



# USING KNOWLEDGE IN PRACTICE

## ATTACHMENT THEORY AND CHILD PROTECTION PRACTICE

Joshua is 5 years old and has been described by his mother (Kay) as extremely difficult to manage. Kay tells you that he is a brat and has been since he was born. She says that he is 'just like his father' who left her when Joshua was 4 weeks old. Kay tells you that she has threatened to hand him over to the welfare if his behaviour does not improve, as he is aggressive, regularly destroys his toys and has recently started terrorising the budgie. In fact, Kay has previously dropped Joshua into your office claiming that she doesn't want him any more. She tells you today that she can't cope and is sick of him. She says that she has enough worries and problems of her own and thinks that Joshua is very selfish. You are the Family Services Officer allocated to this family. From an attachment perspective what is your assessment of this situation and what intervention would you propose?

### WHAT IS ATTACHMENT?

*"Attachment is the deep and enduring connection established between a child and caregiver in the first several years of life. It profoundly influences every component of the human condition – mind, body, emotions, relationships and values.*

*Attachment is not something that parents do to their children; rather, it is something that children and parents create together, in an ongoing, reciprocal relationship" (Levy & Orlans, 1998:1).*

Attachment is the bond between caregiver/s and child. The caregiver could be the child's mother, father, grandparents, aunts, uncles or any other individual with whom a child

develops a strong emotional bond (Berk, 2000; Shaw & Benham, 1997). Attachment forms as a result of a caregiver's responsiveness/interaction and the facilitation of a nurturing, caring and trusting environment. Specifically, attachment is developed when a caregiver's behaviour includes: touching, smiling, eye contact, positive interaction and sensitivity to a child's needs (Levy & Orlans, 1998). Although a child's first year is significant in terms of the establishment of attachment, it does, as Pearce and Pearce-Pezzot (1997:13) explain, undergo

*"transformations and reintegrations, with subsequent developmental accomplishments; it has importance for human development throughout the lifespan".*

### BOWLBY'S THEORY OF ATTACHMENT

Attachment theory has rich theoretical origins.

*"Freud first suggested that the infant's emotional tie to the mother provides the foundation for all later relationships" (Berk, 2000:421).*

Psychoanalytic theory recognised the importance of feeding as a central factor in caregiver-child bonding (Berk, 2000). However, one of the most recognised theorists of attachment is John Bowlby. Bowlby's (1969, 1982, 1988) ethological theory of attachment was grounded on the premise that attachment to a particular caregiver is essential for biological survival. Bowlby was particularly influenced by work conducted by Lorenz and

### TOPICS COVERED

- What is attachment?
- Bowlby's theory of attachment
- Attachment styles
- Attachment and child maltreatment
- Impacts of insecure attachment – biology, intergenerational transmission and maladaptions
- Assessing attachment
- Intervention
- Key points

This information sheet provides a review of relevant research on attachment theory and its implications for child protection practice. We open with a case example. Explanation of the meaning of attachment is then provided, followed by a brief discussion of the concept's theoretical origins and a description of different attachment styles. The link between attachment and maltreatment is then examined in detail, with specific emphasis on how this impacts on children. We then consider strategies/principles for assessing attachment and effective intervention in the child protection context. The paper concludes with a summary of the key issues raised.

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## SEARCH CRITERIA AND PROCESS

Literature published between 1996 and 2001 was reviewed. Material prior to 1996 was also drawn upon where it is particularly relevant to the topic. Literature was located by searching the following databases: Austrom:Family, Social Work Abstracts, Sociofile, Humanities, Eric, Psychlit, and via citation searches. Literature reviewed came from British, American and Australian contexts, with British and American literature being the most prolific.

## WHY ATTACHMENT THEORY/RESEARCH IS IMPORTANT FOR CHILD PROTECTION PRACTICE

- Connections between attachment and maltreatment.
- Intergenerational connections.
- Potential impacts/harms – neurophysiology, disorders and other maladaptions.
- Understanding what can threaten, disrupt or impede healthy attachment.
- Providing appropriate and timely assessment and intervention.
- Recognising the importance of quality alternative care and other social supports.

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Tinbergen (on goslings) and Harlow (on rhesus monkeys) in relation to animal imprinting (Berk, 2000; Shaw & Benham, 1997). Bowlby argued that humans, like animals, had a set of behaviours that would heighten the likelihood that an adult or caregiver would remain close and thus protect and respond to their needs.

*“Infants are genetically predisposed to form attachments at a critical point of their lives (6-12 months). ....The infant is equipped with a repertoire of behaviours that attract the caregiver, such as smiling and crying” (Morton & Browne, 1998:1094).*

Bowlby identified that a child's first three years of life were significant in terms of attachment, and posited four stages:

1. The preattachment phase (birth to 6-8 weeks). At this stage the infant has not yet attached to a caregiver but can recognise his/her mother's voice and smell. The child displays a variety of behaviours such as smiling, crying and grasping, which usually facilitate adult contact.
2. The attachment-in-making phase (6-8 weeks to 6-8 months). During this stage the infant begins to respond preferentially and differently to significant caregiver/s (e.g. smiling and laughing at caregiver/s, settling more easily from caregiver/s actions), however does not protest over separation from them.
3. The 'clear-cut' attachment phase (6-8 months to 18 months-3 years). The hallmark of this stage is the child's clear attachment to caregiver/s. The child seeks out and responds to particular caregivers. Also during this stage, separation anxiety (distress, crying etc) will manifest when a child is separated from a significant caregiver. This reaction subsides upon the return of and comfort by a significant adult.

4. Formation of a reciprocal relationship phase (18 months to 2-3 years and on). This stage is characterised by the recognition that significant caregivers are separate individuals with whom the child can interact and negotiate. Separation anxiety reduces, as the child is increasingly able to understand and predict an adult's departure and arrival in everyday life (Berk, 2000; Bowlby, 1969; Shaw & Benham, 1997).

Experience through these stages impacts on personality development in that infants develop internal working models (a set of expectations) of themselves and their primary caregivers (McMillen, 1992). These cognitive models are

*“based on real interactions with significant others, each mutually affecting and changing the other. Children's models of themselves reflect the image their parents have of them, both from how parents have behaved with them and from what parents have said to them” (McMillen, 1992:207).*

These internal models act as a guide, model or set of assumptions on what to expect by way of interaction, sensitivity and responsiveness from others in future significant relationships (Berk, 2000). These internal working models can be quite resistant to change as they operate primarily at an unconscious level (Putallaz, Costanzo, Grimes, & Sherman, 1998). Attachment then, involves two dimensions or poles – view of self and view of others – and forms a working representational model.

## ATTACHMENT STYLES

Given that primary caregivers may offer different levels of responsiveness, nurturing and care of infants, this will impact on the nature

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and type of attachment relationship formed. Mary Ainsworth and colleagues have been instrumental in identifying different styles of attachment related to the quality and nature of child-caregiver interaction. The delineation of different styles of attachment is supported by empirical research (Ainsworth *et al.*, 1978) and (Belsky, Rovine & Taylor, 1984; Egeland & Farber, 1984; Grossman, Grossman, Spangler, Suess, & Unzer, 1985; cited in Morton & Browne, 1998:1094) in both natural and laboratory environments (Strange Situation Procedure). Four types of attachment pattern have been identified: secure; anxious resistant; anxious avoidant and disorganized/disorientated (Ainsworth, Blehar, Waters & Wall, 1978; Howe, Brandon, Hinings & Schofield, 1999; Levy & Orlans, 1998; Main & Solomon, 1986, 1990; Morton & Browne, 1998). It should be noted that the fourth style (disorganised-disorientated) is the most recent addition to attachment styles/classifications and was identified by Main and Solomon (1986). We now briefly outline the characteristics of each attachment style.

## Secure attachment

A secure attachment is characterised by a child who feels secure and safe in a caregiver's presence and thus explores and examines their environment. If the caregiver leaves the area, the child will become distressed (though not excessively) but is easily comforted by this adult upon return. Levy and Orlans (1998:3) report that children who are securely attached do well (over time) in the following areas:

*“self esteem, independence and autonomy; resilience in the face of adversity; ability to manage impulses and feelings; long-term friendships, relationships with parents, caregivers, and other*

*authority figures; prosocial coping skills, trust, intimacy, and affection, ... behavioural performance and academic success in school; and promote secure attachment in their own children when they become adults”.*

Further, as Putallaz *et al.* (1998) report with reference to several empirical studies (Arend, Gove & Sroufe, 1979; Booth, Rose-Krasnor & Rubin, 1991; Cohn, 1990; LaFreniere & Sroufe, 1985; Waters, Wippman & Sroufe, 1979), secure attachment has been used to predict social competence throughout the lifespan.

## Anxious resistant attachment (also known as resistant/ambivalent attachment)

This style of attachment is characterised by a child who becomes extremely distressed when the significant caregiver leaves but upon the adult's return will respond angrily to the caregiver and will not be easily comforted or reassured by them. Morton and Browne (1998:1095) cite research (*i.e.* Carlson, Cicchetti, Barnett & Braunwald, 1989a; Crittenden, 1988) which found that

*“mothers of anxious ambivalent infants are characterized by withdrawal, uninvolved, and inconsistency”.*

## Avoidant attachment

An avoidant style of attachment is characterised by a child who is unaffected or not distressed by a caregiver's departure from an area. An infant with this style of attachment is also often unresponsive to a caregiver when available and may show little preference for this individual in comparison to a stranger. When an adult does return the child may ignore them and keep their distance (Berk, 2000; Morton & Browne, 1998; Pearce & Pezzot-Pearce, 1997).

