict thinking and possibilities and next steps. ● Using the theory to support conclusions.	*Tends to involve:* ● Drawing on underpinning processes and concepts from the theory. ● Using the theory in a more implicit way. ● Using the theory in a flexible way. ● Using the theory in a way that embraces uncertainty. ● Using the theory to expand thinking and possibilities and next steps. ● Using the theory to generate questions.

A key implication of identification of both these uses of attachment theory is that drawing on attachment theory in child protection social work practice neither automatically leads to, nor is solely invoked in support of, a single way of thinking. These two uses of attachment theory were not found to be equally valuable for practice, however.

Where social workers were observed to label behaviours as attachment related, the labels (e.g., 'attachment difficulties') tended to be used as an all-encompassing explanation and be seen as sufficient, despite not being defined and explained further. This aligns with findings from some previous studies (e.g., Gibson, reported in White et al., 2020; Woolgar and Baldock, 2015). In the current study, use of hazy 'attachment labels' served as a block to further hypothesising about a family's situation, as well as providing limited information for the listener. White et al. (2020) were very critical of the use of attachment labels by social workers and saw this practice as part of a dominant reading of attachment theory in child welfare which encourages "a diagnostic gaze" (p.viii). However, there were a number of social workers in the current study who not only did not use attachment to label, but also raised clear criticisms of this practice. This calls into question White et al.'s portrayal of this use of attachment theory as

pervasive, and shows that some social workers are already adopting the critical stance that White et al. argue for.

Some social workers in the current study were drawing on attachment ideas in the service of exploration. In this form of thinking, attachment theory was not viewed as providing definitive answers but tentative explanations, which could be used as the starting point for further investigation. The social workers who used attachment theory in this way had a deeper and more nuanced understanding of a range of concepts and underpinning ideas from the theory. These social workers thought that drawing on attachment theory was valuable for supporting their understanding of families: providing insights into potential reasons for children's and parents' behaviour and directing them to things to explore further. Several commentators have recommended using attachment theory for understanding. The Granqvist et al. (2017) consensus statement proposed that "the real practical utility of attachment theory and research resides in supporting understanding of families" (p.551). Barnes et al. (2018) and White et al. (2020) make a similar argument. The current study demonstrates that some social workers are already using attachment theory to support understanding, and provides insights into how attachment theory can be used to support understanding in social work assessment practice: by using it to support exploratory thinking and the generation of questions rather than answers about a family's situation.

6.2 Strengths and Limitations of the Study

As a qualitative exploratory study, this study was not designed to produce statistically generalisable findings (Smith, 2018). This research cannot speak to how common the different approaches to understanding and using attachment theory presented are in the wider UK social worker population. It is also not possible to assess how close the research has come to capturing the full range of ways that attachment theory is understood and used by social workers in the UK. Indeed, there is at least one more way attachment theory is being (or at least has been) used by some UK social workers that has not been captured: the application of Shemmings' model (see Section 2.1.3), which was the specific focus of research by Wilkins (2015, 2017). Whilst statistical generalisability is not a relevant concept for judging the value of qualitative research, the concept of transferability – the extent to which findings are transferable to other settings – is a relevant consideration (Smith, 2018).

There are a number of factors related to the sample and recruitment approach that provide some confidence that the findings have transferability beyond the 23 social workers involved in the research. Firstly, the participants were from two local authorities, and thus the sample was not at risk of solely representing practices relating to a particular context within a single organisation (as was the case for Gibson's research, reported in White et al., 2020). Secondly, the participants were from multiple teams within each of those two local authorities. The social workers in the sample therefore had a range of different team supervisors and managers, and thus the sample was not at risk of solely representing an unusual standpoint developed by a particular manager and permeated through a team. Thirdly, the social workers had undertaken their pre-qualifying education via several providers and at a range of times, and had not all undertaken further attachment-related reading or training. Thus, the sample was not at risk of solely representing a particular standpoint encouraged by particular training in attachment (as was the case for the research by Wilkins, 2015, 2017). Fourthly, recruitment did not make any mention of 'attachment', so the sample was not at risk of solely representing the views of those who particularly value attachment theory.

Use of vignettes allowed for direct observation of how practitioners drew on (or did not draw on) attachment theory ideas in their thinking about family case vignettes, rather than just their reported use of attachment theory ideas. This was particularly valuable in light of previous findings showing that social workers who think they are drawing on attachment theory are sometimes drawing on lay understandings of attachment instead (e.g., Bjerre et al., 2023; Lesch et al., 2013), and that social workers who do not think they are drawing on attachment theory may sometimes be doing so indirectly if attachment theory ideas have influenced their informal theories (as argued by White et al., 2020). Use of vignettes also enabled insights into thought processes that are likely to remain out of view in research that observes direct practice or examines child protection assessment records. The vignettes also allowed control of the content discussed and thus an opportunity to see how all the social workers responded to mention of an assessment of disorganised attachment.

Whilst these are valuable strengths of the vignette method chosen, it is important to acknowledge that vignettes provide an analogue to practice rather than direct access to practice. All the social workers said the case vignettes felt familiar to them, and this provided a degree of reassurance that the case vignette content was reflective of practice cases. However, the way the information was presented and the way the

social workers were asked to discuss the vignettes was artificial and may have led to differences in the way the practitioners drew on attachment ideas and attachment language as compared to their day-to-day practice. Likewise, while the recruitment process for the study deliberately avoided mention of attachment theory, or indeed any theory, the study was clearly identified as research being conducted by academics, and this may also have had an influence on the social worker's responses. It may have led some participants to draw more on theoretical concepts than they do in day-to-day practice, if they perceived this to be what was wanted or expected. However, the willingness for some participants to openly acknowledge that research and practice do not feature in their practice suggests that this was at least not a factor that influenced all participants. Knowing the research was being conducted by academics may also have had the opposite effect for some participants, making them less likely to want to mention theoretical concepts for 'fear of getting it wrong'. However, some participants were comfortable to mention theoretical concepts, and those who did not tended to articulate clear reasons for why they did not, which suggested that this reflected their approach to practice and not just the study conditions.

A further strength of this research was inclusion of questions, after the vignette discussions, exploring the social workers' perspectives on the role attachment theory did or did not have in their thinking when discussing the vignettes. These questions provided important insights that the vignette discussions alone could not have provided. An example was the opportunity to confirm whether social workers had or had not been deliberately drawing on attachment theory ideas to make sense of the vignettes in cases where their discussion had been aligned with ideas from attachment theory, but no attachment theory language had been directly used. Inclusion of questions about if and how attachment theory features in their day-to-day practice were also useful for providing insights that the case vignette discussions alone could not have provided. However, findings on how attachment theory features in the social workers' real practice were limited by being obtained via interview discussion and from the social workers' perspective only. For example, where social workers described finding attachment ideas useful to introduce to families, it was unknown whether the families had a corresponding view.

A further limitation of this study was that it did not explore whether understanding the case vignettes or families in practice from an attachment perspective led to different outcomes for families than if understood from a non-attachment perspective. The study provided insights into differences in how the case vignettes were understood

depending on whether attachment ideas were drawn on or not, but did not empirically investigate whether some of those understandings lead to better practice outcomes than others.

6.3 Suggestions for Future Research

To build further on the insights provided by the current study regarding differences in social workers' understanding and use of attachment theory ideas, it would be useful for future research to explore the implications of different understandings and uses of the theory for practice outcomes. One suggestion would be an observational study of practice and case outcomes, combined with interviews with the observed social workers to examine their own perceptions of, and rationale for, using or not using attachment theory. This would enable observation of theory in use alongside reported use, which the current study found was a beneficial combination for generating rich insights.

One of the current study findings was that social workers at times reference attachment but do so using deliberately tentative and/or informal terms. It is unknown how such references are interpreted by others however. It would be valuable for research to be conducted with judges to see how they understand tentative and/or informal attachment references made by social workers in child protection court reports, and the extent to which such references inform their family court decisions.

The current findings suggest the possibility of an alternative interpretation of the Hammarlund et al. (2022) survey findings, but do not discount the possibility that Hammarlund et al.'s current interpretation is the best fit. Hammarlund et al. had already called for replication of their survey in other countries. In work that is already underway, I have been collaborating with Hammarlund et al. to use the findings from my study to help inform improvements to their survey. As an example, one set of revisions were based on the current study finding that respondents may be operating with a different view of what constitutes an attachment assessment than do researchers. Questions are now included to ascertain what respondents mean by the term 'attachment' and whether they view attachment quality as referring to the overall quality of a child's relationship with a caregiver. These additions will help to support interpretation of the meaning of the survey findings. Another set of revisions were based on the current study finding that views on the implications of attachment classifications can be

nuanced. Amendments have been made to allow for better capturing of nuanced views where these exist. Having completed my doctoral study, I plan to use the revised survey in the UK, and the attachment research group at Amsterdam VU are in the process of administering it to Dutch social workers. Use of the same methods of investigation in more than one country will help to identify if and where true inter-country differences in attachment theory understandings and uses exist. Currently the different study methods may be creating or exaggerating the differences that have been found.

Prompted by the publications and training by Shemmings in the UK, the current study obtained social worker responses to a case containing a disorganised attachment classification. The social workers in this sample reported that they had rarely seen reference to this classification in practice, and some viewed the classification as a diagnosis. The current study did not investigate whether social workers specifically perceive disorganised attachment to be a diagnosis or whether unfamiliarity with the term disorganised attachment is leading some social workers to conflate disorganised attachment with the term attachment disorder (a term that has been found to be overused in research; see Allen & Schuengel, 2020; Woolgar & Baldock, 2015). The grouping of insecure attachment, disorganised attachment, and diagnosed attachment disorders under an umbrella term of ‘attachment difficulties’ in the NICE (2015) guidance may be further serving to obscure the differences. It would be useful for future research to explore the extent to which social workers are conflating or differentiating disorganised attachment and attachment disorders. When designing research to investigate this, it would be important to consider the current study finding that the meaning social workers assign to attachment terms is not always aligned with the meaning assigned in academia and psychiatry. For example, it may be that some social workers are clear on the conceptual differences between disorganised attachment and Reactive Attachment Disorder but misunderstand the unspecified term attachment disorder as an umbrella term covering both. Being able to differentiate between terminology confusion and conceptual confusion in any research on this would therefore be helpful.

6.4 Implications for Social Work Practice

The findings suggest that ideas from attachment theory have the potential to enhance child protection social workers’ understanding of families, but that not all aspects and

applications of the theory are found to be equally valuable and an equally good fit with practice. Social workers drawing on, or considering drawing on, attachment theory ideas in their practice should reflect on what ideas and parts of attachment theory they are drawing on, as well as how they are using these ideas.

The current study findings align with proposals from attachment researchers (Forslund et al., 2022; Granqvist et al., 2017) that the classifications of different patterns of attachment are not the critical part of the theory for social work practice. Instead, social workers should be encouraged to learn about and draw on other aspects of the theory. In relation to understanding children, useful ideas from attachment theory include safe haven and secure base needs, the experiences and expectations underpinning variation in attachment security (which varies by degree rather than being simply secure or insecure, reflects relationships rather than individuals, and is amenable to change), and the concept of developmental pathways. Social workers who are not already aware that attachment theory also includes research on adults/parents should be encouraged to explore this part of attachment theory too. Ideas and research findings relating to attachment states of mind and mentalising have much to offer social workers wishing to enhance their understanding of parents. Drawing on attachment theory to think not only about the needs and behaviours of children, but their parents too, could support the generation of more holistic insights and reduction in blame-focused thinking.

The current study findings also highlight the importance of social workers reflecting on how they are using ideas from attachment theory. Figure 6.2, presented earlier in the chapter, could be a useful aid to this reflection. Use of attachment theory in the service of exploration was identified as a particularly valuable way of using the theory in practice, whereas use of the theory in the service of labelling could lead to problems with misapplication and miscommunication. If attachment theory and the associated research is erroneously perceived as providing facts and definitive conclusions that can be applied to individual cases, this can lead to claims and judgements that are not supported by the evidence-base and are oppressive and unjust for families. The value of attachment theory for social work assessment practice is that it can support the generation of questions and tentative hypotheses about what might be going on for a family, which can then be explored further. This has parallels with proposals that attachment theory finds its value in clinical work in the service of formulation (see, e.g., Barnes et al., 2018; Slade, 2004). Social workers may find helpful ideas for their own assessment practice within literature on use of attachment theory in clinical formulation.

The current study found that there is substantial variation between individual social workers with regards to what attachment is thought to be and the level of understanding of attachment theory concepts and findings. An important practice implication of this is the importance of avoiding use of shorthand terms, which require a level of shared meaning and understanding that was not found to exist. The practice of avoiding use of formal classification terms, which most social workers in the current study were already doing, is helpful and should continue. It is also recommended that 'attachment', 'attachment difficulties', and 'attachment issues' are avoided as these terms can serve as a block to understanding. In the place of shorthand terms such as these, it is recommended that social workers explain in longform their meaning plus any assumptions and/or implications they wished to signal. To take one example, if a social worker has developed concerns that a child appears to not have trust in the availability of their caregiver as a safe haven and may be downplaying their needs to avoid disturbing their caregiver, this should be stated, along with the observations that have led to this hypothesis. To label this as 'concerns there are attachment issues' alongside the longform statement does not add any value, and instead brings risks that this label will (erroneously) be seen as sufficient and could be used in place of the longform statement in subsequent reports.

Another finding in the current study, which also aligns with previous study findings, is that 'attachment' and 'child-parent relationship' are seen as synonymous by some social workers. This conflation can occur at a terminology and/or conceptual level. On this issue, Shemmings (2018) has said, "My advice to practitioners is actually not to use the word 'attachment' in their records and reports (I encourage them to substitute 'relationship', as it usually does the trick)." The first half of Shemmings' advice – that it is best to avoid use of the word attachment in social work practice – aligns with a recommendation already made above. However, Shemmings' suggested solution – that the word attachment can and should be simply substituted with the word relationship – is problematic. This advice could further encourage conceptualisation of attachment and relationships as equivalent, and lead to a loss of specificity. There may be strengths or concerns in relation to the attachment (safe haven) related aspects of a child-parent relationship that are distinct from strengths or concerns in other aspects of the relationship. Conceptual conflation of attachment and relationship could draw attention away from the important distinctions. It is recommended that social workers familiarise themselves with the ways in which attachment theory delineates the aspects of the child-parent relationship specifically associated with protection and safe haven seeking. Social workers should not be encouraged to use the word relationship to

mean attachment. Single word synonyms for attachment should not be sought: longform descriptions are more helpful.

6.5 Implications for Social Worker Guidance and Training

Despite Munro (2011) and Narey (2014) both emphasising the importance of child and family social workers being provided with a comprehensive understanding of attachment theory, the current study findings suggest that this is not consistently occurring at present. There is very varied understanding of attachment theory amongst social workers.

The research-practice divide is arguably starker in relation to child protection assessment practice than clinical practice. Previous empirical research (Beckwith, 2021) has found that many international experts in attachment research have experience of working in clinical practice and/or training clinicians. Books (e.g., Steele & Steele, 2008b) and articles (e.g., Slade, 2004) describing how attachment theory ideas can be used to inform clinical thinking have been produced by individuals who have expert insights into both attachment research and clinical practice. This helps to ensure that the most useful aspects of attachment theory for clinical practice settings are disseminated, and that this dissemination is done in a way that maintains the necessary integrity and nuance of the concepts. In contrast, prominent UK social workers who have been promoting attachment ideas for child protection assessment practice, such as David Shemmings, are not involved in attachment research and have an understanding and conceptualisation of attachment theory that is not fully aligned with the one held by attachment researchers. The consensus statements (Forslund et al., 2022; Granqvist et al., 2017) provide an important first step by attachment researchers to directly clarify appropriate and inappropriate uses of attachment theory concepts in child protection practice. It is also helpful that these statements have been published open access. Yet the current research found that some practitioners had turned away from attachment theory due to disenchantment with what they misperceived it to be. Although these social workers held views (e.g., that the attachment classifications are unhelpful for social work practice) that suggest they would agree with the proposals in the consensus statements, they are unlikely to seek out the consensus statements or any other direct writing by attachment researchers. Furthermore, while the consensus statements provided some suggestions for how attachment theory can helpfully be used by child welfare practitioners, this was not their

main focus or purpose. As a result, detailed guidance on how individual practitioners could better utilise attachment theory ideas in their practice was not provided within those statements.

The findings from the current study highlight that it would be useful for a new attachment theory curriculum to be developed for social work pre-qualifying education, to help ensure that focus is on introducing social workers to accurate information about the most relevant concepts for practice from the theory. This study found that social workers are currently not being introduced as standard to concepts from attachment theory that have potential relevance to social work practice (such as safe haven availability, caregiver sensitivity, and mentalising), yet at the same time are being introduced to some aspects that have less relevance (such as the names and Strange Situation presentations of the infant attachment patterns). Highlighting key misassumptions about attachment theory that are in circulation and correcting these would also be important to include in a new curriculum, to reduce the likelihood of continued perpetuation of these misassumptions. Using pre-qualifying education as a means of introducing social workers to a more accurate and practice relevant version of attachment theory from the outset would allow for improvements at scale, and newly qualified social workers would then take that version of attachment theory with them into practice. The current research suggests that there are already some social workers within the qualified workforce who are thinking about and applying attachment theory ideas to social work practice in thoughtful, nuanced, appropriate ways and who would be allies to newly qualified social workers who held a perspective that attachment theory does not equal the Strange Situation and attachment classifications. Work on this curriculum (Foster et al., forthcoming) is now underway, informed by the findings and insights gained from the current research, and with collaborative input from other educators, practitioners, and attachment researchers.

PART B

PRACTITIONERS' ATTACHMENT STATES OF MIND AND PRACTICE-RELATED REFLECTIVE FUNCTIONING

Chapter 7: Systematic Narrative Review

As stated in Chapter 1, the overarching aim of this thesis – to explore the relevance of attachment theory to child welfare assessment practice – was underpinned by two research objectives. Research Objective 2 was to examine the relationship between practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns. Addressing Research Objective 2 is the focus in this part of the thesis (Part B).

This chapter presents a systematic review and narrative synthesis on attachment states of mind and reflective functioning (RF) in helping professionals.

7.1 Introduction

Attachment states of mind, assessed via the Adult Attachment Interview (AAI), have been found to predict a range of differences in behaviour, personal relationships, and personal functioning (see Section 1.1.12). RF, which can also be assessed via the AAI, has been proposed by Fonagy, Steele and Steele as of primary importance for explaining the associations found between attachment states of mind and an adult's interactions with their own child (see Section 1.1.13). Understanding the extent to which practitioners' attachment states of mind and RF levels also predict differences in the professional domain is an important question for professional practice. It may be that these practitioner variables would be useful to consider when selecting, training, supporting, and/or supervising practitioners. Steele and Steele (2008a) proposed that the AAI "may be helpful in identifying the challenges that a given [clinical practice] applicant needs to address and resolve" (p.24), but acknowledged that research assessing the implications of the attachment states of mind and RF levels of practitioners was still limited at that time. More recently, Caron et al. (2018) proposed that a mini-AAI could be used to inform selection or training support decisions for providers of the attachment-based ABC model.

AAI studies examining the implications of the attachment states of mind of professionals are limited when compared to the corpus of studies examining the implications of attachment states of mind for other groups. In Bakermans-Kranenburg and van IJzendoorn's (2009) seminal review of the first 10,000 AAIs, only two of the more than 200 included studies involved professionals as one of their target participant

groups. The number of empirical studies that have examined professionals' attachment states of mind is still limited compared to studies of attachment states of mind in primary caregivers and clinical groups, but is growing.

Searches conducted at the time of developing the protocol for the current review identified five published systematic reviews which considered implications of professionals' attachment for practice. Three of the reviews focused on therapists. Degnan et al. (2016) reviewed the relationship between therapists' attachment and therapeutic alliance and/or outcomes. Degnan et al.'s review included 11 studies, four of which used the AAI to measure attachment and seven of which used self-report measures of attachment. Lingiardi et al. (2018) reviewed the relationship between a range of subjective therapist variables, including but not limited to attachment, and therapeutic outcomes. Lingiardi et al.'s review included six studies which examined the influence of attachment, only one of which used the AAI and five of which used self-report measures of attachment. Steel et al. (2018) reviewed the relationship between therapists' attachment and/or introject and therapeutic relationship quality. Steel et al.'s review included 19 studies which examined the influence of attachment, five of which used the AAI and 14 of which used self-report measures of attachment. Two other reviews focused on other groups of professionals. Cherry et al. (2013) reviewed the relationship between doctors' and medical students' attachment and/or emotional intelligence and their patient-provider communication. Cherry et al.'s review included five studies that examined the influence of attachment, and all these studies used self-report measures of attachment. Mimura and Norman (2018) considered a broader range of helping professionals in their review of the relationship between healthcare workers' attachment and patients' perceptions of care and/or health outcomes. Mimura and Norman's review included 13 studies, five of which used the AAI to measure attachment and eight of which used self-report measures of attachment. No systematic reviews were found which examined implications of professionals' RF.

The current systematic review is different from these previous published reviews in three main ways. Firstly, previous reviews have included studies using self-report assessment of attachment alongside AAI assessment of attachment. However, despite both being described as measures of individual differences in attachment in adulthood, attachment styles assessed via self-report measures and attachment states of mind assessed via the AAI appear to be different constructs (Jacobvitz et al., 2002). A meta-analytic review found only a "trivial to small" correlation between the two measures (Roisman et al., 2007). The current review focuses solely on studies using the AAI. By

not combining self-report and AAI studies, there is opportunity to more clearly identify the commonalities, contradictions, and gaps in existing findings relating to attachment states of mind. Secondly, previous reviews have not included studies assessing professionals' RF levels via the AAI alongside assessing professionals' attachment states of mind via the AAI. Yet there is considerable theoretical and empirical overlap between attachment states of mind and RF (see Section 1.1.13). The current review therefore also includes studies involving AAI assessment of RF. This allows for a more comprehensive exploration of any practice-focused differences related to differences in AAI responses. Thirdly, all but one of the previous reviews (the exception being Mimura & Norman, 2018) have focused on a single specific group of helping professionals, whereas the current review broadens the population of interest to all helping professionals. By including all helping professionals rather than limiting the review to a particular practitioner group, there is opportunity to explore whether findings from individual studies are likely to translate to other professional groups and/or practice settings. This is of value for those in adjunct professions wanting to assess the likely relevance of the findings to them. Looking across professional groups also enables the review to identify whether there are particular helping professions which have been understudied to date, which is useful when considering directions for future research.

7.1.1 Research Questions

The purpose of this review was to examine attachment state of mind and RF level distributions amongst helping professionals, and the implications of these for the professionals, their practice, and outcomes for the clients they work with.

This review was guided by two overarching research questions:

- **Review Question 1:** How do the attachment states of mind and RF levels of helping professionals, assessed via the AAI, compare to non-clinical norms?
- **Review Question 2:** What are the implications of differences in helping professionals' attachment states of mind and RF levels, assessed via the AAI, for their professional practice?

7.2 Methodology

The systematic review was conducted in line with guidance produced by the Centre for Reviews and Dissemination (CRD, 2009) and has been reported according to the

PRISMA 2020 guideline (Page et al., 2021). A review protocol was developed prior to commencement. My two PhD supervisors plus one further academic with substantial systematic review experience (Dr Barry Coughlan) formed the review advisory group. The protocol was submitted to the international prospective register of systematic reviews PROSPERO on 3rd March 2022 and was accepted onto the register (see https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42022314496).

7.2.1 Search Strategy

Search Terms

Terms relating to a) the characteristic of interest and b) the population of interest were identified and combined. The characteristic of interest was attachment state of mind and/or RF, assessed via formal coding of the AAI. These specific measures are usually described in a relatively standardised way in the literature, so it was possible to identify precise search terms rather than search for the imprecise and extremely broad term 'attachment'. It was expected that the majority of relevant studies would be found via searches for 'Adult Attachment Interview' and 'reflective functioning'. As the AAI purports to measure 'attachment states of mind', this was also included as a search term. Some researchers describe the AAI as measuring 'attachment representations', and so this was also included as a search term. The term 'attachment styles' was not included, as this is used in the social psychology literature to describe self-report measures of attachment, which are outside of the scope of this review for the reasons outlined in Section 7.1 above.

The population of interest for this review was helping professionals. A broad definition of helping professionals was adopted: anyone in an occupation that provides health (mental or physical), wellbeing, or education services to individuals and groups, as well as any helping profession students/trainees. The decision was taken to also include helping profession students/trainees because the aim of the review was to make as broad an assessment as possible of the implications of AAI differences for professionals and professional practice. Helping profession students/trainees will be part of the future workforce, and are also involved in direct practice during their training, so including studies conducted with them provided a more rounded picture.

Identifying appropriate search terms for the population of interest required some consideration due to the wide range of roles that come under the broad definition of

helping professionals, and the possible between-country differences in terms used to describe such roles. Furthermore, whilst it was anticipated that some studies would describe their professional sample using their specialist job role, it was also expected that other studies might use more general descriptions, especially those with samples involving practitioners from multiple professions. Both specific and general profession terms were therefore included to help increase the likelihood of the searches identifying all relevant studies. Two initial lists were created, one containing specific helping professions (clinical psychologist, general practitioner, etc) and one of general terms for professionals (practitioner, professional, etc). The search terms were checked against search terms from previous reviews on helping professionals (Mimura & Norman, 2018; Saade et al., 2022), and with the review advisory group for further suggestions. When combining and converting the lists into a single set of search terms, some of the specific professions did not need to be included as search terms because a broader term covered them (e.g., social workers, health care workers, and childcare workers were all covered by the search term “worker”). Other terms needed to be included in more than one format (e.g., different spellings of counsellor and paediatrician). The final search terms are presented in Table 7.1.

Table 7.1 *Final Search Terms*

Domain	**Search Terms**			
Characteristic of interest	1	"adult attachment interview*"	2	"attachment representation*"
	3	"attachment state* of mind"	4	"reflective function*"
Population of interest	5	"case manager*"	6	clinician*
	7	counsellor*	8	counselor*
	9	doctor*	10	GP
	11	GPs	12	"health visitor*"
	13	mentor*	14	nurse*
	15	paediatrician*	16	pediatrician*
	17	physician*	18	practitioner*
	19	professional*	20	provider*
	21	psychologist*	22	psychiatrist*
	23	psychotherapist*	24	staff
	25	supervisor*	26	teacher*
	27	therapist*	28	worker*

Searches

Electronic database searches were conducted on 22nd February 2022. Seven databases were searched: Scopus; Web of Science All Databases; APA PsycInfo via EBSCOhost; CINAHL (Cumulative Index to Nursing & Allied Health) via EBSCOhost; Medline via ProQuest; ASSIA (Applied Social Sciences Index and Abstracts) via ProQuest; and ProQuest Dissertations & Theses Global. Taken together, these databases provided both relevant subject-specific and broader coverage. Titles and abstracts were searched for the search terms. The same search query was run in every database, though the precise syntax for this was modified to each database's specific codes. The database searches can be found in Appendix E.1. No date, geographical restrictions or language restrictions were set.

The reference lists of all studies included in the review, as well as all identified systematic reviews with relevance to the review topic, were checked for additional relevant papers. I also consulted with key researchers working in this area, including some of the authors in this review, to see if they were aware of any further published or unpublished studies which met the inclusion criteria.

7.2.2 Study Selection

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were established and detailed in advance. All primary studies examining helping professionals' attachment states of mind and/or RF, assessed using the AAI, were included. A broad definition of helping professionals was applied and included helping profession students/trainees. To be included, a study did not have to solely focus on helping professionals' attachment state of mind and/or RF – it could for instance also consider clients' attachment states of mind and/or RF. To be included, a study also did not have to solely use the AAI to assess professionals' attachment states of mind and/or RF – it could also include other measures. However, records were excluded if they did not include any focus on professionals' attachment states of mind and/or RF. This was a common reason for exclusion of records at title and abstract screening stage.

If a record had some focus on professionals' attachment and/or RF, the next set of exclusion criteria were considered. Records were excluded if they used a different measure, i.e., if professionals' attachment and/or RF was assessed but only via instruments other than the AAI, or the AAI was conducted with professionals but was not formally coded to assess their attachment states of mind and/or RF. Records were also excluded if the professionals were not in a helping profession. This was not a common reason for exclusion considering the broad definition of helping professionals utilised, with only two records excluded on this basis. Records were also excluded if they involved students who were not directly studying/training for a helping profession, for example, students on general undergraduate psychology courses. Records were excluded if helping professionals' attachment and/or RF were discussed but not examined through an empirical study. This could be because the paper was not reporting a primary research study (e.g., the paper was a review, theoretical paper, or commentary), or because the helping professionals' attachment and/or RF was not part of the scope of the primary research being reported.

Methodological quality assessment was not used as an inclusion/exclusion criterion. To limit language and publication bias, no exclusion criteria were set based on language or publication type and status. It was decided in advance that, where a potentially relevant study was published in a language other than English, efforts would be made to translate it using computer software, but studies would be excluded where this was not possible. No studies had to be excluded due to an inability to translate them. It was also decided in advance that, where only an abstract for a potentially relevant study was published, efforts would be made to obtain the full study details from authors, but studies would be excluded where these could not be obtained. No studies had to be excluded for this reason.

Title and Abstract Screening

The electronic searches produced a total of 1,655 records. All records were transferred from their respective databases to Endnote. I identified and removed the duplicates in Endnote which resulted in 633 records for title/abstract screening. These were transferred to Rayyan (https://www.rayyan.ai/) for screening. The second reviewer (Amy Hillier; A.H.) and I piloted the inclusion and exclusion criteria on 30 (5%) of the titles and abstracts. This piloting process was used to check the inclusion and exclusion criteria were clear and could be applied consistently. We had complete

agreement on those records (excluding 27 and including three) and proceeded to screen the remaining (k = 603) citations

All titles and abstracts were independently screened against the inclusion and exclusion criteria by me and A.H. We both followed a direction to err on the side of inclusion during this initial screening stage where it was unclear if the inclusion criteria were met. After we had each completed our independent screen, we checked our agreement. A further 552 records were excluded by us both and a further 43 were included by us both. There were eight records in which we were in conflict: seven which only I had included and one which only A.H. had included. Cohen's kappa (Cohen, 1960) was used to calculate a chance-corrected measure of inter-rater reliability on these 603 records (i.e., all records screened after the pilot screen of the first 30). Inter-rater reliability was .91 which indicates almost perfect agreement according to Landis and Koch's (1977) benchmarks. We discussed each of the eight records where our screening decisions had differed and decided through consensus to include five (four records only I had included and one record only A.H. had included) and to exclude three (which only I had included).

Full Text Review

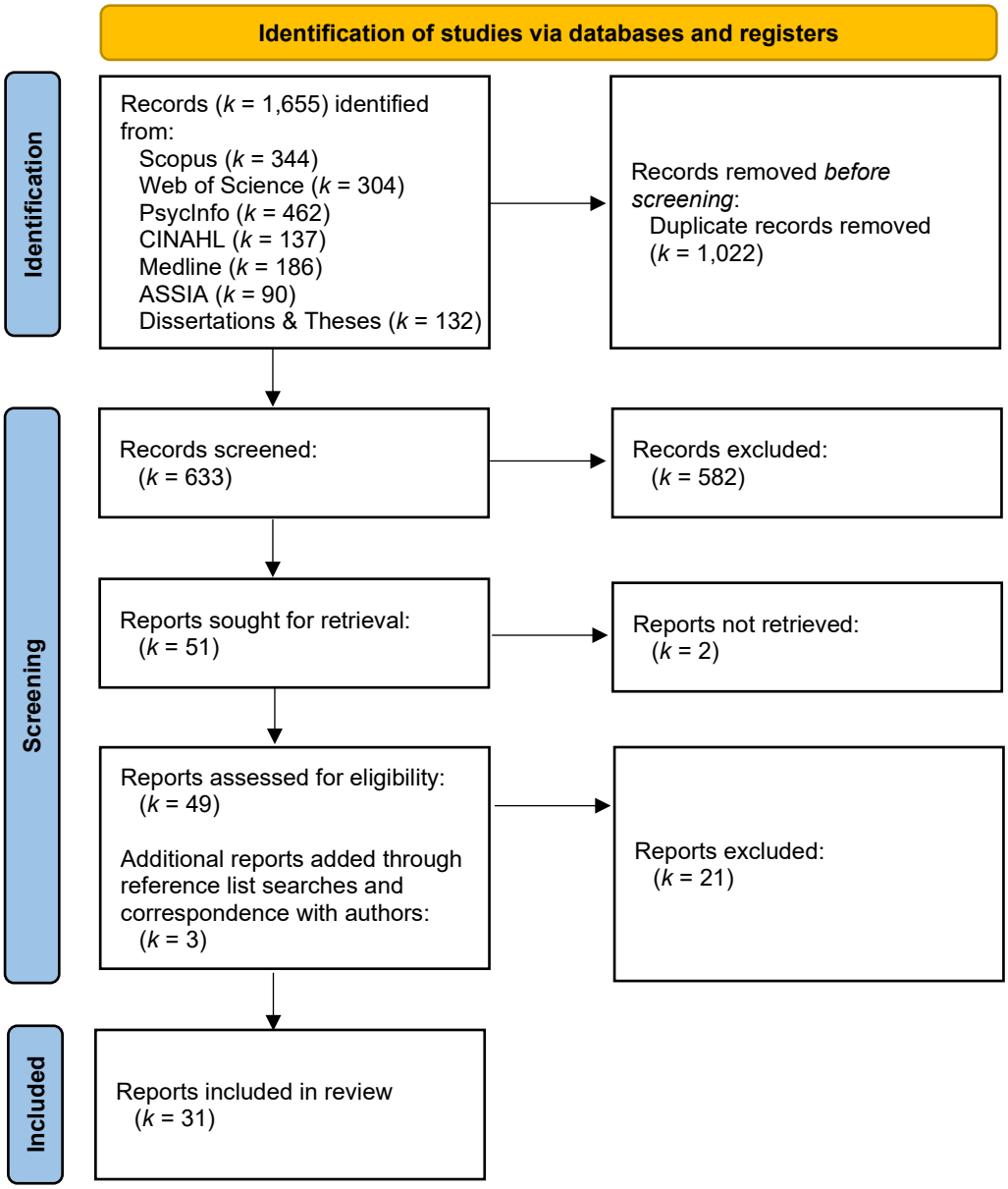
The full texts for each of the 51 titles and abstracts identified as potentially relevant were sought. Translations were made using the DeepL Translator (https://www.deepl.com/en/translator) where the text was not in English. Two texts could not be retrieved: Sordano and Consolini (2007) and Tozer (2017). The title and abstract detail for these two texts suggested they would likely not meet the inclusion criteria, but there was not enough information to confirm this with certainty. The 49 retrieved full texts were all independently checked against the inclusion and exclusion criteria by me and A.H. Decisions were made blind to the other reviewer's decisions.

