Social Sciences are, by their nature, full of clarifying comments or full of qualifications (caveats). That is both because of the difficulty of getting reliable samples for research and because of this maxim *"all human behaviour follows social rules* ***but*** *each human being is an 'N' of one"*.

In many of the areas that this Commission is interested in there are two significant problems with data (i) generally in these areas there is limited research and (ii) in terms of New Zealand there is even less actual research data. New Zealand has not, generally, supported the development of research capacity in these areas.

The purpose of this chapter is to note the central importance of attachment in any discussion about human development and optimal care environments for children. It acknowledges the way in which 'culture' shapes that narrative. It aims to provide an understanding of attachment and its assessment as well as how attachment informed practice (or the lack of it) impacts on children taken into care.

It is written primarily for those with limited or no knowledge of the vast literature in this area. References have been kept to a minimum within the text itself but a references section is included.

Attachment.

What is Attachment[1]?

Attachment is a process which is fundamental to human development. It is a process which creates "a lasting psychological connectedness between human beings" (Bowlby). At its most basic attachment is a bio-physical and psychological bond with another person or persons which normally develops during the early formative development of a child. Forslund describes it like this "an affectional bond in which an individual is motivated to seek and maintain proximity to, and comfort from, particular familiar persons".

Attachment has been described as a motivational behaviour system which is activated when the individual feels threatened. It has been described as a process designed to have the individual organize behaviour whose function is to maintain safety and comfort and/or a feeling of security. Others have described it as an organizational construct within a developmental context. Bowlby and others have described it as functioning to allow the development of Internal Working Models of relationships which carry into adulthood.

One of the key concepts in attachment theory is the "attachment behavioural system," which refers to an organized system of behaviours that has a predictable outcome (i.e., proximity) and serves an identifiable biological function (i.e., protection). According to Bowlby such a system is organized by experience-based "internal working models"

[1] A difficulty in writing about 'attachment' is that the term has a technical/clinical meaning (or meanings) and an/multiple everyday meanings (including within legislation. This difficulty has led to significant debates and schisms across both the academic and clinical practice. This chapter is not intended to address these issues.

of self and environment, including especially the caregiving environment. *"a set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information"* .

Representational models such as the internal working models, serve a protective function on two levels, both incorporating affect- regulation, the development of which is critical to health development across the lifespan. First, they organize behaviour from an expectation of the physical and psychological protection given by an attachment figure or figures. Second, when the attachment figure does not offer adequate protection or comfort, they maintain a feeling that the individual is loved and protected, contrary to reality.

Attachment operates both on structures such as memory systems and on the working models which will eventually shape both identity and behaviour. Understanding this is important for an understanding of the critical importance of attachment and also for how it is assessed, understood and impacts on clinical practice and decision making. Bowlby argued that different kinds of are processed by different neural systems and understanding this provided attachment based information. Bowlby's clinical experience was that his patients described their attachment relationships in one way at a general, semantic, level. At the same time they told about experiences that contradicted this, or were lacking memories of events entirely. From these clinical experiences, he stated that information relevant to attachment is processed by different memory systems, and that a key to understanding the function of representational models is to understand how the individual segregates, omits and disintegrates information at a memory- systems level, in order to maintain a feeling of protection and safety (the idea of the safe haven and secure base).

In considering how individual differences in mothering (parenting) contribute to attachment quality Bowlby adopted Winnicott's conception of "good enough" mothering. Good enough assures a child that probabilistically, and often enough, the mother will prove responsive to the child's signals. Implicit in Bowlby's perspective was the assumption that an infant can make probabilistic inferences and will slowly be able to incorporate the sense of safety and security into its own internal sense of self.

Key attachment constructs.

- that children are born with a predisposition to develop motivation in relationships to significant others ('attachment figures') who have been sufficiently present and responsive. For children, these persons are usually their caregivers.
- that the motivation to develop attachment relationship is universal and governed by an attachment behavioural system. This motivational behavioural system seeks to maintain a certain degree of proximity between child and attachment figures, with the setting for desirable level of proximity changing dynamically in response to internal and external cues.
- that this motivation to increase proximity is activated when an individual is alarmed by internal cues (e.g. pain, illness) and/or external cues (e.g. fear-

evoking stimuli, separation), and that it is displayed in a tendency of the individual to seek the availability of an attachment figure.

- that when the attachment system is strongly activated, some kind of physical contact with an attachment figure is generally sought, especially by infants. It is also recognised that the sense of contact can also be achieved by non-physical means (through verbal forms of communication) later in development.
- a recognition that one of the most important conditions for deactivation of the sense of threat is the perception that an attachment figure is accessible and responsive – able to provide a *safe haven* when the infant is alarmed.
- that caregivers who have regularly interacted with and protected the infant when the infant has been alarmed usually come to be represented by the infant as someone he or she can turn to when in need (i.e. as a safe haven).
- that for a caregiver to provide a safe haven it does not necessitate that this person is constantly accessible for the infant physically, or even psychologically, or that the child is securely attached to that caregiver. Conversely, being physically present does not necessarily mean that a caregiver is emotionally available.
- Attachment shapes the early development of the human brain including
    - Regulation of stress physiology
    - Patterns of accessing information
- Biology and experience meet in the human-caregiver relationship
- Later other factors augment or moderate impact of early attachment
- What happened in infancy remains the base upon which later functioning is built.

Attachment is a process which has an impact on the formation and maintenance of most (if not all) other close relationships between human beings (in childhood and as an adult) and the patterns of attachment can be observed across generations, through cultures as well as in individuals.

Attachment operates at a neuro-biological level- and the neurological connections are sustained through the way in which human beings interact at an ongoing relational level. Human beings can attune to the thoughts and behaviours of others- so multiple attachments at a neurobiological level can occur. Attachment is therefore much more than a bond (which is a sense of connection).

Attachment (that is the relational engagement) is likely to begin before birth as the mother attunes to her role with this life coming into being. How parents (and those who will be part of the child's life) 'hold the child (to come) in mind may be significant and important for the developing structures of the brain. In many cultures this important precursor to the actual attachment process is defined through ritual and narratives. In this way the baby to come is embedded in their cultural context even before they are born.

After birth the repeated interactions with caregivers develop a child's representations of self and other/s as well as impacting on core neurological development and the regulation of bio-behavioural systems. It is a dynamic process which involves both

psychological processes (how the baby is thought about), physical interactions (how a baby is held, touched, looked at), language and the embedding and engagement of a child into the society it will grow up in (social communications, norms and expectations).

Attachment strategies are malleable and can change as a result of changes in the child's caregiving network or experiences such as parental loss. Attachment patterns can and do change (due to reparative relationships, greater everyday stability in life, good therapy etc) but generally patterns of attachment are remarkably enduring, even across generations. (i.e how culture and identity are embedded). Adults tend to engage in their adult relationships and then parent from within the framework of their own attachment experiences (their internal working models). attachment patterns in Even in infancy and early childhood where attachment patterns show stability over time, they are also open to change. Short- and medium-term change in attachment patterns (for example, from insecure to secure) tends to be linked to changes in caregiving (for example, from relatively insensitive to relatively sensitive), or other family circumstances (for example, marital difficulties or separation). Long term stability in attachment security (that is, from infancy into late adolescence or adulthood) is limited, but later attachment outcomes are related to a broader assessment of the quality of familial experiences occurring right across childhood, for example, quality of care, divorce and parental wellbeing.

The real practical utility of attachment theory and research resides in supporting understanding of families and in providing evidence-based interventions. In this way, attachment theory, assessments, and research can have major roles to play in clinical formulation and supportive welfare and clinical work.

Some history.

Attachment (in a broad scientific sense of the word) is now one of the most studied areas involving human beings. Long before science was interested in how relationships between human beings develop, 'attachment' was clearly the subject of observational study in most ,if not all, groups of human beings. One of the interesting aspects of 'attachment' as a behavioural process between human beings is that across cultures how this process operates (and the relationship between, for example, language development and attachment) is much the same. The term attachment itself was first used by Anna Freud (in 1942) describing how children, even when being abused by a parent, still clung to that parents and sought engagement with them.

European science began to 'study' attachment during World War 2 when many children in the U.K. were separated from their parents. Observing those children Rene Spitz noted similar process among these children which we now call 'protest and despair'. At the same time John Bowlby, 'the father of attachment theory', began to write about how early life experiences could lead to psychological disorders. His focus was on the emotional qualities of the home and how they shaped the developing child. He focused on the impact of separation from primary care givers- 'attachment objects', and negative caregiving attitudes to the child.

Attachment theory developed and expanded as a result, firstly of the work of Bowlby (a British psychoanalyst and psychiatrist) and then Mary Ainsworth (a Canadian American developmental psychologist). It continued to be significantly impacted by its close relationship to its psycho-analytic roots until the latter part of the Twentieth Century when new forms of assessment and greater advances in scientific understandings of child development and of human relationships both challenged some psycho-analytic notions and provided new ways of thinking about human development and what might impact on it.

Mary Ainsworth, codified 'attachment' as a result of her observations, the first of which took place in Uganda among tribal communities and the second of which took place in Baltimore, a large ethnically diverse city in the USA. She developed both the categories used now most commonly to assess attachment on a scientific basis and a method for assessing attachment starting when the infant was aged about a year. Ainsworth used detailed observations and her Strange Situation Protocol to try to understand the dynamic processes which helped (or hindered) optimal human development.She suggested three primary attachment classifications which, in various forms, have become the primary way attachment is now formally understood.

With Type A Ainsworth noted that some mothers were averse to close bodily contact. She observed that this rejection by their caregiver was likely to be experienced by infants as rebuffing or as withholding contact in situations when the infant needed it such as when her/his attachment behaviour was activated at high intensity (under threat). Ainsworth proposed that infants with this type A pattern experienced a severe approach/avoidance conflict when they wanted to be close to their mother and that the infant felt angry because s/he expected his/ her mother to be unresponsive but that he/she also was fearful at being painfully rebuffed, This pattern of infant behaviour was identified as an avoidant defence by Ainsworth and proposed as functioning to enable the infant to disconnect their attachment behaviour from the situational cues that activate it. The avoidant behaviour was a mask for the distress being experienced.