## OTHER SIGNS OF SECURE ATTACHMENT

- The child has a positive sense of self.
- The child has a positive and optimistic view of the world, life and others.
- The child shows a strong preference for their significant caregiver.
- When the child is in a new situation, they will seek out the significant caregiver.
- When the child becomes distressed they are easily comforted by the attachment figure and will resume exploring their environment or play quickly.
- Others are perceived to be trustworthy, caring and protective.
- Caregivers are attuned to, responsive, reliable and available to meet the child's needs.
- Secure adults display high social understanding and existing relationships are characterised as reciprocal and cooperative.
- Secure adults can manage anxiety and distress in a constructive, balanced manner. (Howe *et al.*, 1999; Levy & Orlans, 1998; Morton & Browne, 1998)

## OTHER SIGNS OF ANXIOUS RESISTANT ATTACHMENT

- Prior to separation the child seeks closeness, which means that their exploration and examination of their environment is more limited.
- The child displays angry, resistant behaviour (yelling, clinging, hitting, pleading, temper tantrums) on the caregiver's return.
- The child can be clingy to their caregiver and anxious about exploring their environment.
- Negative self-image.
- Once infancy is over, the child with this pattern of attachment yells at their caregivers, demands attention, complains about lack of attention and thus increases their attention-seeking behaviours. Caregivers will sometimes respond with threats of abandonment, which heightens the child's anxiety. At age 3 or 4, the child may also exhibit and use coercive strategies with caregivers (*i.e.* threats, bribes, disarming behaviour).
- Caregivers' availability and responsiveness is erratic and they may not be sensitive to the child's needs.
- Caregiver's attention is more difficult to arouse for the child, hence the occurrence of resistant behaviours. (Howe *et al.*, 1999; McMillen, 1992)

## OTHER SIGNS OF AVOIDANT ATTACHMENT

- The child shows little reaction (or some, but minimal) when a caregiver leaves and returns.
- In childhood, the child with this style of attachment does not seek out emotional care from others. The child quite often appears detached, emotionally inhibited and unresponsive.
- In social and school environments, the child with this type of attachment style is undemanding and tends to comply with authority. The child may be an over-achiever and perfectionist. The child's anxiety, distress and anger may be exhibited through bullying of peers. The child may also lack social perception, awareness and sensitivity and can then seem uncomfortable in social situations.
- Caregiver's availability and receptiveness appears to be the highest when the child is least stressed.
- The higher the stress or distress level, the more likely the caregiver is to become rejecting – so behaviours that normally stimulate a caregiver to respond do not work. (Howe et al., 1999; Levy & Orlans, 1998; Morton & Browne, 1998)

## OTHER SIGNS OF DISORGANISED-DISORIENTATED ATTACHMENT

- The child's contradictory behaviours can follow the sequence of strongly seeking attachment followed by avoidance, confused and dazed behaviour.
- The child can display both attached and avoidant behaviours at the same time. There may be confusing and contradictory behaviours upon reunion with caregiver.
- The child's movements, behaviours and expressions are apparently often slow, lethargic and may appear frozen.
- The child may be parental in their interactions with the significant caregiver.
- The child may have a very negative self-image and basically see themselves as unworthy and undeserving of care.
- The child with this pattern may be fearful that they will be abandoned, rejected or harmed from aggression.
- The child may not perceive or engage with their own and others' emotional feelings/ reactions particularly well and therefore can exclude or ignore these reactions.
- As the child gets older they may attempt to control their environment and others and, as such, can be experienced and observed by others as controlling. (Howe et al., 1999; Levy & Orlans, 1998; Morton & Browne, 1998)

## Disorganized-disorientated attachment

Infants with this style of attachment show confused, conflicting or contradictory behaviour in the presence of a significant caregiver. Their contradictory behaviour could include: initially seeking out very intentionally the caregiver but at the same time keeping head averted or turned away; and/or exhibiting non-directed facial expressions such as fear, confusion, disorientation and a dazed look (Pearce & Pezzot-Pearce, 1997). Shaw and Benham (1997:119) suggest that this usually indicates "a disturbed and unpredictable relationship". Pearce and Pezzot-Pearce (1997), with reference to Main and Hesse (1990) and Lyons-Ruth, Repacholi, McLeod and Silva (1991), comment that this style of attachment may have resulted from a previously caring, positive and responsive caregiver who at some point is perceived/experienced by the child as negative, threatening, alarming, scary or anxiety-inducing. It should be noted that the disorganized-disorientated attachment category can be applied to all three attachment patterns (secure, avoidant and resistant). In other words, there may be an underlying attachment style that is layered with a disorganized-disorientated pattern (Berk, 2000; Howe et al., 1999; Morton & Browne, 1998; Pearce & Pezzot-Pearce, 1997). Specifically, the disorganized-disorientated pattern may emerge in times of stress (Howe et al., 1999).

Obviously a caregiver's reaction, level of sensitivity and care of an infant will impact on the nature and type of attachment style that results. Caregivers then, can have particular attitudes or approaches to attachment, which can be broadly classified as: autonomous, dismissing, preoccupied, or unresolved (Benoit & Parker, 1994).

Briefly, an **autonomous** attachment attitude is one that is valuing and interested in attachment with another.

Adults with this attitude are able to analyse in a considered and balanced way their own previous attachment relationships with parents or significant others (whether positive or negative). Their perceptions of their parents are realistic and sensible. An autonomous attachment attitude can result in a secure attachment with an infant. An adult with a **dismissing** attachment attitude gives little credence and value to attachment relationships and generally does not see their importance in terms of personal development. Although often unable to recall or identify earlier attachment experiences, when they do, they can be idealised and therefore not readily supported by accounts and descriptions. A dismissing attachment attitude can result in an avoidant attachment style with an infant. An adult with a **preoccupied** attachment attitude appears enmeshed and engrossed in their attachment history with significant caregivers. Although they may be able to remember particular events and issues easily, their account and explanations lack coherency. As adults, they may still be attempting to have particular relationships and stimulate particular reactions from significant caregivers. This attachment attitude can result in a resistant attachment style and subsequent behaviours in an infant. Finally, the **unresolved** attachment attitude can have the characteristics of any of the other three styles, but adults with this attitude tend to reason in a confused and disorganised way about their attachment experiences. This attitude, transmitted to an infant, can result in a disorganised/disorientated attachment style (Benoit & Parker, 1994; Berk, 2000; Pederson, Gleason, Moran & Bento, 1998).

The foregoing therefore highlights how the transmission of attachment between caregiver and child (Benoit & Parker, 1994) can result in a particular style of attachment as

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“...the parent’s attachment related cognitions are developmental determinants of the attachment relationship” (Pederson et al., 1998: 925).

We will return to this issue later in the paper.

## ATTACHMENT AND CHILD MALTREATMENT

In attempting to understand the impact of maltreatment on children, one area that has received considerable research attention is the link between attachment and maltreatment. Although, in many studies, different types of harm/abuse have not been delineated, it appears that maltreatment does impact on attachment style.

For instance, maltreated children are frequently assessed/identified as having insecure attachment styles and in particular, exhibiting disorganised-disorientated patterns (Carlson, Cicchetti, Barnett & Braunwald, 1989; Crittenden, 1985; Lyons-Ruth, Connell, Zoll & Stahl, 1987). Howe et al. (1999) report that 80% of maltreated children have a disorganised-disorientated attachment style. Similarly, Cicchetti and Toth (1995, and with reference to Egeland and Sroufe 1981; Schneider-Rosen & Cicchetti 1984, Crittenden, 1985, Lamb et al. 1985 and Schneider-Rosen, et al. 1985) suggest that two-thirds of maltreated children form insecure attachments with their caregivers.

*“This contrasts markedly with the patterns of attachment in nonmaltreated comparisons, where approximately two-thirds of the infants and toddlers evidenced secure attachments” (Cicchetti & Toth, 1995:282).*

Van IJzendoorn et al. (1992) also found from a meta-analysis of 34 clinical samples that children whose mothers were not responsive/sensitive in their caregiving or had some form

of psychiatric illness were less likely to develop secure attachments with significant caregivers.

Insecure and disorganised-disorientated attachment styles can result because maltreated children are often raised in very chaotic and disorganised caring environments (Schneider-Rosen, Braunwald, Carlson & Cicchetti, 1985), with the result that the

*“maltreated child [does] not discover that he is special; does not learn the joy and interest that is elicited from experiences of shared affect with his mother, and does not feel affirmed, identified or important. ... Eventually, the child [does] discover... options that may help get his needs met – screaming at, charming or manipulating others to somehow ‘make’ them do things for him, or finding ways to get what he needs on his own” (Hughes, 1999: 4).*

More recent studies have also continued to make links between maltreatment and attachment, with some focusing on particular types of harm. Given the importance of this issue for child protection work, we include a number of examples of this research below.

Moncher (1996) found from interviewing 48 single mothers (using questionnaires and attachment measures) that a strong relationship existed between a parent’s attachment style and risk of physical harm.

*“Inspection of means indicates that the secure group had the lowest risk of abuse, followed by the avoidant group, with the ambivalent group having the greatest abuse risk” (Moncher, 1996: 344).*

Likewise, research conducted by Browne & Saqi (1988) found that children who had been physically harmed or were recipients of “rough handling” had higher rates of insecure

## WHAT IS THE STRANGE SITUATION LABORATORY PROCEDURE?

The Strange Situation is a standardised, validated tool that is used to assess parent-child interactions. It involves “a series of structured observations of mother, infant, and an unfamiliar female in a laboratory playroom. The central events include two mother-infant separations: during one the infant is with the stranger; during the second the infant is first alone and then briefly with the stranger before the mother’s return” (Van IJzendoorn, Goldberg, Kroonenberg & Frenkel, 1992:841). The events are usually 3 minutes in duration, followed by a period of recovery. The underlying premise is that stressful events will stimulate a child’s attachment behaviour (Goldberg, 2000). The main criticisms of the Strange Situation are: (1) it is primarily orientated to 12-18 month olds; (2) its reliability is difficult to assess because children who have participated in the procedure recall the last occasion; (3) data is qualitative rather than quantitative (Goldberg, 2000).

*“... Maltreated children are frequently assessed/identified as having insecure attachment styles and in particular, exhibiting disorganised - disorientated patterns.”*



## WHAT IS THE ADULT ATTACHMENT INTERVIEW?

The Adult Attachment Interview (AAI) is a semi-structured interview that examines an adult's childhood perceptions and experiences of attachment with significant caregivers. "The participant is asked to provide general descriptions of relationships with their parents, give examples that support those descriptions, describe their parents' reactions to illness, hurt or emotional upset, explain why they think their parents behaved in the way that they did and, if appropriate, to discuss salient losses (e.g. deaths) and traumas (e.g. abuse)" (Goldberg, 2000: 43). Criticisms of the Adult Attachment Interview are: (1) self-reporting limitations (not everything is consciously available); (2) it is labour-intensive; (3) and produces qualitative rather than quantitative data (Goldberg, 2000).

attachments (44% avoidant, 26% ambivalent) than nonabused children (13% avoidant, 13% ambivalent) (cited in edited Milner & Dopke, 1997:45). Connections have also recently been made between a mother's antenatal emotional attachment and risk of harm to her foetus (Pollock & Percy, 1999). Pollock and Percy (1999) found from interviewing 40 pregnant women that a negative preoccupied pattern of antenatal attachment was associated with an increased stated likelihood that the mother would harm the foetus in the future.