There were 26 full texts that we both independently decided to include and 15 that we both independently decided to exclude. There were two full texts I was unsure about and wanted to discuss and four other full texts A.H. was unsure about and wanted to discuss. We were able to come to consensus in our discussion of these six, deciding that two met the inclusion criteria and the other four did not.

In total, 28 full texts identified from the electronic database searches were determined to meet the inclusion criteria. The process of checking reference lists and contacting

researchers led to identification of a further three texts that met our inclusion criteria, leading to a final total of 31 texts (see Figure 7.1).

Figure 7.1 *PRISMA 2020 Flow Diagram of the Systematic Search*



7.2.3 Data Extraction and Quality Assessment

I extracted and summarised relevant data from each text into an excel spreadsheet. A.H. checked the data extraction for accuracy and completeness. As outlined in the protocol, any disagreements were to be recorded and resolved via consensus, or through consultation with the wider review team if necessary. There was no such

disagreement: the check by A.H. provided reassurance that the data had been extracted appropriately and did not lead to other amendments.

Quality assessment of studies was not used in selection, but to provide important context when synthesising and interpreting the findings. Quality assessment was carried out on each study at the same time as data extraction. There are many critical appraisal tools available for assessing the quality of research studies (Katrak et al., 2004; Ma et al. 2020). The quality assessment tool for observational cohort and cross-sectional studies (NHLBI, 2013) was chosen due to being broadly relevant to the type of studies included in this review. One of the previous published systematic reviews on implications of professionals' attachment for practice (Mimura & Norman, 2018) had also used the NHLBI quality assessment tool. The tool was modified slightly to increase its relevance to AAI research studies (see Appendix E.2). The modifications ensured that the tool was better able to distinguish differences in quality between AAI studies, such as whether a proportion of the AAIs had been second coded and satisfactory inter-rater reliability established.

The modified quality assessment tool was first piloted on seven papers (23%) by me and A.H. to check that the modified criteria were appropriate and could be applied consistently, which was confirmed. I then carried out quality assessment on each of the remaining included studies. The original assessment tool guidance highlights that the questions within the tool “are designed to help you focus on the key concepts for evaluating the internal validity of a study. They are not intended to create a list that you simply tally up to arrive at a summary judgement of quality” (NHLBI, 2013). In line with this guidance, and because quality assessment was conducted for context rather than for screening, quality assessment findings have been integrated into the discussion of findings as appropriate rather than presented separately.

7.2.4 Approach to Synthesis

A narrative synthesis was conducted. A meta-analysis was not conducted as the data were too heterogeneous: there was too much variance in the professions, methods for measuring AAI responses, and outcome measures for it to be appropriate to pool samples and findings.

To address Review Question 1, regarding how the attachment states of mind and RF levels of helping professionals compare to non-clinical norms, it was important to first

identify where texts might be drawing on the same or overlapping samples to ensure the same samples were not inadvertently included multiple times. The extracted sample data were compared for similarities and potential overlap. Where it was unclear if a sample was distinct or how a sample overlapped, authors were contacted directly for clarification. The extracted attachment state of mind and/or RF data for each distinct sample was then collated. Where all relevant detail was not reported (for example, where only one of three-way forced and four-way attachment states of mind were reported), paper authors were contacted directly to try to obtain the additional detail. Table E.1 in Appendix E.3 contains details of where additional data were obtained directly from paper authors.

For three-way forced and four-way attachment states of mind, Bakermans-Kranenburg and van IJzendoorn's (2009) distributions from a combined sample of non-clinical and not-at-risk groups (N = 4,393 for the three-way forced distribution, N = 4,454 for the four-way distribution) were used as the norm for comparison. This was chosen as the comparison sample following consultation with Bakermans-Kranenburg. To conduct the statistical comparisons, the Chi-Square Goodness of Fit test was applied to every helping professional sample that was large enough to have an expected cell size of at least 5 for each classification. Standardized residuals were also calculated to show the difference between the observed frequencies for each classification for each sample and the expected frequencies based on the norm.

For RF, the sample of 85 non-clinical control participants in Fonagy et al. (1996) was used as the normative benchmark. This sample was chosen as all the interviews were double coded by two of the original developers of the RF system (Miriam and Howard Steele) and inter-rater reliability was high (r = .91). Whilst the sample in the London Parent-Child Project was larger (N = 200), that sample was not used as it was also the development sample for the RF system. To conduct the statistical comparisons, a two-tailed unpooled variance (Welch) t-test was used. This was chosen as sample sizes were unequal and equal variance was not assumed.

To address Review Question 2, regarding the implications of professionals' attachment states of mind and RF levels for their professional practice, the relevant outcome measure(s) and findings were first summarised for each individual study. The findings were then grouped into themes based on the nature of the professional implications, and were narratively described and analysed, examining commonalities and discrepancies. Methodological differences and quality assessment were drawn on as

important context when interpreting the findings. Possible relationships across the study results were then examined. A visual representation of these possible relationships was developed in line with Popay et al.'s (2006) guidance on conceptual models.

7.3 Findings

The 31 eligible texts comprised 26 published journal articles, four doctoral dissertations, and one unpublished report. A total of 24 distinct helping professional samples involving a total of 1,383 participants were identified within the 31 eligible texts. All the studies were conducted in Western countries, with six samples from the USA, 17 from Europe (six from the UK, five from Germany, three from the Netherlands, one each from Austria, Finland, and Italy), and one from Australia. Sample size ranged from four to 541, with 71% (*k* = 17) of the samples involving less than 50 helping professionals, 25% (*k* = 6) of the samples involving between 50 and 90 helping professionals, and just one sample involving more. The most sampled professional group was therapists/therapist trainees (*k* = 11, 46%) with a further four samples comprising practitioners in other adult mental health roles or training. Three of the samples were of child daycare providers. Two of the samples were of child welfare/protection professionals. The remaining four samples contained distinct practitioner groups: one was of practitioners delivering a parenting intervention, one was of caregivers to disabled people, one was of caregivers to institutionalised youths, and one was of physiotherapists. Table E.1 in Appendix E.3 contains details of which of the texts each sample is reported in.

7.3.1 The AAI Profiles of Helping Professionals

This section reports findings regarding how the attachment states of mind and RF levels of helping professionals compare to non-clinical norms (Review Question 1). Several different methods were used to code the AAIs. Most of the samples in the review (*k* = 16, 67%) reported attachment state of mind three-way forced and/or four-way classifications (Main et al., 2003). Seven samples (29%) reported RF (Fonagy et al., 1998): four alongside reporting attachment state of mind three-way forced or four-way classifications, three as the sole AAI measure. These samples are compared to non-clinical norms below.

The five remaining samples reported other AAI coding data. Three used the Main et al. (2003) attachment states of mind coding system but did not report three-way forced or four-way classification data; Sibrava (2009) and Suess et al. (2015) reported two-way classification breakdowns only, and Petrowski et al. (2013) reported the Waters et al. (2005) scale data only. The Waters et al. (2005) system converts the data generated by Main et al. (2003) system coding into two continuous variables. Another sample (Dozier et al., 1994) used Kobak's (1993) attachment Q-set and the final sample (Tyrrell et al., 1999) used a modified version of Kobak's attachment Q-set. There were no benchmarks to compare these five samples to, nor was there sufficient consistency across their coding methods and/or reporting to compare them to each other, and thus these five samples were not examined further in relation to Review Question 1.

Attachment State of Mind Classification Distributions

Table 7.2 presents the three-way forced and four-way attachment state of mind classification distributions for each sample where this was reported or obtainable, plus statistical comparison to the non-clinical norm (Bakermans-Kranenburg & van IJzendoorn, 2009).

Both three-way forced and four-way attachment states of mind were examined for two reasons. Firstly, both categorisations were not available for all the samples, so choosing just one would have excluded some samples. Secondly, these different categorisations provide different valuable information. The three-way forced approach privileges each participant's global state of mind in the interview: autonomous, dismissing, or preoccupied. The four-way approach separates out into a fourth category participants demonstrating an unresolved state of mind when discussing loss and/or abuse experiences.

Table 7.2 *Percentage Distributions of Three-Way Forced and Four-Way Attachment State of Mind Classifications in Each Sample with Comparisons to the Non-Clinical Norm*

Sample	Professional group(s)	Three-way forced distribution					Four-way distribution					
		N	**F %** **(*sr*)**	**Ds %** **(*sr*)**	**E %** **(*sr*)**	χ^2	***N***	**F %** **(*sr*)**	**Ds %** **(*sr*)**	**E %** **(*sr*)**	**U %** **(*sr*)**	χ^2
Copeland et al., 2020	Child welfare professionals	541	43 (-4.22)***	37 (3.28)***	20 (3.66)***	41.99 *p*<.0001***	541	41 (-3.01)**	32 (3.65)***	13 (2.98)**	14 (-1.44)	33.35 *p*<.0001***
Klasen et al., 2019	Therapist trainees	90	86 (3.70)***	1 (-4.96)***	13 (-0.22)	38.30 *p*<.0001***	90	86 (4.73)***	1 (-4.46)***	9 (-0.15)	4 (-2.77)**	49.96 *p*<.0001***
Horppu & Ikonen-Varila, 2004	Kindergarten teacher students	82	43 (-1.64)	44 (2.40)*	13 (-0.19)	8.52 *p*=.014*	Not available					
Slot & Schuengel, 2014	Child protection family guardians	74	54 (-0.26)	20 (-1.46)	26 (2.61)**	9.03 *p*=.011*	74	50 (-0.02)	19 (-0.93)	13 (1.16)	18 (0.30)	2.31 *p*=.511
Mayer et al., 2020	Childcare providers	66	68 (1.29)	15 (-2.14)*	17 (0.53)	6.53 *p*=.038*	66	65 (1.71)	11 (-2.25)*	5 (-1.28)	20 (0.71)	10.16 *p*=.017*
Schuengel et al., 2012	Caregivers to disabled people	61	56 (-0.06)	25 (-0.70)	20 (1.13)	1.78 *p*=.411	60	53 (0.34)	22 (-0.41)	13 (1.00)	12 (-0.87)	2.03 *p*=.567
Talia et al., 2020	Therapists	50	64 (0.72)	24 (-0.72)	12 (-0.42)	1.21 *p*=.546	50	62 (1.18)	22 (-0.32)	8 (-0.32)	8 (-1.44)	-
Jenkins, 2002	Physiotherapy students	43	81 (2.19)*	16 (-1.60)	2 (-2.07)*	11.63 *p*=.003**	43	79 (2.67)**	7 (-2.30)*	0 (-2.01)*	14 (-0.36)	-
Shmueli, 2003	Clinical psychology trainees	40	53 (-0.32)	38 (0.93)	10 (-0.70)	1.47 *p*=.480	Not available					
Zegers et al., 2006	Caregivers to institutionalised youths	33	55 (-0.13)	15 (-1.52)	30 (2.45)*	-	33	55 (0.35)	12 (-1.41)	15 (1.08)	18 (0.29)	-

Sample	Professional group(s)	Three-way forced distribution					Four-way distribution					
		N	**F %** (***sr***)	**Ds %** (***sr***)	**E %** (***sr***)	χ^2	***N***	**F %** (***sr***)	**Ds %** (***sr***)	**E %** (***sr***)	**U %** (***sr***)	χ^2
Constantino & Olesh, 1999	Childcare providers	Not available					33	52 (0.11)	12 (-1.41)	9 (-0.06)	27 (1.58)	-
Schauenburg et al., 2010	Therapists and therapist trainees	31	65 (0.61)	10 (-2.03)*	26 (1.71)	-	31	61 (0.87)	6 (-2.01)*	10 (0.05)	23 (0.89)	-
Shmueli, 2003	Counselling students	29	52 (-0.33)	34 (0.50)	14 (-0.06)	-	Not available					
Shmueli, 2003	Therapists	16	75 (1.00)	13 (-1.25)	13 (-0.18)	-	Not available					
Rizq & Target, 2010a	Counselling psychologists	Not available					12	50 (-0.01)	17 (-0.53)	8 (-0.12)	25 (0.76)	-
Wittenborn, 2012	Therapist trainees	Not available					7	71 (0.80)	14 (-0.54)	0 (-0.81)	14 (-0.12)	-

Note. Samples are presented in size order, with the largest sample first. F = autonomous; Ds = dismissing; E = preoccupied; U = unresolved; % = sample percentage; *sr* = standardised residual comparison to norm; χ^2 = Chi-Square Goodness of Fit. The normative distributions for comparison are from a combined sample of non-clinical and not-at-risk groups reported in Bakermans-Kranenburg and van IJzendoorn (2009, p.243). As the rounded percentages reported in the paper totalled 99%, the percentages taken to two decimal places were obtained directly from Bakermans-Kranenburg and were used to calculate expected *N*s. The normative three-way forced distribution (*N* = 4,392) was F 56.31%,Ds 29.49%, and E 14.21%. The normative four-way distribution (*N* = 4,454) was F 50.20%, Ds 24.25%, E 9.38%, and U 16.17%. When calculating the standardised residuals and chi-squares, the expected Ns to two decimal places were used. Table E.2 in Appendix E.3 contains the raw data (sample *N*s and expected *N*s for each classification and sample) used to calculate the standardised residuals and chi-squares. The Chi-Square Goodness of Fit test was applied to every sample that was large enough to have an expected cell size of at least 5 for each classification.

* $p < .05$. ** $p < .01$. *** $p < .001$.

There were 13 samples (combined N = 1,156) where the three-way forced distribution was reported or obtainable. Eight (62%) of the samples had a distribution that differed for at least one of the classifications at the $p < .05$ level from Bakermans-Kranenburg and van IJzendoorn's (2009) non-clinical normative distribution of 56% autonomous, 29% dismissing, and 14% preoccupied. Following Bakermans-Kranenburg and van IJzendoorn's (2009) precedent, the more stringent $p < .001$ level was used to identify samples where the distribution robustly differed from the non-clinical normative distribution. Only two samples differed at the $p < .001$ level. Copeland et al.'s (2020) sample of child welfare professionals had a marked underrepresentation of the autonomous classification and a marked overrepresentation of the insecure classifications (dismissing and preoccupied). By contrast, Klasen et al.'s (2019) sample of therapist trainees differed from the normative distribution in the opposite direction, with a marked overrepresentation of the autonomous classification and a marked underrepresentation of the dismissing classification. The Copeland et al. and Klasen et al. samples both included second coding of a subset of the AAIs, though the inter-rater reliability (IRR) of 65% (on 22% of the interviews) for Klasen et al. was low compared to the IRR of 91% (on 25% of the interviews) for Copeland et al.

There were 12 samples (combined N = 1,040) where the four-way distribution (which also includes the classification unresolved states of mind with respect to loss and/or abuse) was reported or obtainable. Five of the samples (42%) had a distribution that differed for at least one of the classifications at the $p < .05$ level from Bakermans-Kranenburg and van IJzendoorn's (2009) non-clinical normative distribution of 50% autonomous, 24% dismissing, 9% preoccupied, and 16% unresolved. Only two samples differed at the $p < .001$ level. These were the same samples (Copeland et al., 2020; Klasen et al., 2019) that had also reported deviating three-way forced distributions. Looking across all the included samples, there was very little deviation from the normative distribution for the unresolved classification, with only one sample (Klasen et al., 2019) with a significant (at $p < .01$) underrepresentation of this classification, and no samples with an overrepresentation.

RF Levels

Table 7.3 presents the RF data for each sample where this was reported or obtainable, plus statistical comparison to the sample of non-clinical control participants in Fonagy et al. (1996).

Table 7.3 *RF Mean, Standard Deviation, and Range in Each Sample with Comparisons to the Non-Clinical Norm*

Sample	Professional group(s)	*N*	RF			*t*-test comparison [a] to non-clinical norm [b]
			Mean	*SD*	Range	
Klasen et al., 2019	Therapist trainees	90	5.8	1.15	2.5 – 8	$t = 2.96$, $p = .004$**
Steinmair et al., 2021	Mental health professionals	39	3.88	1.04	0 – 7.5	$t = -5.67$, $p < .0001$***
Shmueli, 2003	Counselling students	29	3.77	1.24	nr	$t = -5.07$, $p < .0001$***
Trowell et al., 2008	Mental health professional trainees at start of training	27	3.56	1.16	nr	$t = -5.94$, $p < .0001$***
	Mental health professional trainees at end of training	27	4.81	1.15	nr	$t = -1.42$, $p = .161$
Cologon et al., 2017	Therapists and therapist trainees	25	6.12	1.09	4 – 7.5	$t = 3.38$, $p < .001$***
Rizq & Target, 2010a	Counselling psychologists	12	4.29	2.54	0 – 8	$t = -1.21$, $p = .249$
Shmueli, 2003	Therapists (female)	11	5.13	0.60	nr	$t = -0.29$, $p = .776$
	Therapists (male)	6	4.33	0.67	nr	$t = -2.73$, $p = .023$*

Note. Samples are presented in size order, with the largest sample first. *SD* = standard deviation; nr = not reported.

[a] A two-tailed unpooled variance (Welch) t-test was used as sample sizes were unequal and equal variance was not assumed. [b] The normative distribution for comparison was from Fonagy et al. (1996): $n = 85$, $M = 5.2$, $SD = 1.5$.

* $p < .05$. ** $p < .01$. *** $p < .001$.

There were seven samples (combined $N = 239$) where the RF mean and standard deviation were reported. All these samples were of therapy/mental health professionals or trainees. Four samples were found to differ from the norm at the stringent $p < .001$ level. Three of these samples (the counselling student sample in Shmueli, 2003; Steinmair et al., 2021; Trowell et al., 2008) had lower mean RF levels than the non-clinical normative RF mean of 5.2 (Fonagy et al., 1996), though in Trowell et al.'s sample the mean level of RF was re-measured at the end of a 2-year training

programme and had risen by that time to a level that was statistically comparable to the norm. One sample (Cologon et al., 2017) had a mean RF level that was significantly higher at the $p < .001$ level than the norm. Looking across all the included samples, there was a lot of deviation from the non-clinical normative RF level. While this was not all in one direction, the samples with the lowest mean RF levels in the review were more different from the normative level than the samples with the highest RF levels in the review.

7.3.2 The Implications of Helping Professionals' Attachment States of Mind and RF for Professional Practice

This section considers the professional practice implications of helping professionals' attachment states of mind and RF levels (Review Question 2). Findings are reported from 22 studies conducted with 19 distinct helping professional samples. Five of the 24 samples included in the review did not examine any professional practice focused outcomes (Table E.1 in Appendix E.3 provides details of which) and thus were not considered further in relation to Review Question 2.

The relevant studies and findings are summarised in Table 7.4. For some of the studies, the *n* for analysis is smaller than the sample *n* for AAI data reported in Section 7.3.1 above. This is because some studies were not able to collect outcome data for every practitioner they collected AAI data from.

Table 7.4 *Details of Professional Practice Related Outcome Measures and Main Findings for Each Study*

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Cologon et al., 2017	Therapists and therapist trainees, Australia	25	RF (Fonagy et al., 1998).	1. Client reported outcomes.	Significant finding: Practitioners with higher RF had significantly better client outcomes than practitioners with lower RF.
Constantino & Olesh, 1999	Childcare providers, USA	31	Attachment categories (2-way autonomous and insecure) generated from Main et al. (2003) system.	1. Observer rated quality of professional caregiving behaviour. 2. Practitioner rated child aggression.	No significant findings.
Copeland et al., 2020	Child welfare professionals, USA	467	Attachment categories (3-way but not forced: U cases excluded) generated from Main et al. (2003) system.	1. Number of years' professional service in child welfare.	Significant finding: Dismissing practitioners were more likely to have more years of service, preoccupied practitioners were more likely to have fewer years of service.
Dozier et al., 1994	Mental health case managers, USA	18	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated from Kobak (1993) Q-set. *Client attachment also assessed via the AAI and examined for interactions.*	1. Researcher rated depth of intervention with clients. 2. Researcher rated attention to clients' dependency needs.	Some significant direct findings: More preoccupied practitioners intervened in greater depth and perceived greater dependency needs than more dismissing practitioners. Some significant interactions: Insecure practitioners intervened in greater depth and perceived greater dependency needs in preoccupied clients than dismissing clients.
Horppu & Ikonen-Varila, 2004	Kindergarten teacher students, Finland	72	Attachment categories (3-way forced) generated from Main et al. (2003) system.	1. Self-reported motives for entering kindergarten teacher education.	Significant finding: Autonomous students were the most certain about their career choice and were the most likely to express both child-centred and self-centred motives for entering the profession.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Jenkins, 2002	Physiotherapy students, UK	30 / 43	Attachment dimension (coherence of transcript) generated from Main et al. (2003) system.	1. Patient reported satisfaction with interactions. 2. Observer rated clinical skills competence.	No significant findings.
Petrowski et al., 2013	Therapists, Germany	22	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated using Waters et al. (2005) scale.	1. Client rated attachment to practitioner at discharge.	No significant findings for practitioner autonomous versus insecure states. Some significant findings for practitioner preoccupied versus dismissing states: Clients more likely to report preoccupied/merger attachment to more preoccupied practitioners, clients more likely to report avoidant/fearful attachment to more dismissing practitioners.
Petrowski et al., 2011	Therapists, Germany *Appears to be subset of Petrowski et al., 2013*	19	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated using Waters et al. (2005) scale. *Client attachment also assessed via the AAI and examined for interactions.*	1. Client rated therapeutic relationship satisfaction at discharge. 2. Client rated therapeutic outcome satisfaction at discharge.	No significant findings for practitioner autonomous versus insecure states. One interaction found between practitioner attachment and client attachment: Insecure clients treated by more dismissing practitioners rated relationship and outcome satisfaction higher than insecure clients treated by more preoccupied practitioners.
Petrowski et al., 2021	Therapists, Germany *Appears to be subset of Petrowski et al., 2013*	16	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated using Waters et al. (2005) scale.	1. Client rated attachment to practitioner at discharge.	No significant findings.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Rizq & Target, 2010a	Counselling psychologists, UK	12	Attachment categories (4-way) generated from Main et al. (2003) system and RF (Fonagy et al., 1998).	1. How practitioners describe using personal therapy in their clinical practice. 2. How practitioners describe clinical work and the feelings and process issues that arise.	Some noteworthy findings (not tested for statistical significance as qualitative): Lower RF/insecure practitioners emphasised procedural learning and/or questioned the value of personal therapy. Higher RF/autonomous practitioners used insights from how they had felt as a client. Lower RF/insecure practitioners discounted/distanced from strong feelings or became overwhelmed or paralysed by clients' in-session behaviour.
Schauenburg et al., 2010	Therapists and therapist trainees, Germany	31	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated using Waters et al. (2005) scale.	1. Client rated therapeutic alliance quality at discharge. 2. Client and practitioner rated client impairment at start and end of treatment.	No significant direct findings. Some interactions found between practitioner attachment and client pre-treatment impairment: More severely impaired clients had better alliance and outcomes with autonomous practitioners than insecure practitioners.
Dinger et al., 2009	Therapists and therapist trainees, Germany *Confirmed subset of sample in Schauenburg et al., 2010*	12	Attachment dimensions (autonomous-insecure and preoccupied-dismissing) generated using Waters et al. (2005) scale.	1. Client rated therapeutic alliance quality measured weekly during treatment.	No significant findings for practitioner autonomous versus insecure states. One significant finding for practitioner preoccupied versus dismissing states: More dismissing practitioners received higher overall alliance quality ratings than more preoccupied practitioners. One interaction found between practitioner attachment and client pre-treatment impairment: Alliance quality decreased over the course of therapy for more severely impaired clients paired with more preoccupied practitioners.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Schuengel et al., 2012	Caregivers to disabled people, Netherlands	61	Attachment categories (3-way forced) generated from Main et al. (2003) system.	1. Observer rated frequency of practitioner confirmation of client signals. 2. Observer rated proportion of client initiatives followed by practitioner response. 3. Observer rated affective mutuality in the practitioner-client interaction. *Rated twice before intervention coaching and then after each coaching session.*	Some significant findings: Pre-coaching, dismissing practitioners confirmed client signals at a lower rate than autonomous or preoccupied practitioners. These differences remained post-coaching, but with relative improvements for all classification groups. Increase in proportion of client initiatives responded to was moderated by attachment classification, with a post-coaching increase for dismissing and preoccupied practitioners but not for autonomous practitioners. No attachment related findings for affective mutuality: no differences pre-coaching and no differences post-coaching, but with improvements for all.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Shmueli, 2003	Clinical psychology trainees, and same individuals once in practice as clinical psychologists, UK	40 / 31	Attachment categories (2-way autonomous and insecure) generated from Main et al. (2003) system and RF (Fonagy et al., 1998).	1. Observer rated success in different training placements and overall. 2. Trainee beliefs regarding how a good therapist behaves. 3. Practitioner work orientation. 4. Practitioner reported level of difficulty in work. 5. Practitioner reported level of reward in work. *1-2 measured during training, 3-5 measured 6 years into practice.*	Many nonsignificant findings but also some significant findings: Autonomous trainees were rated as being able to formulate their Adult Mental Health placement cases significantly better, but not their Child or Learning Disability placement cases. Higher RF was correlated with higher supervisor rated assessment skills in some but not all placements, and with better supervisor rated use of supervision. Insecure trainees were more likely to believe a good therapist behaves in a manner in line with cognitive models. Autonomous trainees were not associated with any particular orientation. Autonomous practitioners reported a greater level of reward working with clients at all levels of disturbance.
Sibrava, 2009	Therapists, USA	4	Attachment categories (2-way autonomous and insecure) generated from Main et al. (2003) system.	1. Therapist rated therapeutic alliance quality. 2. Client rated therapeutic alliance quality. *Measured at end of sessions 2, 5, 10 and 14.*	No significant findings for therapist rated therapeutic alliance. Some significant findings for client rated therapeutic alliance: Following session 2, autonomous practitioners had lower client ratings of alliance than insecure practitioners. Over time, there was a greater positive change in client ratings of alliance with autonomous practitioners than insecure practitioners. Following session 14, autonomous practitioners had higher client ratings of alliance than insecure practitioners.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Slot & Schuengel, 2014	Child protection family guardians, Netherlands	27 / 19 / 24	Attachment categories (2-way autonomous and insecure) generated from Main et al. (2003) system.	1. Change in points of concern in children's files from the time a care plan is set up to 1 year of guardianship. 2. Achievement of goals set by the family guardians. 3. Likelihood of request for mandated out-of-home placement.	One significant finding: Family-related concerns decreased more if the practitioner was autonomous. This effect was only observed in supervisions lasting 9 months or longer.
Steinmair et al., 2021	Mental health professionals, Austria	39	RF (Fonagy et al., 1998).	1. Whether chose to train to deliver Mentalisation Based Therapy.	Significant finding: Practitioners who chose to train to deliver Mentalisation Based Therapy had significantly higher RF ratings in advance of undertaking the training than those who chose not to undertake the training.
Suess et al., 2015	Parenting intervention facilitators, Germany	18	RF (Fonagy et al., 1998).	1. Attachment security of the client family infants. *Measured at 12 and 24 months.*	No significant findings.
Talia et al., 2020	Therapists, Italy	50	Attachment categories (3-way forced) generated from Main et al. (2003) system.	1. Observer rated in-session practitioner communication about clients' internal states.	Significant findings: Autonomous practitioners are more likely to show intersubjective engagement and make self-state conjectures. Dismissing practitioners are more likely to be detaching. Preoccupied practitioners are more likely to be coercing.

Text	Professional group(s) and location	*N* for analysis	AAI measure(s) used analysis	Relevant outcome measure(s), and when measured if study longitudinal	Findings
Tyrrell et al., 1999	Mental health case managers, USA	21	Attachment dimension (preoccupied-dismissing) generated from a modified version of Kobak (1993) Q-set. *Client attachment also assessed via the AAI and examined for interactions.*	1. Client ratings of the client-practitioner alliance. 2. Client and practitioner ratings of client functioning.	No significant direct findings. Some interactions found between practitioner attachment and client attachment: More dismissing practitioners formed stronger alliances with more preoccupied clients and vice versa. Some measures of client functioning were rated higher where more dismissing practitioners worked with more preoccupied clients and vice versa.
Wittenborn, 2012	Therapist trainees, USA	7	Three attachment groupings (prototypical autonomous, autonomous with elements of preoccupation, dismissing) generated from Main et al. (2003) system.	1. Observer rated practitioner fidelity to Emotionally Focused Couple Therapy model. *Rated after a single simulated therapy session.*	Noteworthy finding (not tested for statistical significance as qualitative): The autonomous practitioners scored higher on therapy model fidelity, including working with emotion and attachment needs than the one dismissing practitioner.
Zegers et al., 2006	Caregivers to institutionalised youths, Netherlands.	28	Attachment categories (2-way autonomous and insecure) generated from Main et al. (2003) system. *Client attachment also assessed via the AAI and examined for interactions.*	1. Client perceived psychological availability of practitioner and reliance on practitioner. 2. Practitioner ratings of client's reliance on them and contact problems. *Measured at 3 and 10 months into the relationship.*	No significant direct findings or interactions at 3 months for availability or reliance. Some significant findings at 10 months: Client perceived psychological availability of practitioners increased for autonomous practitioners and decreased for insecure practitioners. Significant interaction at 3 and 10 months for combination of practitioner and client attachment on contact problems: Preoccupied clients perceived as more hostile by insecure practitioners, dismissing clients perceived as more hostile by autonomous practitioners.

Findings relating to possible professional implications were grouped into the following four aspects/themes:

- Practitioner perceptions of and behaviour towards specific clients.
- The interaction between practitioners and specific clients.
- Client outcomes.
- Practitioner thinking about and behaviour in practice.

Practitioner Perceptions Of and Behaviour Towards Specific Clients

Five studies/samples examined possible implications of practitioner attachment states of mind for practitioner perceptions of and/or behaviour towards specific clients. All but one of these studies reported significant findings (or noteworthy findings where qualitative). No studies in the review examined the possible implications of RF for this aspect of professional practice.

Four studies examined practitioner behaviour via observer-rated measures. In a study of 50 therapists, Talia et al. (2020) found differences in therapist in-session communication about clients' internal states, with autonomous practitioners more likely to show balanced attunement, dismissing practitioners most likely to avoid communicating about their clients' internal states, and preoccupied practitioners most likely to be coercive. Similarly, a qualitative study by Wittenborn (2012) with seven therapist trainees observed that autonomous trainees worked more with emotion and attachment needs than a dismissing trainee. This provides some support for Talia et al.'s finding but should be treated tentatively as a standalone finding due to observation being of a single simulated therapy session and due to the sample including just a single dismissing trainee and no preoccupied trainees. In a study of 61 caregivers to disabled people, Schuengel et al. (2012) found that dismissing practitioners confirmed client signals less frequently than autonomous and preoccupied practitioners but found no differences between practitioners based on attachment classification in terms of their level of responsiveness. Constantino and Olesh (1999) observed the professional caregiving behaviour of 31 child daycare providers, rating their behaviour on standard measures relating to play, promotion of development, interaction, and curriculum. They did not find any differences on these measures between professionals with autonomous versus insecure attachment states of mind.

These four studies were in very different professional contexts and observed different aspects of practitioner behaviour. The studies that observed behaviours clearly related to working with emotions (Talia et al., 2020; Wittenborn, 2012) found noteworthy differences in practitioner behaviour by attachment classification. The studies that observed behaviours less clearly related to working with emotions (Constantino & Olesh, 1999; Schuengel et al., 2012) found less or no significant differences in practitioner behaviour by attachment classification.

Only one study examined practitioners' perceptions of clients, and this study did so alongside examining the practitioners' behaviour towards those clients. Dozier et al. (1994) conducted monthly interviews over 5 months with 18 case managers, asking them about their interactions with specific mental health clients. Dozier et al. developed a coding system to measure the case managers' perception of the level of their clients' dependency needs and the case managers' depth of intervention with their clients. The study found that case managers who were more preoccupied perceived their clients to have greater dependency needs and intervened in greater depth than case managers who were more dismissing. Client attachment was also assessed in this study and an interaction between case manager and client attachment was also found: insecure case managers perceived more preoccupied clients to have greater dependency needs than more dismissing clients, and intervened in greater depth with more preoccupied clients than more dismissing clients. Dozier et al.'s study provides evidence for there being some attachment-related differences in practitioners' perceptions of clients, which could underpin some of the attachment-related differences in their behaviour towards clients.

It is important to note that the attachment measure used in Dozier et al.'s (1994) study, Kobak's (1993) Q-set, had the least alignment to the Main et al. (2003) classification system of any included in this review. Around half the Q-set items relate to aspects of the interviewee's attachment experiences rather than aspects of their attachment state of mind, whereas in the Main et al. system it is only attachment state of mind that is critical for classification. Furthermore, as the Q-set produces orthogonal dimensional data (autonomous-insecure and dismissing-preoccupied), a person assessed as 'more dismissing' or 'more preoccupied' may still be autonomous on the other dimension, which would lead solely to autonomous classification placement in the Main et al. system. Thus, practitioners and clients described as more dismissing or more preoccupied in Dozier et al.'s study cannot be assumed to be equivalent to

practitioners described as having a dismissing or preoccupied classification in studies using the more common Main et al. system.

The Interaction Between Practitioners and Specific Clients

Possible implications of practitioner attachment states of mind for the nature and quality of the interaction/alliance between practitioners and specific clients was examined in 10 studies comprising seven distinct samples. No studies in the review examined the possible implications of RF for this aspect of professional practice.

Seven of the studies, comprising four distinct samples, were with therapists or mental health case managers and examined attachment-related differences in the quality of the therapeutic alliance and/or the clients' attachment to the therapist. Petrowski et al. (2011, 2013, 2021) reported on three studies conducted with an overlapping sample of therapists. In analysis, orthogonal dimensions of autonomous-insecure and preoccupied-dismissing, generated via the Waters et al. (2005) system, were used. In Petrowski et al. (2013) a significant difference in client-rated attachment to the therapist was found based on whether therapists (n = 22) were more preoccupied or more dismissing. More dismissing therapists were found to be more likely to have clients who reported having an avoidant/fearful attachment to them, and more preoccupied therapists were more likely to have clients who reported having a preoccupied/merger attachment to them. However, in Petrowski et al. (2021) no differences were found in client-rated attachment to the therapist based on whether therapists (n = 16) were more preoccupied or more dismissing. In Petrowski et al.'s (2011) analysis of 19 of the therapists, no direct effects of therapist preoccupied-dismissing attachment were found on client-rated therapeutic relationship satisfaction at discharge, but one interaction between this and client attachment was found: insecure clients treated by more dismissing therapists rated therapeutic relationship satisfaction higher than insecure clients treated by more preoccupied therapists. None of these three studies found any significant differences based on whether therapists were more autonomous or more insecure.