Ainsworth observed that Secure (Type B) infants whose mother's appeared sensitive in their responsiveness to infant signals usually displayed positive affect in their interactions with them and cried very little when faced with everyday separations and separations. Ainsworth proposed that these infants (although having their attachment behaviour intensely activated by separation from their mother through under unaccustomed circumstances when being assessed) appeared easily reassured and comforted by their mother's close presence and readily resumed other activities such as play and exploring their environment. Ainsworth hypothesised that children with a secure attachment had not had to focus on the moment to moment behaviour of their caregiver/s and had been able to devote both time to activities which promoted healthy and normal development such as play and exploration. Their cognitive development was less likely to be formed by a sense of anxiety (trauma).

Secure attachment according to Ainsworth had 2 components – the basic confidence that the infant has in the caregiver to be responsive and comforting when the infant is

alarmed or stressed and second secure attachment means that the infant has sufficient confidence in their caregiver to explore and play and to expect support not interference from their mother and can therefore attend fully to exploration when feeling calm. Ainsworth's 'at home' observations showed that infants with a secure (type B pattern) tend to strike a balance between attachment and exploration based on their experience of responsive care.

Ainsworth noted that not all children were as confident as those who were identified as secure. Insecure (Type C) infants were those whose mothers tended to be experienced by their child as inaccessible, unresponsive or responding inappropriately to their behavioural cues for comfort. As a result these children were more likely to appear insecure or anxious in their attachment. They appeared to be appeared to be frustrated by their mother's inconsistency and/or inaccessibility and because of this their (adaptive) attachment behaviours persisted, tended to intensify and appeared mixed with anger.

Other factors which have always been considered to influence attachment security are the level of support available to a parent and their degree of life stress (exposure to or experience of trauma).More recently studies of attachment involve both empirical studies (in both the social sciences and a wide range of other scientific areas such as neurology) and clinical theories based on observational data.

How does attachment develop for a child over time.

Neurological science has demonstrated the central importance of the mother and the other primary caregivers in the first moments of a baby's life after birth and on into the next months. Babies and mothers are designed to be attuned to one another and to learn the vital process of emotional and systemic regulation. Even prior to birth the caregivers are attuning to the baby, preparing for its arrival and patterning its brain development.

In the first two months of a child's life (phase1), infants indiscriminately accept care from any carer and use a repertoire of innate signals, including crying and smiling, to bring and keep potential carers close to them. In the period extending from 2 to 7 months of age (phase 2), infants increasingly begin to recognize their parents and other carers and to prefer interaction with them. They also begin to anticipate carers' responses to their signals although they do not yet understand that people (including carers) continue to exist when they are not present. Infants of this age initiate and enjoy social interactions and start to show signs of "attachment in the making." They do not yet typically protest separations from their parents, but require frequent contact with their parents for attachment formation to continue. In the third phase of attachment development (between 7 and 24 months), attachments become increasingly apparent, as infants preferentially seek to be near and to interact with specific carers, by whom they are more easily soothed than by strangers.

Critical in the first year of life is infants apparent perception of the availability of the caregiver if a need for comfort or protection should arise, and the organisation of the infants response to the caregiver to gain insight into the child's experience of the

world. The infant relates caregiving to an associated awareness of potential threat. The consistent availability and consistent responses of caregivers help the child to begin to regulate itself emotionally. Positive emotional responses allow for easy re-assurance and a return to a normal emotional state. This is the time when primary caregivers who are available and responsive to the babies needs allow the child to develop a sense of safety and security. As the baby comes to know that it has a safe and dependable caregiving environment (the 'secure base') if begins to explore the world while its developmental capacities grow and develop.

As children (and indeed adults) move through life they use the internal working models and the experience of a 'safe haven' and, once language develops, expand their capacity to manage anxiety and distress. Attachment patterns can and do change (due to reparative relationships, greater everyday stability in life, good therapy etc) but generally patterns of attachment are remarkably enduring, even across generations. (i.e how culture and identity are embedded). Adults tend to engage in their adult relationships and then parent from within the framework of their attachment experiences.

Attachment can be profoundly negatively impacted by severe parental mental illness, a lack of appropriate caregiving, neglect, poor care, loss of core attachment figures and trauma. These impacts are most severe between birth and five years of age. Severe maltreatment at the hands of whanau caregivers (like parents) can significantly alter how children relate to caregivers and later to others because of the negative internal working models that have become part of the child's understanding of safety and relationships (internal working models).

How is attachment assessed.

To properly assess attachment (because it first develops at the beginning of child's journey in life) it is necessary to have techniques that delve below conscious surface of behavior (i.e., not conscious self-report). The major forms of attachment assessment utilize various methods to achieve this. Attachment cannot be measured until near the end of the first year of life, where the form of assessment is observational, assessing the child's expectations of caregiver availability. Eventually this moves to assessing the child's representations (internal working models) of availability and caregiving.

A key concept which is central to the 'assessment' of attachment is how loss and grief is managed by a child or an adult. Rene Spritz noted '*In 1760 a Spanish bishop wrote 'in the foundling home the child becomes sad and many of them die from sadness'.* Assessment measures such as the Strange Situation Protocol (SSP) measure enacted strategies in infancy and early childhood to maintain proximity and avoid distress. Other forms of assessment measures in middle childhood, adolescence and adult years using a shift to verbally represented strategies. There is a focus on the coherence of what said (known as Grice's maxims) that is the quantity, relevance and manner of speaking about relationships.

Ainsworth's Strange Situation Procedure (SSP)and Main's The Adult Attachment Interview (AAI) are what is considered the gold standards of attachment measures. They are primarily assessment measures to be used within a research or structured clinical setting. Because of the issues raised in their administration other attachment measures across the age ranges have developed.

The SSP is a semi structured mildly stressful laboratory procedure that involves a short series (8 episodes) of separations and reunions between a caregiver and infant (in which the child is separated and reunited twice with the caregiver). It was designed by Ainsworth to incrementally ratchet up stress on the infant in order to trigger attachment behaviour and yield a categoric dyadic classification on the dimension of security and insecurity. The sequences are videoed to permit close examination and coding by practitioner with specialist training and reliability in administering and scoring the procedure.

In the SSP the infants behaviour toward the parent in reunion episodes is considered of great importance. Only infant behaviours are measured in the SSP because an infant was believed to behave in a way that was consistent with its history with their caregiver. Infant behaviour in the SSP is believed as reflecting the child's expectations of the caregivers availability when distressed.

To reach conclusions from the SSP Ainsworth insisted that it was standardised and that it continues to be conducted in a way that is consistent with her original guidelines. Whilst the SSP was intended to be a mildly stressful procedure it is now recognised that infants stress levels involve various factors including their experience of contact with strangers, and complementary experience of separation from caregivers. None the less its use of assessing proximity seeking, the observation of the secure base effect and separation protest are all consistent with the underlying understanding of attachment. Changes and extensions to the original classification system have extended the value of it as an assessment tool to pre-schoolers and early school aged children.

Ainsworth's work has formed the basis for other forms as assessment of attachment in children older than one year of age. Another attachment assessment , the Crowell Procedure involves a series of structured tasks involving the child and caregiver. Both the Crowell and the SSP involve placing the relationship between child and caregiver under a degree of stress as well as observing points of reunion and (potential) repair in the relationship and free play opportunities. Target and associates developed the Child Attachment Interview which is a series of interview questions which elicit information both about relational perceptions of the parent/caregiver and child relationships, the impact of stress or anxiety and the level of safety and security the child perceives in the relationship. This measure was developed for use with children over the age of 7 who are verbally competent.

A student of Ainsworth, Mary Main and her colleague Eric Hesse, went on the develop the Adult Attachment Interview (AAI) which involves a series of questions aimed to elicit information about the internal working models of the participant. Answers are codified in part using linguistic analysis (Grice's Maxims) and search for underlying

patterns (such as those originally described by Bowlby) which address issues like capacity to tolerate loss and to hold complex views of relationships. This is a tool which used in the long form is also primarily a research tool. A short form is also available for clinicians with appropriate training.

Another student of Ainsworth, Pat Crittenden, has been responsible for a comprehensive model of attachment and a tool for the assessment of attachment across the lifespan, the DMM- Dynamic Maturational Model of Attachment which expanded the categories of child attachment. Her work developed from both traditional understandings of the basis of attachment based behaviour and newer understandings from diverse scientific disciplines.

- Information processing and how human beings survive danger and promote survival of their offspring.
- Infants have behaviors that elicit protection from caregivers
- Attachment strategies are part of psychosocial functioning across the lifespan
- The DMM expands Ainsworth's earlier work on individual differences in middle class, non-maltreating families
- Based on two samples of maltreating families studied by Crittenden in Ainsworth's lab
- Describes a wider array of attachment strategies observed in maltreating families and those with mental illness
- In dangerous families, children's attachment strategies maximize their safety and comfort from particular caregivers
- 'Problem behavior' is seen as having a protective function in a particular context

This is 'strengths-based' model versus labeling extreme attachment behavior as 'disorganized. Crittenden updated Bowlby's construct of Internal Working Models. The DMM describes attachment behaviour in terms of how humans process information regarding the safety of the self in relation to: (a) their attachment figure's ability and avail ability to protect them: and (b) danger. Enlarging Bowlby's use of 'memory systems', the DMM refers to eight such systems, clustered according to: biology (organic states and 'body talk'); cognition (procedural and semantic memory); affect/arousal (imaged memory and connotative language) and integration (episodic memory and reflective integration). All of these yield dispositional representations of attachment. The term 'dispositional representation' is an updating of Bowlby's use of 'internal working models' based on current neuroscience (

The DMM is a process which more easily allows for multi-dimensional understandings of an attachment matrix including adult intimate relationships and those which develop within family/whānau systems. For example the value of sibling relationships which may provide support and stability and encourage a more equal relationship so encouraging negotiation skills.