In focusing on the psychodynamics of children witnessing **domestic violence**, Davidson (1998) also makes reference to attachment theory. Davidson suggests that a child can perceive that one parental figure can be a source of fear, anxiety and terror to another significant carer which can result in the traumatised caregiver exhibiting conflicting caring messages (i.e. nurture and stress) to the infant.

*"This dynamic lays the foundation for the development of a trauma-attachment relationship to emerge" (Davidson, 1998: 74).*

Davidson also adds that the associated dynamics of domestic violence (that is, issues of power, control and isolation) can further exacerbate potential attachment problems as a child may have limited opportunities to acquire attachments with individuals outside the immediate family.

In examining **emotional abuse**, Thompson and Kaplan (1996) identified that this form of maltreatment can damage/delay or harm a child in several ways, including: attachment, psychological development, physical growth, and cognitive processes. In focusing on attachment, Thompson and Kaplan (1996) argue with reference to Patterson (1986) and Crittenden & Ainsworth (1989) that the acts of omission or commission associated

with emotional abuse (i.e. constant ridicule, withdrawal, rejection, terrorising, isolating) will impact or help create a particular style of attachment relationship between caregiver and child. Further, as Hamarman & Bernet (2000:928) explain,

*"emotional abuse ... may impair the child's capacity to develop appropriate emotional responses and may lead to lifelong emotional difficulties".*

A number of recent studies on **sexual abuse** have made reference to attachment principles (Liem & Boudewyn, 1999; Shapiro & Levendosky 1999; Smallbone & Dadds, 1998; Witt, Rambus & Bosley, 1996).

Shapiro & Levendosky (1999) investigated whether attachment style and coping strategies were mediating factors in child sexual abuse. On the basis of questionnaire completion (examining abuse history, coping strategies, relationships, and psychological functioning) by 80 adolescent girls (14-16 years), 26 of whom had previously reported sexual abuse, it was found that attachment mitigates the effects of sexual abuse and subsequent psychological distress. In cases of sexual abuse where a victim reported secure attachment to a caregiver, their psychological distress appeared less, and the authors concluded that

*"a secure attachment style may assist the victim in coping with the trauma or provide a type of resilience not present in victims with insecure attachment styles" (Shapiro & Levendosky, 1999: 1188).*

Smallbone and Dadds (1998) examined three different groups of offenders in terms of maternal and paternal attachment. The three groups were: sexual offenders (48), property offenders (16) and nonoffenders (16).

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On the basis of interviews and questionnaires and the use of measurement scales it was identified that sexual offenders were less secure in their maternal relationships than property offenders and intrafamilial sexual offenders perceived their mothers as less loving, abusive, rejecting, and unresponsive to them than the other two groups. Smallbone and Dadd's (1998:568) research thus supports the premise that sex offenders

*"are likely to have experienced insecure childhood attachments and that they would be insecurely orientated to adult intimate relationships".*

This association also further supports Bumby and Marshall's (1995) research, which found that over 52% of child molesters in their study had fearful-avoidant attachment styles (cited in Witt, Rambus & Bosley, 1996). Ward, Hudson and Marshall (1996) also found that sex offenders were insecurely attached in their romantic relationships with other adults but do point out that this pattern is not unique to sex offenders.

In relation to neglect, O'Connor and Rutter (2000) looked at attachment disturbance and disorder in 165 children adopted from Romania who had suffered severe deprivation, compared to a control group of 52 adoptees from the UK. On the basis of semi-structured interviews and standardised measures of childrens' cognitive and developmental ability, it was found that deprivation is an important predictor of attachment disorder. Interestingly though, those who were identified as having attachment disturbance had experienced varying lengths of deprivation. For instance, it was established that attachment disturbance could occur in children who had suffered neglect in their early months of life. As such,

*"the suggestion is that early deprivation may have long-term effects on the formation of subsequent selective attachment behaviour" (O'Connor & Rutter, 2000: 12).*

This study did not, however, establish what types of deprivation lead to attachment disorder (O'Connor & Rutter, 2000).

Erickson and Egeland (1996) examined parenting and developmental issues of potentially maltreating caregivers (The Minnesota Mother-Child Project). They differentiated their sample of children into five groups: physically abused; verbally abused; neglected; mothers who were psychologically unavailable; and (5) emotionally neglected. In relation to the neglected group it was found from using a variety of measures that

*"among neglected children, two thirds were anxiously attached at 1 year of age. At almost 2 years of age, when videotaped in a problem-solving task with their mothers, neglected children lacked enthusiasm, were easily frustrated, displayed considerable anger, and were noncompliant, and often avoidant and unaffectionate toward their mothers, even though they were highly dependent on them for help" (Erickson & Egeland, 1996: 12).*

At 3 years 6 months it was also found that these children appeared unhappier than the other groups, had poor impulse control and seemed to lack creativity. They also appeared more rigid in their transactions with everyday life. This group was further observed at preschool and day care (age 4 years and 5 months) and in these contexts they were identified as being highly dependent upon teachers and still displaying poor impulse control. They appeared not to have adjusted well to the educational

*"... Sex offenders are likely to have experienced insecure childhood attachments and that they would be insecurely orientated to adult intimate relationships."*

*"... The suggestion is that early deprivation may have long-term effects on the formation of subsequent selective attachment behaviour."*



*“...Trauma and insecure attachment can impact biologically on a child.”*

*“...Traumatised children and adults (who were harmed in childhood) often display symptoms of posttraumatic stress disorder.”*

environment (Erickson & Egeland, 1996). Interestingly, this pattern of poor adjustment and problems appeared to continue, in that at age 4-6 years these children appeared to have the most problems in comparison to the other groups (i.e. inattentive, aggressive, performing less well on IQ tests, anxious, not socialising well with peers and not engaging well in the learning environment).

In summary, this section has highlighted the connection between child maltreatment and attachment style. A number of studies have linked maltreatment with the development of disorganised-disorientated attachment in children. Attachment theory has also been considered in relation to specific types of harm.

### **IMPACTS OF INSECURE ATTACHMENT – BIOLOGY, TRANSMISSION AND MALADAPTIONS**

The preceding sections have included some evidence on the potential negative impacts and harms of insecure attachments. In this section we examine this issue further, specifically addressing neurobiological impacts, intergenerational transmission, and child and adult maladaptions and disorders.

### **NEUROBIOLOGICAL IMPACTS/EFFECTS**

Levy and Orlans (1998) provide a useful summary on the neurobiology of trauma and attachment. Several key points are made on how trauma and insecure attachment can impact biologically on a child. For instance, they state that anxious-disorganised attachment (amongst other factors) can trigger alarm reactions (fight, flight, freeze).

*“Traumatic experiences during infancy and childhood...can trigger prolonged alarm reactions, which*

*alter the neurobiology of the brain and central nervous system. The brain develops sequentially, with the vast majority of structural organization occurring in childhood. .... Lack of critical nurturing and exposure to traumatic stress and abuse alters the nervous system, predisposing the child to be impulsive, overreactive, and violent” (Levy & Orlans, 1998:76).*

Levy and Orlans (1998) and Muller, Sicoli and Lemieux (2000) also point out how traumatised children and adults (who were harmed in childhood) often display symptoms of posttraumatic stress disorder (i.e. flashbacks, nightmares/dreams, anxiety, hypervigilance, sleep difficulties and avoidance of stimuli associated with trauma). The link between attachment and posttraumatic stress disorder has been noted because: (1) PTSD and insecure attachment both “embody a lack of felt security in interpersonal relations” (anxious perception and apprehension of others); and (2) both involve problems in emotion/affect control (Muller, Sicoli & Lemieux, 2000:323-324). Infants develop particular strategies for controlling or regulating their emotions (in particular, anxiety) as a result of their attachment experiences with caregivers. These developed coping strategies may stay with them as they move through different life stages. Given that PTSD is regarded as a disorder involving problematic affect regulation pertaining to particular stressful events/situations,

*“it is plausible that certain attachment styles may create a vulnerability for the development of PTSD, whereas others may act as a protective factor to guard against the development of PTSD” (Muller et al., 2000: 323-324).*



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This latter point is also discussed by Glaser (2000) who indicates that secure attachments can buffer/prevent the elevation of chemical (i.e. cortisol) levels arising from stressful situations. Elevated cortisol levels can impact on the brain, which can damage the hippocampus, which plays an important part in memory function. In particular, Glaser (2000) reports on research conducted by Nachmias et al. (1996) that examined cortisol levels of infants (with different types of attachment) when confronted by a stranger, which in this case was a clown. It was found that

*“...18 month-old children who had a secure attachment to their mother, who was present, showed no elevation of cortisol when responding fearfully to the approach of a stranger (a clown). ...By contrast, constitutionally inhibited and insecurely attached children showed a significant elevation in salivary cortisol when approached by the clown” (Glaser, 2000:105).*

Considering the approach of a clown cannot be considered in any way as traumatic as child abuse and neglect it shows how vulnerable infants with insecure attachment styles are when confronted by stressful situations and events (Glaser, 2000). Van der Kolk (1996) also discusses the buffering effects of secure attachment. The neurobiological impacts of trauma and insecure attachment include: hypervigilance, nightmares, hyperarousal, anxiety, and biochemical and hormonal reactions. Van der Kolk (1996:185) suggests that

*“secure attachment bonds serve as primary defenses against trauma-induced psychopathology in both children and adults... . Our own studies have shown that traumatized adults with childhood*

*histories of severe neglect have a particularly poor long-term prognosis, compared with traumatized individuals who had more secure attachment bonds as children”.*

As such, secure attachment is extremely important for development and optimal physiological functioning.