Dinger et al. (2009) and Schauenburg et al. (2010) examined client-rated therapeutic alliance quality in a second overlapping sample of therapists. Like in Petrowski et al.'s (2011, 2013, 2021) studies, the Waters et al. (2005) dimensions of autonomous-insecure and preoccupied-dismissing attachment were used in the analysis. As in Petrowski et al.'s studies, Dinger et al. found no significant differences in their study

based on whether therapists (*n* = 12) were more autonomous or more insecure. Dinger et al. did however find differences based on therapist preoccupied-dismissing attachment, with client-rated therapeutic alliance quality rated lower overall for more preoccupied therapists. However, while 4 of the 12 therapists in Dinger et al.'s sample were classified in the Main et al. (2003) system as preoccupied, only one was classified as dismissing, and the remainder autonomous. Thus, Dinger et al.'s finding should not be misinterpreted as therapeutic alliance quality being higher for therapists *classified* as dismissing. In a sample of 31 therapists (which included the 12 in Dinger et al., 2009), Schauenburg et al. did not find any significant direct effects of therapist autonomous-insecure or preoccupied-dismissing attachment on therapeutic alliance, but did find an interaction with client pre-treatment impairment, with more severely impaired clients reporting a better therapeutic alliance with more autonomous therapists than more insecure therapists.

A review of these five studies together highlights substantial variation in their findings. This is especially notable considering the similarities between these studies: all were with therapists, some of the studies had overlapping samples, all measured therapist attachment using the same approach, and all had outcome measures related to the therapist-client relationship, rated by clients. What appear to be varied findings could in part reflect the use of autonomous-insecure and preoccupied-dismissing dimensions: depending on the attachment state of mind classification distribution in each sample, what is meant by 'more autonomous' or 'more dismissing' etc could vary. The small sample sizes could also have led to some null effects appearing significant and some real effects appearing non-significant. The variation may also indicate that effects of therapist attachment interact with many other factors and can be magnified or obscured by these myriad factors.

Findings from a further study with therapists adds additional weight to the proposal that effects of therapist attachment may interact with many other factors. Sibrava (2009) conducted a longitudinal study examining both therapist and client perspectives on therapeutic alliance quality over the course of treatment. Contrary to expectation, Sibrava found that autonomous therapists received lower client ratings of alliance than insecure therapists following the second session. However, over time there was a greater improvement in client ratings of alliance for autonomous therapists than insecure therapists and, following session 14, autonomous therapists received higher client ratings of alliance than insecure therapists. This study did not find any differences in therapist ratings of alliance, and the findings should be treated as exploratory due to

the study only involving four therapists. Nonetheless, the findings suggest that time is a factor that may moderate some practitioner attachment effects.

As reported above, Petrowski et al. (2011) found an interaction between therapist attachment and client attachment on client-rated alliance quality. An earlier study had tested for similar interactions in a sample of case managers and their adult mental health clients (Tyrrell et al., 1999). As in Petrowski et al.'s study, no direct effect of case manager preoccupied-dismissing attachment on client-rated alliance quality was found. An interaction was found by Tyrrell et al. however; alliance quality was rated higher where there was 'mismatch', i.e., where more preoccupied clients were treated by more dismissing case managers and where more dismissing clients were treated by more preoccupied case managers. Like in Petrowski et al. therefore, practitioner preoccupied-dismissing attachment was seen in Tyrrell et al. to interact with client attachment, but the client attachment dimension found to interact with this was not the same in these two studies. The difference could in part be due to the different practitioner-client relationship contexts in the studies: in Petrowski et al. the practitioners were providing therapeutic support, in Tyrrell et al. case management support. Differences in how attachment was measured and in the attachment profiles of each of these samples may also have contributed to these differences. Both Petrowski et al. and Tyrrell et al. used orthogonal dimensional measures of preoccupied-dismissing and autonomous-insecure attachment but used different methods to generate these dimensions. In Petrowski et al., Waters et al.'s (2005) system was used; in Tyrrell et al. a modified version of Kobak's (1993) Q-set was used. The modification involved removing the attachment experience items and just retaining the state of mind items, to try to make it more aligned with the Main et al. measure. However, the extent to which the modified Q-set and the Waters' dimensions are comparable is unknown. It is also of note that, in Tyrrell et al., 90% of the case managers were autonomous. As a result, the more dismissing and more preoccupied case managers in their study would still mainly be classified as autonomous in the Main et al. (2003) three-way forced classification system. A true mismatch in practitioner-client insecure attachment classifications may not have generated the same findings. The Petrowski et al. paper did not report any of the therapists' attachment data and thus it was not possible to ascertain whether the more dismissing therapists in this study were likely to be predominantly autonomous or dismissing in the three-way forced classification system.

Three studies/samples examined practitioner-client interactions outside of therapeutic/ mental health settings. Zegers et al. (2006) examined the possible influence of attachment states of mind on the relationship between institutionalised youths and their 28 professional caregivers in a longitudinal study. The study assessed both the professionals' and the youths' attachment states of mind and perceptions of the relationship. When measured three months into the relationship, neither the youths' perceptions of the psychological availability of their caregiver, or the youths' or the caregivers' perceptions of the youths' reliance on their caregiver, differed depending on whether the caregiver was autonomous or insecure. Yet when measured again 10 months into the relationship, youths' perceptions of the psychological availability of autonomous caregivers had increased, whilst youths' perceptions of the psychological availability of insecure caregivers had decreased. Like in Sibrava's (2009) study therefore, benefits of autonomous practitioner attachment for aspects of the practitioner-client relationship were only found later in the relationship. Zegers et al. also found an interaction between caregiver and youth attachment states of mind on caregiver ratings of hostile contact from youths at both three and 10 months. Insecure caregivers rated preoccupied youths as more hostile and autonomous caregivers rated dismissing youths as more hostile. As there were no independent observations of youth behaviour, it is uncertain whether specific combinations of caregiver-youth attachment were eliciting different levels of hostile behaviour in the interaction from youths, or whether it was solely the caregivers' perceptions of behaviour that differed. Overall however, the findings from this study suggest that some attachment-related differences in practitioner-client interactions may only emerge (or, alternatively, may only be noticeable by clients) after an extended period of working together, but that others may be present from early in the relationship.

The other two studies examining practitioner-client interactions outside of therapeutic/mental health settings did not find any significant effects of practitioner attachment. Schuengel et al. (2012) found no attachment-related differences amongst 61 professional caregivers in terms of the degree to which they engaged in verbal and nonverbal exchange of emotions with their disabled clients. This finding does not align with the findings of Talia et al. (2020) reported in the previous section, suggesting that differences in professional setting and/or professional training may moderate the influence of practitioner attachment on communication of emotion. Jenkins (2002) did not find a significant correlation between the attachment coherence of 30 physiotherapy students and patient-reported satisfaction in relation to their interactions with the physiotherapy student. In this study the number of interactions between the

physiotherapy students and the patients rating interaction satisfaction were varied and very limited overall. It was not possible to determine whether the more limited amount of interaction and/or the physical rather than emotional focus of the interactions were the reason for the lack of a relationship between practitioner attachment and patient satisfaction with the interaction.

Client Outcomes

Seven studies/samples examined possible implications of practitioner attachment states of mind and/or RF for client outcomes. Only two of the seven studies found evidence of a main effect. Cologon et al. (2017) found that therapy client self-reported outcomes were better for therapists and therapist trainees with higher RF levels. The findings suggested that 71% of the variance in client outcomes was accounted for by therapist RF level. Cologon et al. found that symptom severity decreased significantly over time for clients of therapists with a RF score of 7 or higher, and decreased over time but to a lesser extent for clients of therapists with a RF score higher than 5 and lower than 7. In this study, therapists with a RF score of 5 or lower had a negligible effect on client symptoms. In a study of family guardians (child protective services officials who are supervising families where suspicions of adverse effects of inadequate parenting or child maltreatment exist), Slot and Schuengel (2014) found that points of family-related concern in child's file decreased more if the family guardian had an autonomous state of mind rather than an insecure state of mind. However, this effect was only seen in supervisions lasting nine months or longer, and the attachment state of mind of the family guardians was not found to have an effect on the other outcome measures in the study, which were whether family guardians indicated that goals had been met and whether there was an application for out-of-home placement.

Three studies examined differences in practitioner attachment states of mind for outcomes for adult clients in therapy/mental health services. These three studies (Petrowski et al., 2011; Schauenburg et al., 2010; Tyrrell et al., 1999) all also examined aspects of the therapeutic relationship, and so were all introduced in the previous section. None of these studies found evidence of significant main effects on outcomes, but all three found some interaction effects. Two found interaction effects between practitioners' and clients' attachment states of mind. Tyrrell et al.'s study of mental health case managers and their clients found that some measures of client functioning were rated higher where more dismissing therapists worked with more preoccupied clients and where more preoccupied therapists worked with more dismissing clients.

Petrowski et al. conducted a similar analysis with therapists and clients with anxiety and found that client self-reported outcome satisfaction at discharge was rated higher by insecure clients treated by more dismissing therapists than by insecure clients treated by more preoccupied therapists. A different client attachment dimension was found to interact with the practitioner preoccupied-dismissing dimension in each of these two studies therefore. A similar difference was seen between these two studies in relation to their therapeutic relationship outcome measures, and the potential reasons for the difference discussed in the previous section would apply here too. The third study (Schauenburg et al., 2010) found an interaction effect between differences in therapists on the autonomous-insecure dimension and the client's level of pre-treatment impairment. In this study more severely impaired clients had better outcomes with more autonomous therapists than with more insecure therapists. These three studies can thus be seen to have quite disparate findings. The variation lends further support to the earlier proposal that effects of therapist attachment appear to interact with many other factors.

Just two studies examined child behaviour outcomes, and neither reported significant findings. Suess et al. (2015) did not find a significant relationship between parenting intervention facilitators' RF levels and the attachment security of infants in the intervention families, assessed using the Strange Situation and Attachment Q-Sort. However, in this study, the outcome variable of attachment security was assessed during the intervention period but the predictor variable practitioner RF was assessed after the intervention was complete. The authors highlighted that facilitators were "constantly challenged to reflect" (p.130) and so their RF levels may have developed over the intervention period. The level of facilitator RF captured by the researchers may not therefore have been representative of the level the facilitators had when delivering the intervention, and this may have obscured the identification of a real effect if one existed. Constantino and Olesh (1999) did not find a significant relationship between child daycare providers' attachment state of mind (autonomous or insecure) and levels of aggressive behaviour in children they had looked after for at least six months. However, in this study, the professional caregivers whose attachment states of mind were known and being tested were not necessarily the children's current carers, and the attachment states of mind of other professional caregivers the children had (including sometimes their current main professional caregiver) were unknown. The substantial variation in how long and how recently the children had been cared for by the professional caregiver involved in the study may have obscured the identification of a real effect, if one existed.

Practitioner Thinking About and Behaviour in Practice

Six studies/samples examined possible implications of practitioner attachment states of mind and/or RF for a range of more overarching aspects of practitioner thinking about, and behaviour in, practice.

Four studies examined outcomes that relate to choices regarding practice-related training or employment. Horppu and Ikonen-Varila (2004) found significant attachment-related differences in self-reported motives for entering kindergarten teacher education in a sample of 72 trainees. They found that autonomous trainees were more certain about their career choice and more likely to express both child-focused and self-focused motives for entering the profession than dismissing or preoccupied trainees. In a study of 39 mental health professionals, Steinmair et al. (2021) found that therapists who took up the opportunity to train to deliver Mentalisation Based Therapy had higher RF levels in advance of the training than therapists who declined the opportunity to undertake training in this specific therapy. Copeland et al. (2020) found significant attachment-related differences in length of service in a sample of 467 child welfare professionals. Dismissing practitioners were found to have the most years of service and preoccupied practitioners the least. Whilst this finding may relate to practitioner choices, it is possible that it may have been caused by factors external to the practitioners, for example, potential changes in recruitment and selection over time due to changes in societal views on what is considered to constitute an 'suitable' employee. Shmueli (2003) found no attachment-related differences regarding which speciality or role 31 clinical psychologists were working in 6 years after training. It may be that the psychologists' attachment states of mind had no influence on their preferences for particular specialities or roles, but practical constraints on choices available may also have obscured any differences in preferences that did exist. When these same clinical psychologists had been asked during training for their views on how a 'good' therapist behaves, the insecure trainees had been found more likely to express a view that good therapists behave in a manner in line with cognitive approaches, whereas autonomous trainees were not found to be aligned to any particular approach. No attachment differences were found regarding which theoretical approach they went on to use in practice however. This may lend support for the proposal that practical constraints can limit the realisation of preferences, or it may be that further training and in-practice experience reduced the attachment-related differences in approach preferences seen at the outset. There was also attrition of nine participants between the initial

assessments when in clinical training and the assessments 6 years into practice, and this change in the sample may also have had an effect.

Two studies examined observer-rated trainee competence. In their sample of 40 clinical psychology trainees, Shmueli (2003) found that autonomous trainees were rated as being able to better formulate their Adult Mental Health placement cases than insecure trainees. However, in the Child and Learning Disability placements this difference was not observed. Similarly, higher RF correlated with higher observer-rated assessment skills in some but not all placements. Higher RF was also found related to better supervisor-rated use of supervision. In this study therefore, autonomous attachment and higher RF were found to be associated with some aspects of trainee competence but not others, suggesting complexity and nuance in the relationships. In Jenkins' (2002), the level of attachment coherence in 43 physiotherapy trainees was not found to be significantly correlated with observer-ratings of their clinical skills competence. The $r = .25$ correlation was in the expected direction however, and it is possible that the lack of statistical significance could have been due to the study being underpowered.

There was also some exploration of professionals' reports of their practice. In Shmueli's (2003) sample of 31 clinical psychologists who were 6 years into practice, autonomous psychologists reported a greater level of reward working with clients at all levels of difficulty than insecure psychologists. There were no attachment-related differences found regarding how difficult they found their work however. Rizq and Target (2010a), in a qualitative study of 12 counselling psychologists, found some differences in psychologists' descriptions of their clinical practice based on their attachment state of mind and RF level. With regards to how the psychologists described drawing on their mandated personal therapy in their clinical practice, the insecure / lower RF psychologists mainly emphasised procedural learning (modelling of particular behaviours and techniques) and/or questioned the value. In contrast, the autonomous / higher RF psychologists reported using insights from how they had felt as a client, and what had felt psychologically beneficial to them, to consider their clients' subtle and complex needs and what might be psychologically beneficial for their clients. Differences were also identified in how the practitioners described the feelings and process issues that arise in clinical work. Insecure / lower RF psychologists revealed how they would discount or distance themselves from strong feelings, or become overwhelmed or paralysed by clients' in-session behaviour. The psychologists with ordinary or marked RF discussed how working on their own problems in therapy

had helped them to tolerate and work with similar issues in their clients. Rizq and Target did not study clinical practice directly, so it is unknown the extent to which these different reports reflected differences in actual practitioner behaviour, versus differences in practitioner perceptions only.

7.4 Discussion

This was the first systematic review to examine attachment state of mind and RF level distributions for all helping professional groups. The review found that some samples were comparable to the non-clinical norms whilst others deviated. Deviations were not unidirectional however, with some samples having greater attachment autonomy or higher RF than norms and other samples having greater attachment insecurity or lower RF than norms. In relation to attachment state of mind, the deviations that were found were of a similar magnitude to deviations found between different non-clinical and not-at risk groups in Bakermans-Kranenburg and van IJzendoorn (2009)'s review, and did not mirror the much greater deviations reported between non-clinical and clinical groups in that same review. Thus, the current review did not find evidence to suggest that helping professionals in general have a specific attachment state of mind profile that differs from that of the general population. In relation to RF, the mean level in some of the helping professional samples in this review was more aligned to the mean level of 3.7 found in a clinical group by Fonagy et al. (1996) than to the mean level of 5.2 found in a non-clinical group in that same study. This was not consistent across the helping professional samples however, and the limited number and size of the included samples reporting RF levels means that this finding should be treated cautiously.

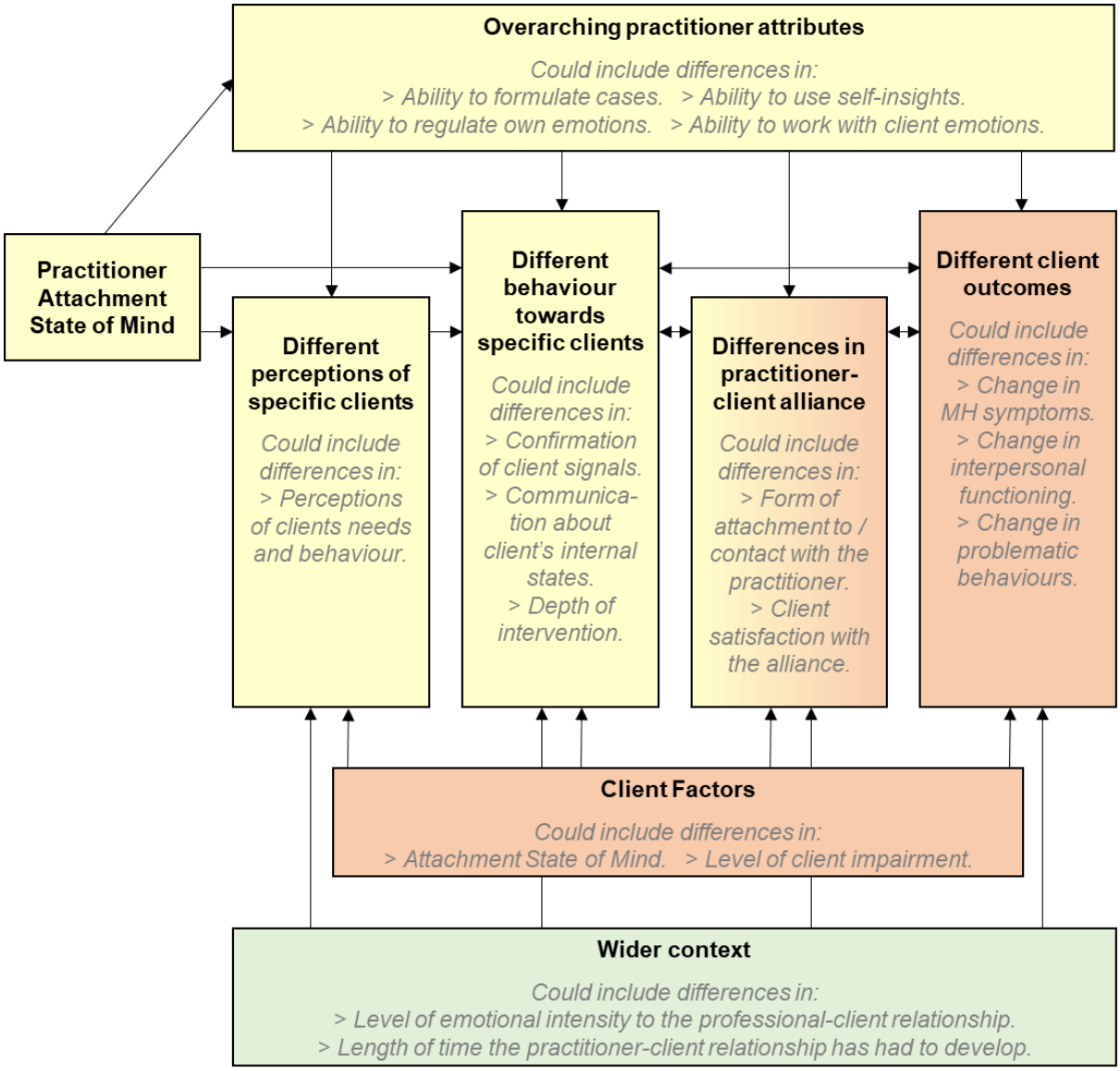
Like in the general population, there was variation in the attachment state of mind classifications of practitioners. All the samples reporting three-way forced attachment state of mind classification data contained practitioners with every classification, and all the samples reporting four-way data contained practitioners within the unresolved classification. There was also great variation in individual practitioner RF levels with some individual practitioners scoring as high as 8 and some as low as 0. This suggests that practice settings contain practitioners with diverse attachment states of mind and a wide range of RF levels.

With regards to implications for practice, the existence of significant findings across multiple studies supports the hypothesis that practitioners' attachment states of mind

and RF do have some implications for professional practice. The general trend from the significant findings was for more autonomous attachment states of mind and higher RF to be most beneficial. Yet the review also found a range of aspects of professional practice and individual settings/samples where practitioner attachment and/or RF did not lead to measurable differences. Some findings also imply that, at times, professionals' attachment states of mind have an effect only in interaction with other factors.

A theoretical model has been developed of the possible relationship between helping professionals' attachment states of mind and different aspects of their professional practice (see Figure 7.2). The model contains aspects of practice that may be associated with differences in attachment states of mind, and contextual and client factors that may affect these associations, based on the empirical findings from the studies in the review. The language of "could include" has been used in the model to indicate that a) many of the empirical findings are not yet replicated and so may not all be robust, and b) limited research has been conducted in this area and so additional aspects of practice related to attachment states of mind, and additional factors that may affect these relationships, could be identified. The relationships included in the model between the different elements are based on what could be feasible relationships, rather than solely representing the relationships that have been empirically investigated to date. This is a heuristic model, developed with the aim of supporting practice reflection and researcher decisions about elements and relationships to test in future studies. It is hoped that the model can be refined further as additional research findings are generated.

Figure 7.2 *Proposed Theoretical Model of the Relationship Between Professionals' Attachment States of Mind and Aspects of Their Professional Practice*



Whilst the model proposed for attachment states of mind is still very tentative and incomplete, the findings currently available in relation to the practice implications of RF are so limited that there has been no attempt to present a model of them. Furthermore, the high overlap found in non-helping-professional studies between attachment states of mind and RF (see Section 1.1.13) suggests that RF will likely not have a separate influence from attachment states of mind on practice, but an inter-related one.

7.4.1 Limitations

Whilst restricting this review only to studies that utilised the AAI reduced some variation in predictor variable measurement, a limitation of this review is that the AAI can still be coded in several ways. This limited the extent to which studies could be directly compared to one other. Another limitation, common to all systematic reviews, is that the limitations within the individual studies are carried forward into the systematic review. Whilst it can be considered a strength that the review includes unpublished material, an implication is that some of the research included has not been subject to the journal peer review process. There was significant variation in the quality of the unpublished and published studies contained in the review, including in terms of sample size, coding quality assurance, and reporting standards. As a narrative review, a particular risk is that tentative findings from smaller exploratory studies can appear as noteworthy as more robust findings. There has been an attempt to somewhat offset this issue by noting such matters when presenting the findings, but this is nonetheless a limitation.

7.4.2 Suggestions for Future Research

Synthesis of the findings from the studies included in this systematic review has highlighted many questions and gaps which would merit further research. The finding of Cologon et al.'s (2017) study, that there is a relationship between professionals' RF levels and clients' self-reported outcomes, indicates that this is an important practitioner variable to investigate. More research on the implications of professionals' RF levels for professional practice would be useful. RF measures the capacity to mentalise both others and the self, and each of these might have a distinct association with professional behaviour/effectiveness and in turn with outcomes. The capacity to mentalise others could potentially support professional effectiveness by enabling practitioners to better understand and respond to the underlying mental states of their clients (a 'direct effect'). The capacity to mentalise the self could potentially support professional effectiveness by enabling practitioners to better understand and regulate their own emotions and behaviour when interacting with clients (an 'indirect effect'). It would be useful for future research examining practitioner RF to separate out the measurement of RF in relation to the self (RF-S) and RF in relation to others (RF-O) (see Bizzi et al., 2019; Ensink et al., 2015; Suchman et al., 2010) and start to test if both are equally important for professional effectiveness.

A second area that is under-researched and would benefit from further exploration is the influence of practitioners' attachment states of mind on differences in their perceptions of clients. This has only been examined in one study to date (Dozier et al., 1994) and so replication and expansion studies would be beneficial, especially as Dozier et al. did not use a common measure of attachment.

A third area worthy of further investigation is the implications of different interactions between practitioners' attachment states of mind and clients' attachment states of mind for alliance and outcomes. Contradictory findings to date regarding which combinations are perceived by clients as more or less beneficial suggest that this is worthy of further investigation. It would be useful for studies on this to also include objective measures of alliance and outcomes alongside client reports, as client attachment states of mind are likely to not only be influencing the alliance and outcomes but also client perceptions of them.

A fourth suggestion for research relates to the finding that time can be a moderator of effects. Further exploration of this would be useful, through longitudinal studies but also cross-sectional studies examining understudied time points, such as initial contact.

Finally, with regards to professional settings, more of the studies to date have focused on therapists and therapeutic settings than any other settings. Whilst there is value in building a critical mass of findings that can be compared to one another, further studies with other professional groups and in other professional settings should also continue to be encouraged, as this supports the broader application of the findings.

The review also highlights some recommendations for AAI study design, in relation to measurement of attachment and sample size. Most of the studies used the Main et al. (2003) attachment states of mind system to code their data. However, many that used categorical data from this system in analysis were unable to utilise the four-way or even sometimes the three-way forced classifications due to small sample size, and instead collapsed the categories into a two-way autonomous-insecure dichotomy. Yet this review has found that this is not the only distinction of potential note: preoccupied-dismissing differences may also be important. Furthermore, the possible implications of unresolved states of mind on practice are all but unknown to date. Researchers should therefore seek to avoid small sample sizes. This would not only prevent the need for collapsing of categories and potential overlooking of important classification differences, but would also increase confidence in findings and reduce the likelihood of

effects not being found due to power issues. AAI studies are time-consuming to conduct and so increasing the number of cross-group research collaborations may help to enable more larger scale studies.

Further suggestions relate to practice in reporting practitioner research involving the AAI. It would be useful for all studies that initially use the Main et al. (2003) coding system to report the three-way forced and four-way classification data as standard, even if the data are converted to dimensions using Waters et al.'s (2005) system for analysis. Detail of the attachment classification profile of a sample can aid interpretation of findings in studies using dimensional data in analysis. It would also be helpful for all studies to clearly report second-coding proportions and IRR, and for the field to establish agreed benchmarks on acceptable levels of second coding and acceptable IRR rates. There was a substantial amount of variation in the studies regarding this.

7.4.3 Implications for Practice

As the findings suggest that a practitioner's attachment state of mind and RF capacity is likely to have an influence on some aspects of their professional practice, this suggests that there could be value in practitioners being supported to bring awareness to this (though this is an empirical question requiring further research). Providing spaces within practitioner training and within supervision for these reflections may be beneficial. The finding from Trowell et al. (2008) that RF capacity can be increased during practitioner training shows that this is possible.

Some of the individual papers in this review (e.g., Talia et al., 2020) mentioned the potential value of their findings for identifying ways to improve selection of helping professional trainees. As seen in Section 7.1, other authors (e.g., Caron et al., 2018) have made similar proposals. This review cautions against using the AAI to inform selection of trainees or staff. There are several reasons for this. Firstly, the review indicates that the extent to which attachment influences practice is still not fully known and is far from the only factor. Secondly, where the significant findings do hold, these are group level rather than individual level predictions. Whilst having a more autonomous attachment state of mind and/or higher RF appears to make some desirable practice-related behaviours and outcomes more likely, it neither guarantees this, nor precludes the possibility that other practitioners with insecure states of mind or lower RF might achieve these too. Thirdly, there are multiple practical challenges

related to assessing attachment states of mind via an AAI during recruitment and selection. Conducting, transcribing, and coding an AAI is extremely time consuming for organisations. There is also an ethical question about the appropriateness of requiring prospective trainees or employees to share that level of intimate personal information. Brief assessment of RF capacity in relation to a practice-related exercise, rather than in relation to the personal AAI may be more feasible and would also address some of the ethical and demand characteristic challenges. Talia et al.'s measure could provide a basis for this. However, for those outside of therapeutic practice, the relative importance of RF for practice as compared to other personal capacities is not known. Findings to date do not therefore support recommendation of widespread adoption of such a measure.

Chapter 8: Methodology

This chapter provides key detail of the methodology for this quantitative strand of research. Appendix A provides detail of the methodology as a whole.

8.1 Study Aims and Research Questions

The systematic review in Chapter 7 identified that practitioners' attachment states of mind, assessed via the Adult Attachment Interview (AAI), have been found to have some implications for their professional practice. However, the review found variation across professional contexts and also highlighted that there had been very little research on implications for child welfare practice specifically. This study therefore aimed to contribute knowledge to this under-researched area by examining the relationship between child and family practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns. Two aspects of the practitioners' thinking were chosen for investigation: 1) reflective functioning (RF) and 2) initial risk perceptions.

Research Question 1 was whether the attachment state of mind classification distribution of this sample of practitioners differed from the non-clinical normative distribution. The systematic review in Chapter 7 did not find evidence to suggest that helping professionals in general have an attachment state of mind distribution that differs from that of the general population. However, one of only two child welfare practitioner samples in the systematic review (Copeland et al., 2020) deviated significantly (at the $p < .0001$ level) from the non-clinical norm in the direction of greater insecurity.

Research Question 2 was whether the practitioners' attachment coherence of mind was associated with their level of RF when conducting an initial assessment of family case vignettes containing child welfare concerns. RF was introduced in Section 1.1.13 and is an operationalisation of mentalising: the capacity to understand behaviour in terms of underlying mental states. As seen in Section 7.3.2, Cologon et al. (2017) found that therapists' levels of RF, measured in the personal context of the AAI, predicted their clients' self-reported outcomes. Cologon et al.'s finding therefore provides some initial evidence for the importance of RF for practice. Yet while multiple studies have found a significant association between attachment state of mind

coherence and RF when both are measured in interviews about personal contexts and relationships (see Section 1.1.13), there is limited research examining the association between attachment states of mind and RF shown in non-personal contexts. Humfress et al. (2002) found an overall association of r = .35 between attachment state of mind coherence and capacity to mentalise in a non-personal context in a group of 12-13-year-old children. The applicability of this finding to adults and professional contexts is, however, unknown. Based on the previous findings showing a relationship between attachment coherence and RF in the AAI (Crugnola et al., 2018; Fonagy et al., 1998; Jessee et al., 2016; Levy et al., 2006; Maxwell et al., 2017; Talia et al., 2019b), it was predicted that greater attachment coherence would be associated with greater levels of RF when discussing family case vignettes.

Research Question 3 was whether the practitioners' attachment state of mind classifications were associated with differences in their perception of risk within family case vignettes containing child welfare concerns. Initial risk perceptions were chosen for investigation as understanding factors that do and do not influence variability in risk perceptions is of practical concern for child welfare practice. The possible role of attachment state of mind in practice-related risk perceptions has not been directly investigated previously, but there are findings from a prior study with practitioners that suggest this is worth exploring. Howard et al. (2017) found that child welfare practitioners with a dismissing attachment state of mind self-reported significantly fewer adverse childhood experiences than an independent rater reviewing their AAI transcript assessed them as having experienced. Practitioners with a preoccupied attachment state of mind in turn self-reported significantly more adverse childhood experiences than an independent rater assessed them as having experienced. Howard et al. posited that this could potentially generalise to an under/over identification of adversity experienced by others, including clients in practice contexts, though this was not investigated directly. Based on the findings of Howard et al., it was predicted that practitioners with a preoccupied attachment state of mind would provide the highest risk ratings for family case vignettes and practitioners with a dismissing attachment state of mind would provide the lowest risk ratings for the same family case vignettes.

8.2 Participants

Participants were 61 child and family practitioners from three professions: social work (n = 23), clinical psychology (n = 21) and general practice (n = 17). These professions

were chosen because child welfare considerations are an important part of their roles. More than one profession was included to allow for possible profession-related differences to be explored and recommendations to be generated that are applicable to more than one profession.

The practitioners all worked in England. The social workers were recruited from two local authorities. The majority were based in either initial assessment (*n* = 9) or longer-term safeguarding (*n* = 8), the remainder in other child and family focused teams. The clinical psychologists were recruited from two NHS Foundation Trusts. The majority (*n* = 18) worked in Child and Adolescent Mental Health Services, the remainder in other child and adolescent focused teams. The general practitioners (GPs) were from 17 different GP practices. The GP practice locations varied from inner city (*n* = 4) to town (*n* = 4), semi-rural (*n* = 6), and rural (*n* = 3). As per the sampling eligibility criteria, all participants worked directly with children and families and had at least 1 year of professional practice experience. Further details of recruitment processes and permissions be found in Appendix A.1 and A.2, and the study recruitment materials can be found in Appendix D.

Table 8.1 *Descriptive Characteristics of the Participants (N = 61)*

	Professional group			Total
	Social workers	**Clinical psychologists**	**GPs**	
***n* (%)**	23 (38)	21 (34)	17 (28)	61 (100)
No. of years' experience				
***M* (*SD*)**	6.9 (5.6)	9.4 (7.3)	13.6 (8.9)	9.6 (7.6)
Range	1–22	1–26	2–31	1–31
Age				
***M* (*SD*)**	36.5 (9.4)	40.6 (7.4)	44.5 (8.6)	40.1 (9.0)
Range	25–58	31–56	31–57	25–58
Gender				
Female *n* (%)	21 (91)	15 (71)	9 (53)	45 (74)
Male *n* (%)	2 (9)	6 (29)	8 (47)	16 (26)

The participating social workers and clinical psychologists were predominantly female (see Table 8.1). This is broadly representative of the workforce gender split for these professions: according to data from the registering body for these professions (HCPC, 2018), 82% of registered social workers and 81% of registered practitioner

psychologists in England were female. For the participating GPs, there was a more even gender balance. This is also broadly representative of the workforce gender split for this profession: according to data from the General Medical Council (GMC, 2016), 52% of licensed GPs in England and Scotland were female.

8.3 Data Collection

8.3.1 Research Materials

Two vignettes ("short hypothetical accounts reflecting real-world situations"; Tremblay et al., 2022, p.1) were developed for this study. The vignettes (see Appendix B) were family cases containing child welfare concerns. The vignettes were designed to be an analogue to family cases the participants receive in their day-to-day practice, and the participants were asked to respond to them from their professional perspective. Vignettes were used, rather than observation of practice, as they allowed for standardisation of the cases being discussed and thus differences in participants' responses to them to be directly compared (Barter & Renold, 1999; Rapaport et al., 2008). Whilst vignettes can be presented in a range of formats (Tremblay et al., 2022), written narratives were chosen as the format of the vignettes used in this study as initial safeguarding referrals are often received in a written format. A series of semi-structured questions were developed to support detailed discussion of the vignettes (see Appendix C, Section B). Further detail on the content of, and approach to developing, the vignettes and associated questions can be found in Appendix A.3.

The AAI (George et al., 1985) is a well-established psychological measure (see Section 1.1.12). It is a semi-structured interview consisting of 20 questions plus a series of semi-structured follow-up probes which require the interviewee to describe and evaluate their early childhood experiences with their primary caregiver(s) and to evaluate the impact of these early attachment experiences upon them.

8.3.2 Procedure

Data collection was carried out from June 2017 to May 2019. Each participant took part in two 1:1 face-to-face interviews. First, each participant completed a practice-related interview, which involved discussion of the two family case vignettes. The vignettes were presented and discussed one at a time, and in the same order for all participants.