There are many other assessment tools available (some of which are used by clinicians in New Zealand but not social workers) such as the Parenting Stress Index and the Attachment Q Set.

Overall no single assessment tool easily allows for an assessment of the complexity of multiple factors which inform both the development of attachment and what compromises it. This is an understanding further addressed in the Developmental Psycho-pathology model[2] the development of which was influenced by Rutter's work with Rumanian Orphan children in the 1990's. Attachment measures do not have sufficient power to serve as stand-alone proxies for individual children's caregiving history or how they will develop. Each form of assessment is conceptually different, was based on different population samples and uses different methods of analysis.

How does disorganised attachment fit in with the child who is in care?

It has become more common to see the term 'disorganised' attachment' used in conjunction with concerns about children in care. Its term is sometimes used by social workers in this way.

Disorganised attachment is a specific attachment classification and its relationship to the presentation of a child coming into or being in care remains a matter of dispute. The development of this classification was a result of early reports that many maltreated infants were found to be unclassifiable in the SSP according to Ainsworth's original classificatory method. To resolve this problem, two of Ainsworth's students, Mary Main and Patricia Crittenden, expanded Ainsworth's classificatory system by developing new categories and coding guidelines with the interest and approval of Ainsworth. This led to the development of 2 major models of attachment Main and Solomon's ABC+ D model and Crittenden's Dynamic Maturational Model.

Main and Solomon's "D/disorganized" fourth category to focused on particular infant behaviours as indices of breakdown of the attachment system in moments of alarm. Later, these ideas were applied to other child focused assessment systems and became the Unorganized/cannot classify (CC) in the Adult Attachment Interview.

[2] Developmental Psychopathology is a theoretical model which uses multi-disciplinary approaches to understand the long term impact of pervasive abuse and neglect on a child's developmental trajectory. A main idea is that psychopathology can be best understood as normal development gone awry.The study of developmental stages and the sequelae of different disorders of childhood and adulthood and factors that influence them. "It is best understood in relation to the changes-progressions, regressions, deviations, successes and failures- that occur in the course of children's attempts to master the developmental tasks they face" (Achenbach, 1974). It is the study of the origins of and the course of individual patterns of behaviourial maladaptations. It is the study of developmental deviation. It addresses the interplay among the biological, psychological and socio-contextual aspects of normal and abnormal development. Core principles are (i) the normative principle, (ii) the systemic principle,(iii) the multi-level principle, (iv) the agency principle, (v) the mutually informative principle and (vi) the longitudinal principle. Developmental psychopathology is a sub-field of developmental psychology and child psychiatry characterized by the following (non-comprehensive) list of assumptions: 1. Atypical development and typical development are mutually informative. Therefore, developmental psychopathology is not the study of pathological development, but the study of the basic mechanisms that cause developmental pathways to diverge toward pathological or typical outcomes; 2.Development leads to either adaptive or maladaptive outcomes. However, development that is adaptive in one context may be maladaptive in another context; 3. Developmental change is influenced by many variables. Research designs in developmental psychopathology should incorporate multivariate designs to examine the mechanisms underlying development;4. Development occurs within nested contexts (see Urie Bronfenbrenner);This field requires that development arises from a dynamic interplay of physiological, genetic, social, cognitive, emotional, and cultural influences across time. Cicchetti ,D. (2006). *Developmental Psychopathology*. New York, John Wiley. Cicchetti, D. and Cohen, D. J. (Eds)1995. Developmental Psychopathology. New York, John Wiley. Masten, A.S. (2006). Developmental Psychopathology: Pathways to the future. *International Journal of Behavioral Development. 30 47-54.* Rutter, M., & Srouffe, A. (2000)Developmental Psychopathology : Concepts & Challenges Developmental Psychopathology 12. 265-29.

The disorganized infant attachment category can be assigned by trained and certified coders to infant behaviour (age 12–20 months) in the Strange Situation when there is a sufficient fit to one or several of the behaviours listed under Main and Solomon's (1986, 1990) seven thematic headings. Main and Solomon identified specified classes of behaviours that – if seen at sufficient intensity and in the presence of the parent in the Strange Situation – could lead to a disorganized attachment classification. The classes of behaviour identified by Main and Solomon were (1) sequential and (2) simultaneous display of contradictory behaviour patterns; (3) undirected, misdirected, incomplete, and interrupted movements and expressions; (4) stereotypies, asymmetrical, and mistimed movements and anomalous postures; (5) freezing, stilling, and slowed movements and expressions; (6) direct indices of apprehension regarding the parent; and (7) direct indices of disorganization and disorientation.

It is important to note that behaviours from Main and Solomon's list can occur for a variety of reasons. They are quite common at low levels in the Strange Situation among infants from populations facing adversity. Only when these behaviours are sufficiently intense can a classification of disorganized attachment be assigned.

Crittenden also incorporated thinking about this group of children in the DMM (Dynamic Maturational Model of Attachment). Crittenden framed these patterns of attachment as 'self-protective strategies'. She proposed that each was associated with differences in information processing, specifically temporal contingencies (called 'cognition') and elicited negative feelings (called "affect") and each was tied to children's adaptation to particular sorts of family circumstances.

Disorganized infant attachment is more common among maltreated infants but does not necessarily indicate maltreatment. As it stands, the disorganized attachment classification cannot be used to screen for maltreatment. This is because a significant proportion of maltreated infants do not show disorganized attachment in the Strange Situation, and many infants showing disorganized attachment in the Strange Situation have not been maltreated. Thus, there are other pathways to disorganized attachment besides maltreatment.

These other pathways to disorganized attachment may feature a parent's unresolved trauma or loss. Such experiences may lead a parent to display subtly frightening, frightened, or dissociative behaviors toward their infant. Stress and separations can cause disorganized behaviors. Therefore, for children in placement who undergo such separations, disorganized behaviors may be especially misleading regarding the usual state of child–parent attachment.

Research at the group level has established disorganized infant attachment as a small-moderate predictor for the development of social and behavior problems. However, disorganized infant attachment does not inevitably cause later problems. When infants classified as disorganized do develop such problems, this may be the result of a continuation of difficult life circumstances rather than solely an effect of early disorganized attachment.

Disorganized infant attachment is not a validated individual-level clinical diagnosis. This is unlike the two attachment-related disorders included in the DSM/ ICD diagnostic systems, developed for the clinical categorization of young children reared in conditions of severe neglect.

It is crucial to recognize that some misapplications of ideas relating to disorganized attachment have accrued in recent years (e.g. in the context of child removal decisions). Such misapplications can result from erroneous assumptions that (1) attachment measures can be used as definitive assessments of the individual in forensic/child protection settings and that disorganized attachment (2) disorganised attachment reliably indicates child maltreatment, (3) is a strong predictor of pathology, and (4) represents a fixed or static "trait" of the child (i.e. is not altered by development or changes in available family support). These are myths or exaggerations regarding disorganized attachment, without support from research evidence.

Misapplications of the term are likely to selectively harm already underprivileged families (e.g. those raised by parents in socioeconomic adversity or with functional impairments). Misapplications may violate children's and parents' human rights and represent discriminatory practice against minorities in need of social and material support. Child removal from his/her original family can never be justified solely by the child's display of disorganized attachment to a caregiver.

Moreover, an infant may display disorganized attachment with one parent and yet display organized, even secure, attachment with the other. Thus, disorganized attachment is not a fixed property or trait of the individual child but tends to be relationship specific.

It is important to recognize that there is robust evidence that both (1) attachment-based interventions and (2) naturalistically occurring reparative experiences (stable, safe, and nurturing relationships) can break intergenerational cycles of abuse and lower the proportion of children with disorganized attachment.

Cultural issues and implications.

Because attachment helps all human beings to form and maintain the important social bonds needed for survival (both as an individual and a group) it is a process seen across cultures but how cultures express, describe and categorise this process reflects critical aspects of each.

The euro-centric approach was a more individualised view of the process. It is monotropic (hierarchical and focused on mother and child). Western notions of attachment have tended to focus on the mother and the child/children (Winnicott's notion that there is no mother without the baby and no baby without the mother). They have also been somewhat dominated by the historical connection to psycho-analysis.

Attachment research, however, shows that babies can and do attach to multiple caregivers and different caregiving situations. Collectivist cultures use multiple caregivers and some cultures care for children in a group manner. None the less the core aspects of the attachment dynamics involved (which can be observed) remain the same. What is sometimes (but not always different) are the beliefs and meaning attached to behaviour (the social milieu) and the stages at which changes to roles and responsibilities occur.

Fleming, in her thesis Ngā Tāpiritanga: In what ways are indigenous Māori perspectives on attachment similar to and different from Western psychoanalytic perspectives on attachment and what are the implications for the practice of psychotherapy in Aotearoa in New Zealand? A Kaupapa Māori Critical Literature review, correctly points out that western attachment theory (as it has developed) has only more recently come to consider the need for multiplicity of caregiving systems or that connections to environment and history are also essential aspects of connection. However she also asserts that the dyadic relationship between parents and a child remains integral for attachment even within the Māori perspective

For Māori how a child (from prior to birth through whakapapa) engages with their community (Whanaungatanga) and how they will ultimately form their identity and sense of self is a communal process defined by shared understandings and beliefs. This is considered a polytropic process, the mother and child are only one of many close relationships developing in a complex social network. From such a perspective children are a treasure, not a possession, belonging to and living within the community which has a shared responsibility for them.

Early research (Ritchie and Ritchie) and commentary such as that of Metge as well as more recent Māori research and analysis (such as that of Fleming discusses the ways in which the attachment dynamic is woven into Māori child rearing practices alongside the understanding of both the social and the spiritual world inhabited.

Ritchie and Ritchie, in research that spanned three decades, noted the changes in Māori child rearing practices. Although not languaged in the way it might be today this research noted the creeping influence of colonisation and the scrutiny of the dominant pakeha discourse on child development. The research done by the Ritchie's (in a study which involved one third Māori participants) noted more traditional forms of childrearing to be collective, to attend to the child's lived history (whakapapa) and to be, at least for young children, more indulgent than pakeha children rearing (children as a taonga, to be treasured).