## INTERGENERATIONAL TRANSMISSION

As discussed earlier infants develop internal working models of themselves and others in relation to quality of interaction, sensitivity, responsiveness and quality of caregiving. This working model can continue throughout different life stages and impact on an individual's relationships as both a recipient and provider of care.

Morton and Browne (1998) suggest that parents who have not had the benefit of secure attachment as children are likely to have insecure attachment relationships with their own children as they have no other representational models of this process. Simply put, they have not experienced sensitive, responsive, appropriate and nurturing caregiving and therefore may not know how to provide such care for another.

*“Thus, it is the caregiving relationship that is transmitted across generations rather than violence per se” (Morton & Browne, 1998:1098).*

Although intergenerational transmission is a complex, multifaceted issue, attachment is seen as an important factor in its occurrence (Zuravin, Mcmillen, DePanfilis & Risley-Curtiss, 1996).

In terms of empirical support for the latter statement, a number of studies have demonstrated or at least recognised attachment as a risk factor for intergenerational transmission of child maltreatment. For instance one

*“Secure attachment bonds serve as primary defenses against trauma-induced psychopathology ...”*

*“This working model can continue throughout different life stages and impact on individual's relationships as both a recipient and provider of care.”*



## WHAT ARE RETROSPECTIVE AND PROSPECTIVE DESIGNS?

Retrospective designs involve looking back in time. This could involve studying a sample of adults who were maltreated in childhood and have maltreated their own children. Criticisms frequently levelled at retrospective designs are distortions in perception and recollection, and the limits of self-reporting. Tomison (1996:4) also suggests that retrospective studies are "commonly perceived as providing over-estimations of the rate of intergenerational transmission of maltreatment". Prospective designs address some of these limitations by following groups forward in time to see whether they will maltreat their own children. A common criticism of prospective designs is that they do not follow-through long enough as many cease when children are in infancy (Tomison, 1996).

*"... Insecure attachments can heighten vulnerability to, but not necessarily cause particular types of psychopathology/disorders and also have ramifications for health and social competence."*

of the questions that Zuravin et al. (1996) investigated in their research was whether quality of attachment relationships was a transmission risk factor for physical or sexual abuse and neglect. They found from interviewing 213 mothers and documentary analysis that

*"quality of attachment with caregivers is a risk factor for transmission. A poorer quality attachment increased the probability of transmission of child maltreatment" (Zuravin et al., 1996:329).*

Rutter (1988, cited in Howe, 1995) examined the parent-child relationships of women who had been institutionalised in childhood. They found that a problematic relationship with their own parents (before they were 4 years old) was the best predictor of problematic relationships with their own children. Green (1998) also reports that most mothers of maltreated children report they had difficult relationships with their own caregivers.

Cowan, Cowan, Cohn and Pearson (1996) found from examining 27 mothers' and 27 fathers' attachment histories that

*"parents' current working models of their growing-up years can also function as risk factors with both direct and indirect links to their children's adaption. Although the AAI does not claim to provide accurate assessments of the grandparent-parent relationship, the pattern of results is consistent with the hypothesis that there is negative emotional spillover across generations" (Cowan et al., 1996:61).*

One of the main limitations of the research conducted on this topic has been the dearth of longitudinal designs that have traced attachment patterns through the lifespan and in different generations. Indeed, most

of this research has utilised methodologies with either retrospective or prospective designs. However, there is some research with longitudinal designs that has examined intergenerational transmission. Van IJzendoorn (1996) reviews four studies (Hamilton, 1994; Waters et al., 1995; Zimmerman, 1994; and Beckwith et al. 1995), three of which offer conclusive findings.

Continuity of attachment style across the lifespan has been illustrated by two studies: Hamilton (1994; cited in Van IJzendoorn, 1996: 227) and Waters et al. (1995; cited in Van IJzendoorn, 1996: 227). Hamilton (1994)

*"found a remarkable stability of attachment across a 17-year period: 77% of her subjects were similarly classified as secure or insecure at 1 year of age and at 17.5 years of age, when they participated in the AAI" (cited in Van IJzendoorn, 1996: 227).*

Likewise, Waters et al. (1995) found from studying 50 white, middle class infants using the strange situation and the adult attachment interview that continuity appeared supported. According to Van IJzendoorn's (1996) review of this study, 70% of participants maintained their attachment classification across 20 years.

In contrast, Van IJzendoorn (1996) reports that continuity was not supported in Zimmermann's (1994) research. Forty-nine families in Bielefeld (northern Germany) were observed and completed the AAI. Parents and children were observed during the child's first, second and sixth year of life. In addition, the children were interviewed at age 10 and in adolescence (16 years of age). One of the main findings was that

*"...attachment security in infancy is not associated with security of attachment representation in adolescence. In particular, divorce and live-threatening illness of*

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*parents appeared to be associated with insecure adolescent attachment representations” (Zimmerman, 1994; cited in Van IJendoorn, 1996: 225).*

Finally, another indicator of the importance of attachment in relation to intergenerational transmission is research that has investigated individuals who were maltreated in childhood and have not perpetuated abuse in their current relationships (Morton & Brown, 1998). Morton and Brown (1998) cite several studies (Cicchetti, Carlson, Braunwald, & Aber, 1987; Egeland, 1991; Egeland, 1988; Egeland, Jacobvitz, & Papatola, 1987; Egeland, Jacobvitz, & Sroufe, 1988) and point out how the cycle of maltreatment appears to have been broken if at some point in an individual's childhood they experienced a positive, caring relationship with a non-abusing adult or counsellor (Putallaz et al., 1998). Putallaz et al. (1998) also report that nonrepeaters are likely to be in relationships that are supportive and caring and that this helps modify their representational models. Further, Egeland (1991; cited in Putallaz et al., 1998) reports that individuals who do perpetrate negative parenting styles cannot provide clear and coherent descriptions of their childhood experiences. This appears indicative of avoidant attachment patterns, which has been suggested as a key feature of intergenerational transmission (Egeland, 1991).

## CHILD AND ADULT IMPACTS/MALADAPTIONS/DISORDERS

*“[Secure] attachment is important because...if you don't ...you are much more likely to be an irritable baby, a difficult toddler, to have delayed cognitive development, poor school performance, and low self esteem. You have major difficulties with peer relations, are likely to be seen as a troublemaker*

*at school or be a bully...likely to be labelled as having ADHD. ...Risk-taking behaviour begins earlier than most and you are more likely to experiment with sex, drugs and alcohol early. You are much more likely to learn depression early, and you are over-represented among youth suicides. ...If you survive, get a partner and have a baby you are likely to have poor attachment to your child and are much more likely to abuse or neglect your child. Basically, a sense of secure attachment is the glue that holds us together through life's crises” (Armstrong, 1998:7).*

It is generally accepted that insecure attachments can heighten vulnerability to, but not necessarily cause, particular types of psychopathology/disorders and also have ramifications for health and social competence (Goldberg, 2000). Indeed the link between attachment and maladaptation is a current and growing area of research (Goldberg, 2000).

Prior to considering some examples of the links between attachment and maladaptation, it is important to distinguish between insecure attachment and an attachment disorder. This is best conceptualised as a continuum, with minor variations of insecure attachment being at one end of the pole and disordered attachment being at the other (extreme) end of pole (Stovall & Dozier, 1998). Several disorders of attachment in infancy or childhood have been identified/classified, namely:

- **Reactive Attachment Disorder**  
Children exhibit developmentally inappropriate social relatedness. Behaviour can range from being over-reactive to highly controlled and include distorted perception of reality, poor cause-and-effect thinking, limited displays of remorse, low self esteem, indifference, guardedness, being difficult to engage and know, being

*“Several disorders of attachment in infancy or childhood have been identified.”*

*“...Disorganised attachment has been linked with dissociative disorders.”*



## WHY DO ATTACHMENT DISTURBANCES OR DISORDERS OCCUR?

Several factors can cause attachment disturbances or disorders. These include: parental, child and environmental factors.

### PARENTAL CHARACTERISTICS

- Depression, low self esteem
- Maternal ambivalence towards pregnancy
- Poor coping skills and parenting ability
- Substance/alcohol misuse
- Intergenerational problems in parent's background
- Abuse and neglect
- Absence from caregiving
- Illness, psychiatric condition
- Parental immaturity, teen pregnancy

### CHILD CHARACTERISTICS

- Prematurity
- Difficult birth
- Disability, illness
- Physical and congenital problems
- Lack of fit with caregivers – perceived temperament problems
- Irregular and difficult patterns of feeding, sleeping

### ENVIRONMENTAL

- Financial pressures
- Separation due to frequent and lengthy hospitalisations
- Abandonment
- Lack of social support
- Inadequate daycare
- High levels of stress in family and household
- Overburdened and unresourced child welfare system
- Problems/inadequacies in alternative care

(Levy & Orlans, 1998; Pickle, 2000; Shaw & Benham, 1997).

*“It has been suggested that, like mental health, attachment can prevent/buffer against illness.”*

coercive and sneaky, rejecting of personal responsibility, lying about the obvious, fire setting out of anger and revenge, hypervigilance and inability to form appropriate, selective attachments (Alston, 2000; Shaw & Benham, 1997).

#### • Nonattached Attachment Disorder

These children have not had the opportunity to develop attachment relationships with others and therefore show no attachment to any individual even when stressed. They may present as disinterested in others and detached (Shaw & Benham, 1997).

#### • Indiscriminate Attachment Disorder

This disorder is characterised by the child who turns to any adult for comfort in times of stress and does not single out the primary attachment figure.

#### • Inhibited Attachment Disorder

The signs of this disorder are when a child is overly dependent or clingy to the primary careprovider to the point that they will not explore and engage with their environment. A child may present as very anxious, shy, withdrawn and excessively compliant to their careprovider (Shaw & Benham, 1997).

#### • Aggressive Attachment Disorder

The hallmark of this disorder is a child who displays significant aggression to themselves and their primary careproviders. This behaviour may manifest even following minor disagreements or frustration with a careprovider (Shaw & Benham, 1997).

#### • Role-Reversed Attachment Disorder

One of the key characteristics of this disorder is a child who appears to take on caretaking

duties that would normally be the primary caregiver's role. Other signs of this disorder may be

*“children who [are] excessively attentive and solicitous or, by contrast, punishing and rejecting”* (Shaw & Benham, 1997: 126).