This interview also included discussion of some follow-on practice-related questions, which generated data that were drawn on in Part A of the thesis only. The average length of the practice-related interview was 62 minutes (*SD* = 17.8). On a separate occasion, each participant completed the AAI (George et al., 1985). The average length of the AAI was 79 minutes (*SD* = 18.8). The length of gap between the two interviews was dictated by participant availability and preference, with four weeks the average. There was no requirement to standardise the gap between the two interviews as attachment state of mind classifications coded from AAI responses have been found to have high stability (e.g., over 2 months, Bakermans-Kranenburg & van IJzendoorn, 1993; over 3 months, Sagi et al., 1994; and over 21 months, Crowell et al., 2002).

8.4 Measures and Variables

In this study there were three variables of interest: 1) attachment state of mind, 2) practice-related RF, and 3) practice-related risk perceptions. The operationalisation and measurement of each of these variables is outlined below.

8.4.1 Attachment State of Mind

The AAIs were coded using Main et al.'s (2003) adult attachment scoring and classification system which assesses a person's 'attachment state of mind' (see Section 1.1.12). This system has been found to have good inter-rater reliability, stability, and discriminant validity (Bakermans-Kranenburg & van IJzendoorn, 1993; Crowell et al, 1996; Sagi et al., 1994).

The system first involves line by line coding of AAI transcripts in order to assign a rating of 1–9 to a series of inferred experience and attachment state of mind scales. The final scale assigned a score by the coder is 'coherence of mind', which is "the overall score providing the most accurate and final indication of the speaker's 'state of mind' with respect to attachment" (Main et al., 2003).

Each AAI is also assigned to one of three attachment state of mind classifications:

- Transcripts are classified as secure-autonomous if the interviewee is coherent and collaborative and acknowledges attachment-related experiences as influential whilst maintaining objectivity and balance when describing and evaluating relationships.

- Transcripts are classified as insecure-dismissing if the interviewee dismisses, devalues, or distances themselves from attachment-related experiences. This may be done through the provision of positive or normalising descriptions of parents which are unsupported or contradicted, using insistence of a lack of memory to avoid answering questions, and/or derogating attachment figures or relationships.
- Transcripts are classified as insecure-preoccupied if the interviewee appears angrily or passively preoccupied with early and/or current relationships with attachment figures and unable to evaluate them in a clear and balanced way.

The classifications and scale scores are both generated as part of the same coding process and are “inherently connected and intertwined” (van IJzendoorn & Bakermans-Kranenburg, 2014, p.162).

If no overriding global attachment state of mind (autonomous, dismissing, or preoccupied) is apparent across the AAI, the interview can be assigned as ‘cannot classify’. Cannot classify cases are rare outside of high-risk samples, and no interviews were cannot classify in the current sample. Transcripts are also considered for classification as unresolved/disorganised with respect to loss and/or abuse if lapses in reasoning or discourse are shown when discussing loss and/or abuse experiences. AAIs assigned this classification are also assigned an ‘alternative’ secondary classification of autonomous, dismissing, or preoccupied to reflect the global attachment state of mind observed in the interview. Thus, the classification system produces both a four-way categorisation of interviews (autonomous, dismissing, preoccupied, and unresolved) and a three-way ‘forced’ categorisation of AAIs (autonomous, dismissing, and preoccupied) with cases that are unresolved placed into whichever of the three global attachment state of mind categories was also assigned to the interview.

The AAI coding was carried out by Samantha Reisz (S.R.), who was blind to study hypotheses, vignette responses, and RF scores. S.R. is a trained and reliable AAI coder. I second coded all 17 AAIs conducted with GPs (28% of the data). I am also a trained and reliable AAI coder. The GP AAIs were chosen as the second coding sample as I had not conducted the AAIs or the practice-related interviews with the GPs. Therefore, whilst I was not blind to the study hypotheses, I was able to code the GP AAIs prior to seeing and becoming familiar with their vignette responses. I coded the GP AAIs blind to S.R.’s coding of them, and prior to receiving the RF coding scores for their case responses. S.R. and I had 88% agreement (15/17) whether we considered a

three-way forced categorisation (autonomous, dismissing, and preoccupied) or a four-way categorisation of the interviews (autonomous, dismissing, preoccupied, and unresolved). With respect to the two AAIs where we differed, the coding and classifications assigned by S.R. were retained for consistency.

8.4.2 Practice-Related RF

'Practice-related RF' was measured by applying the established RF coding guidelines outlined by Fonagy et al. (1998) to the practitioners' discussion of the children and parents in the family case vignettes. RF was introduced in Section 1.1.13. RF scores can be assessed by trained coders with good inter-rater reliability and have reasonable stability (Taubner et al., 2013).

Coding RF using Fonagy et al.'s (1998) system first involves line by line coding of transcripts to identify statements that demonstrate characteristics of any of the defined categories of RF:

- Awareness of the nature of mental states, including awareness of the limitations in being able to fully understand others, and awareness of the defensive nature of some mental states.
- The explicit effort to tease out mental states underlying behaviour, including identification of plausible and specific links between events and mental states, and recognition of the role that mental states might have on behaviour.
- Recognising developmental aspects of mental states, including recognition of how parenting behaviour may be influenced by parents' thoughts and feelings about their own childhood experiences, and showing understanding of how mental states and perspectives develop and change with age.
- Recognising mental states in relation to the interviewer, including not assuming knowledge in the interviewer and clarifying points.

All answers to 'demand questions' (questions which explicitly request RF and require this to be answered fully) are assigned a rating. Answers to 'permit questions' (questions which allow for RF to be shown but do not necessarily require RF to be answered completely) are given a score only if definite RF or active disengagement is shown. The coder then assigns an overall, global rating to the interview by considering the interview as a whole against alternate scale point descriptions.

The coding manual makes a distinction between transcripts demonstrating negative to low RF (< 4) and those demonstrating moderate to high RF (> 4). A global rating of -1 (negative RF) is assigned when an interviewee either actively displays hostile rejection of requests for reflection, or provides unintegrated, bizarre, or inexplicable mental state attributions. The coding manual highlights that ratings of -1 or 0 are very rare in normative samples. A global rating of 1 (absent RF) is assigned when an interviewee either evades requests for reflection, or provides inaccurate, distorting, self-serving mental state attributions. A global rating of 3 (questionable or low RF) is assigned when an interviewee either shows a very simplistic, superficial, and potentially clichéd portrayal of mental states, or provides diffuse, unintegrated mental state attributions. A global rating of 5 (ordinary RF) is assigned when an interviewee either shows a definitive but limited capacity to make sense of self and others in terms of underlying mental states, or when they show an inconsistent level of understanding with higher RF displayed in some parts of the interview and lower RF shown in other parts. A rating of 5 is described in the coding manual as the most common rating in a high functioning normal sample, and this has been supported empirically with a mean score of 5.2 found in Fonagy et al.'s (1996) non-clinical sample. A global rating of 7 (marked RF) is assigned when a transcript displays several different types of RF and a good level of insight into underlying mental states. A global rating of 9 (full or exceptional RF) is assigned when the interviewee shows exceptional depth, sophistication, originality, and complexity in their thinking about mental states across the interview. The coding manual states that global ratings of 9 are rare.

The RF coding system was originally developed for application to AAIs, but there is precedence in applying the system to transcripts beyond the AAI. As well as Slade et al.'s (2004) adaptation of the RF system for coding of Parent Development Interviews (see Section 1.1.13), the RF system has also been used in research to code transcripts of interviews about the experience of pregnancy (Pajulo et al., 2012), interviews with teachers about challenging children (Emerson-Hoss, 2012), interviews with therapists (Diamond et al., 2003; Reading et al., 2019), therapy sessions (Hörz-Sagstetter et al., 2015; Karlsson & Kermott, 2006; Talia et al., 2019a), reflective supervision sessions (Lord, 2020), and written clinician responses to clinical vignettes about suicidal adolescent inpatients (Pierce, 2002). However, as it was novel to apply the RF system to discussion of family case vignettes, it was important to carefully consider and ensure the appropriateness of this new application of the RF system. I attended an RF coding institute prior to developing the vignettes and associated questions, to ensure that I had an in-depth understanding of how RF coding worked. This supported me to design the

vignettes and questions in a way that would allow the data to be meaningfully coded using the RF system. The questions developed for discussion of the vignettes were semi-structured, and deliberately included not only 'permit questions' but also 'demand questions', like in the AAI. The style and content of some questions also mirrored AAI questions, e.g., asking practitioners "Why do you think the mother [in the vignette] might be behaving as she is?" which paralleled the AAI question "Why do you think your parents behaved as they did during your childhood?" Taubner et al. (2013) had found no differences between mean RF scores for the different demand questions in the AAI which suggested that having a more limited number of demand questions was unlikely to significantly change the level of RF displayed.

The RF coding system conventions were followed when coding the family case vignette discussions, i.e., line by line coding, the different conventions for rating demand versus permit questions, and the assignment of passage and overall scores for each of the two family cases. The RF coding was carried out by Lindsey Myers (L.M.). L.M. is a trained and reliable coder of RF on the AAI. A subset of 18 participants' responses to both family case vignettes (30% of the data) were second coded by Howard Steele (H.S.). As one of the original developers and trainers of the RF coding system, H.S. is an expert coder. L.M. and H.S. were both blind to the study hypotheses, the profession and other background and demographic information about each participant, and the AAI data and classification for each participant. L.M. and H.S. had 89% agreement (16/18) within 0.5 points and came to a consensus for the two interviews where they differed by 1 point and 1.5. Having the coding overseen and partially second coded by one of the original developers of the RF coding system offered valued assurance regarding the appropriateness of using the original RF system to code levels of RF displayed in discussion of the family case vignettes.

8.4.3 Practice-Related Risk Perceptions

'Practice-related risk perceptions' were measured by asking participants to provide numerical risk ratings in relation to the family case vignettes. After reading each case vignette, the first question participants were asked was "What is your initial impression of the level of risk in this case from zero (no risk) to five (very high risk)?"

In relation to the first case vignette, participants typically gave a single risk rating. Where they gave a range (e.g., "2 or 3" or "3 to 4") rather than a single rating, the average (arithmetic mean) of the range provided was recorded as their answer (i.e., 2.5

and 3.5 respectively for the two examples just given). If the participant asked whether they should answer in relation to different types of risk (e.g., emotional and physical risk) the researcher would respond “if you want to break it down and provide more than one risk rating you can.” The average of the ratings provided was again recorded as their answer. In relation to the second case vignette, which described the children as currently in foster care, if the participant gave a rating for risk at home and a separate rating for risk in care, the average of both was recorded. If the participant gave a single risk rating, they were not asked to clarify which setting this was for or provide a second answer for the other setting. If the participant asked before giving an answer whether the question was being asked in relation to risk at home or in care, the researcher would respond “if you want to break it down and provide more than one risk rating you can.” Participants were therefore deliberately given the flexibility to choose what to focus on risk-wise, and how to answer these questions. The only constraint put on participants was that they provide a numerical rating. All participants answered these questions and provided one or more numerical risk ratings for each case vignette.

It was unknown whether the ambiguity around whether risk should be rated in relation to the care or home setting in the second case vignette would elicit meaningful or arbitrary differences in choice of focus. It was therefore decided a priori that, unless the risk ratings for the two cases had a significant ($p < .05$) correlation, the risk ratings for the first and second case vignettes would not be combined but would instead be analysed separately.

8.5 Data Analysis

8.5.1 Preliminary Analyses

For the variables coherence of mind and practice-related RF, the data were inspected visually and numerically to see if the scores were distributed approximately normally. The attachment coherence of mind data had some kurtosis (see Section 9.1.1), and this was taken into account in analysis decisions (see Section 8.5.3). The practice-related risk perception data were ordinal and so distribution of scores was not checked.

Possible confounds which might need to be controlled for in the main analyses were considered. Previous studies have confirmed that age (once a person has reached adulthood) and gender are not associated with attachment state of mind or RF

(Bakermans-Kranenburg & van IJzendoorn, 2009; Taubner et al., 2013). However, it was unknown whether number of years of professional experience would be associated with any of the variables of interest. In Copeland et al.'s (2020) sample of child welfare professionals, attachment state of mind classification was related to length of service. Number of years of professional experience could also feasibly be related to the practice-related variables of interest in the current study. Tests were therefore carried out to see whether number of years of professional experience was significantly correlated with any of the variables of interest (attachment coherence of mind, practice-related RF, and practice-related risk perceptions) and needed to be controlled for in the main analyses.

8.5.2 Attachment State of Mind Classifications Distribution

To examine the attachment state of mind classification distribution of this sample (Research Question 1), both the three-way forced and four-way classification distribution were examined, following the example of Bakermans-Kranenburg and van IJzendoorn (2009). The Chi-Square Goodness of Fit test was used to compare the distribution in this sample to the distribution in the combined sample of non-clinical and not-at-risk groups reported by Bakermans-Kranenburg and van IJzendoorn, which contained over 4,000 participants. Following Bakermans-Kranenburg and van IJzendoorn's example, standardised residuals for each classification were also presented.

8.5.3 The Relationship Between Attachment Coherence of Mind and Practice-Related RF

A bivariate correlational analysis was conducted to test the association between attachment coherence of mind and practice-related RF (Research Question 2). Although a positive relationship was predicted based on the previous findings, a two-tailed test was used rather than one-tailed following the recommendation of Field (2018). As the assumptions of normality were partly violated for the attachment coherence of mind data, and this could affect the significance value when using parametric statistics, correlations were tested using not only Pearson's correlation coefficient but also the non-parametric Spearman's correlation coefficient. Spearman's coefficient was chosen over Kendall's tau, as its results can be more readily compared to Pearson's coefficient (Field, 2018). Bootstrap confidence intervals were also

calculated for both correlational tests, as these are not affected by the distribution of scores (Field, 2018). Bias-corrected bootstrap confidence intervals (BCa CI) based on 1000 bootstrap samples and at a confidence interval level of 95% were generated. An a priori decision was taken to solely report the Pearson test findings if these and the Spearman test findings were equivalent, or to report both the Pearson and Spearman test findings if they were not equivalent. Both tests produced equivalent results (see SPSS output, Appendix F) and so only the Pearson correlations are reported in the findings chapter.

A set of exploratory post hoc analyses were conducted to test the association between attachment coherence of mind and practice-related RF for each of the three professional groups within the sample, i.e., for the social worker, clinical psychologist, and GP subsamples separately. Previous findings supported the generation of a priori hypotheses in relation to the whole sample, and there is precedence in previous AAI studies (e.g., Copeland et al., 2020) for treating a sample of practitioners containing more than one profession within it as a single group. Nonetheless, as there was potential for findings to differ at the professional group level, and as this would be of interest for practice, it was decided to explore this post hoc if there was a significant finding for the sample as a whole. Prior to testing the association between attachment coherence of mind and practice-related RF for each profession, potential differences in these variables by profession were tested. Both parametric (one-way ANOVA) and non-parametric (Kruskall-Wallis) independent-samples tests of difference were conducted and reported in relation to the variable attachment coherence of mind, due to the assumptions of normality being partly violated. Only parametric (one-way ANOVA) tests of difference were conducted in relation to practice-related RF as this variable was distributed normally. For the one-way ANOVAs, Welch's F correction was reported rather than testing for violations of the assumption of homogeneity of variance, and the Games-Howell post hoc test was used as the sample sizes were different and equal variance was not assumed.

8.5.4 Differences in Practice-Related Risk Perceptions by Attachment State of Mind Classification

As the hypothesis being tested in relation to Research Question 3 predicted differences in practice-related risk perceptions based on whether practitioners had an autonomous, dismissing, or preoccupied attachment state of mind, the three-way forced attachment state of mind classifications were used as a categorical variable. The independent-

samples Kruskall-Wallis test was used to test for differences in practice-related risk perceptions by attachment state of mind classification (Research Question 3). A non-parametric test was chosen as the risk perception data were ordinal. A two-tailed test was again used, following the guidance of Field (2018).

A set of exploratory post hoc analyses were conducted to test for possible differences in practice-related risk perceptions by practice-related RF level. In order to make this post hoc comparable to the test of differences in practice-related risk perceptions by attachment state of mind classification (Research Question 3), the practice-related RF scale data were transformed into classification data. Three RF groups were created: 'RF under 4', 'RF of 4', and 'RF of 5 or above'. These group cut-off points were chosen as the RF coding manual (Fonagy et al., 1998) makes a distinction between transcripts demonstrating negative to low RF (< 4) and those demonstrating moderate to high RF (> 4). The independent-samples Kruskall-Wallis test was used as the risk perception data were ordinal.

8.5.5 Reporting Practices

As is common in published psychological research, the probability level of $p < .05$ was used as the threshold for statistical significance. However, in recognition of critiques of significance testing and the arbitrariness of the .05 threshold (e.g., Wasserstein et al., 2019, see also van IJzendoorn & Bakermans-Kranenburg, 2021), test results were reported in full alongside *p*-values even where *p*-values were > .05, and conclusions were not drawn based solely on the presence or absence of conventional statistical significance, but also in relation to confidence intervals and effect sizes.

For interpreting effect sizes, Funder and Ozer's (2019) advice to use empirically derived benchmarks rather than Cohen's historic guidelines was followed. After reviewing meta-analytic correlations in social and personality psychology, Gignac and Szodorai (2016) proposed that correlations of $r = .10$ should be considered small, $r = .20$ typical and $r = .30$ relatively large. Schuengel et al. (2021) similarly proposed adjusted effect size benchmarks based on the attachment meta-analyses of $r = .10$ as small, $r = .20$ medium and $r = .30$ large. The Schuengel et al. benchmarks were therefore adopted.

Chapter 9: Findings

This chapter presents the research findings. Preliminary analyses are presented first. The exploratory post hoc analyses are presented after each of the relevant main analyses but are clearly separated and transparently identified as per the recommendations of Hollenbeck and Wright (2017).

Data were analysed with IBM SPSS Statistics (Version 28.0.1.1). The SPSS syntax and output can be found in Appendix F.

9.1 Preliminary Analyses

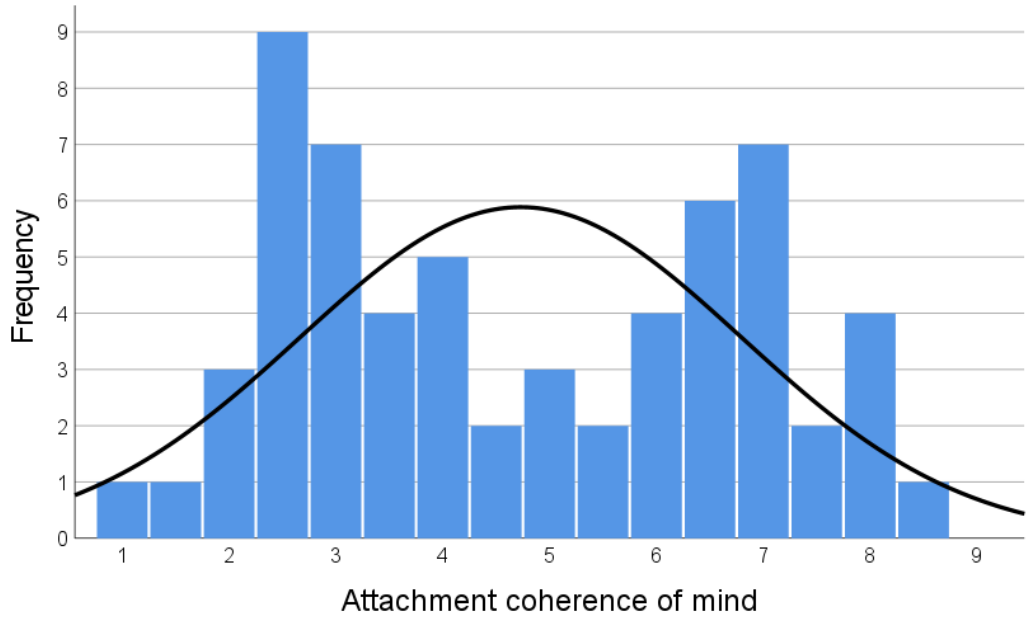
9.1.1 Data Inspection

Attachment Coherence of Mind

As expected, based on the nature of the Main et al. (2003) coding system, attachment coherence of mind strongly correlated with the dichotomised autonomous versus insecure attachment state of mind classifications (r_{pb} = .90, 95% BCa CI [.86, .94], p < .001). All participants who had been classified as having an autonomous attachment state of mind had also been assigned a coherence of mind score ≥ 5 during the coding process. All participants who had been classified as having an insecure (dismissing or preoccupied) attachment state of mind had also been assigned a coherence of mind score < 5.

In this sample (N = 61), attachment coherence of mind ranged from 1.0 to 8.5 (M = 4.73, SD = 2.07). The data were explored visually (see Figure 9.1) and numerically. The skewness and kurtosis values were converted to z-scores by dividing by their standard error. The z-score of skewness was 0.44. The z-score of kurtosis was -2.22. These values indicated no problems with skew but some deviance in kurtosis (significant at p < .05; Field, 2018) for attachment coherence of mind.

Figure 9.1 *Histogram Including Normal Curve for the Variable Attachment Coherence of Mind*

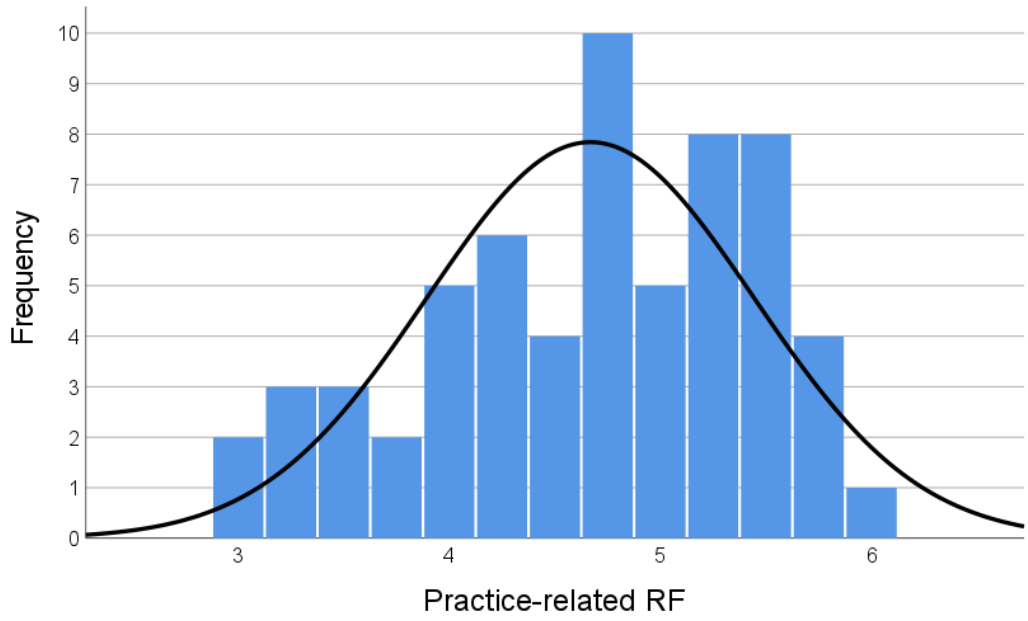


Practice-Related Reflective Functioning

The overall practice-related reflective functioning (RF) scores for the two case vignettes were strongly correlated (r = .70, 95% BCa CI [.53, .82], p < .001). An overall RF score ('practice-related RF') was therefore computed as the mean of both RF case scores.

In this sample (N = 61), practice-related RF ranged from 3.0 – 6.0 (M = 4.67, SD = 0.78). The data were explored visually (see Figure 9.2) and numerically. The z-score of skewness was -1.49. The z-score of kurtosis was -1.08. As neither of these z-scores were smaller than -1.96 or larger than 1.96, these values indicated no problems with skew or kurtosis (at p < .05; Field, 2018) for practice-related RF.

Figure 9.2 *Histogram Including Normal Curve for the Variable Practice-Related RF*



Practice-Related Risk Perceptions

The overall practice-related risk perception scores for the two case vignettes were uncorrelated (r_s = -.19, 95% BCa CI [-.44, .09], p = .145). The risk perception scores for case vignette 1 and case vignette 2 were therefore kept separate.

In this sample (N = 61), practice-related risk perceptions for case vignette 1 ranged from 2.5 – 5.0 (M = 3.77, SD = 0.71). Practice-related risk perceptions for case vignette 2 ranged from 1.0 – 5.0 (M = 4.09, SD = 1.17).

9.1.2 Check for Possible Confound From Number of Years of Professional Experience

There was no significant relationship between number of years of professional experience and any of the variables of interest (see Table 9.1). This background variable did not, therefore, need to be controlled for in the analyses.

Table 9.1 *Correlations Between Number of Years of Professional Experience and Each of the Variables of Interest*

Variable	*r*	95% BCa CI		*p*
		LL	*UL*	
Attachment coherence of mind	-.09 [a]	-.30	.16	.508
Practice-related RF	-.10 [a]	-.35	.15	.441
Practice-related risk perception case vignette 1	-.01 [b]	-.29	.28	.969
Practice-related risk perception case vignette 2	-.09 [b]	-.34	.16	.477

[a] Pearson correlation. [b] Spearman correlation.

9.2 Attachment State of Mind Classifications Distribution

Research Question 1 concerned the distribution of attachment state of mind classifications in this practitioner sample (N = 61), compared to the distribution in the combined sample of non-clinical and not-at-risk groups reported in Bakermans-Kranenburg and van IJzendoorn (2009).

Table 9.2 presents the three-way forced distribution as compared to the expected distribution derived from the combined sample. The three-way forced distribution of attachment state of mind classifications in the current sample of practitioners showed no significant deviation from the expected distribution (Goodness of fit χ^2 = 5.51, df = 2, N = 61, p = .063). Table 9.3 presents the four-way distribution as compared to the expected distribution derived from the combined sample. The four-way distribution of attachment state of mind classifications in the current sample of practitioners also showed no significant deviation from the expected distribution (Goodness of fit χ^2 = 2.40, df = 3, N = 61, p = .494).

Table 9.2 *Three-way Forced Distribution of Attachment State of Mind Classifications in This Practitioner Sample (N = 61) as Compared to the Non-Clinical Norm*

Attachment state of mind classification	Sample *n* (%)	Expected *n* (%)	Standardised residual
Autonomous	29 (48)	34 (56)	-0.91
Dismissing	17 (28)	18 (29)	-0.23
Preoccupied	15 (25)	9 (14)	2.15

Note. Expected *N* derived from the distribution in a combined sample of 4,392 non-clinical and not-at-risk groups (Bakermans-Kranenburg & van IJzendoorn, 2009, p.243). As the rounded percentages reported in the paper totalled 99%, the percentages taken to 2 decimal places were used, which were provided directly by Bakermans-Kranenburg and were 56.31% autonomous, 29.49% dismissing, and 14.21% preoccupied. When calculating *sr* and Goodness of fit, the expected *n*s to 2 decimal places were used.

Table 9.3 *Four-Way Distribution of Attachment State of Mind Classifications in This Practitioner Sample (N = 61) as Compared to the Non-Clinical Norm*

Attachment state of mind classification	Sample *n* (%)	Expected *n* (%)	Standardised residual
Autonomous	25 (41)	31 (50)	-1.02
Dismissing	17 (28)	15 (24)	0.57
Preoccupied	8 (13)	6 (9)	0.95
Unresolved	11 (18)	10 (16)	0.36

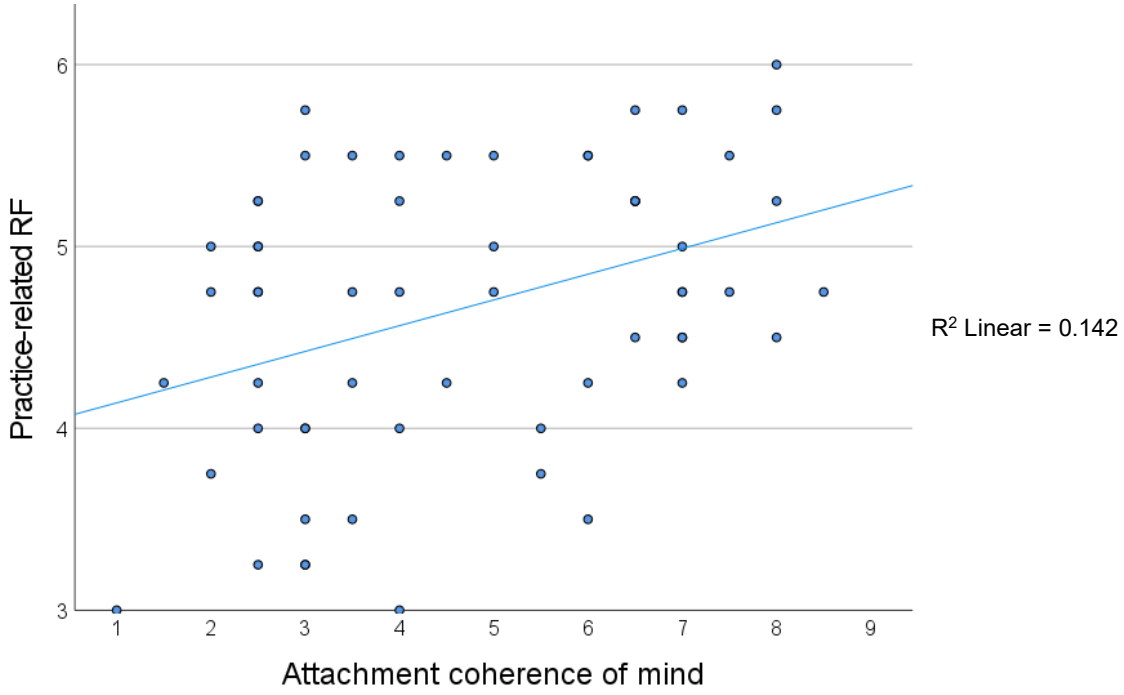
Note. Expected *N* derived from the distribution in a combined sample of 4,454 non-clinical and not-at-risk groups (Bakermans-Kranenburg & van IJzendoorn, 2009, p.243). As the rounded percentages reported in the paper totalled 99%, the percentages taken to 2 decimal places were used, which were provided directly by Bakermans-Kranenburg and were 50.20% autonomous, 24.25% dismissing, 9.38% preoccupied, and 16.17% unresolved. When calculating *sr* and Goodness of fit, the expected *n*s to 2 decimal places were used.

9.3 The Relationship Between Attachment Coherence of Mind and Practice-Related RF

9.3.1 Results for Research Question 2

Research Question 2 concerned the relationship between the practitioners' attachment coherence of mind and their practice-related RF. The relationship was first examined visually (see Figure 9.3).

Figure 9.3 *Scatterplot of Practice-Related RF by Attachment Coherence of Mind*



In this practitioner sample (N = 61), attachment coherence of mind was significantly correlated with practice-related RF, r = .38, 95% BCa CI [.18, .55], p = .003. The proportion of shared variance was 14%.

9.3.2 Exploratory Post Hoc: Exploring the Association at Profession Level

Attachment coherence of mind and practice-related RF were examined for the three professional groups within the overall sample (see Table 9.4).

Table 9.4 *Attachment Coherence of Mind and Practice-Related RF Mean, Standard Deviation, and Range by Professional Group*

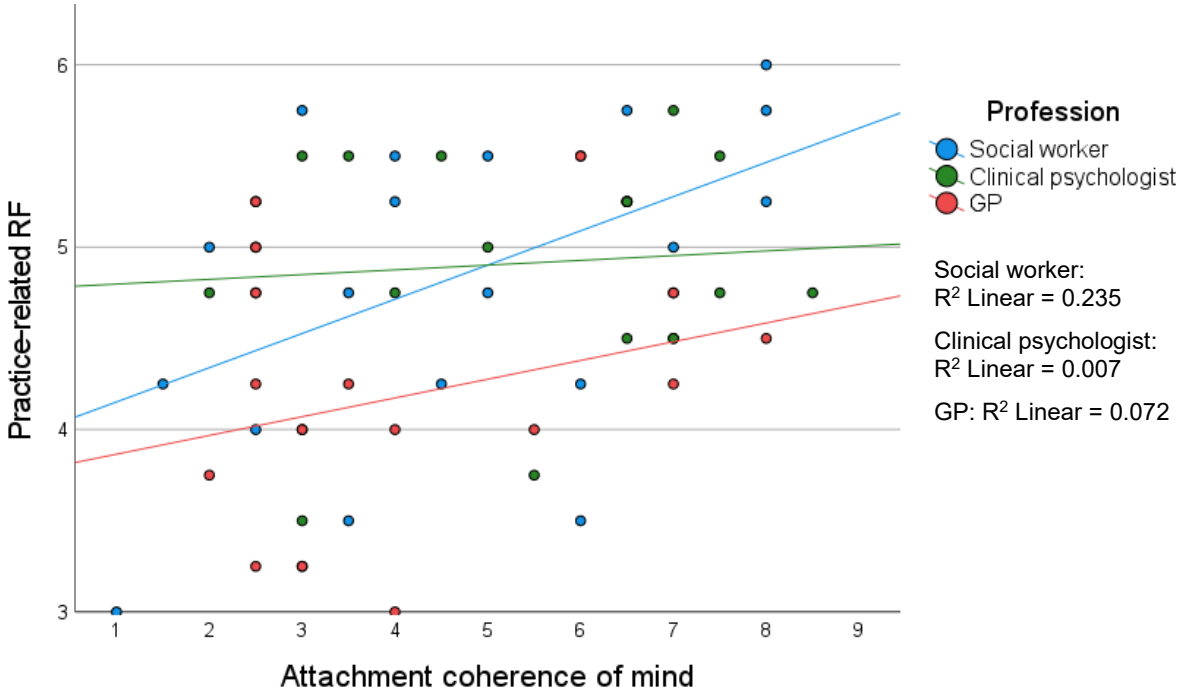
	Professional Group			Total
	Social workers	**Clinical psychologists**	**GPs**	
n (%)	23 (38)	21 (34)	17 (28)	61 (100)
Attachment coherence				
***M* (*SD*)**	4.5 (2.1)	5.6 (1.9)	4.0 (1.9)	4.7 (2.0)
Range	1.0–8.0	2.0–8.5	2.0–8.0	1.0–8.5
Practice-related RF				
***M* (*SD*)**	4.8 (0.8)	4.9 (0.6)	4.2 (0.7)	4.7 (0.8)
Range	3.0–6.0	3.5–5.8	3.0–5.5	3.0–6.0

Parametric testing showed a significant difference in attachment coherence of mind by professional group, $F(2, 37.62) = 3.29$, $p = .048$. The Games-Howell post hoc test showed that the general practitioners (GPs) had significantly lower attachment coherence of mind than the clinical psychologists (mean difference = -1.54, $p = .047$). Non-parametric testing indicated lower confidence in the significance of this difference, $H(2) = 5.79$, $p = .055$.

There was a significant difference in practice-related RF by professional group, $F(2, 36.38) = 5.92$, $p = .006$. The Games-Howell post hoc test showed that the GPs had significantly lower practice-related RF than both the social workers (mean difference = -.63, p = .041) and the clinical psychologists (mean difference = -.74, $p = .005$).