More recent research (prepared with funding from the Office of the Children's Commissioner) sought to bring to the fore the collective and individual ways in which attachment was transmitted both in the parent-child dyads' and the community as a whole. The authors noted

'This knowledge can be found in the whakapapa, the tipuna (ancestral) links to the spiritual world, the purakau (oral histories), the waiata oriori (lullabies), whakatauki (proverbs), and nga korero iwi (tribal stories). In all of this literature, the tikanga (rules,

custom, methods) of parenting are signposted. The fundamental principle for raising children was the underlying belief that children were favoured as gifts from the atua (spiritual beings), from the tipuna (ancestors) and preceded those unborn, which meant that they were tapu (under special rules and restrictions). Any negativity expressed to them was breaking the tapu by offending the atua and the tipuna gone before. Because of their intrinsic relationship to these spiritual worlds, the children inherited their mana (power, prestige). They were treated with loving care (aroha) and indulgence. Punitive discipline in whatever degree, as a method of socialising children, was an anathema to the tipuna'.

This work stressed the central importance of narratives of identity and belonging (myths, whakatoki and pepeha among them) for developing connection at every level of the person (child) and their relationships.'

In the Māori world view there is a seamless integration of the now (say a pregnancy-being 'hapu') and the belongingness to place, to people, to the spirit world within a context in which the past and the future are always present. This is a notion that is incorporated into the concept of whakapapa which is a connecting framework for people. Oral narratives, history and identity are all imparted through engagement with those who already have the knowledge. The child interacts with those people within the collective experience of both whānau care and Whanaungatanga.

Māori authors addressing child rearing practices note the strength of connection to whenua (land), the belongingness to place which, like whakapapa, links past, present and future. Māori wellbeing is associated with that relationship and the responsibilities (Kaitiakitanga) that accrue from it. Rituals such as tangi embody those responsibilities. In Tangi the collective engagement in the process of a person passing from one realm to another joins the collective together caring for the spirit that is passing as well as those left behind. Children are considered to be integral participants in such processes because they embody the performance of a lived whakapapa which holds knowledge linking those living now to the ancestors. Attachment is not just to the person but to all of those who are spoken of at such times.

Attachment provides an individual the sense that social connections (relationships) have a permanence that will sustain the individual through life both practically, psychologically and (for many) spiritually. Such a sense does not come simply from a single or even dual attachment (to say a mother or parents). For Māori the connection is much wider and relates to the central notions of Whakapapa and Whanaungatanga.

Attachment and Identity.

How attachment (contributes to/informs) identity.

'E kore koe i ngaro, he kākano i ruia mai i a Rangiatea'. You can never be lost for you are a seed sown from Rangiatea.

Attachment is one process through which the individual forms their sense of themselves and their identity. Identity is the fact of being who or what a person is on an individual basis and the relation established by psychological identification with others with whom we are in relationship. Having a genuine and secure sense of 'self' (whether that is individual or collective) is an essential part of being human, of belongness and of confidence in and liking for oneself. It is an essential part of a 'healthy' self.

Identity is 'transmitted' through our lived relationships and through the knowledges that are thus imparted. In that sense all identity has a cultural imprint. While we are all, as a species, recognisably 'human' we are also all defined by the culture/s we have developed within (and by aspects such as our perceptions of gender and those of our culture) All cultures impact this in multiple ways, indeed it is a process that begins prior to birth as the parent/s and those surrounding them begin to conceptualise the life coming into being. Oral narratives, history and identity imparted through engagement with those who already have the knowledge. Parents speak to the baby of the world it cannot comprehend, songs are sung to the baby and names given, all of which impart both individual and cultural information about identity. Through the engagement with rituals (such as birthday's, Tangi and funerals, religious occasions) and through forms of formal and informal education children find commonality within their world. Language itself confers a sense of identity, a belongness to one's 'group' and one's history.

Identity is a core aspect of a person's positive sense of self and self esteem. Māori might discuss this as Tino Rangatiratanga, in pakeha terms we could talk about the capacity for autonomy and self determination. The ability to have control of one's own aspirations and well being. Having a core sense of one's identity provides the capacity to feel healthy and mentally well. Whether Māori or Pakeha a secure identity depends on the health of the family and community in which the child is embedded.

Māori identify the role of the community (including the parents) in supporting the development of identity as involving Taha Hinengaro- psychological wellbeing, cognitive functioning and capacity to communicate, to think and feel; Taha Tinana physical health and the capacity for physical growth and development; Taha Whānau, who makes you feel you belong, who you care about and who you share your life with. Taha Whānau is about extended relationships and Taha Wairua the capacity for spiritual wellbeing. When a person has a secure sense of themselves (a sense of identity) they can develop dreams and aspirations (moemoea).

For Māori information about identity is provided in whakapapa (connection to biological parentage and ancestors) which encompass a wide perspective of relationship. For other cultures such a sense of 'belonging and identity' might involve religious beliefs or a more narrow range of relationships, it might focus more on a collective history of a people rather than on individuals. Whakapapa is identity, the loss of whakapapa is the loss of identity and thus the loss of attachment. Only birth whānau can share knowledge directly associated with pepeha, tupuna, maunga and awa korero.

Te Pa Harakeke

Hutia te rito o te harakeke	If you pluck the centre shoot of the flax
Kei whea te komako e ko?	Where will the bellbird sing?
Ka rere ki uta, ka rere ki tai	It will fly inland, it will fly seawards
Kī mai koe ki au	If you ask me
he aha te mea nui o te Ao?	What is the most important thing in the world
Maku e kī atu	I will reply
He tangata, he tangata he tangata	It is people, it is people, it is people

Harakeke is a living symbol of 'whānau'. Harakeke, the collective strength of people and the protection of the vulnerable. At the centre is the shoot (the child- the vulnerable) te rito. Without children the collective will not survive. To remove the centre is to stop the plant from flourishing. Harakeke survives the elements and can be woven. As Puketapu-Hetet 1986:40-41explains:

> *People are like weaving, they hold each other together. I am talking about Maori families. We need to interweave our lives to make the fibre strong.... People are not perfect. We all need each other. We all hold each other together, just one harakeke(strip of flax) in a rourou(food basket) does. Take the spotted or discoloured ones out and your rourou will fall to pieces.'*

Using form of engagement, pepeha, Fleming speaks of pepeha as defining a wide range of connections not just to people. She says *" Pepeha marks the relationship that an individual has with both human and non human connections"* referencing Mutu's view that key geographical and historical connections are intrinsic to attachment and identity. All elements of traditional Māori understanding are part of identity (Taonga tuku iho -being Maori) the use of Te Reo, Matauranga Maori and Tikanga Maori- creating both in person and spiritual and cultural relationships. Whakapapa is identity, the loss of whakapapa is the loss of identity and thus the loss of attachment.

Relationship to Oranga Tamariki Legislation and current social work practices.

Misapplications of attachment theory in general, and disorganized attachment in particular, have accrued in recent years in social work and other clinical (western) practices. These are sometimes reflected, for example, in some child removal decisions. These misapplications can result from erroneous assumptions that (1) attachment measures can be used as definitive assessments of the individual in forensic/child- protection settings and that (2) disorganized attachment reliably indicates child maltreatment (3) poor attachment is a strong predictor of pathology and (4)attachment cannot be changed through interventions in the child's original home. Such misapplications may selectively harm already underprivileged families, such as those facing multiple socioeconomic risk factors or including a parent with functional impairments. These misapplications not only violate children's and parents' human rights but in many cases, they may also represent discriminatory practice against minorities in need of social and material support.

However the real practical utility of attachment theory and research resides in supporting understanding of families and in providing supportive, evidence-based interventions. Attachment theory, assessments, and research can have major roles to play in clinical formulation and supportive welfare and clinical work. There is robust evidence that attachment-based interventions as well as naturalistically occurring reparative relationship experiences (stable, safe, and nurturing relationships) can break intergenerational cycles of abuse and lower the proportion of children displaying, for example, disorganized attachment.

In addition research into attachment and the consequences of difficulties in caregiver/child relationships also fits well into research which delineates general issues which compromise parenting and lead to children coming into care. The most prominent issues which com promise parenting include poor parenting skills and capacity (which may directly link to adverse experiences in the parents childhoods including poor attachment), parental mental illness, parental substance use and wider issues such as family violence, housing and employment and finance issues. Many of these are not issues which are a focus for social work assessment (at least not at a properly professional level) and so they cannot properly drive overall assessment and intervention approaches. This suggests that placement in care decisions can easily be based on inadequate information analysis.

The Children, Young Persons and Their Families Act (CYPF) came into being as a result of the consultation process led by John Rangihau and the publication of Te Puao Ata Tu. The resultant legislative changes sought a shift from the 'institutional' social work perspective largely developed in the United Kingdom and focused on 'risk' to a more family/whānau basis with intervention orientated towards change within family/whānau. These assumptions were evident in the principles of the Children, Young Persons and their Families Act (now Children, Young Persons and their Families-Oranga Tamariki legislation). These principles envisage the whānau/family as being at the centre of children's wellbeing and provides for attention to the 'three pou' which are seen as universal for all children. These place 'relationships' as central to

children's wellbeing through an identification of whakapapa, identity and whanaungatanga.

In a paper prepared prior to the legislation becoming law, Judge Annis Somerville (Kai Tahu) noted that western approaches to child welfare issues often focused on the self and individuals whereas the Māori world focused on belonging. The legislation (since 1987) which has been supposed to govern child welfare practices in New Zealand has, she noted, always had core relationships (attachment relationships) at the centre of its principles. It has always indicated a need to strengthen a child's relationships with whānau and to support families (whether Māori or other) to care for and develop productive relationships for and with children. The current legislation, however, only uses the word 'attachment' twice Section 13 (Principle 13.2. I. E) and Part 2 where a Family Group Conference can only be held where there is, in attendance, someone to whom the child or young person has an *'attachment'* to. The Act is silent on any definition of 'attachment'.