This section has focused thus far on disorders in infancy and childhood. Links have also been made between insecure attachments and other dysfunctions and disorders that may manifest in adolescence and adulthood.

### Mental health

Goldberg (2000) reviews how disorganised attachment has been linked with dissociative disorders. In citing research undertaken by Lotti (1995) he explains how many of the behaviours associated with disorganised attachment in infancy are similar to dissociative states in adults. There is the suggestion that processes or patterns that are learnt or established in childhood form pathways to dissociative disorders in adulthood.

Muller and Lemieux (2000) found from interviewing sixty-six adult abuse survivors (questionnaires and scales) that negative view of self (one dimension of attachment) was significantly related to psychopathology measures. It was concluded that negative view of self along with other risk factors is a strong predictor of psychopathology.

Lyons-Ruth (1996) found from reviewing attachment related studies of early aggression that insensitive, rejecting and hostile parental behaviour can contribute to aggressive behaviour in children, and that this can at times be at a disordered level (i.e. oppositional defiant disorder (ODD) and conduct disorder (CD)).

### Relationships

Insecure attachment has also been linked to problematic intimate

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relationships. McCarthy and Taylor (1999) suggest that if dysfunctional or unhealthy patterns are experienced in childhood this can affect the likelihood of successful adult romantic relationships in the future. From a review of several studies on dating and marriage in adulthood, Goldberg (2000) suggests that there is some evidence that couples where at least one partner is insecure are likely to experience more conflict in the relationship than secure couples. Milner and Dopke (1997) also suggest that children who have experienced poor or unsupportive caregiving relationships may as adolescents seek partners with similar characteristics.

## Physical health

Goldberg (2000) reports that there is growing interest in the relationship between attachment and physical health. It has been suggested that, like mental health, attachment can prevent/buffer against illness. This has been explained with reference to help seeking behaviour, and psychological and physical stressors (Goldberg, 2000). First, in relation to help seeking behaviour, children who have secure attachments are likely to report symptoms of discomfort/unwellness and thus will most likely receive appropriate care. This may not necessarily be the case for children with insecure attachments. These children may not be responded to when illness or discomfort is expressed and therefore may not learn the importance of help-seeking behaviour in relation to illness (Goldberg, 2000). Second, in relation to stress, as was raised earlier in this paper, secure attachment can buffer the impacts of psychological and physical stress. Given that some attachment styles have heightened levels of anxiety, this can increase an individual's vulnerability to illness (Goldberg, 2000).

In summary, this section has examined the impacts of insecure attachment by focusing on

neurobiological effects, intergenerational transmission of child maltreatment and child and adult maladaptions and disorders. It has been shown that insecure attachment can create problems for the developing child and for adults in several ways. For instance, insecure attachment has been linked with posttraumatic stress disorder, elevated cortisol levels and a higher propensity to perpetuate problematic caregiving. Child and adult maladaptions and disorders have also been linked. It is evident then, that attachment is an important factor, among others, in healthy psychological and physical functioning.

## IMPLICATIONS FOR CHILD PROTECTION PRACTICE

### Assessing attachment

Given the importance of attachment to healthy psychological and physical functioning, assessment of attachment is vital in child protection work. This does not mean that every case will require a detailed attachment assessment (Howe et al., 1999). One of the key benefits of having a thorough understanding of attachment theory is recognising when this level of assessment may be required and arguing for its relevance in appropriate forums (i.e. supervision, SCAN team meetings, case notes, courts) (Howe et al., 1999).

Using a number of methods for gathering information is recommended. These may include observations, interviews, case records/reports, drawings and sentence completion/narrative story stem technique (see Bretherton, Ridgeway & Cassidy, 1990) as well gathering information from a number of sources (such as parents, teachers, day care providers, doctors, grandparents, alternative careproviders, and other services). This may also involve multiple sites (i.e. home and office based assessments). This heightens the likelihood of a thorough, systematic,

*“One of the key benefits of having a thorough understanding of attachment theory is recognising when this level of assessment may be required and arguing for its relevance in appropriate forums.”*

*“Using a number of methods for gathering information is recommended.”*



*“Cultural sensitivity is also crucial in undertaking any assessment and one has to be mindful and become aware of the particular or specific modes of caregiving and reactions in different cultures.”*

## INTERESTED IN ASSESSMENT TOOLS FOR ATTACHMENT AND BONDING?

Prentky and Bird Edmunds (1997:25-27) have identified several tools that can be used for assessing attachment and bonding, some of which are:

### FAMILY BONDING SCALE (FBS)

This scale examines a number of issues: caring and trust, identity support, control and supervision, intimate communication and instrumental communication. The tool can be used with adolescents and adults. Prentky & Edmunds (1997) explain that this tool has emerged from research that has focused on attachment variables and delinquency. For further information see: Dernkovic, S.A., & Giordano, P.C. (1987). Family relationships and delinquency, *Criminology*, 25, 295-321 [cited in Prentky & Bird Edmunds, 1997: 25-27].

### PARENTAL BONDING QUESTIONNAIRE (PBQ)

This tool assesses the perceived attitudes of an adult to his/her perceived mother figure. For further information see: Parker, B., Tupling, H., & Brown, L.B. (1979). A parental bonding questionnaire. *British Journal of Medical Psychology*, 52, 1-10 [cited in Prentky & Bird Edmunds, 1997: 25-27].

### RELATEDNESS QUESTIONNAIRE (RQ)

This tool specifically examines the quality of a child's relationship to a number of people: friends, peers, teachers, mother. This tool can be used with children of 8 years and older. Dr Michael Lynch and Dr Dante Cicchetti developed this tool and copies of it can be requested from them directly at Mt Hope Family Center, Department of Psychology, University of Rochester, Rochester, N.Y 14608 [cited in Prentky & Bird Edmunds, 1997: 25-27].

ecological assessment. Further, gathering information from a variety of sources strengthens the validity of the assessment (i.e its truthfulness) as points of convergence (agreement) and divergence (disagreement) can be identified (Levy & Orlans, 1998).

A number of authors have provided useful guidelines on the type of information that should be gathered and the best ways to achieve this when undertaking an attachment assessment. In summarising this work (Howe et al., 1999; Goldberg, 2000; Levy & Orlans, 1998; Pearce & Pezzot-Pearce, 1997; Rolfe, 1999) the following content areas are suggested:

- Parental reactions to the child – prenatally, toddler and subsequent years (parents' perception of the child throughout time to the present day).
- Parents/caregivers' descriptions of the child's behaviour in relation to them and others.
- Parents' relationship and perception of other children in the family (may be successfully parenting other children in the family; this may indicate competence to a certain level depending on the perceived difficulty of a child).
- Child's developmental history – social, intellectual, emotional, behavioural, physical.
- Child's attachment history (focus on the first 3 years of life – events, placements changes, availability of caregivers etc).
- Parents' perceptions and recollections of their own childhood experiences and relationship with significant caregivers (helps identify the caregivers internal working model).
- Parents' perception of their current relationships and level of support.
- Level of external and internal stressors on the family, past and present (financial, personal, environmental, domestic violence,

deaths, illness, mental health, employment, divorce/separation etc).

- Level of social and professional support for both parents and children – siblings, friends, extended families, clubs, sporting facilities, welfare system.
- Child's perception of self and others in terms of caregiving. Children can project onto other relationships their internal working models of attachment and caregiving. Can the child give emotionally?
- Child's behaviour to significant caregivers (i.e. does he/she spontaneously initiate affection with the caregiver?; seek help from them in times of distress?; show preference for them?)
- Child's behaviour – can he/she explore the environment, initiate and be involved in positive play without engaging in negative behaviour afterwards? Can the child learn new information? Can the child engage in unsupervised age-appropriate play?
- Child's perception of their behaviour to caregivers/others.
- Parental-child relationship (current relationship between caregiver and child – reactions to separation and reunion, parental level of sensitivity, reciprocity, responsiveness and monitoring of the child, parent-child level of synchrony – how engaged they are with each other).
- Parental and child strengths and existing capabilities.

This list is not exhaustive but does signpost a number of areas that can be explored in attempting to gain information pertinent for assessing attachment. As mentioned earlier, using a variety of means is recommended for information gathering. This also entails attending to both verbal (what they are saying, how they are saying it, and emotional tone) and non-verbal behaviour

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(between parent and child, child and others, in discussion with you) and exploring the best mediums for expression of these issues. For instance, depending on the age and developmental level of a child, sentence completion, drawings or psychodramatic re-enactment may be useful (Howe et al., 1999; Levy & Orlans, 1998).

Cultural sensitivity is also crucial in undertaking any assessment and one has to be mindful and become aware of the particular or specific modes of caregiving and reactions in different cultures. Harwood, Miller and Irizarry (1995:13) state with reference to Grossmann & Grossman (1990) and Sagi (1990),

*“The main issue is whether the different attachment strategies observed may be differentially adaptive in different cultures.... It may well be that behaviour strategies are universal, but that the relevance for them may be culture-specific” (Grossmann & Grossman, 1990:37; cited in Harwood et al., 1995:13).*

*“We can conclude that attachment theory is useful in the broader sense but always must be applied within the context of cultural idiosyncrasies. Or, to state the case from a universalistic point of view, the repertoire of attachment behaviours is similar across countries, but the selection of these behaviours is culturally specific” (Sagi, 1990:19; cited in Harwood et al., 1995:13).*

Assessment of attachment is important in child protection practice. Although the child protection worker may not always conduct this type of assessment (it may be undertaken by a professional outside the statutory agency), knowledge of attachment and how to detect problems (via information gathering) is essential. Assessments should be ecological in

their scope, including child, parental, and environmental/system factors.

In addition, they should be supported by multiple methods in a variety of contexts and be culturally sensitive.

## INTERVENTION

In the child protection context the principal focus is on the safety and well-being of a child. The child's safety is paramount and emphasis is given to assessing risk of harm and implementing strategies that aim to minimise the likelihood of future harm. As argued in this review, attachment is inextricably connected to maltreatment and therefore will often require attention at the interventive level. Simply put, focus should be afforded to: (1) reducing circumstances that are developmentally harmful and; (2) assisting in the rebuilding or enhancing of the child's development (Howe et al., 1999). Intervention can be child, parental and/or systems centred (Howe et al., 1999). Generally, intervention should be directed at all three of these interconnected areas. Attachment disturbance should not be conceptualised as the fault of any party and as such the focus should be “...[on the] relationship between the infant and the parent” (Shaw & Benham, 1997:134).