The relationship between attachment coherence of mind and practice-related RF for each of the professional groups was examined visually (see Figure 9.4).

Figure 9.4 *Scatterplot of Practice-Related RF by Attachment Coherence of Mind by Professional Group*



The association between attachment coherence of mind and practice-related RF was tested for each of the professional groups. Only the correlation coefficient for the social worker professional group was statistically significant and did not have a confidence interval that crossed zero (see Table 9.5).

Table 9.5 *Correlations Between Attachment Coherence of Mind and Practice-Related RF for Each Professional Group*

Professional group	*n*	*r*	95% BCa CI		*p*
			LL	*UL*	
Social workers	23	.48	.14	.72	.019*
Clinical psychologists	21	.09	-.38	.44	.710
GPs	17	.27	-.11	.62	.297

* $p < .05$.

However, there was no significant difference between the social worker and clinical psychologist correlation coefficients ($p = .18$), nor between the social worker and the GP correlation coefficients ($p = .48$), nor between the GP and clinical psychologist correlation coefficients ($p = .60$).

9.4 Differences in Practice-Related Risk Perceptions by Attachment State of Mind Classification

9.4.1 Results for Research Question 3

Research Question 3 concerned attachment state of mind differences in practice-related risk perceptions. In this sample (N = 61) there were no significant differences in practice-related risk perceptions for case vignette 1 by attachment state of mind classification (autonomous, dismissing, preoccupied) $H(2) = 1.60$, $p = .450$. There were also no significant differences in practice-related risk perceptions for case vignette 2 by attachment state of mind classification $H(2) = 0.60$, $p = .741$.

9.4.2 Exploratory Post Hoc: Exploring Differences in Practice-Related Risk Perceptions by Practice-Related RF Group

Three practice-related RF groups were created: 'RF under 4' (n = 10), 'RF of 4' (n = 24), and 'RF of 5 or above' (n = 26). In this sample (N = 61) there were no significant differences in practice-related risk perceptions for case vignette 1 by practice-related RF group $H(2) = 1.25$, $p = .536$. There were also no significant differences in practice-related risk perceptions for case vignette 2 by practice-related RF group $H(2) = 1.13$, $p = .569$.

Chapter 10: Discussion

This was the first study to examine the implications of child and family practitioners' attachment states of mind, assessed via the Adult Attachment Interview (AAI), for aspects of their thinking when conducting an initial assessment of family case vignettes containing child welfare concerns. Two aspects of the practitioners' thinking were investigated: reflective functioning (RF) and initial risk perceptions. The study found a significant positive relationship between the practitioners' attachment coherence of mind and the level of RF they displayed when discussing the case vignettes. The practitioners' attachment states of mind were not associated with differences in their initial perceptions of the overall level of risk in the cases. This chapter discusses the study findings in relation to the previous literature, considers the methodological limitations of the study, provides suggestions for future research, and considers implications of the findings for practice.

10.1 Discussion of Findings

10.1.1 Distribution of Attachment State of Mind Classifications

This is the first known sample of UK-based child and family practitioners in which attachment state of mind was examined. The sample had an attachment state of mind classification distribution that was comparable to the distribution in the combined sample of non-clinical and not-at-risk groups reported by Bakermans-Kranenburg and van IJzendoorn (2009). This finding is in line with the finding from the systematic review (Chapter 7) that the majority of helping professional samples have comparable attachment state of mind distributions to the non-clinical normative distribution (see Section 7.3.1). An exception was one of only two child welfare practitioner samples in the systematic review (Copeland et al., 2020), which deviated significantly (at the $p <$ .0001 level) from the normative distribution. Copeland et al.'s sample of 541 USA-based practitioners had a marked underrepresentation of the autonomous classification and a marked overrepresentation of the insecure classifications (dismissing and preoccupied). In an earlier paper (Howard et al., 2013) discussing a subset of the same sample, the authors posited that child welfare professionals may be more likely to have insecure attachment states of mind than the general population. Howard et al. did, however, note that their participants were all employed at a single organisation and so speculated that the distribution they had found could be representative of the

organisation rather than the profession. They called for further studies examining the attachment state of mind distribution of child welfare practitioners. The current study responded to this call. Considered alongside Slot and Schuengel's (2014) unpublished sample of Netherlands-based child protection family guardians (reviewed in Section 7.3.1), the current study adds support to the supposition that the greater level of attachment state of mind insecurity found in Copeland et al.'s (2020) sample is not representative of the child welfare profession in general.

10.1.2 Variation in Levels of Practice-Related RF Displayed

The overall practice-related RF level displayed by practitioners when discussing the family case vignettes ranged from 3 to 6. RF can range from -1 to 9. Fonagy et al. (1998) note that negative RF (-1) ratings are very rare in normal samples and transcripts achieving exceptional RF (9) ratings are rare. Thus, ratings at the very extremes of the RF scale were not anticipated in the current sample. However, the range was truncated further, with none of the practitioners in the current study discussing the family cases in a way that demonstrated either the lows of absent RF (0 – 1) or the highs of marked RF (7 – 8). There was more limited variance in RF levels in the current study than has been observed in previous studies with helping professionals. RF levels as low as 0 have been found in some previous studies (Rizq & Target, 2010a; Steinmair et al., 2021), and RF levels as high as 7.5 or 8 have been found in all previous helping professional samples where RF ranges were reported (Cologon et al., 2017; Klasen et al., 2019; Rizq & Target, 2010a; Steinmair et al., 2021). A possible explanation for this difference is that the previous studies assessed RF on the AAI whereas the current study assessed RF in relation to discussion of practice-related written family case vignettes.

The RF task in the AAI is to reflect on mental states underpinning your own behaviour in attachment relationships and experiences, and on the mental states underpinning the behaviour of your key caregivers. In the AAI the content is personal and emotionally charged, which for some people can elicit non-mentalising states that lead to very low RF scores. Nolte et al. (2013) found that an attachment-related stressor had a greater negative impact on mentalisation-related brain activity than a general stressor. However, enduring personal relationships also provide the opportunity to build, test, and refine complex models of the mental states of self and key others and the many interactions between the two. For those with a developed capacity for RF, the

focus of the AAI provides opportunity to discuss those complex models and understanding, leading to high RF scores.

In the current study the RF task was quite different. The practitioners were asked to respond from a professional perspective to written information about hypothetical families. Thus, what was being measured was the practitioners' capacity to mentalise in a professional context (rather than a personal, emotionally charged context), hypothesise about possible mental states based only on written information (and not observable cues), immediately mentalise others (rather than present an aggregated model built from multiple interactions), solely mentalise others (rather than others and self), and mentalise others who they did not know (rather than others with whom they had a personal, established relationship). The lack of personally and emotionally charged content may have enabled all participants to reach a minimum RF level of 3 (low RF). However, the limited information about the case family members and requirement to discuss the cases having only just seen them for the first time likely made it difficult for any participants to reach the higher levels of RF that some might have been able to reach when discussing their own personal attachment experiences and relationships.

Although the range of practice-related RF scores displayed by the professionals in the current study was quite limited, the variation found may not be inconsequential. The RF coding system (Fonagy et al., 1998) makes a distinction between two main levels of RF: negative to low versus average to high RF, with a score of 4 as borderline. Furthermore, Cologon et al. (2017) found differences in client outcomes depending on whether therapists had a RF level over 5 versus 5 and lower. The range of 3 – 6 seen in the current study therefore crosses these borders. However, the coding system and Cologon et al.'s study both considered RF levels assessed in the AAI. It is important to note that RF levels measured in the AAI are not necessarily equivalent to RF levels measured in relation to case vignettes, for the reasons discussed in the previous paragraphs. The practical relevance of the variation in RF seen in the current study is therefore currently unknown.

10.1.3 Attachment Coherence of Mind is Related to Practice-Related RF

In the current study, attachment coherence of mind was found to be positively associated with practice-related RF. The strength of the association found (r = .38)

exceeded Schuengel et al.'s (2021) benchmark for a large effect. The finding is aligned with previous findings of a positive association between attachment coherence and RF when both are measured in the AAI (Crugnola et al., 2018; Fonagy et al., 1998; Jessee et al., 2016; Levy et al., 2006; Maxwell et al., 2017; Talia et al., 2019b). The strength of the association in the current study is almost identical to that in Jessee et al.'s study (r = .39) with expectant parents. The current study finding extends the previous findings by demonstrating that this association can be found even when RF capacity is assessed in relation to professional responses to hypothetical families.

Prior research with early adolescents by Humfress et al. (2002) had found a positive association (r = .35) between attachment coherence of mind, measured via the Child Attachment Interview, and the capacity to mentalise hypothetical others in vignettes, measured using a coding system developed for that study. The current study finding supports the Humfress et al. finding, and extends it by showing that this association is also present for adults and when attachment coherence and reflective functioning are assessed using the gold standard measures.

Previous studies with helping professionals found that some attachment-related differences in practitioner-client interactions and client outcomes were observable only after an extended period (e.g., after 14 therapy sessions, Sibrava, 2009; after 9 months of supervision, Slot & Schuengel, 2014; after 10 months of interaction, Zegers et al., 2006). These findings left open questions regarding whether a practitioners' attachment state of mind might become an influencing factor only once a practitioner-client relationship has become established, or whether a practitioners' state of mind might be an influencing factor from the outset but in ways not captured by those studies. The current study provides evidence to suggest that attachment-related individual differences in RF can be observed from the very initial point of receiving written information about families. This suggests that a practitioners' attachment state of mind is associated with some differences in their practice-related thinking even before there is any relational interaction between them and a client. RF may be an important mechanism underlying the association found in previous studies between practitioners' attachment states of mind and practitioner-client interactions and client outcomes, though this is an empirical question and currently unknown.

When associations between attachment coherence of mind and practice-related RF were tested separately for the three professional groups, a strong association was found for the social workers, but not for the clinical psychologists or the GPs in this

study. This was an exploratory post hoc analysis on small subsamples. The finding should therefore be treated tentatively and as hypothesis-generating for future studies (van IJzendoorn & Bakermans-Kranenburg, 2021). A possible speculative explanation for the finding relates to differences in training and practice expectations. For social workers, training and practice involves exposure to a variety of frameworks and ideas: some psychologically focused, some sociologically focused, and some procedural. As a result, there may be more latitude for social workers (as compared to clinical psychologists or GPs) to gravitate to different models and ways of thinking, with some gravitating towards working in a more psychologically focused way, and others towards working in a predominantly procedural and non-psychological way, for example. The social worker subsample had the greatest range of practice-related RF scores of any of the three professional groups in this study, which lends some tentative support to this interpretation. If there is more flexibility to think about families from a range of perspectives, there may be more scope for personal factors, including attachment state of mind, to have an influence on what perspectives are chosen. For the GP subsample, there was a trend in the expected direction between attachment coherence of mind and practice-related RF, but it was not statistically significant. For GPs, it may be that an expectation to respond in practice with a predominantly medical model may somewhat overlay individual GPs personal tendencies and reduce the practice-related expression of any individual differences in RF capacity. The GPs in this sample had significantly lower practice-related RF than the other professional groups, which lends some tentative support to this interpretation. However, the GP subsample was also the smallest subsample in the study, and it may be that sample size obscured what could have been a significant association in a larger sample. For the clinical psychologist subsample, there was no correlation between attachment coherence of mind and practice-related RF. For clinical psychologists, it may be that a focus in professional training on thinking about mental states and behaviour, an expectation to think psychologically in practice, and/or the reflective space provided in clinical supervision, may typically lead to higher levels of practice-related RF. The clinical psychologists in this sample had the highest mean level and the smallest variation in observed practice-related RF of the professional groups in this study, which lends some tentative support to this interpretation.

10.1.4 Initial Perceptions of Risk Level May be Unaffected by Attachment State of Mind or Practice-Related RF

This study did not find that practitioners' attachment state of mind predicted differences in the initial risk rating provided for each family case. This was not due to a lack of variation in risk ratings. The practitioners were asked to quantify their initial impression of the level of risk in each case vignette on a scale from zero (no risk) to five (very high risk) and the ratings in relation to the first case ranged from 2.5 to 5, and for the second case from 1 to 5. Thus, there was variation in how risky the practitioners perceived the cases to be, but this variation was not found to be systematically related to the practitioners' attachment state of mind.

There is no known prior research which directly examines the relationship between attachment state of mind and practice-related risk perceptions. A relationship had been anticipated based on Howard et al.'s (2017) finding that dismissing child welfare practitioners self-reported having experienced fewer adverse childhood experiences and preoccupied practitioners self-reported having experienced more, compared with scores from an independent rater. Based on this finding, Howard et al. speculated that "insecurely attached individuals may struggle to identify what constitutes an adverse experience" (p.135) and raised concerns that this could lead some practitioners to fail to appropriately identify children experiencing adverse childhood experiences. The current study provides some initial evidence to suggest that this concern may be unfounded. In the current study, attachment state of mind differences in how practitioners perceived and/or reported the adversity they have personally experienced did not generalise to differences in how they perceived the level of risk experienced by the hypothetical family case members.

One possible reason for the null finding could be that being asked to assess written family cases from a professional perspective is not an attachment-priming situation for practitioners. Although the cases contained general attachment themes and so could have had the potential to activate the attachment system (as is the case with story stem assessments), the cases may not have contained information that resonated with professionals' own personal history. Thus, some of the strategies seen in the context of discussing personal adversity during the AAI might not be seen in the context of professional responses (e.g., see Crowell et al., 1996).

Another possibility is that attachment state of mind does affect initial perceptions of risk in practice-related cases, but in a way that the design of this study was unable to detect. The family case vignettes designed for use in this study contained both emotional and physical risks. The vignettes were designed such that the level of emotional risk within each case was not obviously greater or lesser than the level of physical risk in that same case. This was done to avoid providing cues steering practitioners towards a necessary focus on physical risk over emotional or vice versa, and thus to provide a context within which individual differences in RF capacity could be observed. However, a possible consequence of this was that any differences in perceptions of the emotional risk level as compared to the physical risk level in the cases could have been obscured. For example, if practitioners with a dismissing attachment state of mind did direct their attention away from emotional risks in the cases in this research, they may have instead directed their attention towards physical risks in the cases. In turn, if practitioners with a preoccupied attachment state of mind directed their attention towards emotional risks in the cases in this research, they may in turn have directed their attention away from physical risks in the cases. As the level of emotional and physical risk within the cases in this study was similar, this could have led to similar ratings of risk, even if very different elements of risk were feeding into the ratings.

There were also no measurable differences in initial risk ratings based on the practitioners' level of practice-related RF, which was examined in an exploratory post hoc analysis. This may be because RF has no relationship with risk perceptions. An alternative possibility could be that RF may affect risk perceptions in a way that could not be detected by the measures used in this study, by leading to differences in what particular risks are reflected on, rather than to a blanket higher or lower rating of risk. Greater consideration of the possible mental states underlying the behaviour of children and parents in family cases with child welfare concerns (i.e., greater practice-related RF) may lead to consideration of a greater range of potential risk and protective factors, for instance. This might not necessarily change the risk rating given (depending on the nature of the case itself) but may change the complexity of the factors that contribute to that rating. Differences in RF may also lead to differences in the extent to which an initial risk assessment is held as a fallible, tentative formulation versus a more confident judgement. For example, it may be that practitioners with higher RF more often revise their initial risk assessments in light of later information and insights than those with lower RF, and thus that the differences are not apparent at the outset but only after time.

10.2 Limitations

There are several limitations to this study. Whilst there was a clearly defined sample frame for the study, there was a need to rely on the organisations involved in the research to circulate study details and invitations to eligible practitioners. The numbers and details of eligible practitioners within the targeted organisations were unknown, as was whether all eligible practitioners received details of the study. This prevented a random sampling procedure and made it impossible to ascertain the participation rate or representativeness. Consequently, it is important to note that this may limit the generalisability of the findings (van IJzendoorn & Bakermans-Kranenburg, 2014). This is a common limitation of AAI studies: in a review of the first 200 AAI studies, Bakermans-Kranenburg and van IJzendoorn (2009) found that most AAI study samples are "convenience samples" and that "random selection from well-defined populations has almost never been conducted" (p.252).

A second limitation relates to sample size. AAI studies often have relatively small samples due to the time intensive nature of data collection, transcription, and coding. In Bakermans-Kranenburg and van IJzendoorn's (2009) review of all AAI studies using the Main et al. (2003) coding system published to that date, 54% of the studies involved 60 participants or less. In the systematic review (Chapter 7) of helping professional AAI studies using the Main et al. coding system, 63% of the studies involved less than 60 participants. Whilst the current study sample size of 61 was, therefore, not unusually small for an AAI study, the overall sample size translated into small attachment classification and profession-specific subsample sizes. This limited the analyses that could be run at subsample level and confidence in the profession-specific exploratory analysis findings. It also meant that some exploratory questions of theoretical and practical interest could not be explored. One example is the question of whether unresolved states of mind with regards to personal abuse experiences have implications for practitioners' thinking about practice cases where there is potential abuse. This was not possible to examine in the current study as only 13 of the participants in this sample met the specific AAI criteria for abuse experiences and, of these, only three were classified as having an unresolved state of mind with respect to their experiences of abuse.

A third limitation relates to the use of case vignettes as a proxy for initial practice referrals. Although the authenticity of the content of the case vignettes was widely

confirmed by the practitioners (see Appendix A.3), assessing how practitioners respond to case vignettes is not a direct measure of practice and may not mirror the way practitioners respond to initial written information they receive about families in their real day-to-day practice. Mentalising/RF capacity has been found to be affected by stress (Nolte et al., 2013), and the level of stress the practitioners felt when discussing the case vignettes might have differed from the level of stress they feel when thinking about real cases. The interview setting (in which practitioners had time to think about the cases without interruption and would know there were no real-world implications of their assessments) could have elicited less stress for some or all practitioners than is felt when they are thinking about comparable cases in their day-to-day practice. Alternatively, it may be that the interview setting (in which practitioners had to provide immediate answers about previously unseen cases to an unfamiliar person, knowing their answers were being recorded and would be studied in depth) could have elicited more stress than is felt in day-to-day practice. Another difference between the study task and real practice is that the participants were asked to respond to cases on their own, whereas in practice there may be the potential to confer about family cases with colleagues. Thus, in this study, RF was treated as an individual property severed from its supportive or hindering context in a team and organisation (see Chapter 9 in Duschinsky & Foster, 2020, for discussion of mentalising and the social system). However, whilst use of vignettes did not provide direct insights into practice, their use did enable direct comparison of different practitioners' responses to standardised case information (Barter & Renold, 1999; Rapaport et al., 2008). Use of vignettes also provided the opportunity to capture practitioners' thoughts on family cases in a way that is unlikely to be possible in real practice, where observation typically allows for capturing of behaviour but limited or no insight into the real-time thought processes underpinning those behaviours.

10.3 Suggestions for Future Research

An important avenue for future research is to examine possible child welfare practice implications of attachment-related individual differences in RF. The current study confirms that individual differences in practice-related RF are apparent and are related to attachment state of mind. Whether and how those differences in practice-related RF lead to differences in practice behaviour, interactions with families and/or family outcomes was outside the scope of this study, however, and would be a worthwhile next step for investigation. A linked question also still to be investigated regards the

optimal level of practice-related RF for child welfare assessment. Whilst higher RF may appear desirable, due to being found associated with greater caregiving sensitivity and child attachment security in personal contexts (see Section 1.1.13) and with improved client outcomes in therapeutic contexts (Cologon et al., 2017), this does not necessarily mean it will be desirable for child welfare assessment practice specifically. For example, it is possible that, in child welfare assessment, higher RF could be at the expense of consideration of important practical and sociological factors. Indeed, we (Duschinsky & Foster, 2021) have previously highlighted how the design of the RF scale treats discussion of possible sociological, cultural, and physical factors underpinning behaviour as intrinsically contrary to mentalising, rather than as potentially complementary considerations. Whilst there are some child welfare-related factors that may be best understood by considering underpinning mental states (i.e., through RF), there are also a range of practical factors (including physical neglect) and sociological factors (including poverty) that are important to consider in the context of questions about risk, wellbeing, and later outcomes. A focus on the sociological and/or physical at the expense of the psychological might not be helpful, but neither might a focus on the psychological at the expense of the sociological and/or physical. Family cases with child welfare concerns might be best understood via a combined bio-psycho-social perspective (Berzoff & Drisko, 2015; Bisman, 2001; Healy, 2016). It is possible, therefore, that the optimal level of practice-related RF for child welfare assessment practice might be lower than the optimal level for therapeutic practice. Further research is needed to examine the implications of different levels of practice-related RF for child welfare practice and outcomes.

Another recommendation is for research on how time interacts with levels of practice-related RF. It may be that the differences in RF observed in this study are the starting point for increasingly magnified differences in mentalisation of a family as they are worked with. Alternatively, it may be that the level of differences seen here are maintained, or even reduce, as more information is received about a family. A longitudinal study comparing practitioners' RF levels in relation to real incoming referrals, and tracking their RF levels in relation to those families over time, would therefore be informative. Additionally, further research examining professional training and practice contexts that may moderate the relationship between attachment coherence of mind and practice-related RF is also recommended. This would help to identify the extent to which the association can be generalised across different helping professions and in what contexts attachment states of mind can be expected to predict practice-related RF.

In the current study, neither attachment state of mind nor practice-related RF were found to be related to overall risk ratings for practice-related cases. As this was a new area of research, examining overall risk ratings provided a useful baseline. Risk perceptions are multifaceted however, and so it would be useful for future research to examine other aspects of practice-related risk perceptions that may be affected by attachment state of mind and/or practice-related RF. For example, a study with a similar design to the current one but in which some vignettes contain greater emotional than physical risk and others greater physical than emotional would be useful for enabling exploration of whether attachment state of mind is associated with greater or lesser attention on particular types of risk.

10.4 Implications for Practice

The findings have some potential implications for child welfare practice. They highlight that practitioners vary in the extent to which they consider the underlying mental states of children and their parents (i.e., their level of RF) when formulating initial thoughts about levels of risk, behaviour, and next steps in relation to family cases with welfare concerns. The findings show that this variation is found even amongst practitioners within the same profession and team/service and when considering the same family cases. This study did not examine whether a particular level of RF is more optimal than another for child welfare practice, and it does not propose that psychological considerations are superior to practical and sociological considerations. However, against the backdrop of ethical concerns regarding variability in child welfare practice (Keddell, 2023), the variation found in the extent to which underlying mental states are considered suggests there would be value in practitioners and services considering 1) the extent to which they habitually focus on thinking about the possible mental states of family members from the very first moment of receiving information about them, 2) whether the balance might beneficially be different at times, and 3) whether greater consistency in the extent to which underlying mental states are considered could be achieved across a team/service. Linked to this last point, it is worth noting that RF is a capacity that can be developed through training (e.g., Trowell et al., 2008) and so it would be feasible for organisations to support the staff within teams/services to achieve a greater level and consistency in use of RF. The ideas and resources on how to create a mentalising team, developed as part of the Adaptive Mentalisation Based Integrative Treatment approach (see https://manuals.annafreud.org/ambit/), may be of value to teams/services.

The findings also add to the body of evidence that personal factors are associated with some practice-related differences. The current study adds further support to previous findings that a practitioner's current perspective on their own past attachment experiences is a personal factor that can have an influence on aspects of practice. It would therefore be valuable for practitioners to reflect on the influence that this may be having on their professional practice. Creating and facilitating opportunities to reflect on this during professional training and in-practice supervision would be valuable, as practitioners with insecure attachment states of mind and lower RF capacity are less likely to naturally or constructively engage in such reflection individually.

In line with concerns regarding premature translation of research to practice (van IJzendoorn & Bakermans-Kranenburg, 2021) a few cautions are important to note in relation to the practice relevance of the findings. Firstly, while the relationship found between attachment coherence of mind and practice-related RF was strong for a relationship between any two psychological variables, attachment coherence of mind was found to account for 14% of the variance in practice-related RF level in this study. This suggests that, whilst personal attachment coherence is a significant factor, it is clearly far from the only factor at play. Furthermore, some practitioners had markedly lower or higher practice-related RF levels than would be expected from their level of attachment coherence. This suggests that personal attachment coherence does not guarantee or preclude the ability to think about practice-related families' underlying mental states. It is also important to emphasise again that this study did not assess whether there is an optimal level of RF for child welfare practice. Whilst one prior study produced findings that suggest higher RF can lead to better client outcomes (Cologon et al., 2017), another highlighted that higher RF does not always equate to better practice (Rizq & Target, 2010a).These studies were both in the context of therapeutic work which does not necessarily have the same practitioner capacity requirements as child welfare practice. Furthermore, in line with concerns about overconfident application of attachment findings to practice (discussed in Part A of this thesis) it is also important to be clear that the current findings offer no viable basis for informing assessment or screening of practitioners, for example in recruitment and selection. The potential for change in an individual's attachment coherence and capacity for RF, the only partial association between these two factors, and the as-yet unknown value of RF for outcomes in child welfare practice, are key reasons for this.

OVERALL CONCLUSIONS

Chapter 11: Overall Conclusions

This thesis considered the relevance of attachment theory to child welfare assessment practice. Whilst a range of supportive attachment-based interventions have been developed and shown to be effective (e.g. ABC: Dozier & Bernard, 2017; VIPP-SD: Juffer et al., 2017), the dominant focus in the UK child welfare system is on assessing families rather than supporting them (MacAlister, 2022). It was therefore useful to examine if and how attachment theory has relevance to child welfare practice outside of attachment-based interventions and in relation to the dominant practice of assessment. The specific part of assessment practice focused on in this research was initial assessment of family cases with child welfare concerns. This focus was chosen because important decisions can be made by practitioners at this point, such as whether to make or accept a safeguarding referral.

Two distinct lines of enquiry were followed. The first involved exploring if and how ideas about attachment were being used by practitioners. The second involved examining the implications of attachment states of mind for how practitioners think about cases. Thus, this thesis examined both the *application* of a psychological theory *by* practitioners and the *implications* of that same psychological theory *for* practitioners.

11.1 Contributions to Knowledge About Application of Attachment Theory by Social Workers

The first line of enquiry (reported in Part A of the thesis) considered how child and family social workers conceptualised attachment, how their conceptualisation compared to the published academic account, and if and how they used attachment theory and research in their child welfare assessment practice. These were important questions because a review of the existing literature (presented in Chapter 2) identified concerns raised by both attachment researchers (Forslund et al., 2022; Granqvist et al., 2017) and social work academics (White et al., 2020) regarding possible misunderstandings and misuses of attachment theory in child welfare practice. The literature review also identified that multiple, sometimes conflicting, recommendations have been made about if and how social workers should use attachment theory in child welfare assessment practice. However, empirical findings on social workers' actual understanding and use of attachment theory in child welfare assessment practice were very limited. Findings from recent survey research in Sweden (Hammarlund et al.,

2022) were interpreted by the study authors as indicating widespread, overconfident use of attachment classifications in child protection investigations. However, the extent to which these findings would also apply to the UK child protection context was uncertain. Furthermore, the nature of the survey method used left open the possibility of alternative interpretations of Hammarlund et al.'s findings.

The study reported in Part A of the thesis therefore contributed knowledge to an area in which there was little existing empirical research, by providing detailed insights into the role of ideas about attachment in the thinking of UK-based social workers when conducting an initial assessment of family cases with child welfare concerns. A qualitative exploratory design was used. Semi-structured interviews were conducted with 23 child and family social workers recruited from two English local authorities. Two family case vignettes developed specifically for this study were presented and discussed, followed by further questions exploring the social workers' views on attachment theory, its relevance for practice, and their reported use of it in their practice. Data were analysed thematically.

This study was the first to observe if and how attachment ideas were constructed and applied by social workers when thinking about family cases with child welfare concerns alongside gathering the social workers' own reports of their understanding and use of attachment theory. The study findings suggest that understanding and use of attachment theory in UK child welfare practice is considerably more varied than previously proposed. The findings provide an empirically grounded rebuttal of previous portrayals of the practice application of attachment theory which claim or imply uniformity (see, e.g., Forslund et al., 2022; White et al., 2020).

The study provided insights into how social workers conceptualise attachment. While early work on individual differences in children's attachment was found to be dominant in the social workers' conceptualisations of attachment theory, levels of understanding of this aspect of attachment theory varied. Most of the social workers were not aware of concepts and research from attachment theory focused on adults/parents including attachment states of mind and mentalising capacity and their influence on caregiving behaviour, though there were some noteworthy exceptions. There were some misunderstandings of attachment theory shown by some of the social workers but, overall, inaccurate knowledge was much less common than limited knowledge. Reassuringly, the social workers in this sample did not misunderstand disorganised attachment as indicative of maltreatment. This was a particular concern that had been

raised by attachment researchers (see, e.g., Forslund et al., 2022; Granqvist et al., 2017) in light of training and articles by UK social work academics (Shemmings, 2011; Wilkins, 2012) promoting disorganised attachment as a maltreatment indictor. The study also identified a distinction made by some of the social workers between attachment theory and attachment as a phenomenon. This had the potential to lead to communication issues and misunderstandings.

The study findings challenged depictions (e.g., by Forslund et al., 2022; Garrett, 2023; Smith et al., 2017; White et al., 2020) of attachment theory as a prominent, often dominant, perspective in social work practice. The findings also challenged depictions of social workers as being insufficiently critical of attachment theory and its practice applications. Most social workers in the current study were either ambivalent or very critical about the use of attachment classifications in practice, and there was no evidence of widespread overconfident use of attachment classifications in this sample. The study findings contrasted with Hammarlund et al.'s (2022) findings regarding Swedish child protection practice. This contrast may reflect between-country differences, but insights from the current study also provided an alternative interpretation of Hammarlund et al.'s finding (see Section 6.1.5).

The study findings imply that ideas from attachment theory have further potential to enhance child protection social workers' understanding of families. Not all aspects and applications of the theory were found to be equally valuable and an equally good fit with practice. Use of the theory in the service of exploration was identified as a particularly valuable way of using the theory in practice, whereas use of the theory in the service of labelling could lead to problems with misapplication and miscommunication. Implications for practice (see Section 6.4) included that it is important for social workers to reflect on what they are using attachment theory ideas to do and what language they are using when drawing on attachment theory ideas.

The findings also highlighted that it would be useful for a new attachment theory curriculum to be developed for social work pre-qualifying education, to help ensure that focus is on introducing social workers to accurate information about the most relevant concepts for practice from the theory (see Section 6.5). Work on this curriculum (Foster et al., forthcoming) is now underway, informed in part by the findings and insights gained from this study.

11.2 Contributions to Knowledge About Implications of Attachment Theory for Child and Family Practitioners

The second line of enquiry (reported in Part B of the thesis) examined the relationship between child and family practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns. This was important to examine because a systematic review (presented in Chapter 7) identified that practitioners' attachment states of mind have been found to have implications for professional practice, including practitioner-client relationships and client outcomes, but found that there had been very little research on implications for child welfare practice specifically. Yet the systematic review also found that one of only two prior child welfare practitioner samples (Copeland et al., 2020) deviated significantly from the non-clinical norm in the direction of greater insecurity. This led the authors (in Howard et al., 2013) to speculate that child welfare practitioners could have a different distribution of attachment states of mind to the general population, and this could have a negative impact on the families they work with.

The study reported in Part B of the thesis therefore contributed knowledge to an area in which there was little existing empirical research. A cross-sectional quantitative design was used. The study used the Adult Attachment Interview (AAI) to assess child and family practitioners' attachment states of mind, and measured their level of reflective functioning (RF) and their perceptions of risk in relation to two written family case vignettes containing child welfare concerns. A total of 61 UK-based practitioners participated: 23 social workers (the same sample as involved in the Part A research study), 21 clinical psychologists, and 17 general practitioners (GPs). The study tested whether the practitioners' attachment coherence of mind was associated with their level of RF when discussing the family case vignettes, and whether the practitioners' attachment state of mind classifications were associated with differences in their perception of risk within those same family cases.

This was the first known study of UK-based child and family practitioners in which attachment state of mind was examined. Of the 61 practitioners, 48% were classified as autonomous, 28% as dismissing and 25% as preoccupied. This distribution was statistically comparable to the non-clinical norm (Bakermans-Kranenburg & van IJzendoorn, 2009). The different distribution found in Copeland et al.'s (2020) USA-based child welfare practitioner sample was not seen in this sample, suggesting that

the distribution in Copeland et al. sample is not representative of the child welfare profession in general.

The study found that the practitioners' attachment coherence of mind was associated with their level of RF when conducting an initial assessment of family case vignettes containing child welfare concerns. The strength of the association found (r = .38) exceeded Schuengel et al.'s (2021) benchmark for a large effect. This finding supports previous findings of a positive association between attachment coherence and RF when both are measured in the AAI (Crugnola et al., 2018; Fonagy et al., 1998; Jessee et al., 2016; Levy et al., 2006; Maxwell et al., 2017; Talia et al., 2019b) but extends those findings by showing that this association is also present when RF is assessed in relation to hypothetical others being discussed from a professional perspective. The study also provided evidence that attachment-related individual differences in RF can be observed from the very initial point of receiving written information about families, before there is any relational interaction between the practitioner and clients. Practitioners' RF may be an important mechanism underlying the association found in previous studies between practitioners' attachment states of mind and practitioner-client interactions and client outcomes.

When examined at individual profession level however, there was a significant association between attachment coherence of mind and practice-related RF for the social workers only, and not for the clinical psychologists or GPs. This suggests that differences in training and/or professional contexts are important factors, and a relationship between attachment coherence of mind and practice-related RF cannot be assumed to generalise across all helping professions.

The study did not find that practitioners' attachment state of mind predicted differences in the initial risk rating provided for each family case. As this was a new area of research, examining overall risk ratings provided a useful baseline. Risk perceptions are multifaceted however, and so it would be useful for future research to examine other aspects of practice-related risk perceptions that may be affected by attachment state of mind and/or practice-related RF (see Section 10.3).

11.3 Concluding Remarks

Taken as a whole, the research suggests that attachment theory has considerable relevance to child welfare assessment practice. The theory can be applied by practitioners to inform their understanding of children and families. The theory can also help to explain some differences in the ways practitioners think about children and families.

The research highlights that it is useful to look beyond just the aspects of attachment theory focused on individual differences in children's attachment, despite these being the aspect focused on in many of the texts summarising attachment theory for child welfare practitioners. In the current research, social workers who were drawing on other aspects of attachment theory including parental attachment states of mind and intergenerational patterns, reported finding attachment theory particularly valuable to draw on in their practice with children and families (see Part A). Furthermore, in the current research, the AAI and construct of attachment states of mind proved relevant for predicting some differences in how practitioners thought about children and families in practice-related cases (see Part B).

The AAI – and the insights it has brought to understanding parents' attachment states of mind and mentalising capacity and their impact on caregiving behaviour – has "transformed attachment research and built new bridges between attachment theory and the domain of clinical work" (Steele & Steele, 2008a, p.3). Yet the insights generated by research using the AAI may be outside of the scope of awareness for many UK-based child and family practitioners with a role in child welfare assessment. Only a fifth of the practitioners in the current study had awareness of the AAI and related constructs and research findings. The findings of the current research suggest that increasing child welfare practitioners' awareness of the insights generated from AAI research would not only provide practitioners with useful knowledge they can draw on to help them to think about the families they work with, but would also help practitioners to reflect on the way their own attachment state of mind and mentalising capacity may be influencing the way they think about the families they work with.