It is however clear that since 1987 there has been a legislative focus on 'belonging' which, while often framed in Māori terminology, is focused on ensuring that a child or young person regardless of ethnicity is able to develop a sense of themselves (identity) and belonging (attachment) and that, where possible, that occurs within the context of their family/whānau whether with parents or others to whom they have a connection.

Fleming argues that although Oranga Tamariki does focus on an attachment lens for children in care it does so from a wholly euro-centric perspective of the mother and the baby. However few social workers in New Zealand have training in assessing attachment and most have a limited understanding of it in any formal sense. This means when it is used by Oranga Tamariki and indeed others they are using the term in many and various ways. This illustrates a major concern raised by attachment researchers in respect to the use of the terminology and forms of assessment.

There has been (and remains) a lack of clarity about the way in which 'risk' should be managed in respect to children and young people. Oranga Tamariki no longer uses the Risk Estimation Model[3] developed for New Zealand (with appropriate cultural consultation). It is also unclear whether social work training in New Zealand or ongoing professional development within Oranga Tamariki appropriately supports understanding of assessing 'risk' and considering appropriate interventions (outcomes) either from pakeha or Māori perspectives. The constant restructuring (and underfunding) of Oranga Tamariki since 1990 has prevented the intention of the 1987 Act being realised and diminished knowledge bases within Oranga Tamariki (the failure to embed the Competency Model for example) further impacted directly on practice. All of this also occurred without appropriate resources being transferred to other sources (Māori providers in particular) to meet the needs of Māori and other

[3] Risk Estimation System. Developed by CYFS in 2000 from a model developed in Canada. It reflects international best practice in the assessment of 'risk' in child welfare settings. It is a decision making system which provides a framework for analysis of data which should be collected within a social work context. RES asks a social worker to consider the following variables, Vulnerability, Likelihood of Reoccurrence and Severity and to plot available data (and/or to collect missing data) to assess overall risk. It is no longer used by Oranga Tamariki. See RES: Risk Estimation System Manual. Child Youth and Family. Wellington.

communities . It is of note that resources have been transferred to non state caregiving services in the care sector (often faith based service) but it remains unclear whether this has reduced 'harm' associated with care.

Relationship to residential care.

Many forms of residential care, not just state welfare care have now been subject to scrutiny. These include state care institutions for children and young people, orphanages (both religiously based and other), residential homes (educational), mental health facilities, boarding schools and many of processes where care is provided by non kin to the vulnerable in a physical institutional setting. Overwhelmingly it has been found that such care is less than optimal and carries inherent risks (easily identifiable from the social science perspective) regardless of the purpose of that care.

Residential care, by its very nature, cannot provide the opportunity for a child or young person to develop secure attachments with staff. That is a key feature of institutional care, there is no continuity of relationship and no formal sense of belonging. There is usually limited stability over time in relationships although even where there has been stability (as in religious settings) staff are constantly changing often from day to day. The lack of a genuine sense of relationship (family) has led to very adverse outcomes for both children and adults.

In addition the environment of caregiving institutions (whatever their purpose) in itself can lead to difficulties in adjustment and can disrupt healthy development. Care giving institutions simply cannot replicate a 'family environment'. If anything they often create abnormal 'families' among children, among adults, between the placed and the caregiving and between caregivers. All of this occurs without the benefit of the normal family/whānau hierarchy with its socially proscribed rules and expectations. Institutions cannot offer the embedding of identity, a sense of self and they cannot model core attachment relationships which are healthy and enduring.

In some cases residential institutions have been associated with severely detrimental environments where children have been further subject to abuse and neglect. Those children/young people are likely to enter adult life even more likely to have adverse long term mental health and to struggle to form and maintain healthy relationships with others because they have experienced further trauma/

In general institutional care is considered to lead to detrimental outcomes for individuals. However research also indicates that, to some extent, the purpose that led to a child or an adult being placed in an institution and the background can confer protection against some of the less favourable aspects of such care. Each child brings to their experiences innate aspects of themselves such as temperament[4] which can

[4] Temperament is a brain-based aspect of personality. Temperament is discussed from the perspective of an individuals behavioural style and fit. Three main areas are assessed when looking at temperament. **Reactivity:** this is how strongly children react to things like exciting events or not getting their own way. Reactive children tend to feel things strongly.**Self-regulation:** this is how much children can control their behaviour, including the way they show their feelings. It's also about how much children can control their attention and how persistent they are. **Sociability:** this is how comfortable children are when they meet new people or have new experiences.

buffer a child from adverse experiences or make them more sensitive to them. Temperament is often seen, associated with an individual's sense of attachment as a buffer against adverse life experiences. For some children/young people being in residential care is not optimal but it is better that the circumstances of their previous life.

When Attachment (identity) is disturbed/lost, what might happen?

Developmentally

There is a substantial literature, internationally, which identifies significant adverse outcomes when attachment is disrupted or fails. This is particularly the case where a child is having their attachment (of any form) disrupted when they are older. The older the child the more difficult a transition to another caregiver is and the less likely that a good 'attachment' or a sense of true belonging will develop (although it may). Care, regardless of how necessary or optimal, does compromise children's development because it is not how we were designed to grow as human.

The removal of a child from their family of origin in state welfare situations usually follows the identification of significant risk to that child (that is a need for care and protection) or the need to address significant offending where the family/whānau seems unable to intervene successfully. Thus the decision to remove the child balances the needs of the child in one area (to be safe, to have the child's needs addressed) against the potential adverse outcome of the loss of attachment (belonging within whānau/community).

A significant secondary problem for state welfare when children (or young people) are removed from whānau-family is that they often present with complex issues related to the circumstances which has led to their being 'in care'. It is also more likely that children removed from their parents/whānau care for such reasons have a less than optimal attachment dynamic anyway. This in itself is a risk factor that is rarely acknowledged but the pre-existing difficulties with attachment can compromise the child's ability to engage with any caregiver (whānau, parents or non kin care).These are not children who will easily relate to, trust and feel safe with unknown caregivers.

Attachment dynamics and the normal ways in which human beings develop and think about relationships also impact on how attachment plays out in care for the caregivers. It is hard to fully emotionally commit to a child if you may need to see that child leave your care, it is hard to fully believe caregivers are your family if you as a child think you will be sent somewhere else to live. Caregivers may themselves struggle with the potential for grief if a child leaves their care and withhold important psychological engagement within relationships as a result.

The literature and research evidence indicates that the younger a child is placed in (any form of) care the better their adjustment. That is because the younger the child and presuming the care situation is optimal, the greater chance of a secure attachment being able to develop. Where that can be combined with ongoing connection to

whanau and wider community (birth and otherwise) the better the child's overall development and wellbeing. In general the literature suggests that placements (which are intended to sustain) made when a child is younger that three are more likely to be successful.

Older children fare much less well in care, their pre-existing trauma's (life experiences) and their disrupted attachment(s) are less able to be addressed through quality care and connection. Older children use the proximity of caregivers and their secure base to begin to understand the feelings of others and their self representations aiding in the development of social, interpersonal and emotional literacy in themselves. If they have a number of changes in care (often because their distressed behaviour makes them hard to care for, they interpret caregiving behaviour through the lens of their previous experiences) this increases the sense of dislocation the child or young person experiences.

Tarryn-Sweeny describes the wide range of presenting behaviours and symptoms seen in children in care. Many of these actually speak to the profound damage caused by disruptions to attachment- i.e. they relate to bio-physical impacts or impacts on core developmental factors such as the development of language, recognition of (culturally normal) social cues and the recognition of the mind(s) of others (theory of mind). They include dysregulated affect (emotions) and behaviour; inattention / over-activity; trauma related anxiety, hypervigilance and re-experiencing trauma; dissociation and sensory disturbances; negative and unstable perceptions of oneself and others; attachment disorders and other attachment-related interpersonal difficulties; conduct problems, oppositional-defiance, low empathy and aggression; sexual behaviour problems; food maintenance behaviours (hoarding, storing, gorging); restricted, odd and stereotypic behaviours; depression; self-injury; and suicidal ideation and behaviour.

Attachment is so fundamental to human development, and every aspect of our development (including the development of language) , that loss of those bonds creates deep anger and distress and sometimes very serious developmental delay and long term mental illness. Children's responses in these situations often involve the development of psychological maladaptations including poor self-esteem, depression, issues with adult attachment and intimacy, alcohol abuse, issues with self-direction (or self-agency or efficacy in life), difficulties with social engagement (being able to identify with, and engage with, others), fears of abandonment and difficulties becoming independent (that is termed becoming instrumentally competent).

Tarryn-Sweeny (notes that even as adults the complex presentations of those who have experienced child maltreatment lead to unhelpful single factor diagnoses, often resulting in them receiving multiple diagnoses to explain their distress. Commonly they may be diagnosed as having Borderline Personality Disorder, other Personality Disorders, Complex Post Traumatic Stress Disorder, Post Traumatic Stress Disorder, Attention Deficit and Hyperactivity Disorder, Bi-Polar Disorder, forms of Dissociative Disorders, Drug and Alcohol dependence issues and forms of Depressive Disorders. He goes on to say that his research has shown that complex attachment psycho-

pathology and trauma related psychopathology is not amendable to traditional diagnostic classification because the presentations are too complex. That is current western medically based ways of viewing people with this background are inappropriate.

One of the important categories which Tarryn Sweeny discusses is *'disturbances in self organisation'* which includes issues with affect regulation (both over and under reactive states), negative self evaluations and difficulties sustaining relationships. All of these are known and key outcomes of attachment disruption and of loss of identity.

The work of Tarryn Sweeny and others has shown that maladaptive psychological presentations (such as the development of what are often diagnosed as Borderline and possibly Anti-social Personality Disorder) are consistent with the way adolescents in care present and are often then mis-treated. Children with early trauma experiences and core attachment difficulties can exhibit a state of 'primitive' or primal' rage, it is an indication of distress that is so profound it cannot be 'thought' about or managed.