### Child centred intervention

A variety of child centred interventions can be helpful in assisting a child with attachment disturbance. Simply put, child centred intervention should focus on assisting a child to express feelings and gain greater emotional awareness, strengthening the child's resilience, improving self esteem/self worth, improving their capacity and ability to handle stress and difficulties, challenging existing internal models of care and reducing current situations/circumstances that are hindering their social, emotional and

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*“Focus should be afforded to: (1) reducing circumstances that are developmentally harmful and; (2) assisting in the rebuilding of the child's development.”*

*“...It is beneficial to initially organise intervention according to the parents’ view.”*

*“Success of intervention with parents ... is inextricably linked to quality of relationship between practitioner and client.”*

intellectual development (Howe et al., 1999). The type of intervention offered will depend upon the age and developmental level of the child.

For instance, Pearce and Pezzot-Pearce (1997:147) explain

*“...young children (below 5 years of age) do not have the requisite verbal or cognitive skills to benefit from [individual treatment]... Intervention should be focused on helping the parents become the primary agents of change”.*

Several child centred intervention techniques have been discussed in the literature:

#### **Recognising and naming feelings**

Techniques focus on assisting a child to become aware of their feelings and discuss them. This can result in a child being able to consider current situations/circumstances more constructively. Howe et al. (1999) refers to Morris’s (1996) work on this technique.

#### **Cognitive-behavioural therapy**

Children may have negative representational models towards current and potentially new relationships. Cognitive therapy can assist in challenging these models.

*“The overarching goals of therapy are the facilitation of a reality-based view of the world, rather than reliance on preconceived and potentially invalid assessments of the environment” (Cicchetti & Toth, 1995:300).*

Howe et al. (1999) point out that children with attachment disturbance can develop conduct disorders and suggest that cognitive-behavioural therapy can assist in improving existing cognitive and problem-solving skills. This can encompass the use of techniques such as modelling, anger management, role-playing and positive reinforcement.

#### **Psychotherapy**

Cicchetti and Toth (1995) explain how a child will often replay in therapeutic interactions modes of normal interaction (for them). They cite the example of a child who had frequently experienced rejection and would act in a way that would heighten the likelihood of rejection by others in the therapeutic interchange. This expectation was challenged in counselling, as the practitioner was positive, sensitive and not rejecting. Psychotherapy can facilitate the ventilation and identification of cognitions which may prevent the continuation of “idealised” images of a child’s caregivers which may be sustained by defence mechanisms such as projection, displacement, dissociation and so on (Pearce & Pezzot-Pearce, 1997).

#### **Peer-pair counselling**

Cicchetti and Toth (1995) cite work undertaken by Selman, Nakkula, Barr, Watts & Richmond (1992) where children with aggressive or withdrawn behaviour are paired with a child with the opposite style. This technique has been regarded as particularly effective as an early preventative/interventive technique for vulnerable children.

#### **Play therapy**

Howe et al. (1999) with reference to Russ (1995) suggest that play therapy can be a useful technique for children with attachment disturbance. Through play children can express thoughts, feelings, desires and wishes. The therapeutic value of this has been identified as: catharsis; recognising and naming feelings; having the opportunity and forum to work through difficult emotions; problem-solving; and learning coping strategies. Howe et al. (1999) also note that play therapy can be particularly effective if combined with cognitive-behavioural approaches.





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## Group work and therapy

Groups can be particularly useful for support and further challenging of a child's working representational model (Cicchetti & Toth, 1995).

## Parent centred intervention

Intervening with parents is not necessarily an easy task in relation to attachment issues. As Colin (1996) explains these parents' own representational models are likely to expect negative, unresponsive and insensitive responses from others. They anticipate and expect not to be cared for, loved, respected and reliably responded to. Success of intervention with parents then is inextricably linked to quality of relationship between practitioner and client (Cicchetti & Toth, 1995; Colin, 1996). The therapeutic relationship can be conceptualised as the "background of safety" for exploration and subsequent change (West & Keller, 1994:322).

Erickson, Korfmacher & Egeland (1992; cited in Cicchetti & Toth, 1995) suggest the following practice principles for achieving a quality relationship with clients:

- 1) being consistent and reliable with the adult;
- 2) identifying and acknowledging the strengths of mother and child;
- 3) empowerment;
- 4) making links between current behaviour (between client and practitioner) and parental attachment history; and
- 5) communication of content that challenges or alters representational models (cited in Cicchetti & Toth, 1995).

Colin (1996) suggests that it is beneficial to initially organise intervention according to the parents' view. The reason for this is that a parent is more likely to respond to help if they feel their view is considered legitimate and listened to.

*"The help must be for the parent, not only for the child. The intervener must treat the parent as someone who is valuable in his or her own right; the parent is not just a tool for the therapist to use for the baby's benefit. The intervener can help the parent find ways to change the baby's behaviour so that the relationship will be easier and more rewarding for the parent"* (Colin, 1996: 207).

Of course, in the child protection context this may be more difficult, given there may be issues of significant harm and risk to the child. Intervention may need to be multifaceted (Colin, 1996) and involve different practitioners for different tasks.

As with child centred intervention, parent focused intervention can involve different therapeutic responses depending on the specifics and requirements of a case. Some options are:

- Strengthening parental awareness, sensitivity and knowledge of children's needs. This can involve direct teaching and education about children's needs and emotions, recognising cues etc, modelling and coaching sensitivity and responsibility to a child, learning how to facilitate positive and enjoyable interactions, effectively communicating emotion, and skills that assist in improving a child's sense of security.
- Individual and caregiver-child psychotherapy. This can involve the individual examining his/her own attachment history and the feelings, reactions and issues associated with this (Shaw & Benham, 1997). Infant-parent psychotherapy can also assist in the treatment of attachment disturbance as interactional problems/reciprocal influences can be addressed in the

*"Intervention may need to be multifaceted ... and involve different practitioners for different tasks."*

*"Achieving a degree of emotional awareness about self and past and present relationships may in turn, enable a parent to provide more sensitive and nurturing care to their child."*



*“...Alternative careproviders, do themselves need a secure and healthy attachment history/base.”*

*“Alternative careproviders, more so than ever, require skills, knowledge and personal capabilities for caring for these often-difficult children.”*

therapeutic session. Cicchetti & Toth (1995) suggest that at times individual and dyadic sessions need to be alternated, as it may be inappropriate for the child to witness his/her parent's distress.

- Advocacy and assistance with financial, material and housing issues. This can assist in the development of trust, which is an important foundation for other forms of therapeutic assistance.
- Emotional support from the practitioner or members of a support group (Colin, 1996; Cicchetti & Toth, 1995; Page, 1999).

Colin (1996) reports that effective intervention programs with parents involve going beyond educating and informing parents of children's needs to also including psychotherapy that explores personal issues, experiences and reactions of the parent (see Lieberman, Weston & Pawl, 1991). Achieving a degree of emotional awareness about self and past and present relationships may in turn, enable a parent to provide more sensitive and nurturing care to their child.

In general, a number of intervention options may be useful for creating change in families where attachment disturbance is a potential risk or a current issue. Colin (1996:215) provides a useful concluding statement:

*“When the primary challenge to developing secure attachment is infant irritability, as few as three intervention visits with a very specific focus on teaching the mother to respond sensitively to her infant's signals and to develop enjoyable interactions with him or her may have a profound positive impact. When the primary impediment to the development of secure attachment rests in the*

*mother's personality, treatment can still be successful but is likely to require much more time, effort, depth, and scope. In high-risk families, interventions that are brief or simple, such as parent education, are not effective.*

*Successful programs for such families include psychotherapy... practical assistance, social support, modelling, and instruction; successful programs generally continue to provide clients with services for a year or more”.*

## OTHER SYSTEMS

### Preparation, training and support for alternative careproviders

As was noted earlier in this paper when discussing the relationship between intergenerational transmission and attachment, positive, sensitive and nurturing caregiving and therapeutic assistance can potentially change children's working models of care. This signals the importance of quality caregiving for the maltreated child so as to increase the likelihood of positive social, emotional and developmental outcomes for them. As such, this has important implications for alternative care in terms of training, support and planning.

Steward and O'Day (2000) signal the importance of careful recruitment of foster and adoptive families. Children placed with alternative careproviders are increasingly exhibiting a greater variety and severity of behavioural problems (Hughes, 1999; Penzerro & Lein, 1995; Steward & O'Day, 2000; Wise, 1999). Children can particularly display acting-out and anti-social behaviours at points of disruption or transitions (Penzerro & Lein, 1995).

Alternative careproviders, more so than ever, require skills, knowledge and personal capabilities for caring for these often-difficult children.



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*“Woven throughout these skills must be the ability to provide the attunement experiences which will help the child develop and/or maintain secure attachments. Most parents can easily relate to the attunement activities one does with an infant (touching, cooing, eye contact, holding, smiling, talking, rocking, singing, etc). Unfortunately, many may not understand that they must find ways to have that same type of ‘connecting’ experience with an angry or withdrawn child who never had those important interactions as an infant” (Steward & O’Day, 2000: 153).*

As such, alternative careproviders do themselves need a secure and healthy attachment history/base. If this is lacking, such careproviders may find it extremely difficult to manage and respond appropriately to children with behaviours associated with attachment disturbance. As Steward & O’Day (2000: 156) so aptly express

*“...attachment-disordered children have been known to ‘chew up’ the new and uninitiated”.*

Training and support is vital for alternative careproviders. Alternative careproviders require the knowledge and skills to effectively care for these children (Steward & O’Day, 2000; Stovall & Dozier, 1998; Tyrrell & Dozier, 1999). Steward & O’Day (2000) suggest the following topics for alternative care education on this issue:

- 1) child development;
- 2) biological impacts;
- 3) developmental and emotional delay;
- 4) attachment theory;
- 5) behaviour/skills for facilitating attunement and attachment; and
- 6) behaviour management techniques.