APPENDICES

Appendix A: Complete Methodology

As explained in Chapter 1, this thesis contains two strands of research. Each focused on addressing one of the two research objectives, and each are presented within a separate part of the thesis. Research Objective 1 was explored through a qualitative strand of research and is explored in Part A of the thesis. Research Objective 2 was examined through a quantitative strand of research and is reported in Part B of the thesis.

There was some overlap, but also some divergence in which parts of the sample and collected interview data were drawn on for each strand of research, with the analysis approach being distinct for each.

Within parts A and B of the thesis, relevant detail from the research methodology is provided. The content in this appendix does therefore overlap with, and in part repeat, content in Chapters 3 and 8. However, those chapters contain a partial picture, as each only focuses on the elements of the methodology relevant to that strand. The goal of this appendix therefore is to provide a complete picture of the study design and set up, recruitment and sampling, the full data collection procedure, and data management. It is envisaged that this will be of value for the reader who wishes to obtain a more comprehensive understanding of how the research as a whole was developed and carried out. Data analysis is not covered in this appendix as this was entirely divergent for each strand of research and so is described in Chapters 3 and 8.

A.1 Study Context and Set-Up

Broader Study Context

In July 2015 I was offered and accepted employment as a Graduate Tutor at Northumbria University. The Graduate Tutor post comprised teaching responsibilities as well as the requirement to complete a part-time PhD. No explicit restrictions were placed on my choice of PhD research focus and aims, so I had considerable freedom when designing my PhD research programme. However, my decisions were influenced by three key contextual factors.

Firstly, the role I was in prior to accepting the Graduate Tutor post was a Research Assistant working with Professor Robbie Duschinsky (R.D.) on a Wellcome Trust Investigator Award (WT103343MA) project entitled 'Disorganised attachment in contemporary attachment theory'. R.D.'s project investigated developments in the field of attachment research, and implications of perspectives on these developments for child welfare and clinical practice. Whilst working directly on R.D.'s project I had started to develop an idea to undertake vignette-based research with child welfare practitioners, to explore their understanding and practice use of the concept of disorganised attachment and attachment theory more broadly. R.D. moved to Cambridge University, and I moved across to my new role at Northumbria University prior to this research being able to be carried out, but I was still keen to complete this research and R.D. was disposed to maintain a collaborative link. This research idea therefore became the initial basis of my PhD research plans, and I developed my PhD research plans with alignment to the aims of R.D.'s Wellcome Trust project in mind. R.D. was able to formalise the links to his project through a role as one of my PhD supervisors, organising Visiting Researcher status for me at Cambridge University, and involving me as a member of his research group. The medical focus of R.D.'s new department was a driver for the inclusion of general practitioners (GPs) as one of the specific professions recruited to the research.

Secondly, the base for the teaching side of my role was the Department of Social Work, Education and Community Wellbeing. I was principally developing and delivering teaching to undergraduate and postgraduate students on pre-registration social work programmes, with the focus of that teaching predominantly on psychological concepts and their significance for social work practice. Thinking about the relevance of attachment theory for social work practice was therefore a core consideration in the teaching I delivered, and this was both supported by my existing research interests and in turn developed my research interests further. The commitment to focus my research on child welfare practice and include social workers as one of the specific professions in the research was strengthened through my daily exposure to, and conversations with, social work qualified teaching colleagues and social work students.

Thirdly, my academic background and core discipline is psychology and so I applied to undertake my PhD in Psychology and was accepted as a PhD student by Professor of Developmental Psychology Greta Defeyter. I was also provided with the opportunity to undertake training and reliability in a psychological measure from attachment theory: the Adult Attachment Interview (AAI). Whilst the existing plans for the PhD involved

examination of a psychological theory, I aligned the PhD even more with my discipline by also utilising the AAI in the research, and by including clinical psychologists as one of the specific professions in the research.

Research Focus and Research Aims

The overarching aim of this research was to explore the relevance of attachment theory to child welfare assessment practice.

The overarching aim was underpinned by two research objectives:

- **Research Objective 1:** To explore the role of ideas about attachment in the thinking of social workers when conducting an initial assessment of family cases with child welfare concerns.
- **Research Objective 2:** To examine the relationship between practitioners' attachment states of mind and aspects of their thinking when conducting an initial assessment of family cases with child welfare concerns.

Research Methodology and Underpinning Assumptions

This research study used both qualitative and quantitative methods. The raw data collected from participants was qualitative. The first strand of research (that was conducted to answer Research Objective 1, reported in Part A) drew directly on a subset of the qualitative interview data, and analysed it using qualitative methods. The other strand of research (that was conducted to answer Research Objective 2, reported in Part B) transformed the qualitative interview data into quantitative categories and scale scores using standardised coding processes, and analysed it using quantitative methods.

This research study was underpinned by the assumptions of pragmatism (Cresswell & Cresswell, 2023). Methodological choices were not driven by a commitment to a particular set of epistemological and ontological assumptions. Instead, the focus was on the research aim and objectives, with research methods chosen to meet those.

Study Set-Up

This research study was originally designed and planned with the expectation that it would be conducted with participants from two professions: social work and clinical psychology. All work related to this 'core study' was completed by me, with oversight from my academic supervisors Professor Greta Defeyter at Northumbria University and Professor Robbie Duschinsky (R.D.) at Cambridge University. I designed the study methodology and protocols, developed the novel study materials (see Appendices B and C), obtained the relevant approvals, and recruited and carried out all the interviews with the participating social workers and clinical psychologists.

After I had designed the core study, the opportunity arose for additional data collection (with a third professional group: GPs) by the research team of my Cambridge University-based academic supervisor R.D. This did not lead to any reduction or other changes in the recruitment and data collection for the core study, but instead led to an increased total study sample size and inclusion of an additional profession in the sample. This 'supplementary study' utilised all the same materials and protocols as the core study. Obtaining ethical approval, recruitment, and data collection for this supplementary study were all overseen by Dr Sophie Reijman (S.R.) within R.D.'s team, in consultation with me. After completion of data collection in the supplementary study, the data (interview audio recordings and transcripts) were electronically transferred to my secure Northumbria account electronically using a secure transfer service provided by Cambridge University. I then combined this supplementary study data with my core study data prior to commencement of coding and analysis.

To facilitate the collaborative work on the supplementary study, and the transfer of the supplementary study data from Cambridge University to Northumbria University, I was provided with a Visiting Researcher Agreement in the Department of Public Health and Primary Care at Cambridge University from August 2016 until April 2020. A Knowledge Transfer Partnership Arrangement between the University of Northumbria and the University of Cambridge in relation to this research project was also drawn up and signed by all relevant parties in January 2018, prior to data transfer.

Study Approvals

I submitted the research proposal for the core study on 25th May 2016 to the Northumbria University Faculty of Health and Life Sciences Research Ethics

Committee for independent peer review (ID SUB082_Foster_250516). Ethical approval was granted on 7th June 2016. S.R. submitted the research proposal for the supplementary study on 12th October 2016 to the University of Cambridge Psychology Research Ethics Committee for independent peer review (ID PRE.2016.079). Ethical approval was granted on 25th January 2017.

Two of the three professional groups targeted for participation in this research (clinical psychologists and GPs) are part of the National Health Service (NHS). As NHS staff in England were to be recruited, Health Research Authority approval needed to be sought via the Integrated Research Application System (IRAS) Form process prior to research commencement. The research did not require review by a Research Ethics Committee within the UK Health Departments' Research Ethics Service in addition to University Research Ethics review, as no NHS patients or service users were to be involved in the research, only NHS staff.

I made an IRAS Form submission (ID 210817) for the core study on 27th February 2017 and received written confirmation of Health Research Authority Approval on 4th April 2017. On 12th May 2017, both NHS Foundation Trusts from which I wished to recruit clinical psychologists provided email confirmation of capacity and Letters of Access in relation to the research study. These emails and letters have not been enclosed, as details of the organisations involved in the research have been withheld to help ensure participant anonymity, but they can be produced for review by the examination team if required. S.R. made an IRAS Form submission (ID 218291) for the supplementary study on 10th October 2017 and written confirmation of Health Research Authority Approval was received on 16th October 2017. The supplementary study applied for, and was adopted into, the research portfolio of the National Institute for Health Research Clinical Research Network (ID 34810) which enabled access to local recruitment support.

As the other professional group targeted for participation in this research (social workers) were local authority children's services staff, the Association of Directors of Children's Services (ADCS) Research Group guidelines (2017) were consulted regarding the possible need for their approval of the research. It was clear from the guidelines that ADCS approval was not needed. The recruitment plan was to approach three English local authorities and the guidelines stated that the ADCS Research Group only needed to review the project if I planned to involve four or more children's services departments. The guidelines advised that departments should otherwise be

approached directly. I made a written approach to child and family service directors at three local authorities in late May/early June 2017. On 23rd May and 14th August 2017 I received email confirmation from two of the three approached local authorities of their willingness to be involved in the research. These emails have not been enclosed, as details of the organisations involved in the research have been withheld to help ensure participant anonymity, but they can be produced for review by the examination team if required. The other local authority expressed some initial interest in the research, but this did not ultimately translate into involvement. No further local authorities needed to be approached as the recruitment target was met by the two participating local authorities.

A.2 Participants

Sampling Eligibility Criteria

All practitioners working with children have a role to play in safeguarding and promoting child welfare (HM Government, 2018). In this research study, three groups of UK professionals who work with children and families were chosen for inclusion: social workers, clinical psychologists, and GPs. These specific professions were chosen because child welfare considerations are an important part of their roles and attachment theory has been proposed as a useful theoretical framework for these professions. More than one profession was included to allow for possible profession-related differences to be explored and recommendations to be generated that are applicable to more than one profession.

The research programme used purposeful sampling. Sampling eligibility criteria were:

- qualified and practising social worker, clinical psychologist, or GP,
- working directly with children and families, and
- with at least 1 year of professional practice experience.

By definition of being a practitioner sample, all eligible individuals were adults of working age and not considered vulnerable.

The research aimed to recruit a total of 60 practitioners (with sub-group targets of 20 per profession). The target sample size was chosen pragmatically. It was based in part on the non-clinical and not-at-risk normative distribution (Bakermans-Kranenburg & van

IJzendoorn, 2009) indicating that a sample needs a minimum *N* of 54 to achieve an expected cell size of at least 5 for each of the four-way attachment state of mind classifications, and thus to enable Goodness of Fit testing of the distribution. Recognition of the benefits of larger samples for quantitative analysis meant that the target sample size was set as large as possible within the constraint of needing to ensure that the qualitative data collection, coding, and analysis would be achievable within the time and resources available. The research was exploratory work in the 'context of discovery' rather than the 'context of justification' and so the target sample size was not determined based on a power calculation.

Recruitment Process

Recruitment processes differed for each profession, due to the nature of their different employers. For the social workers, I asked the service directors at the two local authorities that agreed to be involved for their assistance in getting study details and invitations to child and family social workers. Study details were shared with social work team managers, who in turn were encouraged to circulate a study invitation email plus the research information sheet (see Appendix D) to social workers within their teams, asking them to contact me if they wished to take part or find out more.

For the clinical psychologists, part of the IRAS approval process involved identifying the research sites (in this study two NHS Foundation Trusts) and providing the name of a local collaborator at each site. I approached principal clinical psychologists known to my supervisor R.D. at each of the two NHS Foundation Trusts I wished to involve and secured their agreement to be local collaborators for the research. These local collaborators acted as recruitment champions for the research. They each circulated a study invitation email plus the research information sheet to the clinical psychologists working with children and/or families in their Trust. The clinical psychologists were invited to contact me if they wished to take part or find out more.

For the GPs, a local Clinical Research Network hub provided recruitment support. The Clinical Research Network sent information about the study including the research information sheet to GP Practices in the region to gain interest, asking them to sign and return a form to the Clinical Research Network if they were willing to take part.

A total of 66 practitioners expressed interest in taking part in the study. Of these, 61 participated in both interviews and are described in the next section. The interviews

were all conducted between June 2017 and May 2019. One social worker and three GPs expressed interest in taking part but did not respond to attempts to organise interviews with them. One further social worker took part in a practice-related interview but did not complete the AAI due to time pressures. This social worker did not formally withdraw from the study but, as data collection was incomplete, the partial data that were collected from this participant has not been included in any of the analyses. No participants chose to withdraw their data during or after participation.

Participant Demographics

Participants were 61 England-based child and family practitioners. These practitioners were from three professions: social work (*n* = 23), clinical psychology (*n* = 21) and general practice (*n* = 17).

The social workers were from two local authorities. The majority were based in either initial assessment (*n* = 9) or longer-term safeguarding (*n* = 8), the remainder in other child and family focused teams. The clinical psychologists were from two NHS Foundation Trusts. The majority (*n* = 18) worked in Child and Adolescent Mental Health Services, the remainder in other child and adolescent focused teams. The GPs were from 17 different GP practices. The GP practice locations varied from inner city (*n* = 4) to town (*n* = 4), semi-rural (*n* = 6), and rural (*n* = 3).

Table A.1 *Descriptive Characteristics of the Participants (N = 61)*

	Professional group			Total
	Social workers	**Clinical psychologists**	**GPs**	
n (%)	23 (38)	21 (34)	17 (28)	61 (100)
No. of years' experience				
***M* (*SD*)**	6.9 (5.6)	9.4 (7.3)	13.6 (8.9)	9.6 (7.6)
Range	1–22	1–26	2–31	1–31
Age				
***M* (*SD*)**	36.5 (9.4)	40.6 (7.4)	44.5 (8.6)	40.1 (9.0)
Range	25–58	31–56	31–57	25–58
Gender				
Female *n* (%)	21 (91)	15 (71)	9 (53)	45 (74)
Male *n* (%)	2 (9)	6 (29)	8 (47)	16 (26)

The participating social workers and clinical psychologists were predominantly female. This is broadly representative of the workforce gender split for these professions: according to data from the registering body for these professions (HCPC, 2018), 82% of registered social workers and 81% of registered practitioner psychologists in England were female. For the participating GPs, there was a more even gender balance. This is also broadly representative of the workforce gender split for this profession: according to data from the General Medical Council (GMC, 2016), 52% of licensed GPs in England and Scotland were female.

A.3 Materials

Vignettes and Associated Questions

Vignettes are “short hypothetical accounts reflecting real-world situations” (Tremblay et al., 2022, p.1) which participants are asked to respond to. Their use in qualitative research supports the generation of complex data (Wilks, 2004) which can be explored in situational context (Barter & Renold, 1999).

The two vignettes developed for this study (see Appendix B) were family cases containing child welfare concerns. The vignettes were designed to be an analogue to family cases the participants receive in their day-to-day practice, and the participants were asked to respond to them from their professional perspective. Whilst vignettes can be presented in a range of formats (Tremblay et al., 2022), written narratives were chosen as the format of the vignettes developed for this study as initial referrals are often received in a written format. Two vignettes were used, as having more than one vignette provided opportunity to discuss a greater range of circumstances which can lead to child welfare concerns, but discussing more than two vignettes in depth would have been too time consuming. Though they are described as vignettes here, as this reflects the typical research description of them, when discussing them with the participating practitioners they were described as ‘cases’ as this term is more practice relevant.

Previous studies with practitioners have made use of vignettes (e.g., Daly & Mallinckrodt, 2009; Holley & Gillard, 2018; MacIntyre et al., 2011; Nygren et al., 2019; Østby & Bjørkly, 2011; Sheppard et al., 2000). Vignettes were used, rather than observation of practice, as they allowed for standardisation of cases being discussed

and thus differences in participants' responses to them can be directly compared (Barter & Renold, 1999; Rapaport et al., 2008). This was particularly important for Research Objective 2 (examining the relationship between practitioners' own attachment states of mind and aspects of their thinking when discussing the vignettes). Use of vignettes, rather than more general discussion of practice, increased the possibility of eliciting practitioners' 'theory-in-use' as opposed to 'espoused theory' (Argyris et al., 1985; Osmond et al., 2008). Argyris et al. (1985) explain that "espoused theories are those that an individual claims to follow. Theories-in-use are those that can be inferred from action" (p.82). By asking the social workers to think about and discuss their response to family cases, it was possible to study whether and how theory naturally entered into their thinking. This was particularly important for Research Objective 1 (exploring the role attachment ideas have in practitioners' thinking when discussing the vignettes). Further benefits to using vignettes were being able to control what content was contained within the family cases discussed (to ensure maximum relevance to Research Objective 1) and being able to see how practitioners think about family cases in a less ethically challenging way than direct observation of practice.

Prior to creating the vignettes, I established the requirements for them. They needed to:

- Be sufficiently realistic and authentic.

- Have relevance to social workers, clinical psychologists, and GPs.

- Be short enough that participants would be able to read and meaningfully reason about them in the allocated time, whilst being sufficiently complex that there was not one single way of viewing and thinking about them.

- Allow for exploration of individual differences in the extent to which the practitioners considered the potential underlying feelings and mental states of the family members (i.e., exploration of individual differences in the level of RF shown when discussing them). This meant the vignettes needed to describe behaviours in a way that provided scope for consideration of underlying mental states, whilst not revealing them.

- Allow for exploration of individual differences in practice-related risk perceptions. This meant the vignettes needed to contain a sufficiently ambiguous level of risk to ensure that different risk rating scale answers would be feasible.

- Contain sufficient welfare concerns with relevance to attachment that drawing on attachment theory would be meaningful to help understand them, whilst not being designed such that they could only be understood by drawing on attachment theory.

- Avoid explicit mention of attachment in the first vignette (thus enabling examination of whether practitioners explicitly use attachment terms when there was no clear demand characteristic to do so) and include explicit mention of disorganised attachment in the second vignette (thus enabling examination of how the practitioners respond to this specific attachment concept).

Serious Case Reviews were used as the basis of the vignettes. Serious Case Reviews are conducted when a child is seriously harmed, fatally or otherwise, because of abuse or neglect. Each review contains detail of the family circumstances and the events that occurred, as well as analysis and recommendations. I decided to base the vignettes on Serious Case Reviews because these report cases where there was serious risk, but serious risk that for various reasons did not 'stand out' at the time. Basing the vignettes on Serious Case Reviews also helped to ensure their authenticity. Drawing on Serious Case Reviews was considered ethical as they are published and freely available in the public domain, they were being drawn upon with a goal of advancing child welfare practice (and thus the aim of their use in this research aligned with the aim of their publication in the first place), and the vignettes developed for this research were inspired by but not direct replications of real family cases.

To develop the vignettes, I accessed the national case review repository on the NSPCC Learning site and reviewed the abstracts for the 62 Serious Case Reviews published in 2014. I first focused on reviews reporting family situations with relevance to social workers, clinical psychologists, and GPs, and then looked in more detail at reviews containing analysis that pointed to a lack of focus on phenomena that attachment theory could have drawn attention to. Two Serious Case Reviews stood out as particularly relevant. I found one review (Trench & Griffiths, 2014) which identified how a focus on neglect in relation to poor home conditions and/or a focus on a label such as ADHD could detract attention away from issues in parent-child relationships. I

found another review (Connelly-Webster & Jennings, 2014) which identified a failure to recognise the possible impact of childhood difficulties on the children's mother and her parenting. I used some detail from these two relevant Serious Case Reviews in the development of the vignettes and added specific reference to attachment assessments in the second vignette. In choosing what detail from the reviews to include and omit, it was important to ensure that I did not create vignettes that presented at the crisis level that the Serious Case Reviews ultimately reached, as the goal was to present cases that had sufficiently uncertain levels of risk that variation in responses was possible.

Once developed, my academic supervisors reviewed the vignettes against my established requirements for them. A social worker, two clinical psychologists, and a GP then reviewed the vignettes to check if they felt authentic and relevant to their profession. Their feedback confirmed that the vignettes had authenticity and relevance to all three professions, and led to a few minor but helpful amendments to detail and terminology (adding clarification of what type of medication the mother in the first vignette was receiving, and changing Autism Spectrum Condition to Autism Spectrum Disorder).

When developing the semi-structured questions to be asked about the vignettes (see Appendix C, Section B), it was important to consider what questions would be relevant to, and comparable across, the three practitioner groups. The social worker, clinical psychologists and GP who reviewed the vignettes also reviewed the questions to be asked about the vignettes to ensure their relevance to their profession. The questions were developed to support detailed discussion of the vignettes and to allow for the potential for variation in response. They were, therefore, predominantly qualitative semi-structured questions. Questions were first asked about risk and key features, then about the behaviour of different family members, and finally about intervention and outcomes. As the RF coding system (see Section 8.4.2) was to be used to analyse responses to these questions to address Research Objective 2, it was important to ensure the inclusion of not only 'permit questions' (questions which allow for RF to be shown but do not necessarily require this for them to be answered completely) but also 'demand questions' (questions which require RF to be shown in order to answer them fully).

Some follow-on practice-related questions were asked after the questions about the two vignettes. The purpose of these was to explore some of the factors that may have influenced the role that attachment theory did or did not have in the participants'

thinking when discussing the vignettes. The follow-on questions explored the participants' perceptions of what they drew on when working through the vignettes, their knowledge and use of attachment theory, and their views on attachment theory. This part of the interview guide was designed with different sets of questions to use depending on the individual participants' initial responses in this section, to support the tailoring of the discussion to the participants' responses (see Appendix C, Section C).

The vignettes and associated questions were piloted. An initial pilot was carried out with a social work colleague to check clarity of the vignettes and questions, and as a time check. This pilot confirmed the materials were clear and the timings appropriate. I then carried out more formal pilot interviews with two social workers and two clinical psychologists, where the vignettes were presented and the questions asked under the same conditions they would be in the main study. This pilot confirmed the suitability of the materials and procedure and did not lead to any further changes to the vignettes or questions.

During data collection, after both case vignettes had been presented and discussed, the first question put to every research participant was "how familiar did those cases feel to you, compared to the kind of children and families you work with?" The purpose of this was to provide further assurance of the authenticity and relevance of the vignettes, or important contextual information to be accounted for during analysis should participants state that the vignettes did not feel familiar.

All 23 social workers said the vignettes felt familiar. Comments included "sadly very familiar", "these are pretty standard", "really common", "that's bread and butter to me, every day", "that could be half my cases", "felt very much like a family I'd worked with", and "day-to-day stuff that we're dealing with." Some even made spontaneous comments while reading the cases, before any question was asked about how familiar they felt. For example, one social worker said while reading the first case, "ok, sounds like one of my referrals", another said, "that's a pretty commonplace referral that would come in to us", and, when reading the second case, another said, "I think you've got this from our case files." The only thing highlighted as less familiar by some was the disorganised attachment assessment, and this was explored further in the analysis reported in Part A.

All 21 clinical psychologists also said the vignettes felt familiar. Comments included "really, really familiar", "very reminiscent of many families I've worked with", "they're

regular referrals that we get into our service", and "completely familiar, this is what I've been doing for the last 18 years." Like with the social workers, some made spontaneous comments while reading the cases. For example, one clinical psychologist said while reading the first case, "typical family, right", another said, "it's a typical referral that" and, when reading the second case, "we've got a lot of Ellies."

The majority (11) of the GPs said the cases felt familiar. Comments included "very familiar, these easily could be families I know now", "very familiar, I think we discuss similar cases all the time", "unfortunately we do get similar cases here", "I've seen quite a few cases like this sadly", "it feels like you might have taken both the cases from a surgery in [name of city]", and "case one I see every single day, I could name you families that fit into case one, case two less, although I did see somebody yesterday with a similar situation." Like with the social workers and clinical psychologists, some made spontaneous comments while reading the cases. For example, one GP said whilst reading the first case, "ok, it sounds quite typical of a lot of things I deal with actually", and another said, "ok, yeah, I know families like this." However, six of the GPs – who were all based at rural practices in more affluent areas – said that the cases were not very familiar compared to the kind of children and families they work with. Comments included "fortunately not very familiar, because we don't see this very often at all in the village", "I don't think we experience a high level of that kind of difficulty in the practice here in the village", and "it does happen here, but it's sporadic." Whilst the cases were not as familiar to all the GPs as they were to the social workers and clinical psychologists, the comments still indicated that all the GPs did come across such cases, just not always frequently. Reassurance of the authenticity and relevance of the vignettes to this professional group was therefore still provided.

Adult Attachment Interview

The Adult Attachment Interview (AAI; George et al., 1985) is a well-established psychological measure (see Section 1.1.12). It is a semi-structured interview consisting of 20 questions plus a series of semi-structured follow-up probes which require the interviewee to describe and evaluate their early childhood experiences with their primary caregiver(s) and to evaluate the impact of these early attachment experiences upon them.

A.4 Procedure

When a potential participant made contact to express an interest in taking part, their eligibility was checked. If they met the sampling eligibility criteria, the researcher checked if they had already received and read the research information sheet via the member of their organisation who had shared details of the research with them (all had). The researcher checked if they had any questions about the study and participation. If they wished to participate, they were asked when and where would suit them for the first interview. Participants who wanted to arrange dates and times for both interviews at this point could, but they were not obliged to. Participants were also advised at this stage that there were some materials to read in the first interview, and they were asked if these needed to be presented in a different format (this was required for just one participant and involved presenting the materials in a larger font size).

Mention of ‘attachment’ or any related terms, including the ‘Adult Attachment Interview’, was avoided in the recruitment and interview booking discussions and paperwork. This was done to a) avoid introducing self-selection bias towards or against practitioners with particular views on attachment theory, and b) prevent demand characteristics and priming participants to draw on attachment theory when discussing the family case vignettes if they otherwise would not.

All the data collection took place via 1:1 face-to-face interviews. Most interviews were conducted with participants during their working day, with their managers’ agreement if they were employees (this was the case for the social workers and clinical psychologists but not always for the GPs). Some interviews were conducted in participants’ personal time, i.e., during early evening or on days they had taken as annual leave or flexi leave. Interviews were conducted at either the participant's workplace or at the researcher's university, dependent on participant preference. Where interviews took place at participants’ workplaces, they were asked to arrange a quiet, private room that we could use. Where interviews took place at the university, a suitably quiet and private room was booked by the researcher.

First, each participant completed a ‘practice-related interview’ (see Appendix C). Before starting to ask the questions in this interview, the purpose of the research was reiterated, and a paper copy of the information sheet (see Appendix D) was provided.

Participants were given time to look through this again if they wished. The researcher summarised key points, including the right to withdraw during or between interviews or their data up to a month after. Confidentiality (and the harm exception to this) was also reiterated. After checking if there were any questions, participants were then given two paper copies of the consent form (see Appendix D), one for them to read and sign if they were happy to participate, and one for them to keep for their own records. After signing the consent form the researcher reiterated that the signing of the consent form did not negate their continued right to withdraw. Participants were then reminded of the wish to audio record the interview, a final check was made that they were happy for the interview to be recorded, then the recorder was switched on and the interview commenced. The practice-related interview consisted of collecting some background and demographic information, discussion of the two vignettes, and discussion of the follow-on practice-related questions.

The vignettes were presented and discussed one at a time, and in the same order for all participants. The participants were given as long as they wanted to read each vignette prior to discussing it, and still had the vignette to hand during the discussion of it. The participants were not sent the vignettes in advance of the interview. As highlighted earlier, one of the goals of using vignettes was to provide some standardisation. Had the vignettes been made available to participants in advance, some may have had more opportunity to read and think about them than others, which could have introduced an additional cause of response variation. Furthermore, the interest in this study was on initial and immediate responses to the vignettes, rather than responses made after opportunity to digest the vignettes over an extended period.

From an ethical standpoint, whilst the vignettes attended to emotionally sensitive matters it was not anticipated that this would cause any discomfort or distress to participants above that experienced in their day-to-day roles, as the vignettes reflected the circumstances of cases the participants face in their professional lives.

At the end of the first interview, participants were told that they would be provided with a fuller debrief at the end of the second interview but were asked if they had any questions at this point. The confidentiality and right to withdraw was reiterated. If they were happy to continue, the date and time for the second interview was arranged or confirmed.

Participants had been informed that the first interview would last approximately 90 minutes. At the start of the interview, the researcher checked with the participant how long they had available, to ensure that the interview did not exceed this time. The participants had all cleared sufficient time in their diaries for the interview, and the case discussions did not have to be rushed or cut short in any of the interviews. The average length of the practice-related interview was 62 minutes (*SD* = 17.8).

Second, each participant completed the AAI. At the start of this second interview, participants were reminded of the confidentiality, anonymity, and the right to withdraw. Participants were then reminded of the wish to audio record the interview and the interview commenced.

The AAI deals with personal and sometimes emotional material, including any loss or other traumatic experiences the participant has had. Depending on the participant's life experiences, topics that are upsetting may therefore be broached, and so an important ethical consideration was the need to take steps to reduce potential distress or discomfort for participants when undertaking the AAI. Procedures to deal with this were as follows:

- Both in written form during recruitment, and verbally at the start of both interviews, participants were clearly informed that their participation was voluntary and that they were free to withdraw from the study at any time. At the start of the AAI the participant was also reminded that this interview was about their own life experiences and that they should answer questions only with as much or as little detail as they wished and should feel free to ask to move on from any questions or topics that they did not want to discuss. Some participants did make such a request (e.g., to not discuss a recent bereavement in any detail) and such requests were followed immediately.

- Participants were clearly informed that their responses would be kept confidential and anonymous, with the only exception to this being if any of their responses indicated that they or others were at risk of serious harm if the information was not shared. As well as this being stated in the information sheet and consent form, this was also stated verbally at the start of the interview.

- The interviews were conducted in private rooms. Where interviews took place at the university, care was taken by the researcher to only book comfortable, quiet

and private rooms for the research. The researcher booked the same room for the AAI that a participant had been in for their first interview, so that the room would be more familiar to the participant.

- The AAI was conducted as the second interview for all participants. This meant that the participant had already undertaken a practice-related interview with the researcher and thus had developed some familiarity with the researcher and the process of taking part in interviews with the researcher.

- The AAI protocol contains ethical safeguards, including a clear prioritisation of the welfare of the participant over data collection (shown through clear advice on when to avoid asking follow-up questions, for example), and the inclusion of more positive questions at the end of the interview to support participants to return to a more neutral affective state. The protocol and built-in ethical safeguards were followed.

- An additional set of questions inviting the participant to reflect on the experience of participating in the AAI were asked following completion of the standard AAI questions and before the participant left the room. These questions were designed to provide the participant with an opportunity to ‘step back from’ and reflect on/make sense of their experience of participating in the AAI.

- The interviewers had prior experience of conducting AAIs and/or other interviews on sensitive topics with vulnerable participants. This expertise was drawn on to conduct the interviews in a sensitive and ethical manner.

- All participants were provided with contact details for appropriate support services via the debrief sheet.

At the end of the AAI the researcher provided a verbal debrief, answered any questions the participant had, and gave the participant the paper debrief sheet (see Appendix D). Confidentiality was reiterated, as was the right to withdraw, and the participant was encouraged to get in touch with the researcher if they had any questions at any point.

Participants had been informed that the second interview would last approximately 90 minutes. As with the previous interview, at the start of the interview the researcher checked with the participant how long they had available, to ensure that the interview

did not exceed this time. The participants had all cleared sufficient time in their diaries for the interview. The average length of the AAI was 79 minutes (*SD* = 18.8).

The practice-related interview and the AAI were conducted on separate occasions. Participants were told that the ideal gap between the two interviews would be no less than one week and no more than four weeks. This recommendation was purely pragmatic: it was anticipated that participants would be more likely to participate in the second interview if the time elapsed since interview one was neither very long or short. However, there was no requirement to standardise the gap between the two interviews as attachment state of mind classifications coded from AAI responses have been found to have high stability (e.g., over 2 months, Bakermans-Kranenburg & van IJzendoorn, 1993; over 3 months, Sagi et al., 1994; and over 21 months, Crowell et al., 2002). The length of gap between the two interviews was dictated by participant availability and preference, and the average gap between interview one and two was four weeks.

A.5 Data Management and Protection

The interviews were audio recorded on pin protected Dictaphones. All 61 practice-related interviews and all 61 AAIs were successfully audio recorded. The audio recordings were uploaded from the Dictaphones to the researcher's password protected folder on the university server as soon as practicable following interviews, and then deleted from the Dictaphones. Until upload and deletion from the Dictaphone occurred, the Dictaphones were stored in a locked cabinet apart from when they were being transported from interviews and to the university, during which time they were kept in sight and reach of the Chief Investigator. Signed consent forms were also transported to the university as soon as practicable following interviews and stored in a locked cabinet within the Chief Investigator's office.

Data were anonymised. Participants were assigned a 'Participant ID number' at the recruitment stage. Their name, job role, employer and contact details were only linked to their 'Participant ID number' on an electronic recruitment log stored in the researcher's password protected folder on the university server. A second log contained all the participant ID numbers along with separate interview ID numbers for each of the participant's interviews (i.e., one ID number for their practice-related interview and a separate ID number for their AAI). These interview ID numbers were then used as the identifiers for the interview recordings, ensuring that participants'

names or other identifiers were not directly linked to their interview data. Completed consent forms contained the participants' name and signature, but did not contain any of the ID numbers, thus preventing linking of the consent forms to the interview data.

The interviews were transcribed verbatim by two professional transcribers, both of whom signed confidentiality agreements prior to gaining access to the audio recordings. The transcribers did not have access to any participant data outside of that contained in the verbal content of the interview recordings. During the transcription process, any further details within the data that could reasonably enable identification of any individuals or organisations were removed. For the AAIs, Main's (1996) transcription guidelines were followed. These include capturing the length of pauses, noting interruptions, and paying careful attention to accurate capturing of slips of the tongue and run on sentences. All the AAIs were transcribed by a sole professional transcriber to ensure consistency in the transcription approach, and I checked the transcripts to ensure accuracy and anonymisation.

Appendix B: The Family Case Vignettes

Case 1

Mother – Jade, aged 35 Father – Alex, aged 37 Son – Sam, aged 8 Son – Tom, aged 6 Daughter – Poppy, aged 6 months

Jade was known to the locality team as a child. She was on a child protection plan for sixteen months from the age of two and placed in foster care on a care order from the age of five to seven. Jade has ongoing depression and anxiety, and is taking anti-depressant medication.

Over the past 5 years there have been a number of reported incidents of domestic abuse. These include reports from Jade herself about Alex's violence, and others from neighbours when they heard angry scenes in the home. Alex no longer lives with the family, but sees them on a regular basis and is sometimes the carer for the children.

During Jade's recent pregnancy, the midwife asked about the domestic abuse. Jade said she "didn't want to discuss it." She said that the threat from Alex and their upsets and arguments were "all in the past", and that there was no current violence.