Because attachment is a significant aspect of the way in which identity is formed and confers a sense of belonging for human beings, the loss of (even) less than optimal attachments can lead to a loss of social capital (a western notion). Connection to others (belongingness) confers advantages to children both during their development and into adulthood. Social capital can be thought of as the links, shared values and understandings in society that enable individuals and groups to trust each other and so work together for advantage and development. It can be thought of as the psychological, emotional and social contributions that provided to children by parents, siblings, extended family, peers and also by organisations and groups (.It confers on individuals a capacity that is greater than that of the individual. Research on the impact of social capital, and it's loss, has focused on the way in which families increase social capital (as do communities) or decrease it (as when there is a parental separation or removal from family care). Research has identified social capital (and the loss of it) as a factor in childhood behaviour problems.

Research has specifically identified the matrix of extended family relationships, especially, for example grandparents which enhance children's development across the lifespan. It is through these relationships that identity and belonging become embedded. Research in both the area of the experiences of adoptee's and those who have had their relationship with a parent or parents ended or significantly disrupted all show similar patterns of negative and adverse outcomes.

Sibling relationships are also often significantly disturbed by placement in non kin care. This also has serious developmental impacts. Sibling relationships are often the longest lasting of all human relationships for an individual and the loss of that form of attachment can be profound.

For Māori the loss of sibling connections has important cultural impacts. The idea of whanaungatanga relationships in Māori society includes the specific obligations associated with birth order and siblings. These encourage siblings to guide and support

each other and care for their siblings. This requires brothers and sisters to spend time to grow together, develop enduring affection and concern for each other and become inter dependent and develop within their own personalities and their own particular whanau and whāanui environments.

'Mā te tuakana ka tōtika te taina, mā te taina kte tuakana tōtika'
It is through the older sibling that the younger one learns the right way to do things, it is through the younger sibling the older one learns to be tolerant.

Within Māori understandings of such disturbances (disruptions) the loss of access to the 'belongingness' to whānau and to whakapapa is seen as damaging to the very spirit of the person, their wairua. This is encompassed in Durie's notion of Maramatanga living as Maori means having access to the Māori world. This encompasses holding in mind (the past and the present and the future) through collective engagement and discussion. For Māori this can occur in waiata and stories, the weaving of people together through whakapapa and whakatoki. The importance of whenua, of Te Reo are all essential for understanding and supporting the wellbeing of the person.

Children who are taken into care (whānau based or non kincare, for the short term or long term) are children who need highly skilled caregivers focused on supporting a child to engage at a psychological level and many need formal interventions which are not readily available (and usually not available at all).

Children and young people who come into (and who came into) care do not present with a diagnostic profile which easily fits traditional psychiatric (medical) criteria. However children in care in New Zealand have only been assessed within traditional criteria (criteria which are widely criticised because of their mono cultural perspective). Oranga Tamariki and it's precursors have always been almost entirely reliant on access to (western) medically based mental health services and these continue to inform(sic) the view of the child. These services, in themselves woefully under resourced for at least 40 years[5], do not, generally have staff skilled in using contemporary (and culturally appropriate) models for either assessment or intervention.

The current primary form of assessment of children in care is a Gateway Assessment which functions entirely within the western medical model. Although more recently some health services have used the ACES's model[6] for assessment of 'adversity', few

[5] Herald 30.5.22. briefing to Minister of Health, severe long term underfunding of Child and Adolescent Mental Health services (ICAMHS). Two issues, long term and serious underfunding and lack of people resources. *'years of under investment and poor planning' ' even in a system riddled with pressing needs services for children and teenagers stand out as particularly challenging' 'low level of baseline funding compared with other sectors' 'receive less per client funding than adult services'' disparity is long standing', they acknowledge raising their criteria for acceptance into the services.*

[6] ACES Model The ACE model is based on a well regarded research study into the impact of adverse childhood events on development and well being into adulthood. It is a large-scale study of the influence of stressful and traumatic childhood experiences on the origins of behaviours that underlie leading causes of disability, social problems, health related behaviors, and causes of death. For the purposes of the ACE Study, adverse childhood experiences were defined as: emotional, physical, or sexual abuse, emotional or physical neglect, growing up in a household where someone was an alcoholic, a drug user, mentally ill, suicidal, where the mother was treated violently, or where a household member had been imprisoned during the person's childhood. The **number of ACE** was used to assess the total amount of stress during childhood. Cognitive and neuroscience researchers have examined possible mechanisms that might explain the negative consequences of adverse childhood experiences on adult health. Adverse childhood experiences can alter the structural development of neural networks and the biochemistry of neuroendocrine systems and may have long-term effects on the body, including speeding up the processes of disease and aging and compromising immune systems. Additionally, epigenetic transmission may occur due to stress during pregnancy or during

western orientated services have practitioners who use models such as the Developmental Psychopathology model and there is usually no reference at all to the attachment literature when assessing 'risk' to children. Many health based services have a limited understanding of the impact of all forms of trauma on children and their development. Even where there is some appreciation of the potential role attachment (belonging) might play in the development of adverse outcomes for children assessment (and intervention) within mental health services relies heavily on western medical models of thinking.

The attachment-related disorders listed in psychiatric diagnostic systems such as the Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 2013) refer to clusters of behaviours first described among children reared from infancy in orphanages, without biological parents present. In the DSM, there are two attachment-related diagnoses, and both are strongly associated with experiences of extreme social neglect, capturing 'distinctive patterns of aberrant attachment and social behaviours in young children who are socially neglected or are being raised in environments that limit opportunities to form selective attachments". The first is reactive attachment disorder (RAD), which is assigned to children who are very inhibited or withdrawn from their caregivers and who do not show proximity seeking or contact maintenance to the care- givers, even when the children display high distress. The second attachment-related diagnosis in the DSM is disinhibited social engagement disorder (DSED; formerly RAD subtype II: disinhibited). It is characterized by failure to show a preference for familiar caregivers, even when the child is frightened or distressed. One important study reported data suggesting the widespread overuse of the attachment disorder diagnoses for children who do not meet the DSM criteria.

Unlike disorganized attachment, which is a response to a particular caregiver in a specific situation, both attachment-related disorders described signify behaviours that are understood to permeate many naturalistic situations in the child's life. While an association between disorganized attachment with the primary caregiver in infancy and DSED has been reported disorganized attachment is much more prevalent than either of the two attachment-related disorders and cannot be equated with them. For instance research found that rates of disorganized attachment substantially declined for infants randomly assigned to high-quality foster care – but, by contrast, rates of DSED did not differ between infants who remained institutionalized and those in foster care. It is unclear whether DSED should be considered an 'attachment' disorder at all, as it 'may occur in the absence of attachment, in an aberrant attachment or in a healthy attachment to a subsequent foster or adoptive parent'.

Tarryn Sweeny and others have used different terms (including Complex Attachment Disorders) to denote the specific issues that arise for children who are placed in care and who may have experienced multiple forms of trauma in a range of contexts.

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interactions between mother and newborns. Maternal stress, depression, and exposure to partner violence have all been shown to have epigenetic effects on infants. Centre for Youth Wellness. (2014). Data Report: A hidden crisis. Findings on Adverse Childhood Experiences in California. San Francisco

Interpersonally.

Attachment relationships are not developed in the short term or momentary processes that occur between people. They are long term and need the cycles of rupture and repair that occur in all human interactions. They are day to day, moment to moment experiences and ultimately they are enduring across generations. For Māori that is encompassed in notions of whakapapa but all cultures carry, in their traditions and stories, the role of relationships, past, present and future, as being part of who a person is.

Where a child has experienced a secure attachment which is then disrupted or lost, a child will have an internal working model for attachment which can be transferred to another caregiver (not necessarily without difficulty). That does require a caregiver who is sensitive and psychologically primed for the potential challenges as the 'new' attachment become embedded. It may also requite support and help, traditionally that might be through the community supporting the new caregiver (say when a parent has died) or it might mean professional help.

Children with poor attachment (and likely experiences of trauma) transfer their negative internal working models onto their new caregivers and placement. These children present with disruptive, angry and distressed behaviour and are very difficult to care for. Caregivers may behave reactively setting up a negative cycle of difficult child behaviour and inappropriate adult responses often leading to low level abusive behaviour by caregivers. Such placements often then breakdown.

Children can 'return' to their original caregiver/parent/whānau but such 'returns' can also be highly problematic. If the issues which led to the initial removal have not been addressed in a productive manner which is honest and open then the child will remain wary and likely distrusting. This will make it hard for the relationship to gain (or regain) its strength. Children are not (generally) removed from parents/whanau and have not been for years unless there is substantial abuse or major parenting deficits. Most children understand this, like children managing parental separation they want something to change so they can go home (or in the latter their parents can get back together) but children do not forget being abused or neglected. Being in care may not be great but it may be better than return and many, many children in care do develop strong bonds to (if not attachment) their caregivers who they know care for and look after them well (or well enough).

Relationships are not static and when a child has been placed out of a home both the child and their parents/whānau will have changed by the time of the 'return'. If this is not recognised and worked with then the return will feel unsatisfactory to everyone. Children usually have limited capacity (even well into adolescence) to recognise that they have changed and that their parent has changed in such situations and have a 'hoped for' fantasy of the return. Some parents may have failed to consider the child who is returning is not the child who left, that is they have not been able to hold the child in mind and consider the likely changes. This may lead to a 'returned' child experiencing grave difficulties in re-engaging and the return itself leading to

residential instability. This may mean an adequate (if not optimal) placement is lost but the 'return' placement also 'fails'.

Such understandings inform the use, among Māori of Whāngai, placement of children within kin networks. Such placements enable the possibility of ongoing connections with parents and a child usually remains embedded in the wider community. They retain a sense of 'belonging' and they know wider whānau through attending tangi and other everyday events. The whāngai approach allows for transparency of knowledge about identity and belonging. However even such a culturally embedded form of care is reported to have had poor outcomes for some. For example children placed with Koru or Korua who then age and find care difficult thus leading to a more culturally based but still unstable forms of care.