It should not be assumed that careproviders have this level of knowledge from experience. For instance, Tyrrell and Dozier (1999) found from examining foster parents’ understandings of attachment strategies that they were not any more skilful or knowledgeable than other parents. They suggest this is inadequate as alternative careproviders play a critical role in the therapeutic process.

Needless to say, careproviders also require support and guidance so as to prevent placement breakdown and disruptions. Placement disruption, which is synonymous with changing carers, environments, workers etc, can further exacerbate a child’s already damaged representational model of attachment (Lynch, 2000; Pilowsky & Kates, 1996).

## **Preserving attachments and permanency planning**

Two other issues important for attachment in the context of alternative care and child protection are: preserving attachments and permanency planning. Every effort should be made to maintain and further strengthen existing attachment relationships. This could be with biological parents, siblings, relatives, other careproviders, peers and others (Hegar, 1993). Notably, some research has found that attachment relationships may be ignored or de-emphasised by child protection workers (Grigsby, 1994). Indeed, although there may be instances where contact between parent and child is so detrimental that questions may be raised as to whether contact should be maintained, a focus of the child protection worker should be on finding ways of making interactions with significant others positive. This can be achieved by attending to issues that may assist in addressing a parents’ needs or alternatively teaching a parent sensitive and

*“Placement disruption, which is synonymous with changing carers, environments, workers etc can further exacerbate a child’s already damaged representational model of attachment.”*

*“Training and support is vital for alternative careproviders.”*

*“Every effort should be made to maintain and further strengthen existing attachment relationships.”*



*“... It is also important to note the limitations or criticisms that have been made of this theory.”*

nurturing caregiving behaviour (Howe et al., 1999).

Attachment should also be considered along with kinship and permanence when deciding on placement options (Hegar, 1993; Pilowsky & Kates, 1996). For instance, Stokes and Strothman (1996) identify a number of situations in which attachment assessments may be useful when considering permanency planning:

- 1) a child who has been in alternative care for several years and the parent is requesting reunification based on adequately achieving agreed goals and tasks;
- 2) situations where more than one family or significant careprovider is seeking custody of the child;
- 3) situations where different professional groups have differing opinions on who should primarily care for a child.

Although these types of situations are complex and many factors require consideration and assessment, attachment is one dimension, among others, that can assist with permanency decision making (Grigsby, 1994).

#### **Preschool and school environments**

Cicchetti and Toth (1995) suggest that therapeutic preschool programs can be effective for preschoolers with attachment disturbance. Provided the staff are adequately trained and aware of the type of behaviours that will manifest as a result of attachment disturbance, this form of supplementary careproviding can assist in challenging and altering a child's caregiving representational model. Cicchetti and Toth (1995:296) explain further.

*“By helping classroom personnel to respond to each child in ways*

*that cause the child to question the accuracy of his or her representational models, we are addressing a major goal, namely, helping the child to keep his or her models of relationships open to new and potentially positive experiences”.*

#### **Daycare as an intervention**

Colin (1996) points out the value and usefulness of daycare as a form of intervention. Positive experiences in daycare can assist a child with their emotional, social and intellectual development. This also allows parents to have time away from the child, so when the child is in their care, the interaction is hopefully more positive. It is important to note however, that positive outcomes have not always been achieved from the use of daycare in this way. Colin (1996) cites research undertaken by Crittenden (1983) who investigated 22 children for whom mandatory daycare had been ordered. It was found that enforced separation exacerbated parental and child anger, distress and rejection which increased the risk of harm in these homes.

#### **THE LIMITS OF ATTACHMENT THEORY**

This review thus far has in the main offered substantial support for the importance and utility of attachment theory in the child protection context. In an effort to provide a balanced review of this topic it is also important to note the limitations or criticisms that have been made of this theory. These are briefly summarised in **Table 1** as identified by Bolen (2000) and Goldberg (2000).

Considering the arguments offered in **Table 1**, it would be reasonable to query whether or not attachment theory should guide and inform child protection practice. We, similarly to Bolen (2000) would say

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'yes' but its limits need to be recognised and thus applied critically. We conclude with Bolen's (2000:149) advice:

*"Clinicians must...remain clear about the limits of the knowledge base. Furthermore, it is essential that attachment theory remain value neutral so that it does not become an excuse for punishing*

*victims or their families. Finally, and perhaps most important, attachment theory only contributes to the understanding of processes at the level of the individual and family. A narrow focus on these ecological levels will seriously undermine efforts to understand causal patterns of violence and abuse, which are best conceptualized at the macrolevel".*

**TABLE 1 CRITICISMS OF ATTACHMENT THEORY**

| <b>BOLEN (2000)</b>   | <b>GOLDBERG (2000)</b>   |
|---|--|
| Attachment theory has been strongly supported and based on experiments with nonhuman subjects.  | Definitions of attachment can be both broad and narrow. Definitional issues either enhance or limit links to a range of developmental issues and other outcomes. As such, attachment theory could be seen as encompassing and connecting to everything or having very limited applicability.   |
| Attachment theory is offered as having generic applicability. The cross-cultural dimension has not been sufficiently examined and therefore attachment theory may be culturally biased. | Methodological limitations of attachment research do confound or limit conclusions. Criticisms have been particularly levelled at the Strange Situation. As discussed earlier, the Strange Situation has been criticised as being orientated to 12-18 month olds, being difficult to replicate with previously exposed participants and primarily producing qualitative information. |
| Although there is convincing support for the intergenerational transmission hypothesis, methodological issues limit conclusions that have been drawn.                                   | Attachment theory has been viewed as 'mother blaming' by some commentators.  |
| The principle that attachment is passed from caregiver to child is overly simplistic and gives the impression that this process is linear.  | Insufficient understanding of internal working models. Issues surrounding the development, working and integration of these models still require attention.  |
|   | Issues surrounding infant determinism. Clarification is still required on the extent to which early experiences determine later development.   |
|   | Lumping together insecure attachment styles in earlier research, which means that valuable information has been lost on individual attachment differences and potential connections and outcomes of such differences.  |

## KEY POINTS

- Attachment is the connection that exists between a child and caregiver. Attachment forms as a result of the level of responsiveness, care, sensitivity and reliability of a careprovider.
- Different styles of attachment result on the basis of child-caregiver interaction. There are four identified styles: secure, anxious-resistant, avoidant and disorganised-disorientated attachment.
- Caregivers can have particular attitudes to attachment: autonomous, dismissing, preoccupied or unresolved.
- Maltreated children have frequently been assessed as having disorganised-disorientated attachment styles.
- A number of empirical and theoretical links have been made between attachment and maltreatment.
- Insecure attachment can impact on the physiological functioning of a child.
- Attachment is an integral component of intergenerational transmission of child maltreatment.
- Insecure attachments can heighten vulnerability to illness, disorders and other maladaptions.
- Assessment of attachment should be multi-method, multi-source and multi-site.
- Attachment assessment needs to be culturally sensitive and appropriate.
- Intervention involves attention to three interconnected sites: child, parent and environment.
- Although attachment theory is useful and relevant to child protection practice, it does have limitations.

## REFERENCES

- Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Alston, J.F. (2000). *Correlation between childhood Bipolar I disorder and Reactive Attachment disorder, disinhibited type*. In T. M. Levy (Ed), *Handbook of attachment interventions* (pp. 193-243). San Diego: Academic Press.
- Armstrong, K. (1998). *Gene therapy, molecular biology and other modes of promoting caregiver infant attachment*. *Australian Family*, 19 (2), 5-12.
- Benoit, D & Parker, K.C.H. (1994). *Stability and transmission of attachment across three generations*. *Child Development*, 65, 1444-1456.
- Berk, L. (2000). *Child development*. Fifth edition. Boston: Allyn and Bacon.
- Bolen, R.M. (2000). *Validity of attachment theory*. *Trauma, Violence, & Abuse*, 1(2), 128-153.
- Bowlby, J. (1969). *Attachment and loss. Separation*. Vol 11. New York: Basic Books.
- Bowlby, J. (1982). *Attachment and loss: Retrospect and prospect*. *American Journal of Orthopsychiatry*, 52, 664-678.
- Bowlby, J. (1988). *A secure base: Parent child attachment and healthy human development*. New York: Basic Books.
- Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). *Assessing internal working models of the attachment relationship*. In M. Greenberg, D.Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 273-308). Chicago: University of Chicago Press.
- Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). *Finding order in disorganization: Lessons on maltreated infants' attachment to their caregivers*. In D. Cicchetti, & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 494-528). Cambridge, UK: Cambridge University Press.
- Cicchetti, D., & Toth, S.L. (1995). *Child maltreatment and attachment organisation. Implications for intervention*. In S. Goldberg, R. Muir and J. Kerr (Eds.), *Attachment theory. Social, developmental, and clinical perspectives*. Hillsdale, NJ: The Analytic Press.
- Colin, V.L. (1996). *Human attachment*. Philadelphia: Temple University Press.
- Cowan, P.A., Cowan, C.P. Cohn, D.A., & Pearson, J.L. (1996). *Parents' attachment histories and children's externalising and internalising behaviours: Exploring family system models of linkage*. *Journal of Consulting and Clinical Psychology*, 64 (1), 53-63.
- Crittenden, P. (1985). *Maltreated infants: Vulnerability and resilience*. *Journal of Child Psychiatry and Psychology*, 26, 85-96.
- Davidson, T. (1998). *The psycho dynamics of witnessing domestic violence for babies: Some thoughts for protection and therapy*. In *Everybody's business: 2nd National Conference on Children, Young People and Domestic Violence: Conference proceedings*. Brisbane, Qld: Domestic Violence Resource Centre, 71-76.
- Erickson, M.F & Egeland, B. (1996). *Child neglect*. In J. Briere, L. Berliner, J. Bulkley, C. Jenny & T.Reid (Eds.), *The APSAC handbook on child maltreatment*. Thousand Oaks: Sage Publications.
- Glaser, D. (2000). *Child abuse and neglect and the brain - A review*. *Journal of Child Psychology and Psychiatry*, 41(1), 97-116.
- Goldberg, S. (2000). *Attachment and development*. London: Arnold.
- Green, A.H. (1998). *Factors contributing to the generational transmission of child maltreatment*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37 (12), 1334(3).
- Grigsby, R.K. (1994). *Maintaining attachment relationships among children in foster care*. *Families in Society: The Journal of Contemporary Human Services*, 75(5), 269-276.
- Hamarman, S. & Bernet, W. (2000). *Evaluating and reporting emotional abuse in children: Parent based, action based focus aids in clinical decision making*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(7), 928-930.
- Harwood, R.L, Miller, J.G. & Irizarry, N.L. (1995). *Culture and attachment. Perceptions of the child in context*. London: The Guilford Press.
- Hegar, R.L. (1993). *Assessing attachment, permanence, and kinship in choosing permanent homes*. *Child Welfare*, LXXII (4), 367-378.