There have been several reported accidents involving the children, which appear to relate to inadequate supervision. Since the birth of Poppy, there have also been a number of missed essential health appointments for the children. The Health Visitor's records note that Jade "has difficulty providing stimulation for the children and often leaves them in front of the TV." The Health Visitor has also noted the poor state of the family home: unclean and very cluttered, with not enough space for the baby to develop physically. The Health Visitor believes Jade "has good intentions, but easily forgets."

Jade says that she is unable to manage her children's behaviour. Sam has been diagnosed with ADHD and receives medication for this. Jade has suggested to professionals that Tom also has ADHD, reporting that he shows "wild behaviour", but clinical assessment indicated that he did not meet diagnostic criteria for ADHD. Jade has asked for an assessment of Autism Spectrum Disorder for Tom. Jade describes Tom as violent and out-of-control at home and says that he and Sam fight and risk physically hurting each other.

The children regularly arrive late at school and there is a high, and increasing, level of school absences. Teachers have noted that the boys' academic progress is below average in all areas of the curriculum. Tom is described by his teacher as quite quiet and subdued at school. The SENCO has expressed concerns about Tom's "extremely withdrawn and unhappy behaviour" at school and made a referral.

Case 2

Mother – Amy, aged 22 Father – Chris, aged 39 Daughter – Ellie, aged 5 Son – Jack, aged 18 months

Concerns arose six months ago when police were called by neighbours about a domestic violence incident. When they arrived they found Chris outside the family home: drunk, shouting and causing damage. The children were inside the house alone. Amy had taken an overdose of pills and fled on foot from the house. Chris was arrested and a search started for Amy. The Local Authority Emergency Duty Service attended and worked with the police to place the children with an emergency foster carer.

Amy was located the following day. She was taken by ambulance to the local hospital. Despite some minor physical injuries caused by Chris, the overdose, and having been outside overnight, Amy presented well. She was cleared physically and revealed no current thoughts of self-harm. The overdose was interpreted as an isolated incident in response to the domestic abuse. It was decided that admission to a mental health ward was not required, and Amy was referred to her GP for further support.

Chris was charged with common assault and released on bail with a range of bail conditions including not to contact the children or Amy.

Whilst placed with foster carers, Ellie disclosed details of neglect, and repeated abuse she had witnessed against her mother by her father. The foster carer reported that Ellie was having difficulty going to sleep, had regular nightmares about being alone and lost, and often seemed “on edge.” The foster carer also mentioned that Jack would sometimes lie prone on the floor, barely moving and eyes glazed, even when they tried to rouse him.

Amy was seen by her GP. She disclosed being physically and emotionally abused by Chris. She also disclosed that she had experienced difficulties in her childhood but was not specific about this. Amy was assessed as moderately to severely depressed, with severe anxiety. She was offered and agreed to medication and counselling. In the first counselling session it was noted that Amy might have unresolved feelings about the death of her father 2 years ago. She reported sometimes seeing her father’s angry face in Jack’s features when she looked at him.

Regular supervised contact is being facilitated between the children and Amy. Assessments have begun into Amy’s parenting ability and the children’s attachment to her, and Amy’s willingness to engage with this process has been noted. As part of the assessments, both children have been assessed as having a disorganised attachment.

Appendix C: Practice-Related Interview Schedule

Intro (approx. 5 mins)

Reiterate the focus and length of this interview, confidentiality and anonymity (and the risk of significant harm exception to this), and the right to withdraw. Provide the participant with two copies of the consent form to sign (one for them to keep and one for the researcher to keep). Reconfirm permission to record the interview and start the recorder. State the ID number, then begin.

A. Participant Background (approx. 5 mins)

1. To start, could you give me a brief overview of your current role?

   E.g., what client groups do they work with and what services do they provide?

2. How many years ago did you qualify as a [profession]?

   Where did you do your qualifying training?

3. How many years' experience do you have working directly with children and/or families?

   If not obvious from the previous answers, clarify if this is all post-qualifying experience, or if they also have pre-qualifying experience of working directly with children and/or families (and the details of this).

4. How old are you?

B. Vignette Discussions (approx. 40 mins)

I'm going to show you two family cases, one at a time, and I'm going to ask you for your thoughts on each. *Present first vignette.*

Take your time reading it. You'll still have it in front of you when we discuss it.

Once the participant indicates they are ready to discuss it: Obviously you've not had long to consider this, and more information could be sought, but I'm going to ask you for your initial thoughts on the case based on what you have here.

1. What is your initial impression of the level of risk in this case from zero (no risk) to five (very high risk)?

   Why did you say ___?

   Do you regard this level of risk as representing threat of serious harm?

2. What things stand out to you as the most noteworthy features of this case, when thinking about the wellbeing of the children?

   If they do not explain their reasoning unprompted, ask: Why did you say ___?

   Could use the optional prompt: What is informing that?

   If stop at one or two features, ask: Were there any other features of this case that particularly stand out, when thinking about the children's wellbeing?

3. Why do you think the children (Sam and Tom / Ellie and Jack) might be behaving as they are?

4. Why do you think the mother (Jade / Amy) might be behaving as she is?

5. What would be your next steps in relation to this case?

6. Overall, what needs to happen to make sure the children are safe in the future?

7. What do you think could happen if this family hadn't come to the attention of services and so there was no intervention or support?

   If only focused on short-term risk implications in answer, follow up with: What do you think could be the longer-term impacts of this experience for the children?

   How likely do you think those kind of outcomes are?

Remove the first vignette and present the second vignette. Repeat questions 1-6 then ask:

7. How likely do you think it is that these children would be able to return home?

8. Assuming things improve for these children, whether that's back home with appropriate changes and support, or in a stable looked after placement, do you think there could be longer-term impacts for the children from the experience they have been through to date?

   Can use the optional prompt: How likely do you think those kind of outcomes are?

9. At the end of this case, it mentions that the children have been assessed as having disorganised attachments. Did that feed into your thinking about this case?

   Why / why not?

   If it didn't feed into their thinking because of lack of familiarity with the term, ask: Is this a term you have ever seen in notes about children you work with?

   If it did feed into their thinking, ask: How did that inform your thinking about the case?

C. Practice-Related Questions (approx. 20 mins)

1. How familiar did those cases feel to you, compared to the kind of children and families you work with?

2. As you were working through the two cases, what did you find yourself drawing on to make sense of them?

   If they remain unsure how to answer, ask: models / experience / research / theory?

   If theory is mentioned, ask: Which theories did you find yourself drawing on?

3. Does this reflect your practice, i.e., is *[what they stated they draw on]* what you tend to draw on most in your day-to-day practice?

If interviewee <u>does not draw on theory</u> ask the following questions, otherwise skip to next section.

4. What is it about *[what they stated they draw on]* that you find more useful than theory when making sense of cases?

5. Are there any other factors that constrain your ability to draw on theory in practice?

6. How much of a feature was theory during your professional training?

   Which theories were covered in your training? In how much depth?

   Did some of these seem more useful or relevant than others? Which? Why?

7. *If not already mentioned:* What about attachment theory, is this a theory you are familiar with?

   If familiar with:

   How much knowledge do you have of attachment theory?

   When and where did you gain this knowledge?

   What do you think of attachment theory?

   Do you think that attachment theory could be useful to draw on at times in your practice? *If yes:* when and why? *If no:* why not?

   If not familiar with:

   Do you think it could be helpful to your practice to have knowledge of attachment theory? Why / why not?

If interviewee draws on theory but hasn't mentioned attachment theory, ask the following questions, otherwise skip to next section.

4. Why do you tend to draw on *[theories they stated]* when making sense of cases?

5. How much of a feature were these theories during your professional training?
   Have you undertaken further reading or training on these theories since?

6. Were any other theories covered in any depth in your training?
   If yes: Which? Why do you draw on these theories less?

7. *If not already mentioned:* What about attachment theory, is this a theory you are familiar with?
   If familiar with:
   How much knowledge do you have of attachment theory?
   When and where did you gain this knowledge?
   What do you think of attachment theory?
   Do you think that attachment theory could be useful to draw on at times in your practice? *If yes:* when and why? *If no:* why not?
   If not familiar with:
   Do you think it could be helpful to your practice to have knowledge of attachment theory? Why / why not?

If interviewee draws on attachment theory, ask the following questions, otherwise skip to next section.

4. One of the theories you mentioned was attachment theory. What do you think of attachment theory?

5. How much knowledge do you have of attachment theory?
   When and where did you gain this knowledge?

6. How do you use attachment concepts, theory and/or research in your practice?
   Probe for use in screening, assessment, treatment.
   Why? What value / benefits does this bring?
   What factors support this?
   What factors constrain this?

7. When you use the term "attachment", what do you mean by it?
   Do you use other specific attachment terms too? *If yes:* Which? When? How?

Essential questions to prioritise and ask of all:

8. To what extent do you think a person's early experiences with their parents influences their longer term development?

   Ask them to rate from zero (not at all) to five (the greatest single influence), and why.

9. To what extent do you think a person's early experiences with their parents influences how they parent once they have their own children?

   Ask them to rate from zero (not at all) to five (the greatest single influence), and why.

Stop the audio recording.

Close (approx. 5 mins)

Explain the purpose of this interview and ask them if they have any questions. Remind them that their responses will be treated confidentially and fully anonymised prior to use. Remind them of the right to withdraw. If they wish to continue and participate in the second interview, reconfirm the date/time/location of the second interview, or arrange if not yet done so.

Appendix D: Participant Documents

Children and families: thinking about relationships and assessment practice

RESEARCH INFORMATION SHEET

Lead Researcher: Sarah Foster, Northumbria University

This leaflet will help you to understand why this research study is being carried out and what would be involved if you decided to participate in it.

Reading this leaflet, discussing it with others, or asking any questions you might have will help you decide whether or not you would like to take part.

What is the purpose of the study?

The aim of this study is to provide important insights into reflective practice with children and families in England, focusing on professionals' perspectives on relationships and their thinking when conducting assessments.

Who can take part in this study?

You can take part in the study if you are a qualified social worker or clinical psychologist who works with children and/or families and have at least one year's experience in the profession.

Do I have to take part?

No. It is up to you whether you would like to take part in the study. If you do decide to take part, you can stop being involved in the study at any time, without giving a reason and without any penalty.

What will happen if I decide to take part?

The study involves participation in two face-to-face interviews, each lasting approximately 90 minutes. You will not need to do anything in preparation for either interview

If you decide to take part, I will contact you to arrange dates and times that suit you for the two interviews. You can also choose whether you would like the interviews to take place at your workplace, or at Northumbria University's City or Coach Lane Campus.

The first interview will relate to your practice. I will ask you questions about hypothetical family case studies and about your day-to-day practice, and I will also ask you to complete some short paper-based questionnaires. The second interview will relate to your own experiences outside of work. I will ask you questions about your relationship experiences in childhood and beyond, and your views on these. With your permission, I will audio-record both interviews to make sure I capture everything you talk about.

Will I be compensated for taking part in this study?

If you decide you would like one or both of your interviews to be held at Northumbria University's City or Coach Lane Campus (rather than at your workplace), you will be able to claim back bus, metro or parking costs incurred on production of the receipt(s).

Will my taking part in this study be kept confidential and anonymous?

Yes. Your name will not be written on any of the data we collect. Your name and any other information within the data that could reasonably identify you will be excluded from the interview transcripts and from any reports and documents resulting from this study.

The data collected from you in this study will be confidential. Your data will be stored securely and in accordance with University guidelines and the Data Protection Act (1998) and will be destroyed 7 years after completion of the study. Your data will only be accessible to the researchers involved in the study at Northumbria University and the University of Cambridge, and to a transcriber. The only exception to this confidentiality would be if any of your responses indicate that you or others are at risk of serious harm if the information is not shared.

What will happen to the results of this study?

The general findings from this study will be written up as a PhD thesis by the lead researcher and may also be reported in scientific journals and presented at research conferences. Summary findings may also be shared with the organisations that have been involved with the study. However, the findings will be anonymised, and you and the data you have provided will not be personally identifiable in any outputs. We can provide you with a summary of the findings from the study if you email the lead researcher at the address listed below.

Who has reviewed this study?

The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

What if something goes wrong?

If you have a concern about any aspect of this study, you should speak to the Lead Researcher Sarah Foster (see contact details below) who will do her best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this by contacting the Chair of the Faculty Ethics Committee, Dr Nick Neave (nick.neave@northumbria.ac.uk)

Northumbria University has Public Liability Insurance for unforeseen consequences of research where we may be at fault. This insurance is for accidental injury or accidental damage to property. To make a claim you would need to inform us in writing of your problem (fi.insurance@northumbria.ac.uk) and explain why you think we are at fault.

Who can I contact for further information?

Sarah Foster, Department of Social Work and Community Wellbeing, Northumbria University sarah.l.foster@northumbria.ac.uk

Children and families: thinking about relationships and assessment practice

PARTICIPANT CONSENT FORM

Lead Researcher: Sarah Foster, Northumbria University

	please tick or initial where applicable
I have carefully read and understood the Research Information Sheet.	☐
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.	☐
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	☐
I understand that by taking part in this study I may be exposed to materials or asked questions that may generate some psychological distress during and/or after the study has finished. I accept the small risk of experiencing psychological distress as part of this research.	☐
I agree to take part in this study.	☐

Signature of participant..... Date.....……
(NAME IN BLOCK LETTERS).....……
Signature of researcher..... Date.....……
(NAME IN BLOCK LETTERS).....……

Children and families: thinking about relationships and assessment practice

PARTICIPANT DEBRIEF SHEET

Lead Researcher: Sarah Foster, Northumbria University

Thank you for taking part in this research project. Your input is very much appreciated.

What was the aim of the study and what was the purpose of the different questions and interviews?

There are two key aims of this study. The first aim is to explore how professionals understand and reason about cases involving potential child-welfare concerns, and whether they draw on concepts and evidence from attachment theory to do so. Attachment theory is one potential lens through which family cases can be understood, but there is limited research on whether and how it is currently used in English social work and clinical psychology practice. The discussion of case studies and your current practice in the first interview generated information that will support this aim.

The second aim is to test whether a range of different factors are linked to the way professionals understand and reason about child-welfare concerns. These factors include profession, thinking style, relationship style, and family relationship experiences. To enable any differences by profession to be explored, the study is recruiting participants from three different professional groups (social workers, clinical psychologists and GPs). The questionnaire you completed at the end of the first interview generated information on your preferred thinking and relationship style, and the second interview generated information on your family relationship experiences.

How will I find out about the results?

Once the study is complete, a summary of the research findings will be available on request. If you would like to receive a copy, please let the lead research Sarah Foster know via email: sarah.l.foster@northumbria.ac.uk

What will happen to the information I have provided?

The data collected from you in this study is confidential. Your data will be stored securely and in an anonymised form. Your data will only be accessible to the researchers involved in the study at Northumbria University and the University of Cambridge, and to a transcriber. Your identifiable data will be destroyed 7 years after completion of the study.

The general findings from this study will be written up as a PhD thesis by the lead researcher and may also be reported in scientific journals and presented at research conferences. Summary findings may also be shared with the organisations that have been involved with the study. However, the findings will be anonymised, and you and the data you have provided will not be personally identifiable in any outputs.

If you wish to withdraw your data, please contact the lead researcher Sarah Foster via email (sarah.l.foster@northumbria.ac.uk) within one month of taking part. After this date, it may not be possible to withdraw your individual data as it could already have been analysed.

Who can I contact if I have any questions about the research?

If you have further questions about the research study itself, you can contact the lead researcher Sarah Foster via email: sarah.l.foster@northumbria.ac.uk

This study received full ethical approval from the Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University. If you require confirmation of this, or if you have any concerns about this research or wish to register a complaint, please contact the Chair of the Ethics Committee, Dr Nick Neave, via email: nick.neave@northumbria.ac.uk

What should I do if I feel emotionally upset after this interview?

It is possible that while taking part in this interview you may have recalled distressing situations which may leave you emotionally upset. If this is the case then you should consider seeking support. Some of the following links may be helpful, and you can also access support through your GP.

The Samaritans (24 hour support), telephone: 116 123

Cruse (Bereavement support), telephone: 0808 808 1677

National Association of People Abused in Childhood, telephone: 0800 085 3330

Appendix E: Additional Systematic Review Detail

E.1 Syntax for Database Searches

The same search query was run in every database, though the precise syntax for this was modified to each database's specific codes.

Scopus

Combined search query:

TITLE-ABS ("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") AND TITLE-ABS ("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*)

Web of Science All Databases

Combined search query:

(TI=("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") OR AB=("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*")) AND (TI=("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*) OR AB=("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*))

APA PsycInfo via EBSCOhost

The search had to be built line by line into the database.

CINAHL (Cumulative Index to Nursing & Allied Health) via EBSCOhost

The search was built line by line into the database. It was also entered as a single combined search query to check the same number of results were returned from both searches. They were, which confirmed that the line by line search (also used in PsycInfo) and the single combined search quey (also used in Scopus, WoS and the ProQuest databases) were both correct and equivalent.

Combined search query:

(TI ("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") OR AB ("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*")) AND (TI ("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*) OR AB ("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*))

Medline via ProQuest

Combined search query:

TI,AB("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") AND TI,AB("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR

professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*)

ASSIA (Applied Social Sciences Index and Abstracts) via ProQuest

Combined search query:

TI,AB("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") AND TI,AB("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*)

ProQuest Dissertations & Theses Global

Combined search query:

TI,AB("adult attachment interview*" OR "attachment representation*" OR "attachment state* of mind" OR "reflective function*") AND TI,AB("case manager*" OR clinician* OR counsellor* OR counselor* OR doctor* OR gp OR gps OR "health visitor*" OR mentor* OR nurse* OR paediatrician* OR pediatrician* OR physician* OR practitioner* OR professional* OR provider* OR psychologist* OR psychiatrist* OR psychotherapist* OR staff OR supervisor* OR teacher* OR therapist* OR worker*)

E.2 Modified Quality Assessment Tool Used in the Review

The quality assessment tool for observational cohort and cross-sectional studies (NHLBI, 2013: https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools) used in this study is below. The modifications made to increase its relevance to the studies included in this review are in grey text, with the original no-longer-relevant text striked-out.

Where the original guidance on the tool questions was added to, this is noted in the table through use of superscript letters. The additional guidance has been provided under the table.

Criteria		Yes	No	CD, NR, NA*
1.	Was the research question or objective in this paper clearly stated?			
2.	Was the study population clearly specified and defined?			
3.	Was the participation rate of eligible persons at least 50%?			
4.	Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants?			
5.	Was a sample size justification, power description, or variance and effect estimates provided?			
6.	For the analyses in this paper, were ~~the exposure(s) of interest~~ the attachment states of mind and/or reflective functioning (RF) levels of the helping professionals measured prior to the outcome(s) being measured? [a]			
7.	Was the timeframe sufficient so that one could reasonably expect to see an association between ~~exposure~~ the professionals' attachment and/or RF and outcome if it existed? [b]			
8.	~~For exposures that can vary in amount or level,~~ did the study examine different levels of ~~the exposure~~ the professionals' attachment and/or RF ~~as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)~~? (e.g., more than two categories or on a scale). [c]			

Criteria	Yes	No	CD, NR, NA*
9. Were the ~~exposure~~ measures ~~(independent variables)~~ of attachment and/or RF clearly defined, valid, reliable, and implemented consistently across all study participants? [d]			
10. ~~Was the exposure(s) assessed more than once over time?~~ Was a proportion of the attachment and/or RF coding second coded, and satisfactory inter-rater reliability established? [e]			
11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
12. Were the outcome assessors blinded to the exposure status of participants? [f]			
13. Was loss to follow-up after baseline 20% or less? [g]			
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between ~~exposure(s)~~ attachment and/or RF and outcome(s)?			

* CD = cannot determine; NR = not reported; NA = not applicable.

Additional guidance

[a] Regarding question 6 (exposure assessed prior to outcome measurement): Many of the studies will be cross-sectional and will not be attempting to establish cause and effect, just an association, and so it will be rare the answer will be yes to this question. If there is no attempt to establish cause and effect and no claim of this, with the paper clear that only a correlation has been established, note N/A rather than 'No'.

[b] Regarding question 7 (sufficient timeframe to see an effect): For some studies this is relevant, for example, if measuring client satisfaction with the professional or therapeutic alliance, an important quality check is that the outcome variable is measured far enough into the professional-client relationship that meaningful differences could be observed. In contrast, in some of the studies there will not be any expectation that there would need to be any length of timeframe before the outcome variable can be meaningfully measured. So cross-sectional studies should not automatically receive a 'No' as per the original guidance. If they are cross-sectional and

this is appropriate because there is no need for a delay before measuring the outcome variable, choose ‘Yes’.

[c] Regarding question 8 (different levels of the exposure of interest): It is likely the answer will be yes in relation to most studies, as the attachment and RF coding systems contain multiple categories and/or scales. However, if any studies have collapsed attachment or RF purely into two categories, rather than being scaled or using more than two categories, the answer should be ‘No’.

[d] Regarding question 9 (exposure measures and assessment): By nature of the study inclusion criteria, i.e., use of a valid attachment or RF measure, the answer should always be yes for this.

[e] Regarding question 10 (repeated exposure assessment): This question was not relevant in its original form for the types of studies being included in this review. Instead, this question has been fully changed to asking about whether a proportion of the attachment and/or RF coding was second coded and satisfactory inter-rater reliability established, as this increases confidence that this variable was correctly measured/classified. This fits the spirit of the original question, which was about confidence that the exposure status was correctly classified.

[f] Regarding question 12 (blinding of outcome assessors): Check whether the coders of the study outcome variables were different from the coders of the professionals’ attachment/RF, and blind to the attachment/RF data?

[g] Regarding question 13 (follow up rate): This will often be N/A for studies included in this review, as many will be cross-sectional.

E.3 Supplementary Systematic Review Tables

Table E.1 *Breakdown for the 31 Included Texts of the Distinct Samples, Available Adult Attachment Interview Data, and Whether Relevant Outcomes Were Explored*

Text	Publication details	Sample size, professional group(s) and location	Distinct or overlapping sample?	Type of Adult Attachment Interview coding	Practice outcomes researched?
Cologon et al., 2017	Published journal article	25 Therapists and therapist trainees, Australia	Distinct sample	RF	Yes
Constantino & Olesh, 1999	Published journal article	33 [a] Childcare providers, USA	Distinct sample	Attachment four-way	Yes
Copeland et al., 2020	Published journal article	541 Child welfare professionals, USA	Main text for sample	Attachment three-way forced [b] and four-way	Yes
Call et al., 2019	Published journal article		Confirmed subset of sample in Copeland et al., 2020		No
Call, 2012	Doctoral dissertation		Confirmed subset of sample in Copeland et al., 2020		No
Howard et al., 2013	Published journal article		Confirmed subset of sample in Copeland et al., 2020		No
Howard et al., 2017	Published journal article		Confirmed subset of sample in Copeland et al., 2020		No
Dozier et al., 1994	Published journal article	18 Mental health case managers, USA	Distinct sample	Kobak's attachment Q-set	Yes
Horppu & Ikonen-Varila, 2004	Published journal article	82 Kindergarten teacher students, Finland	Distinct sample	Attachment three-way forced	Yes
Jenkins, 2002	Doctoral dissertation	43 Physiotherapy students, UK	Distinct sample	Attachment three-way forced and four-way	Yes
Klasen et al., 2019	Published journal article - translated	90 Therapist trainees, Germany	Distinct sample	Attachment three-way forced [b] and four-way, RF	No

Text	Publication details	Sample size, professional group(s) and location	Distinct or overlapping sample?	Type of Adult Attachment Interview coding	Practice outcomes researched?
Mayer et al., 2020	Published journal article - translated	66 Childcare providers, Germany	Distinct sample	Attachment three-way forced and four-way	No
Petrowski et al., 2013	Published journal article	22 Therapists, Germany	Main text for sample	Waters secure vs insecure and dismissing vs preoccupied scales	Yes
Petrowski et al., 2011	Published journal article		Appears to be subset of Petrowski et al., 2013		Yes
Petrowski et al., 2021	Published journal article		Appears to be subset of Petrowski et al., 2013		Yes
Rizq & Target, 2010a	Published journal article	12 Counselling psychologists, UK	Main text for sample	Attachment four-way, RF	Yes
Rizq & Target, 2010b	Published journal article		Exact same sample as in Rizq & Target, 2010a		No
Rizq, 2011	Published journal article		Exact same sample as in Rizq & Target, 2010a		No
Schauenburg et al., 2010	Published journal article	31 Therapists and therapist trainees, Germany	Main text for sample	Attachment three-way forced and four-way	Yes
Dinger et al., 2009	Published journal article		Confirmed subset of sample in Schauenburg et al., 2010		Yes
Schuengel et al., 2012	Published journal article	61 Caregivers to disabled people, Netherlands	Distinct sample	Attachment three-way forced [b] and four-way [b] for larger sample than in text [c]	Yes
Shmueli, 2003	Doctoral dissertation	40 Clinical psychology trainees, UK	Distinct sample	Attachment three-way forced, RF but not reported	Yes
		29 Counselling students, UK	Distinct sample	Attachment three-way forced, RF	No
		17 Therapists, UK	Distinct sample	Attachment three-way forced [d], RF	No

Text	Publication details	Sample size, professional group(s) and location	Distinct or overlapping sample?	Type of Adult Attachment Interview coding	Practice outcomes researched?
Sibrava, 2009	Doctoral dissertation	4 Therapists, USA	Distinct sample	Attachment two-way F vs non-F	Yes
Slot & Schuengel, 2014	Unpublished report - translated	74 Child protection family guardians, Netherlands	Distinct sample	Attachment three-way forced [b] and four-way	Yes
Steinmair et al., 2021	Published journal article	39 Mental health professionals, Austria	Distinct sample	RF	Yes
Suess et al., 2015	Published journal article	18 Parenting intervention facilitators, Germany	Distinct sample	Attachment two-way F vs non-F and U vs non-U, RF but not reported	Yes
Talia et al., 2020	Published journal article	50 Therapists, Italy	Distinct sample	Attachment three-way forced and four-way	Yes
Trowell et al., 2008	Published journal article	27 Mental health professional trainees, UK	Distinct sample	RF	No
Tyrrell et al., 1999	Published journal article	21 Mental health case managers, USA	Distinct sample	Modified version of Kobak's attachment Q-set	Yes
Wittenborn, 2012	Published journal article	7 Therapist trainees, USA	Distinct sample	Attachment four-way	Yes
Zegers et al., 2006	Published journal article	33 Caregivers to institutionalised youths, Netherlands	Distinct sample	Attachment three-way forced [b] and four-way	Yes

Note. Texts are presented in alphabetical order, except where a text contains a duplicate or subsample, in which case it is presented underneath the main text for the sample. RF = reflective functioning; F = autonomous; U = unresolved.

[a] This sample was reported as *N* = 31 throughout and the majority of the data in the paper was in line with this, but the reported attachment state of mind classification breakdown equalled 33. The authors could not be reached for clarification. [b] This data was not reported within the text but was able to be obtained directly from the authors via personal communication. [c] In the text, only the subset of the full sample for whom outcome data was available was reported. In personal communication the authors provided the attachment classification data for the full sample. The four-way classification data for the full sample excludes one case because the loss/trauma questions were 'cannot rate'. [d] The three-way forced classification data excludes one case because the interview was 'cannot classify'.

Table E.2 *Sample Ns Plus the Expected Ns for Each Classification and Sample*

Sample	Professional group(s)	Three-way forced distribution				Four-way distribution				
		N	**F *N* (exp)**	**Ds *N* (exp)**	**E *N* (exp)**	***N***	**F *N* (exp)**	**Ds *N* (exp)**	**E *N* (exp)**	**U *N* (exp)**
Copeland et al., 2020	Child welfare professionals	541	231 (304.64)	201 (159.54)	109 (76.88)	541	222(271.58)	173(131.19)	72 (50.75)	74 (87.48)
Klasen et al., 2019	Therapist trainees	90	77 (50.68)	1 (26.54)	12 (12.79)	90	77 (45.18)	1 (21.83)	8 (8.44)	4 (14.55)
Horppu & Ikonen-Varila, 2004	Kindergarten teacher students	82	35 (46.17)	36 (24.18)	11 (11.65)	Not available				
Slot & Schuengel, 2014	Child protection family guardians	74	40 (41.67)	15 (21.82)	19 (10.52)	74	37 (37.15)	14 (17.95)	10 (6.94)	13 (11.97)
Mayer et al., 2020	Childcare oroviders	66	45 (37.16)	10 (19.46)	11 (9.38)	66	43 (33.13)	7 (16.01)	3 (6.19)	13 (10.67)
Schuengel et al., 2012	Caregivers to disabled people	61	34 (34.35)	15 (17.99)	12 (8.67)	60	32 (30.12)	13 (14.55)	8 (5.63)	7 (9.70)
Talia et al., 2020	Therapists	50	32 (28.16)	12 (14.75)	6 (7.11)	50	31 (25.10)	11 (12.13)	4 (4.69)	4 (8.09)
Jenkins, 2002	Physiotherapy students	43	35 (24.21)	7 (12.68)	1 (6.11)	43	34 (21.59)	3 (10.43)	0 (4.03)	6 (6.95)
Shmueli, 2003	Clinical psychology trainees	40	21 (22.52)	15 (11.80)	4 (5.68)	Not available				
Zegers et al., 2006	Caregivers to institutionalised youths	33	18 (18.58)	5 (9.73)	10 (4.69)	33	18 (16.57)	4 (8.00)	5 (3.10)	6 (5.34)
Constantino & Olesh, 1999	Childcare providers	Not available				33	17 (16.57)	4 (8.00)	3 (3.10)	9 (5.34)
Schauenburg et al., 2010	Therapists and therapist trainees	31	20 (17.46)	3 (9.14)	8 (4.41)	31	19 (15.56)	2 (7.52)	3 (2.91)	7 (5.01)
Shmueli, 2003	Counselling students	29	15 (16.33)	10 (8.55)	4 (4.12)	Not available				
Shmueli, 2003	Therapists	16	12 (9.01)	2 (4.72)	2 (2.27)	Not available				
Rizq & Target, 2010a	Counselling psychologists	Not available				12	6 (6.02)	2 (2.91)	1 (1.13)	3 (1.94)

Sample	Professional group(s)	Three-way forced distribution				Four-way distribution				
		N	F *N* (exp)	Ds *N* (exp)	E *N* (exp)	*N*	F *N* (exp)	Ds *N* (exp)	E *N* (exp)	U *N* (exp)
Wittenborn, 2012	Therapist trainees	Not available				7	5 (3.51)	1 (1.70)	0 (0.66)	1 (1.13)

Note. F = autonomous; Ds = dismissing; E = preoccupied; U = unresolved; *N* = sample *N*; (exp) = expected *N*s derived from the normative distribution. Three-way forced normative distribution from a combined sample of 4,392 non-clinical and not-at-risk groups (Bakermans-Kranenburg & van IJzendoorn, 2009, p.243). As the rounded percentages reported in the paper totalled 99%, the percentages taken to two decimal places were used, which were provided directly by Bakermans-Kranenburg and were F 56.31%, Ds 29.49%, and E 14.21%. Four-way normative distribution from a combined sample of 4,454 non-clinical and not-at-risk groups (Bakermans-Kranenburg & van IJzendoorn, 2009, p.243). As the rounded percentages reported in the paper totalled 99%, the percentages taken to two decimal places were used, which were provided directly by Bakermans-Kranenburg and were F 50.20%, Ds 24.25%, E 9.38%, and U 16.17%.