A key issue in assessing causation of negative outcomes of being taken into care is what made the child vulnerable prior to coming into care, for example, parental mental illness, Drug and Alcohol issues, frank trauma (family violence, sexual abuse) and poor attachment. Each of these may in themselves be causative of long term negative outcomes which may not be easily remedied regardless of what kind of 'care' is provided. Equally assessing outcomes requires consideration of whether coming into care itself was the cause of the negative outcome for the child even if they return to their parent's/whānau's care

There is no good quality research which looks at whether children who have experienced one form of abuse (say sexual abuse) have better outcomes in care than those who have experienced another form of abuse (say physical abuse). Children who have experienced any form of abuse (ACES) have poorer outcomes that children who have not had such experiences but causation is not simple.

The aim of care should always be to help restore developmental capacity where it has been lost (i.e where children have been damaged by their experiences) and to restore, create or resume a social orientated and familial lifestyle for the child that focuses on maintaining developmental capacity. For the state (or whānau) to provide that requires both a full understanding of the needs of a child and the access to appropriate services which can support both caregivers(whether kin or non kin) and the child. Caregivers need insight into the difference between care and the ongoing lived experience of growing up within attachment based relationships.

How might a CYP's experience in care placement(s) impact on their attachment style and ability to form secure attachments.

Where children move into adulthood with a history of problematic attachments (for whatever reason, not just being taken into care) it is more likely than not that they will struggle with forming and maintaining successful adult relationships and with parenting. Attachment dynamics tend to persist over generations and do not change without different experiences of relationships, conscious choice to change by an individual or formal intervention of some kind. This means that those who have had very disrupted attachment and feel a loss of identity and belonging may find it hard to

trust others. More significantly they may have no internal working models of how to psychological 'be' in relationship with others in the way they desire. More likely they will replicate, at least in part, the dysfunctional behaviours that they experienced as a child in their adult lives, including as a parent.

There is research which clearly indicated that multiple caregiving placements are more likely to have adverse outcomes. This is because with each 'loss' (that is change in care and loss of relationship) the child/young person has to go through a grieving process and a loss of hope develops. Such children/young people often believe (and maybe told) that the loss of a placement or a move into an institution is because of them, that they are in some way intrinsically damaged. This leads into a belief that they cannot ever achieve satisfactory relationships or trust others. Because such children/young people/adults have had profound (if unrecognised) experiences of grief they may fear the pain associated with potential relationship loss and choose simply to avoid deeper human connectedness.

It is now understood that some of these negative outcomes relate to how the experience of 'attachment' (as with the experience of trauma) impacts on brain development and core cognitive (neurological) functions. As previously indicated younger children who receive good quality care and remain kin connected do better than children who are placed at older ages and (often) experience multiple placements (and have multiple adverse experiences). They fail to develop a sense of relationship and belonging in a caregiving environment.

It is the repeated interactions with caregivers that develop a child's representations of self and other/s as well as impacting on core neurological development and the regulation of bio-behavioural systems. Researchers refer to the 'attachment network' noting that although the 'network' is seen it is not always given legal consideration. They argue that thinking about where a child or children should live and with whom needs to be informed by both a developmental perspective and the context in which the child is (and may/will be) living. They argue that multiple contextual factors need to be taken into account to understand attachment bonds.

State care is often assumed to be transitory, constrained by legislation, ill defined and subject to philosophical and political whim. Just as many children experience as 'abuse' the forced removal from family/whanau some children experience the forced removal from caregivers as an abuse. Caregivers may have complex reasons for becoming a caregiver (infertility among them) and these may impact on who they engage (attachment wise) to the child. Caregivers may fear the removal of a child to whom they have devoted love and care and the ongoing legal processes may impact on the developing bond and ultimately on an attachment having any possibility of developing. Placement instability is a major predictor of mental illness in the long term for children in care.

Can the loss of attachment (to parents and perhaps whānau) be viewed as a form of abuse? Can it lead to a person moving into criminal offending?

This question lies at the heart of having any form of statutory (or community) 'risk' management system for children and young people. All forms of interventions which disrupt 'normative' relationships create difficulties in and of themselves. The issue is, is the response (removal of a child from a home or determining a child should have only -for example- non contact communications with a parent) proportionate to the identified risk or concerns. If the response (say removal of a child from a home) is not proportionate then it is a form of abuse. Equally however to leave a child in a home where they are being sexually abused by one parent, despite the child having a secure attachment to the other (who chooses not to leave) will also be both detrimental and abusive.

On a lessor level modelling of behaviour is a powerful way in which we replicate aspects of the behaviour of others. Leaving a male child in a home where there is very serious family violence directed both at the child and at the mother by the father, despite the child having a secure attachment to the mother, could likely lead to that child or young person growing up to behave in abusive ways towards others, especially women. So that statutory welfare or community managed child protection (including the care of young people who come before the Justice system) cannot use an either or approach to the management of risk or the consideration of abuse. They have to be able to manage complexity in making decisions about children and their welfare.

There is indeed a lot of evidence that joining many forms of 'group' (including the Army or a 'gang') can be a replacement for the difficulties in childhood associated with family situations, including where a child is taken into care. There is no doubt that the sense of 'belonging' which can develop in institutional care can move, in adulthood, into the continued 'belonging' to groups such as gangs. Gangs by their structure and by the rewards they can offer members (there are a variety of rewards) can replace both dysfunctional families and the sense of loss of relationships that removal from family leads to.

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Appendix One: Tables of key concepts and definitions.(Copyright acknowledgment will follow).

Table 1.3 Some key concepts in Bowlby's writings

Concept	Mistaken for	Technical meaning
Attachment system	The instinctive relationship with a familiar caregiver	The 'attachment system' is a way of describing a form of motivation. The motivation is activated when a person is alarmed. When the person feels that a particular, familiar person—or familiar people—is available and responsive to their concerns, the motivation is reduced. Where the system strongly activated, some form of contact is generally sought (though this contact may still be verbal rather than touch). T motivation has some basis in evolution, and for this reason especially easy for humans to develop. However, a great de about this motivation, including exactly the conditions that prompt and terminate it, are shaped deeply by experiences relationships. This is why it is misleading to think of attachm as an 'instinct'. The attachment system has some characteristic behaviours but in principle any behaviour can be recruited that helps achieve the goal of attachment figure availability. Attachment researchers have debated the conditions that le to the satisfaction of the attachment system and a reduction display of attachment behaviour. The physical and attention availability of a familiar caregiver has been emphasised as terminating conditions in infancy; other attachment researchers, since Sroufe and Waters, have emphasised th infant's 'felt security' as the terminating conditions for the system. In general it is agreed that experience, circumstance, and culture can all shape the conditions under which the attachment system is activated, the forms of behaviour recruited by the attachment system, and how these are expressed.
Attachment behaviour	Pre-set behaviours that express attachment as an instinct	Anything in principle can be an attachment behaviour. All th is required is that the behaviour should be clearly directed towards gaining the availability and responsiveness of a

Concept	Mistaken for	Technical meaning
		familiar person or familiar people. It is not an 'instinctual' pre set pattern of behaviour. Attachment behaviours are observable, whereas the motivation they are presumed to express is inferred. The term 'attachment behaviour' was used in two different ways by Bowlby. His most common use of the term was to refer to proximity-seeking and contact-maintaining behaviou such as smiling, crawling towards the caregiver, clinging, ar directed cries to attract the caregiver's attention. These behaviours were understood as direct expressions of the attachment behavioural system. Sometimes, however, Bowlby also used the term 'attachme behaviour' to refer to any behaviour that occurs in the conte of the activation of the attachment system. This could even include withdrawal from the caregiver and attempts at self-reliance by a child who had found that seeking proximity wit their caregiver when alarmed or distressed would be counterproductive. Often these two meanings are aligned. However, some behaviours, such as when a child shows caregiving behavio towards a parent, are attachment behaviours in the second sense, but not the first sense. At times this has caused a la of clarity in discussing such behaviour, its eliciting condition and its relationship with the attachment behavioural system
Attachment bond	Parent–child bonding	Bowlby characterised relationships and their qualities as diverse. Attachment dynamics characterised only some relationships and not others. He therefore distinguished the broad class of affectional bonds, in which members are spe to one another and seek to remain in contact. Within this br class are relationships with attachment dynamics. These ar characterised by the fact that the other person is taken to b the object of the attachment behavioural system: there is a disposition to seek this person under conditions of alarm, ar a sense of security when this person is reliably available an responsive to concerns.

Concept	Mistaken for	Technical meaning
		The attachment bond is distinct from 'parent–child bonding' the process by which parents develop an affectionate bond with their child and take the child as the familiar target of the caregiving behavioural system.
Attachment relationship	An absolute state characteristic of a child's relationship with their mother	Being an attachment figure is not a yes/no situation. Bowlby proposed that an attachment relationship is present to the extent that an individual is disposed to seek the availability familiar other when alarmed. This disposition may exist eve the other is rejecting or abusive. Bowlby felt that an individual could have a variety of attachment relationships—including wider kin (e.g. grandparents), divine beings, and also a person's relationsh with their physical home. However, he believed that evolutio had primed humans to develop these dynamics especially w our familiar caregivers from childhood. Other relationships would be more contingent in the degree to which these dynamics would be expected.
Major separation	Occasions when the child and parent are not together	Attachment researchers sometimes discuss children experiencing 'major separations'. This is a technical term, which can easily be confusing. What makes a separation 'major' is that the child is alarmed by the absence of their attachment figure, and this alarm continues for long enough that the attachment behavioural system then becomes chronically unresponsive for a long period. In effect, the chil appears to give up searching for, calling, or expecting the parent to return. The result is that even when the caregiver available, the child is not able to use them—at least for a time—to regulate distress. Or, in Bowlby's terms, the behavioural system becomes chronically unresponsive for a period to cues for its activation and/or termination. The classic case of a major separation was the long-term hospitalisations observed by James Robertson in the 1950s which there were no or few visits to young children over several months.