# USING KNOWLEDGE IN PRACTICE

- Howe, D. (1995). *Attachment theory for social work practice*. Houndmills: Macmillan.
- Howe, D., Brandon, M., Hinings, D., & Schofield, G. (1999). *Attachment theory, child maltreatment and family support*. Houndmills: Macmillan.
- Hughes, D.A. (1999). *Adopting children with attachment problems*. *Child Welfare*, 78(5), 541-560 or electronic version (1-10).
- Levy, T.M. & Orlans, M. (1998). *Attachment, trauma, and healing*. Washington, DC: CWLA Press.
- Lieberman, A.F., Weston, D.R., & Pawl, J.H. (1991). *Preventive intervention and outcome with anxiously attached dyads*. *Child Development*, 62, 199-209.
- Liem, J.H., & Boudewyn, A.C. (1999). *Contextualizing the effects of childhood sexual abuse on adult self and social functioning: An attachment theory perspective*. *Child Abuse and Neglect*, 23(11), 1141-1157.
- Lynch, M. (2000). *The role of the body as the medium in child psychotherapy: Snapshots of therapy with an 11 year old, severely abused, multiply placed girl*. *Journal of Child Psychotherapy*, 26(2), 159-181.
- Lyons Ruth, K. (1996). *Attachment relationships among children with aggressive behaviour problems: The role of disorganized early attachment patterns*. *Journal of Consulting and Clinical Psychology*, 64(1), 64-73.
- Lyons Ruth, K., Connell, D.B., Zoll, D., & Stabl, J. (1987). *Infants at social risk: Relations among infant maltreatment, maternal behaviour, and infant attachment behaviour*. *Developmental Psychology*, 23, 223-232.
- Kinzl, J.F., Mangweth, B., Traweger, C., & Biebl, W. (1996). *Sexual dysfunction in males: Significance of adverse childhood experiences*. *Child Abuse and Neglect*, 20(8), 759-766.
- Main, M., & Solomon, J. (1986). *Discovery of a disorganized/disorientated attachment pattern*. In: T.B. Braxelton & M.W. Yogman (Eds.), *Affective Development in Infancy* (pp. 95-124). Norwood, NJ: Ablex.
- Main, M. & Solomon, J. (1990). *Procedures for identifying infants as disorganized/disorientated during the Ainsworth strange situation*. In M. Greenberg, D. Cicchetti, & M. Cummings (Eds.), *Attachment during the preschool years* (pp. 121-160). Chicago, IL: Chicago University Press.
- McCarthy, G., & Taylor, A. (1999). *Avoidant/ambivalent attachment style as a mediator between abusive childhood experiences and adult relationship difficulties*. *Journal of Child Psychology and Psychiatry*, 40(3), 465-477.
- McMillen, J.C. (1992). *Attachment theory and clinical social work*. *Clinical Social Work Journal*, 20 (2), 205-218.
- Milner, J.S. & Dopke, C. (1997). *Child physical abuse*. In D.A. Wolfe, R.J. McMahon & R.D. Peters (Eds.), *Child abuse. New directions in prevention and treatment across the lifespan* (pp. 27-54). Thousand Oaks: Sage Publications.
- Moncher, F.J. (1996). *The relationship of maternal adult attachment style and risk of physical child abuse*. *Journal of Interpersonal Violence*, 11(3), 335-350.
- Morton, N., & Browne, K.D. (1998). *Theory and observation of attachment and its relation to child maltreatment: A review*. *Child Abuse and Neglect*, 22(11), 1093-1104.
- Muller, R.T. & Lemieux, K.E. (2000). *Social support, attachment, and psychopathology in high risk formerly maltreated adults*. *Child Abuse and Neglect*, 24(7), 883-900.
- Muller, R.T. & Sicoli, L.A. & Lemieux, K.E. (2000). *Relationship between attachment style and posttraumatic stress symptomatology among adults who report the experience of childhood abuse*. *Journal of Traumatic Stress*, 13 (2), 321-332.
- O'Connor, T.G., & Rutter, M. (2000). *Attachment disorder behaviour following early severe deprivation: Extension and longitudinal follow up*. *Journal of American Academy of Child and Adolescent Psychiatry*, 39(6), 703.
- Page, T. (1999). *The attachment partnership as conceptual base for exploring the impact of child maltreatment*. *Child and Adolescent Social Work Journal*, 16(6), 419-435.
- Pickle, P. (2000). *Community focused attachment services*. In T. M. Levy (Ed), *Handbook of attachment interventions* (pp. 261-278). San Diego: Academic Press.
- Pearce, J.W. & Pezzot Pearce, T.D. (1997). *Psychotherapy of abused and neglected children*. New York: The Guilford Press.
- Pederson, D.R., Gleason, K.E., Moran, G., & Bento, S. (1998). *Maternal attachment representations, maternal sensitivity, and the infant mother attachment relationship*. *Developmental Psychology*, 34(5), 925-933.

g



- Penzerro, R.M. & Lein, L. (1995). *Burning their bridges: Disordered attachment and foster care discharge*. *Child Welfare*, LXXIV (2), 351-366.
- Pilowsky, D.J. & Kates, W.G. (1996). *Foster children in acute crisis: Assessing critical aspects of attachment*. *Journal of American Academic Child and Adolescent Psychiatry*, 35(8), 1095-1097.
- Pollock, P.H., & Percy, A. (1999). *Maternal antenatal attachment style and potential fetal abuse*. *Child Abuse and Neglect*, 23(12), 1345-1357.
- Prentky, R., & Bird Edmunds, S. (1997). *Assessing sexual abuse: A resource guide for practitioners*. Brandon: The Safer Society Press.
- Putallaz, M., Costanzo, P.R., Grimes, C.L., & Sherman, D.M. (1998). *Intergenerational continuities and their influences on children's social development*. *Social Development*, 7(3), 389-427.
- Rolfe, S.A. (1999). *Assessing attachment relationships: One psychologist's contribution to the child protection team*. In 7th Australasian conference on child abuse and neglect, Perth, Western Australia October 17-20.
- Schneider Rosen, K., Braunwald, K.G., Carlson, V., & Cicchetti, D. (1985). VIII. *Current perspectives in attachment theory: Illustration from the study of maltreated infants*. *Monographs of the Society for Research in Child Development*, 50(1-2), 194-210.
- Shapiro, D.L. & Levendosky, A.A. (1999). *Adolescent survivors of childhood sexual abuse: The mediating role of attachment style and coping in psychological and interpersonal functioning*. *Child Abuse and Neglect*, 23(11), 1175-1191.
- Shaw, R.J. & Benham, A.L. (1997). *Disorders of attachment*. In H. Steiner & I.D. Yalom (Eds.), *Treating Preschool Children* (pp. 113-136). San Francisco: Jossey Bass Publishers.
- Smallbone, S.W. & Dadds, M.R. (1998). *Childhood attachment and adult attachment in incarcerated adult male sex offenders*. *Journal of Interpersonal Violence*, 13(5), 555-573.
- Steward, D.S., & O'Day, K.R. (2000). *Permanency planning and attachment: A guide for agency practice*. In T.M. Levy (Ed.), *Handbook of attachment interventions* (pp. 150-171). San Diego: Academic Press.
- Stokes, J.C., & Strotzman, A.M. (1996). *The use of bonding studies in child welfare permanency planning*. *Child and Adolescent Social Work Journal*, 13(4), 347-367.
- Stovall, K.C. & Dozier, M. (1998). *Infants in foster care: An attachment theory perspective*. *Adoption Quarterly*, 2(1), 55-88.
- Thompson, A.E. & Kaplan, C.A. (1996). *Childhood emotional abuse*. *British Journal of Psychiatry*, 168, 143-148.
- Tomison, A.M. (1996). *Intergenerational transmission of maltreatment*. *Issues in Child Abuse Prevention Number 6*. National Child Protection Clearing House, 1-30.
- Tyrrell, C., & Dozier, M. (1999). *Foster parents' understanding of children's problematic attachment strategies: The need for therapeutic responsiveness*. *Adoption Quarterly*, 2(4), 49-64.
- Van der Kolk, B. (1996). *The complexity of adaptation to trauma. Self regulation, stimulus discrimination, and characterological development*. In B. A. Van der Kolk, A. C. McFarlane, A & L. Weisaeth (Eds.), *Traumatic stress*. New York: The Guilford Press.
- Van IJzendoorn, M.H. (1996). *Commentary*. *Human Development*, 39, 224-231.
- Van IJzendoorn, M.H., Goldberg, M.H., Kroonenberg, P.M., & Frenkel, O.J. (1992). *The relative effects of maternal and child problems on the quality of attachment: A meta-analysis of attachment in clinical samples*. *Child Development*, 63, 840-858.
- Ward, T., Hudson, S.M., & Marshall, W.L. (1996). *Attachment style in sex offenders: A preliminary study*. *Journal of Sex Research*, 33(1), 17-26.
- West, M., & Keller, A. (1994). *Psychotherapy strategies for insecure attachment in personality disorders*. In M.B. Sperling and W.H. Berman (Eds.), *Attachment in adults. Clinical and developmental perspectives* (pp. 313-330). New York: The Guilford Press.
- Wise, S. (1999). *Children's coping and thriving. Not just in care*. *Children Australia*, 24(4), 18-28.
- Witt, P.H., Rambus, E., Bosley, T. (1996). *Current developments in psychotherapy for child molesters*. *Sexual and Marital Therapy*, 11(2), 173-185.
- Zuravin, S., McMillen, C., Depanfilis, D., & Risley Curtiss, C. (1996). *The intergenerational cycle of child maltreatment. Continuity versus discontinuity*. *Journal of Interpersonal Violence*, 11(3), 315-334.

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