Appendix F: SPSS Syntax and Output

```
*SECTION 8.2 PARTICIPANTS.

*Descriptive Characteristics of the Participants.

MEANS TABLES=Experience Age BY Profession
 /CELLS=COUNT MIN MAX MEAN STDDEV.
```

Profession		No. of years' experience	Age
Social Worker	N	23	23
	Minimum	1	25
	Maximum	22	58
	Mean	6.91	36.48
	Std. Deviation	5.616	9.385
Clinical Psychologist	N	21	21
	Minimum	1	31
	Maximum	26	56
	Mean	9.43	40.57
	Std. Deviation	7.298	7.373
GP	N	17	17
	Minimum	2	31
	Maximum	31	57
	Mean	13.59	44.47
	Std. Deviation	8.896	8.596
Total	N	61	61
	Minimum	1	25
	Maximum	31	58
	Mean	9.64	40.11
	Std. Deviation	7.596	8.980

```
CTABLES
 /VLABELS VARIABLES=Profession Gender DISPLAY=LABEL
 /PCOMPUTE &cat1 = EXPR([1] + [2] + [3])
 /PPROPERTIES &cat1 LABEL = "Total" FORMAT=COUNT F40.0, ROWPCT.COUNT
PCT40.1 HIDESOURCECATS=NO
 /TABLE Profession [COUNT F40.0, ROWPCT.COUNT PCT40.1] BY Gender
 /CATEGORIES VARIABLES=Profession [1, 2, 3, &cat1, OTHERNM]
EMPTY=INCLUDE
 /CATEGORIES VARIABLES=Gender ORDER=A KEY=VALUE EMPTY=INCLUDE
 /CRITERIA CILEVEL=95.
```

Custom Tables

		Gender			
		Male		Female	
		Count	Row N %	Count	Row N %
Profession	Social Worker	2	8.7%	21	91.3%
	Clinical Psychologist	6	28.6%	15	71.4%
	GP	8	47.1%	9	52.9%
	Total	16	84.3%	45	215.7%

```
*SECTION 9.1 PRELIMINARY ANALYSES.

*Section 9.1.1 Data Inspection.

*Point-biserial correlation between attachment coherence of mind and the
dichotomised autonomous versus insecure attachment state of mind classifications.

BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=AAI_Classification_2 AAI_M_Coherence
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
CORRELATIONS
 /VARIABLES=AAI_Classification_2 AAI_M_Coherence
 /PRINT=TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=AAI_Classification_2 AAI_M_Coherence
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
NONPAR CORR
 /VARIABLES=AAI_Classification_2 AAI_M_Coherence
 /PRINT=SPEARMAN TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
```

Correlations

				Attachment Coherence of Mind	Two-way forced Attachment State of Mind classification
Attachment Coherence of Mind	Pearson Correlation			1	.902**
	Sig. (2-tailed)				<.001
	N			61	61
	Bootstrap[b]	Bias		0	.001
		Std. Error		0	.017
		BCa 95% Confidence Interval	Lower	.	.863
			Upper	.	.940

**. Correlation is significant at the 0.01 level (2-tailed).
b. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Correlations

			Attachment Coherence of Mind	Two-way forced Attachment State of Mind classification
Spearman's rho	Attachment Coherence of Mind	Correlation Coefficient	1.000	.869**
		Sig. (2-tailed)	.	<.001
		N	61	61

	Bootstrap[b]	Bias		.000	-.006
		Std. Error		.000	.011
		BCa 95% Confidence Interval	Lower	.	.849
			Upper	.	.872

**. Correlation is significant at the 0.01 level (2-tailed).
b. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

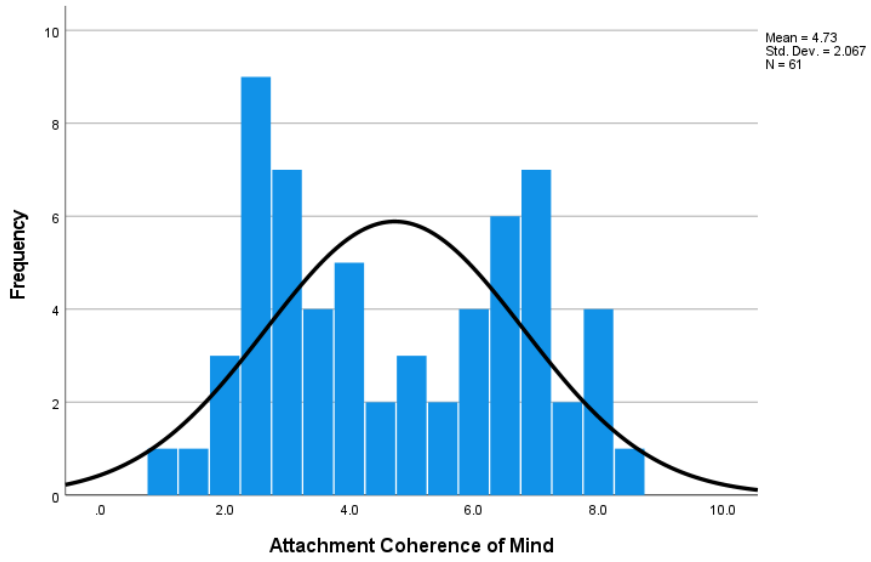
*General descriptives plus histogram for variable attachment coherence of mind.

```
FREQUENCIES VARIABLES=AAI_M_Coherence
 /FORMAT=NOTABLE
 /STATISTICS=STDDEV MINIMUM MAXIMUM MEAN SKEWNESS SESKEW
KURTOSIS SEKURT
 /HISTOGRAM NORMAL
 /ORDER=ANALYSIS.
```

Statistics

Attachment Coherence of Mind

N	Valid	61
	Missing	0
Mean		4.730
Std. Deviation		2.0667
Skewness		.134
Std. Error of Skewness		.306
Kurtosis		-1.341
Std. Error of Kurtosis		.604
Minimum		1.0
Maximum		8.5



*Correlations (Pearson and Spearman) between Case 1 practice-related RF and Case 2 practice-related RF.

```
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
```

```
 /VARIABLES INPUT=RF_C1 RF_C2
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
/MISSING USERMISSING=EXCLUDE.
CORRELATIONS
 /VARIABLES=RF_C1 RF_C2
 /PRINT=TWOTAIL NOSIG FULL
/MISSING=PAIRWISE.
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=RF_C1 RF_C2
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
/MISSING USERMISSING=EXCLUDE.
NONPAR CORR
 /VARIABLES=RF_C1 RF_C2
 /PRINT=SPEARMAN TWOTAIL NOSIG FULL
/MISSING=PAIRWISE.
```

Correlations

				Overall RF score case 1	Overall RF score case 2
Overall RF score case 1	Pearson Correlation			1	.704**
	Sig. (2-tailed)				<.001
	N			61	61
	Bootstrap[b]	Bias		0	.001
		Std. Error		0	.062
		BCa 95% Confidence Interval	Lower	.	.531
			Upper	.	.821

**. Correlation is significant at the 0.01 level (2-tailed).
b. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Correlations

					Overall RF score case 1	Overall RF score case 2
Spearman's rho	Overall RF score case 1	Correlation Coefficient			1.000	.707**
		Sig. (2-tailed)			.	<.001
		N			61	61
		Bootstrap[b]	Bias		.000	-.005
			Std. Error		.000	.075
			BCa 95% Confidence Interval	Lower	.	.546
				Upper	.	.822

**. Correlation is significant at the 0.01 level (2-tailed).
b. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

```
*General descriptives plus histogram for variable practice-related RF.

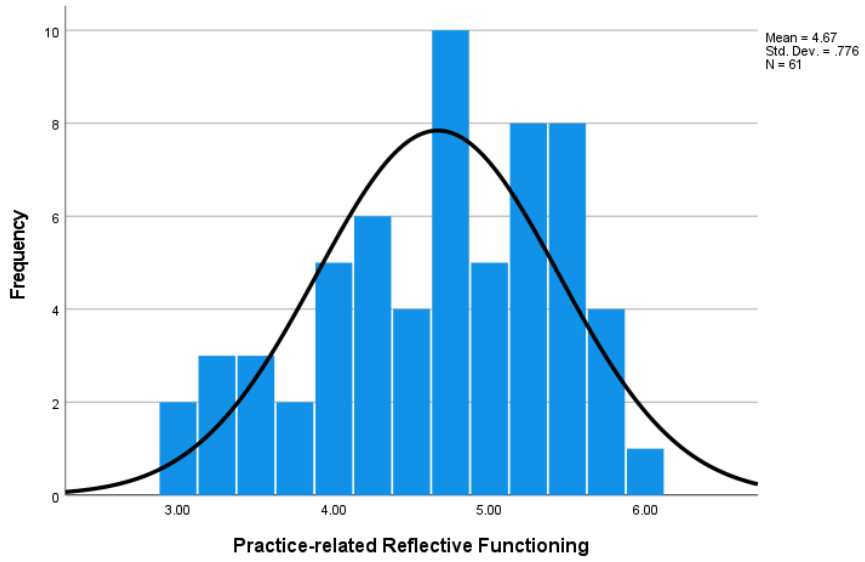
FREQUENCIES VARIABLES=RF_Overall
 /FORMAT=NOTABLE
 /STATISTICS=STDDEV MINIMUM MAXIMUM MEAN SKEWNESS SESKEW
KURTOSIS SEKURT
 /HISTOGRAM NORMAL
```

/ORDER=ANALYSIS.

Statistics

Practice-related Reflective Functioning

N	Valid	61
	Missing	0
Mean		4.6680
Std. Deviation		.77557
Skewness		-.455
Std. Error of Skewness		.306
Kurtosis		-.649
Std. Error of Kurtosis		.604
Minimum		3.00
Maximum		6.00



*Correlation (Spearman only as ordinal data) between Case 1 practice-related risk perceptions and Case 2 practice-related risk perceptions.

```
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=Risk_C1 Risk_C2
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
NONPAR CORR
 /VARIABLES=Risk_C1 Risk_C2
 /PRINT=SPEARMAN TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
```

Correlations

			Risk Rating Case 1	Risk Rating Case 2
Spearman's rho	Risk Rating Case 1	Correlation Coefficient	1.000	-.189
		Sig. (2-tailed)	.	.145
		N	61	61

	Bootstrap[c]	Bias		.000	.009
		Std. Error		.000	.120
		BCa 95% Confidence Interval	Lower	.	-.435
			Upper	.	.086

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

*General descriptives for variable practice-related risk perceptions.

```
FREQUENCIES VARIABLES=Risk_C1 Risk_C2
 /STATISTICS=STDDEV MINIMUM MAXIMUM MEAN
/ORDER=ANALYSIS.
```

Statistics

		Risk Rating Case 1	Risk Rating Case 2
N	Valid	61	61
	Missing	0	0
Mean		3.7705	4.0861
Std. Deviation		.71048	1.17161
Minimum		2.50	1.00
Maximum		5.00	5.00

***Section 9.1.2 Check for Possible Confound From Number of Years of Professional Experience.**

*Correlations (Pearson and Spearman) between number of years' professional experience and the variables of interest.

```
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=Experience AAI_M_Coherence RF_Overall Risk_C1 Risk_C2
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
CORRELATIONS
 /VARIABLES=Experience AAI_M_Coherence RF_Overall Risk_C1 Risk_C2
 /PRINT=TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=Experience AAI_M_Coherence RF_Overall Risk_C1 Risk_C2
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
NONPAR CORR
 /VARIABLES=Experience AAI_M_Coherence RF_Overall Risk_C1 Risk_C2
 /PRINT=SPEARMAN TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
```

Correlations

	No. of years' experience	Attachment Coherence of Mind	Practice-related Reflective Functioning	Risk Rating Case 1	Risk Rating Case 2

No. of years' experience	Pearson Correlation			1	-.086	-.101	.069	-.046
	Sig. (2-tailed)				.508	.441	.595	.724
	N			61	61	61	61	61
	Bootstrap[c]	Bias		0	.000	-.001	-.003	-.014
		Std. Error		0	.119	.129	.157	.111
		BCa 95% Confidence Interval	Lower	.	-.303	-.354	-.258	-.247
			Upper	.	.160	.152	.356	.113

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Correlations

				No. of years' experience	Attachment Coherence of Mind	Practice-related Reflective Functioning	Risk Rating Case 1	Risk Rating Case 2
Spearman's rho	No. of years' experience	Correlation Coefficient		1.000	-.052	-.066	-.005	-.093
		Sig. (2-tailed)		.	.692	.615	.969	.477
		N		61	61	61	61	61
		Bootstrap[c]	Bias	.000	-.001	-.006	.003	.001
			Std. Error	.000	.129	.134	.147	.125
			BCa 95% Confidence Interval Lower	.	-.306	-.318	-.287	-.338
			BCa 95% Confidence Interval Upper	.	.192	.179	.283	.163

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

***SECTION 9.2 ATTACHMENT STATE OF MIND CLASSIFICATIONS DISTRIBUTION.**

*Three-way forced distribution of attachment state of mind classifications.

```
CTABLES
 /VLABELS VARIABLES=AAI_Classification_3 DISPLAY=LABEL
 /TABLE AAI_Classification_3 [COUNT F40.0, COLPCT.COUNT PCT40.1]
 /CATEGORIES VARIABLES=AAI_Classification_3 ORDER=A KEY=VALUE
EMPTY=INCLUDE
 /CRITERIA CILEVEL=95.
```

Custom Tables

		Count	Column N %
Three-way forced Attachment State of Mind classification	F	29	47.5%
	Ds	17	27.9%
	E	15	24.6%

*Four-way distribution of attachment state of mind classifications.

```
CTABLES
 /VLABELS VARIABLES=AAI_Classification_4 DISPLAY=LABEL
```

```
 /TABLE AAI_Classification_4 [COUNT F40.0, COLPCT.COUNT PCT40.1]
 /CATEGORIES VARIABLES=AAI_Classification_4 ORDER=A KEY=VALUE
EMPTY=INCLUDE
 /CRITERIA CILEVEL=95.
```

Custom Tables

		Count	Column N %
Four-way Attachment State of Mind classification	F	25	41.0%
	Ds	17	27.9%
	E	8	13.1%
	U	11	18.0%

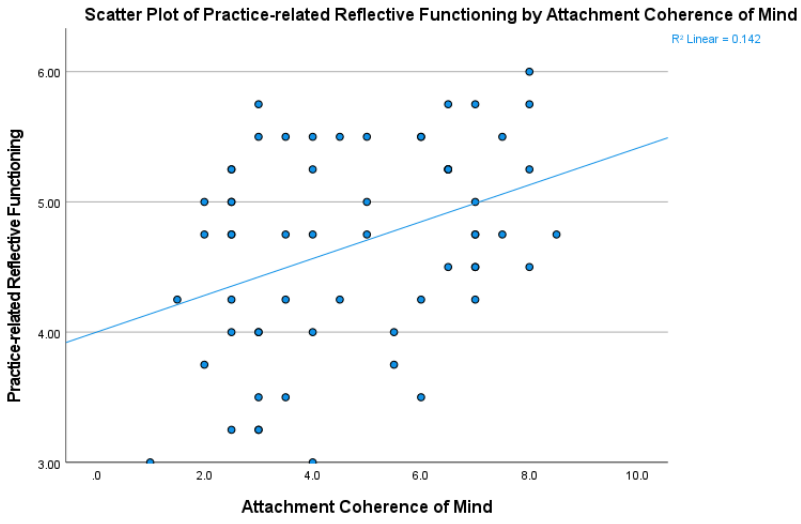
```
*SECTION 9.3 THE RELATIONSHIP BETWEEN ATTACHMENT COHERENCE OF
MIND AND PRACTICE-RELATED RF.

*Section 9.3.1 Results for Research Question 2.

*Scatterplot of practice-related RF by attachment coherence of mind.

GGRAPH
 /GRAPHDATASET NAME="graphdataset" VARIABLES=AAI_M_Coherence
RF_Overall MISSING=LISTWISE
 REPORTMISSING=NO
 /GRAPHSPEC SOURCE=INLINE
 /FITLINE TOTAL=YES SUBGROUP=NO.
BEGIN GPL
 SOURCE: s=userSource(id("graphdataset"))
 DATA: AAI_M_Coherence=col(source(s), name("AAI_M_Coherence"))
 DATA: RF_Overall=col(source(s), name("RF_Overall"))
 GUIDE: axis(dim(1), label("Attachment Coherence of Mind"))
 GUIDE: axis(dim(2), label("Practice-related Reflective Functioning"))
 GUIDE: text.title(label("Scatter Plot of Practice-related Reflective Functioning by
Attachment ",
 "Coherence of Mind"))
 ELEMENT: point(position(AAI_M_Coherence*RF_Overall))
END GPL.
```

GGraph



*Correlations (Pearson and Spearman) between attachment coherence of mind and practice-related RF.

```
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=AAI_M_Coherence RF_Overall
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
CORRELATIONS
 /VARIABLES=AAI_M_Coherence RF_Overall
 /PRINT=TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
BOOTSTRAP
 /SAMPLING METHOD=SIMPLE
 /VARIABLES INPUT=AAI_M_Coherence RF_Overall
 /CRITERIA CILEVEL=95 CITYPE=BCA NSAMPLES=1000
 /MISSING USERMISSING=EXCLUDE.
NONPAR CORR
 /VARIABLES=AAI_M_Coherence RF_Overall
 /PRINT=SPEARMAN TWOTAIL NOSIG FULL
 /MISSING=PAIRWISE.
```

Correlations

				Attachment Coherence of Mind	Practice-related Reflective Functioning
Attachment Coherence of Mind	Pearson Correlation			1	.377**
	Sig. (2-tailed)				.003
	N			61	61
	Bootstrap[c]	Bias		0	-.009
		Std. Error		0	.102
		BCa 95% Confidence Interval	Lower	.	.183
			Upper	.	.552

**. Correlation is significant at the 0.01 level (2-tailed).
c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Correlations

					Attachment Coherence of Mind	Practice-related Reflective Functioning
Spearman's rho	Attachment Coherence of Mind	Correlation Coefficient			1.000	.337**
		Sig. (2-tailed)			.	.008
		N			61	61
		Bootstrap[c]	Bias		.000	-.001
			Std. Error		.000	.110
			BCa 95% Confidence Interval	Lower	.	.088
				Upper	.	.543
				Upper	.543	.

**. Correlation is significant at the 0.01 level (2-tailed).
c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

***Section 9.3.2 Exploratory Post Hoc: Exploring the Association at Profession Level.**

*Descriptive statistics: range, mean and standard deviation for attachment coherence of mind and practice-related RF by profession.

```
MEANS TABLES=AAI_M_Coherence RF_Overall BY Profession
 /CELLS=COUNT MIN MAX MEAN STDDEV.
```

Means

Report

Profession		Attachment Coherence of Mind	Practice-related Reflective Functioning
Social Worker	N	23	23
	Minimum	1.0	3.00
	Maximum	8.0	6.00
	Mean	4.478	4.8043
	Std. Deviation	2.1399	.82901
Clinical Psychologist	N	21	21
	Minimum	2.0	3.50
	Maximum	8.5	5.75
	Mean	5.571	4.9167
	Std. Deviation	1.8992	.57191
GP	N	17	17
	Minimum	2.0	3.00
	Maximum	8.0	5.50
	Mean	4.029	4.1765
	Std. Deviation	1.9160	.73296
Total	N	61	61
	Minimum	1.0	3.00
	Maximum	8.5	6.00
	Mean	4.730	4.6680
	Std. Deviation	2.0667	.77557

*Test of differences (ANOVA and Kruskall-Wallis) in attachment coherence of mind by profession.

```
ONEWAY AAI_M_Coherence BY Profession
 /ES=OVERALL
 /STATISTICS WELCH
 /MISSING ANALYSIS
 /CRITERIA=CILEVEL(0.95)
 /POSTHOC=GH ALPHA(0.05).
```

ANOVA

Attachment Coherence of Mind

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	24.670	2	12.335	3.089	.053
Within Groups	231.617	58	3.993		
Total	256.287	60			

ANOVA Effect Sizes[a,b]

		Point Estimate	95% Confidence Interval Lower	Upper
Attachment Coherence of Mind	Eta-squared	.096	.000	.236
	Epsilon-squared	.065	-.034	.209
	Omega-squared Fixed-effect	.064	-.034	.207
	Omega-squared Random-effect	.033	-.017	.115

a. Eta-squared and Epsilon-squared are estimated based on the fixed-effect model.
b. Negative but less biased estimates are retained, not rounded to zero.

Robust Tests of Equality of Means

Attachment Coherence of Mind

	Statistic[a]	df1	df2	Sig.
Welch	3.293	2	37.620	.048

a. Asymptotically F distributed.

Post Hoc Tests

Multiple Comparisons

Dependent Variable: Attachment Coherence of Mind
Games-Howell

(I) Profession	(J) Profession	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Social Worker	Clinical Psychologist	-1.0932	.6090	.184	-2.573	.386
	GP	.4488	.6442	.767	-1.125	2.023
Clinical Psychologist	Social Worker	1.0932	.6090	.184	-.386	2.573
	GP	1.5420*	.6227	.047	.017	3.067
GP	Social Worker	-.4488	.6442	.767	-2.023	1.125
	Clinical Psychologist	-1.5420*	.6227	.047	-3.067	-.017

*. The mean difference is significant at the 0.05 level.

```
NPTESTS
 /INDEPENDENT TEST (AAI_M_Coherence) GROUP (Profession)
KRUSKAL_WALLIS(COMPARE=PAIRWISE)
 /MISSING SCOPE=ANALYSIS USERMISSING=EXCLUDE
 /CRITERIA ALPHA=0.05 CILEVEL=95.
```

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.[a,b]	Decision
1	The distribution of Attachment Coherence of Mind is the same across categories of Profession.	Independent-Samples Kruskal-Wallis Test	.055	Retain the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

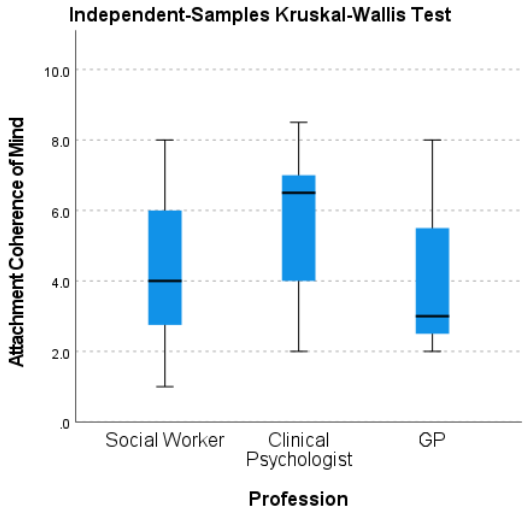
Independent-Samples Kruskal-Wallis Test

Attachment Coherence of Mind across Profession

Independent-Samples Kruskal-Wallis Test Summary

Total N	61
Test Statistic	5.793[a]
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.055

a. The test statistic is adjusted for ties.



Pairwise Comparisons of Profession

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
GP-Social Worker	3.972	5.654	.703	.482	1.000
GP-Clinical Psychologist	13.249	5.767	2.298	.022	.065
Social Worker-Clinical Psychologist	-9.277	5.335	-1.739	.082	.246

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

*Test of differences (ANOVA only as normally distributed) in practice-related RF by profession.

```
ONEWAY RF_Overall BY Profession
 /ES=OVERALL
 /STATISTICS WELCH
 /MISSING ANALYSIS
 /CRITERIA=CILEVEL(0.95)
 /POSTHOC=GH ALPHA(0.05)
```

ANOVA

Practice-related Reflective Functioning

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.833	2	2.917	5.591	.006
Within Groups	30.257	58	.522		
Total	36.090	60			

ANOVA Effect Sizes[a,b]

		Point Estimate	95% Confidence Interval Lower	Upper
Practice-related Reflective Functioning	Eta-squared	.162	.016	.313
	Epsilon-squared	.133	-.018	.289
	Omega-squared Fixed-effect	.131	-.018	.285
	Omega-squared Random-effect	.070	-.009	.166

a. Eta-squared and Epsilon-squared are estimated based on the fixed-effect model.
b. Negative but less biased estimates are retained, not rounded to zero.

Robust Tests of Equality of Means

Practice-related Reflective Functioning

	Statistic[a]	df1	df2	Sig.
Welch	5.915	2	36.379	.006

a. Asymptotically F distributed.

Post Hoc Tests

Multiple Comparisons

Dependent Variable: Practice-related Reflective Functioning
Games-Howell

(I) Profession	(J) Profession	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Social Worker	Clinical Psychologist	-.11232	.21320	.859	-.6316	.4070
	GP	.62788*	.24796	.041	.0223	1.2335
Clinical Psychologist	Social Worker	.11232	.21320	.859	-.4070	.6316
	GP	.74020*	.21720	.005	.2046	1.2758
GP	Social Worker	-.62788*	.24796	.041	-1.2335	-.0223
	Clinical Psychologist	-.74020*	.21720	.005	-1.2758	-.2046

*. The mean difference is significant at the 0.05 level.

*Scatterplot of practice-related RF by attachment coherence of mind by specific professional group.

```
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COLOR9(178,134,0),
 COLOR10(0,157,154), COLOR11(1,39,73), COLOR12(138,56,0),
COLOR13(165,110,255),
 COLOR14(236,230,208), COLOR15(69,70,71), COLOR16(92,202,136),
COLOR17(208,83,52),
 COLOR18(204,127,228), COLOR19(225,188,29), COLOR20(237,75,75),
COLOR21(28,205,205),
 COLOR22(92,113,72), COLOR23(225,139,14), COLOR24(9,38,114),
COLOR25(90,100,94), COLOR26(155,0,0),
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 GUIDE: axis(dim(1), label("Attachment Coherence of Mind"))
 GUIDE: axis(dim(2), label("Practice-related Reflective Functioning"))
 GUIDE: legend(aesthetic(aesthetic.color.interior), label("Profession"))
 GUIDE: text.title(label("Scatter Plot of Practice-related Reflective Functioning by
Attachment ",
 "Coherence of Mind by Profession"))
 SCALE: cat(aesthetic(aesthetic.color.interior), include(
"1", "2", "3"))
 ELEMENT: point(position(AAI_M_Coherence*RF_Overall), color.interior(Profession))
END GPL.
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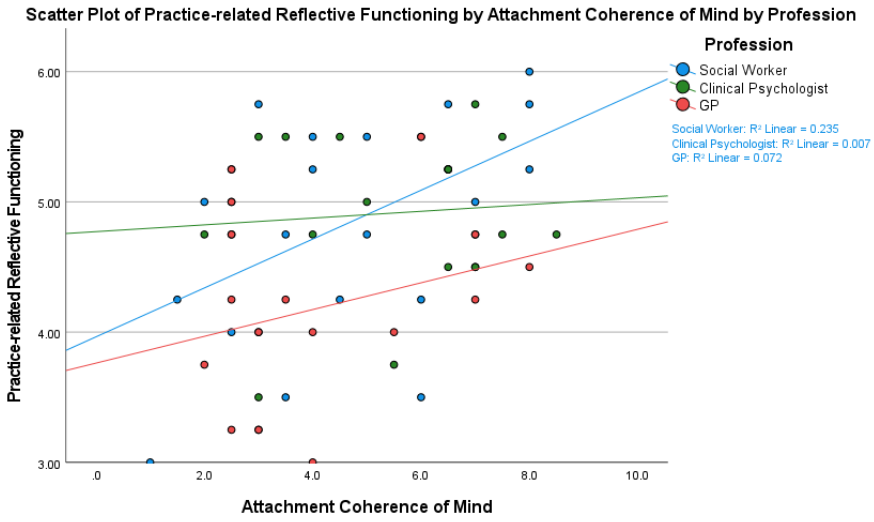
GGraph



*Correlations (Pearson and Spearman) between attachment coherence of mind and practice-related RF, run for each professional group separately.

```
SORT CASES BY Profession.
SPLIT FILE LAYERED BY Profession.

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NONPAR CORR
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Correlations

Profession					Attachment Coherence of Mind	Practice-related Reflective Functioning
Social Worker	Attachment Coherence of Mind	Pearson Correlation			1	.484*
		Sig. (2-tailed)				.019
		N			23	23
		Bootstrap[c]	Bias		0	-.022
			Std. Error		0	.174
			BCa 95% Confidence Interval	Lower	.	.138
				Upper	.	.721
Clinical Psychologist	Attachment Coherence of Mind	Pearson Correlation			1	.086
		Sig. (2-tailed)				.710
		N			21	21
		Bootstrap[c]	Bias		0	-.026
			Std. Error		0	.232
			BCa 95% Confidence Interval	Lower	.	-.380
				Upper	.	.440
GP	Attachment Coherence of Mind	Pearson Correlation			1	.269
		Sig. (2-tailed)				.297
		N			17	17
		Bootstrap[c]	Bias		0	-.010
			Std. Error		0	.201
				Lower	.	-.114

			BCa 95% Confidence Interval		Upper	.	.619

*. Correlation is significant at the 0.05 level (2-tailed).
c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Correlations

Profession						Attachment Coherence of Mind	Practice-related Reflective Functioning
Social Worker	Spearman's rho	Attachment Coherence of Mind	Correlation Coefficient			1.000	.488*
			Sig. (2-tailed)			.	.018
			N			23	23
			Bootstrap[c]	Bias		.000	-.014
				Std. Error		.000	.179
				BCa 95% Confidence Interval	Lower	.	.116
					Upper	.	.768
Clinical Psychologist	Spearman's rho	Attachment Coherence of Mind	Correlation Coefficient			1.000	-.030
			Sig. (2-tailed)			.	.897
			N			21	21
			Bootstrap[c]	Bias		.000	.008
				Std. Error		.000	.219
				BCa 95% Confidence Interval	Lower	.	-.475
					Upper	.	.446
GP	Spearman's rho	Attachment Coherence of Mind	Correlation Coefficient			1.000	.129
			Sig. (2-tailed)			.	.623
			N			17	17
			Bootstrap[c]	Bias		.000	-.004
				Std. Error		.000	.268
				BCa 95% Confidence Interval	Lower	.	-.445
					Upper	.	.624

*. Correlation is significant at the 0.05 level (2-tailed).
c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

SPLIT FILE OFF.

***SECTION 9.4 DIFFERENCES IN PRACTICE-RELATED RISK PERCEPTIONS BY ATTACHMENT STATE OF MIND CLASSIFICATION.**

***Section 9.4.1 Results for Research Question 3.**

*Test of differences (Kruskall-Wallis only as ordinal data) in practice-related risk perceptions for case 1 by Attachment State of Mind classification.

NPTESTS

```
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Hypothesis Test Summary

	Null Hypothesis	Test	Sig.[a,b]	Decision
1	The distribution of Risk Rating Case 1 is the same across categories of Three-way forced Attachment State of Mind classification.	Independent-Samples Kruskal-Wallis Test	.450	Retain the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

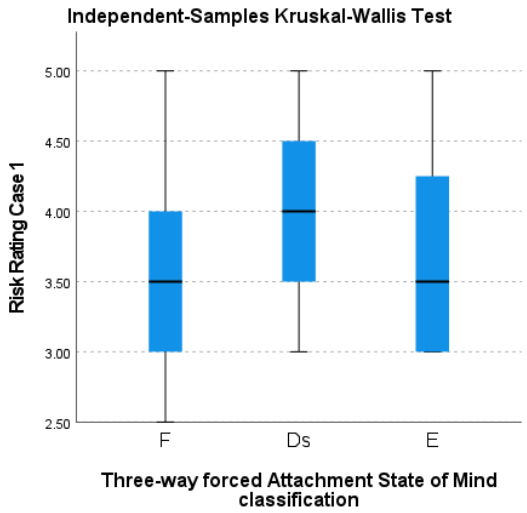
Independent-Samples Kruskal-Wallis Test

Risk Rating Case 1 across Three-way forced Attachment State of Mind classification

Independent-Samples Kruskal-Wallis Test Summary

Total N	61
Test Statistic	1.597[a]
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.450

a. The test statistic is adjusted for ties.



Pairwise Comparisons of Three-way forced Attachment State of Mind classification

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
E-F	1.460	5.512	.265	.791	1.000
E-Ds	7.078	6.140	1.153	.249	.747
F-Ds	-5.619	5.294	-1.061	.289	.866

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .050.
a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

*Test of differences (Kruskall-Wallis only as ordinal data) in practice-related risk perceptions for case 2 by Attachment State of Mind classification.

```
NPTESTS
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/CRITERIA ALPHA=0.05 CILEVEL=95.
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Hypothesis Test Summary

	Null Hypothesis	Test	Sig.[a,b]	Decision
1	The distribution of Risk Rating Case 2 is the same across categories of Three-way forced Attachment State of Mind classification.	Independent-Samples Kruskal-Wallis Test	.741	Retain the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

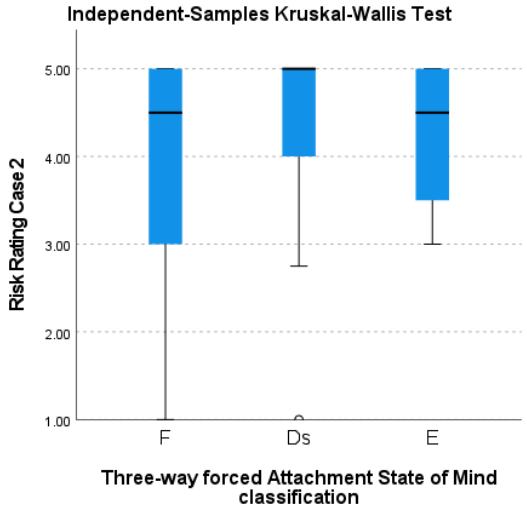
Independent-Samples Kruskal-Wallis Test

Risk Rating Case 2 across Three-way forced Attachment State of Mind classification

Independent-Samples Kruskal-Wallis Test Summary

Total N	61
Test Statistic	.599[a]
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.741

a. The test statistic is adjusted for ties.



Pairwise Comparisons of Three-way forced Attachment State of Mind classification

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
F-E	-2.338	5.289	-.442	.658	1.000
F-Ds	-3.814	5.080	-.751	.453	1.000
E-Ds	1.476	5.891	.251	.802	1.000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .050.
a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

***Section 9.4.2 Exploratory Post Hoc: Exploring Differences in Practice-Related Risk Perceptions by Practice-Related RF Classification.**

*Practice-related RF level grouping frequencies.

```
FREQUENCIES VARIABLES=RF_Group
/ORDER=ANALYSIS.
```

RF Rating Groupings

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 4	10	16.4	16.4	16.4
	4	25	41.0	41.0	57.4
	5 or above	26	42.6	42.6	100.0
	Total	61	100.0	100.0	

*Test of differences (Kruskall-Wallis only as ordinal data) in practice-related risk perceptions for case 1 by practice-related RF classification.

```
NPTESTS
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 /MISSING SCOPE=ANALYSIS USERMISSING=EXCLUDE
/CRITERIA ALPHA=0.05 CILEVEL=95.
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Hypothesis Test Summary

	Null Hypothesis	Test	Sig.[a,b]	Decision
1	The distribution of Risk Rating Case 1 is the same across categories of RF Rating Groupings.	Independent-Samples Kruskal-Wallis Test	.536	Retain the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

Independent-Samples Kruskal-Wallis Test

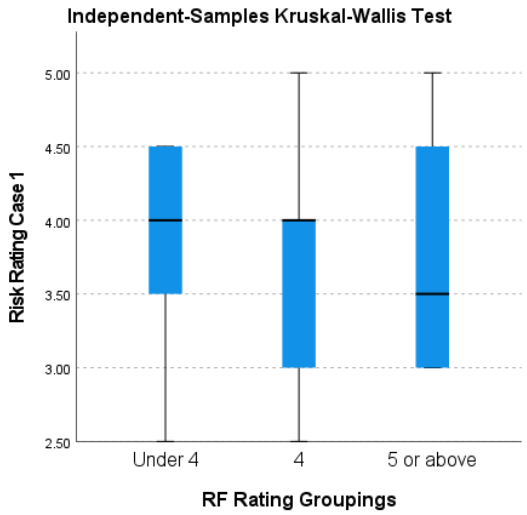
Risk Rating Case 1 across RF Rating Groupings

Independent-Samples Kruskal-Wallis Test Summary

Total N	61

Test Statistic	1.246[a]
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.536

a. The test statistic is adjusted for ties.



Pairwise Comparisons of RF Rating Groupings

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
5 or above-4	.683	4.855	.141	.888	1.000
5 or above-Under 4	6.973	6.449	1.081	.280	.839
4-Under 4	6.290	6.485	.970	.332	.996

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .050.
a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

*Test of differences (Kruskall-Wallis only as ordinal data) in practice-related risk perceptions for case 2 by practice-related RF classification.

```
NPTESTS
 /INDEPENDENT TEST (Risk_C2) GROUP (RF_Group)
KRUSKAL_WALLIS(COMPARE=PAIRWISE)
 /MISSING SCOPE=ANALYSIS USERMISSING=EXCLUDE
/CRITERIA ALPHA=0.05 CILEVEL=95.
```

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.[a,b]	Decision
1	The distribution of Risk Rating Case 2 is the same across categories of RF Rating Groupings.	Independent-Samples Kruskal-Wallis Test	.569	Retain the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

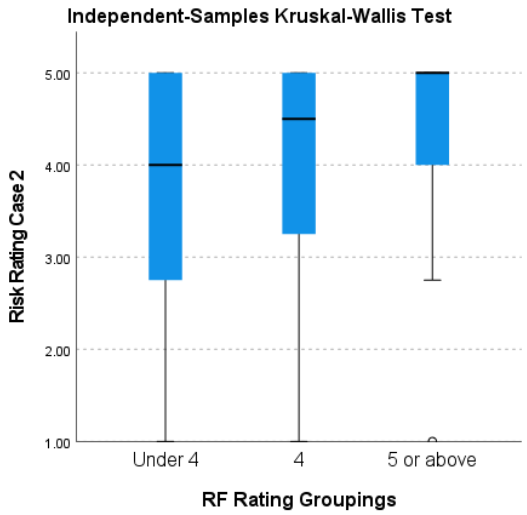
Independent-Samples Kruskal-Wallis Test

Risk Rating Case 2 across RF Rating Groupings

Independent-Samples Kruskal-Wallis Test Summary

Total N	61
Test Statistic	1.126[a]
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.569

a. The test statistic is adjusted for ties.



Pairwise Comparisons of RF Rating Groupings

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Under 4-4	-2.520	6.222	-.405	.685	1.000
Under 4-5 or above	-6.023	6.188	-.973	.330	.991
4-5 or above	-3.503	4.658	-.752	.452	1.000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

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