Concept	Mistaken for	Technical meaning
		Attachment researchers do not regard some use of daycare a 'major separation' in the technical sense.
Monotropy	The exclusivity and priority of child–*mother* attachment	Bowlby introduced the term 'monotropy' in 1958 with the intention that it would refer to particular, special relationship shaped by time and habit. Unfortunately, the literal meaning the term is 'mono' (one) + tropy (turning to). This gave the mistaken impression he meant the exclusive importance of one caregiver for children. Bowlby later mostly abandoned the term, given the extent o misapprehension of his meaning.
Caregiving system	The natural capacity of parents, especially mothers, to care for their children	The 'caregiving system' is a way of describing a kind of motivation. A motivation to help is activated when a child or other person in our care is alarmed, and terminated when w have identified and responded to what we understand to be their concerns. In his initial description of caregiving as a behavioural syste Bowlby focused on the caregiver's motivation to retrieve infants who are alarmed or in trouble. However, later in his career he described caregiving as more broadly concerned with encouragement, support, help, and protection.
Effects of early experience	The notion that early social experience can be expected at an individual level to strongly determine later emotional and social experience	In his early writings, Bowlby sometimes made claims that implied that every child who receives poor care or who experiences major separations will develop social and emotional problems. From the 1970s onwards, he was more careful, claiming that—on average—poor care or major separations are likely to increase the chances of later socia and emotional problems. Later attachment researchers have synthesised findings fro many studies through meta-analysis, indeed finding that ea care does have effects on later socioemotional developmen but that early experience does not determine later outcome and that there are important mediators and moderators.

Concept	Mistaken for	Technical meaning
Internal working model	Representations of caregivers, which become generalised to all relationships with development	This is perhaps the single most confusing concept used by attachment researchers. Bowlby used the term in two differe ways. Firstly, he intended it only to mean that the way the attachm system works depends on expectations based on previous experiences of interaction with caregivers in childhood—and with partners and friends in adulthood. So a synonym for the internal working model, in this sense, in ordinary language i simply 'expectations'. Bowlby's point was that expectations about early relationships can play a role in shaping our assumptions about later social relationships and interaction Both humans and non-humans will have expectations abou our caregivers or partners and their availability. However, humans also develop elaborated cognitive and cultural representations about ourselves and our attachment figures These include narratives and images about the availability o attachment figures, and how we think they feel about us. A second use of the term 'internal working model' by Bowlby w therefore to refer to the specific symbolic and affective representations made by humans about attachment figures and their availability, and the efficacy of attempts to seek th when alarmed. When Mary Main and colleagues introduced the Adult Attachment Interview (AAI) in the 1980s, they documented individual differences in the coherence of autobiographical accounts by participants of their childhood. Initially she referred to these differences in speakers' narratives as reflecting differences in 'internal working models' about attachment. By the 1990s, she had abandoned and criticise the use of the term 'internal working model' to refer to these differences. Given the two different meanings above, she fe that the term was confusing and misleading for describing what the AAI was measuring. Main preferred to characterise individual differences in the AAI as reflecting 'states of mind regarding attachment'. However, many attachment researchers still refer to the AAI as measuring internal work models.

Concept	Mistaken for	Technical meaning
Segregation	The inhibition of information; essentially the same as dissociation	In Bowlby's later writings the term 'segregation' is used to re to a coping strategy in which some information is filtered ou experience. This can be minor and remain flexible: the filter can be raised or dropped as needed. Or the flow of informa to or from whole behavioural systems can be blocked over a long period, regardless of the circumstances. Bowlby distinguished two forms of segregation. A first was 'defensive exclusion'. Here the filter is placed on perception So, certain things in the world may not be noticed. Or if noticed, they may not prompt a response. The paradigmatic form of defensive exclusion is the infant in an avoidant attachment relationship, who directs attention away from the caregiver on reunion. In doing so, they filter out information about their situation that might otherwise prompt the activat of the attachment system. A second form of segregation was 'cognitive disconnection' Here the filter is placed on memory. So, certain memories n not be available. Or if available, they may not be tagged wit well-defined and accurate meanings. The segregation of information about attachment figures wa anticipated by Bowlby to contribute to an individual holding multiple incompatible perceptions and expectations of these figures. Bowlby's primary book on segregation, defensive exclusion and cognitive disconnection remained unpublished. The ter appear only briefly in his published works. As a result, these terms are only used rarely now by attachment researchers.
Multiple attachments	Bowlby felt that a child should always be cared for by their mother	In his early writings Bowlby sometimes made claims that suggested a child should always be cared for by their mothe However, he subsequently regretted these claims. In his mature writing Bowlby saw value in a child having access to multiple secure bases and safe havens, and did not think th one attachment would be at the expense of another. Bowlby's final statement was that the attachment system 'contributes to the individual's survival by keeping him or he touch with one or more caregivers'. The idea of attachment

Concept	Mistaken for	Technical meaning
		relationships as a network was developed by subsequent researchers such as Avi Sagi-Schwartz and Marinus van IJzendoorn.

Duschinsky provided a useful table of differences in how attachment constructs have been interpreted across popular discourse, developmental science, social psychological science, psychiatry and psychotherapy and child welfare practices.

Table 1. Typification of differences in conceptualisation of attachment

Popular discourse	The child's love for a parent, predominantly the mother; it is often used to signal moral expectations on the parent
Developmental science	The use of a caregiving figure as a safe haven (as well as potentially a secure base) signalling a history of the caregiving relationship
Social psychological science	Close relationships with emotion regulatory functions; signalling the extent of anxiety or avoidance an individual's experiences in these relationships
Psychotherapy	Close relationships with emotion regulator functions, signalling the extent of the individuals difficulties with relational and self-understanding
Psychiatric diagnosis	The disposition to discriminate and seek a familiar caregiver when alarmed, signalling the existence of an attachment relationship as the basis for mental health
Child welfare practice	The relationship quality between the child and their caregiver, signalling the child's best interest

Table 2 Typification of differences in conceptualisations of "security".

Popular discourse	A good and confident psychological state, and is presented as a desired state for everyone.
Developmental science	The perceived availability of a safe haven in one's attachment figure(s) ("felt security").

Social psychology science	The absence of attachment anxiety and avoidance.
Psychotherapy	The mechanism of good mental health in the therapeutic relationship, and in a client's other interactions
Child Welfare practice	A good parent-child relationship, indexing a child's best interest

Table 3 Typification's of differences in the conceptualisation of internal working model

Developmental science	Used internal working model variously to mean • Expectations about the availability of the attachment figures built up on the basis of repeated sequences of procedural interaction • Elaborated symbolic meanings and images built up by humans about attachment figures and their availability • A synonym for attachment representations, as used by Main in the 1980s (but subsequently abandoned). • Expectations about the availability of attachment figures built up on the basis of repeated sequences of procedural interaction.
Social Psychological Science	Used internal working model to mean • The elaborated symbolic and affective representations made by humans about attachment figures and their availability, and the value of the self to these attachment figures.
Psychotherapy	Used internal working model to mean • Elaborated conscious and unconscious symbolic meanings and images held by humans about attachment figures and their availability, and considered to be malleable through therapy.

Table 4. Typification of differences in conceptualisations of "attachment-related trauma". "Attachment-Related Trauma"

Popular discourses	Separations and other disruptions of the "natural" family
Developmental Science	Negative impact of adverse events like loss and abuse on an individual's current psychological state, evidenced by disoriented, incoherent discussion of these events
Social Psychological Science	An adverse event presumed to be a predisposing factor or cause of attachment anxiety and avoidance and/or an adverse event made psychologically disruptive by pre-existing attachment insecurity
Psychotherapy	Any experience from family life that is chronically disruptive of an individual's internal and external regulatory capabilities. Includes abuse and neglect from caregivers or other trusted adults. Sometimes also referred to as "developmental trauma
Psychiatric Diagnosis	DSM/ICD definition of posttraumatic stress disorder.
Child Welfare Practice	Experiences that compromise the health and development of a child, and occurring in the context of the parent-child relationship

Table 5. Typification of differences in conceptualisations of "disorganisation".

Developmental Science	Used variously to mean: ● Conflict, confusion and/or apprehension shown by an infant towards their caregiver in the Strange Situation. ● A significant disruption of a behavioural system. It is this (invisible) disruption at the level of motivation, which is presumed to cause the visible conflicted, confused or apprehensive behaviour seen, for instance, in the Strange Situation. ● A category label for infant-caregiver dyads seen in the Strange Situation, where conflicted,

	confused and/or apprehensive behaviour is seen to a significant degree. ● The category label for controlling-punitive and controlling-caregiving behaviour in the Main and Cassidy 6-year reunion system. The behaviour was generally smoothly sequenced, goal-oriented, and often resulted in some form of caregiver availability – so it was not technically disorganised at a behavioural level. However, Main and Cassidy used the term "disorganised" to signal developmental continuities from infancy, and to highlight that controlling-punitive and controlling-caregiving behaviour likely arises in the context of disruption to the child-caregiver relationship and its usual hierarchies. ● The psychological process indicated by unresolved loss and trauma in the Adult Attachment Interview.
Social Psychological Science	• The co-presence of attachment anxiety and avoidance and/or random chaotic behaviour.
Psychotherapy	• A mechanism underpinning the contribution of emotion dysregulation to mental ill health.
Child Welfare Practice	• A bad parent child relationship, indexing a failure to align with a child's best interests

Robbie Duschinsky, Lianne Bakkum, Julia M. M. Mannes, Guy C. M. Skinner, Melody Turner, Alissa Mann, Barry Coughlan, Sophie Reijman, Sarah Foster & Helen Beckwith (2021) Six attachment discourses: convergence, divergence and relay, Attachment & Human Development, 23:4, 355-374, DOI: 10.1080/14616734.2021.1918448