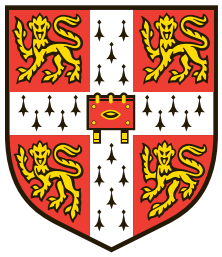
Understandings of attachment theory for clinical practice



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A thesis submitted for the degree of

Doctor of Philosophy

Lent Term 2021

This work is dedicated to my Mum, Dr Sally Beckwith, who died very suddenly and unexpectedly two weeks after submission, for she has had the greatest influence on my development as a person, as a clinician, and as a researcher, and who delighted in how much her own life had been changed by completion of a PhD.

Declaration

This dissertation comprises work conducted by Helen Beckwith for the degree of Doctor of Philosophy from the University of Cambridge. Helen Beckwith has led all the work included and reported here.

Abstract

Understandings of attachment theory for clinical practice

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Attachment theory and research is considered to have a great deal of relevance for clinical and social welfare practice. Practitioners are encouraged, through literature, training and policy, to learn, understand, refer to and use their knowledge of attachment theory and research when working to meet the needs of the children and families they encounter. However, there has been very little empirical study of how practitioners have understood attachment concepts and methods in order to do this. The research reported here examines how clinicians and researchers understand attachment theory and research in the context of clinical practice for child mental health.

Chapter 1 spotlights the gap in empirical work pertaining to practice-based understandings and behaviour, with respect to attachment theory. It draws on theories and models of professional knowledge to contextualise the forthcoming study; framed as an evaluation of attachment theory's intelligibility.

Chapter 2 reviews a range of source materials surrounding the development and distribution of attachment knowledge. It presents a narrative synthesis of the diverging ways attachment concepts are used within academic, policy and practice literature. Attention is given to issues arising from each discourse when considering implications for clinical practice. This work generated the initial themes that informed the study design and development.

Chapter 3 explores what beliefs about attachment applications may exist by assembling a pool of relevant claims observed from the literatures. Q-methodology was used to examine the views of international attachment researchers and clinicians working with children, adolescents and their families in the UK. Additional background and demographic information were collected to explore potential mediating influences that may shape the perspectives of these participants.

Chapter 4 reports in detail on the by-person factor analysis employed to make sense of the data. A substantial degree of commonality was observed, alongside profiles of three perspectives that diverged on a number of key issues. Participants clustered around these viewpoints based on shared professional characteristics.

Chapter 5 discusses the findings with particular emphasis on identified areas of consensus and divergence between researchers and clinicians. In addition, it reflects on the contextual influences which shaped the views and concerns expressed by participants.

Chapter 6 concludes with a consideration of how knowledge is shared between domains of research and practice, and a coherent and incisive position on the current state of play. It ends with a reflexive narrative about approaching and conducting this work as a practicing clinician and researcher within the field.

The work reported in this dissertation will be of particular value to i) researchers interested in how best to communicate with and learn from practitioners and wider publics; and ii) practitioners interested to think further about the implications of attachment theory and research for their own work.

Acknowledgements

I am hugely fortunate to have had such an established network of support and expertise within which to conduct and complete this work. First and foremost, I must thank my primary research supervisor Dr Robbie Duschinsky for his endless support, encouragement and wise direction throughout my doctoral training. Robbie has never wavered in his belief in me to conduct this work and to complete it to a high standard, and he has prioritised making himself available for feedback, discussion and support alongside formidable competing demands on his time and energy.

My sincerest thanks also go to my co-supervisors, Professor Mark Freeston, Professor Marinus van IJzendoorn, and Dr Matt Woolgar for the wealth of expertise they have developed and shared with me, for the generosity of time and investment they gave to this work, and also to their personal interest and development of me as a clinician-researcher. The scholarship of my supervisory team is truly colossal and genius; it has been a great privilege to work with them.

I am particularly grateful to Professor Marian Bakermans-Kranenberg and Professor Paul Stenner for their additional support and on technical matters that significantly enhanced the quality of this study. Special thanks also to past and present members of our research team: Dr Sophie Reijman, Sarah Foster, Lianne Bakkum, Barry Coughlan, Guy Skinner and Julia Mannes for their collaboration, support and friendship along the way.

Thank you also to all the clinicians who made time to participate in this study, and to researchers in the attachment community who participated and engaged with this project at various stages. I am delighted to thank the Wellcome Trust who funded the studentship that made this work possible – their vision and approach to supporting scientists in health research is wide-ranging, pioneering and ideal for the 'incurably curious'.

Lastly, I want to thank my personal network of favourite people for their unwavering love, support and encouragement of me in everything I do: my team-mate Günther Turk, my best friend Dr Lauren Mawn, my sister Pippa, and my parents Dr Sally and Jeremy Beckwith. I'm grateful for our shared interests and value of education, curiosity and personal development that have been solid foundations for the work produced here. Special thanks to my friends, Dr Melanie Jans-Singh and Dr Jack Fraser, who travelled this journey with me; Dr Kasia Wyczesany who made sure we did as much walking as writing during pandemic lockdown, and to superstar Annabel Reed for sensitively celebrating my wins whilst holding my losses.

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Chapter 1

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INTRODUCTION

1.1. Attachment research and professional practice

Attachment theory (Bowlby, 1969; 1982) has been a major research programme within developmental psychopathology research for the last 50 years and has a great deal of relevance for clinical and social welfare practice. It is primarily a theory of child development, emphasising the importance of early caregiving experiences and availability of at least one trusted adult in order to ensure survival. Bowlby theorised a universal predisposition to seek proximity to a caregiver ('attachment figure') when distressed, tired, hungry or unwell. The theory developed to propose two key functions of this attachment relationship: provision of i) a 'safe haven' to soothe an child in times of distress, and ii) a 'secure base' from which to explore the environment. Close observation of parent-child interactions led to the development of an attachment classification system, which has evolved into one of the most substantial research paradigms in developmental psychology and beyond. In particular, individual differences in the quality of caregiving and subsequent implications for later development have attracted the attention of applied practitioners, multidisciplinary scientific research and public interest.

Professional training programmes across health and social care teach attachment theory as a core framework for understanding child development and mental health. This encourages practitioners to use their knowledge of attachment theory and research when working to meet the needs of the children and families they encounter. Practitioners in the UK have been

especially encouraged to work with an awareness of children's attachment across all areas of health, social care and education, following the publication of national guidelines for practice by the National Institute of Clinical Excellence (NICE: NG26, 2015). In addition, attachment concepts have been discussed in Parliamentary debates on mental health (2010; 2012) and child development (2014; 2016), and related policy initiatives (Healthy Child Programme, 2009; Building Great Britons, 2015; Transforming Children and Young People's Mental Health Provision, 2017), which have further spread and reinforced the relevance of this framework for practitioners working with children and families in the UK.

There are an extraordinary amount of books and articles advising practitioners on how to use attachment theory in different areas of practice: A google scholar search using the terms 'attachment in psychotherapy' yields over 400,000 results, and there are just under 3.5 million hits for 'attachment in social work' (September, 2020). One area of application has been attachment-based interventions across the lifespan, and their evaluation (Steele & Steele, 2017). However, beyond this empirical literature, other discussions have included more speculative guidance for clinicians on working with children with developmental trauma (Crittenden, 2008/2016; Hughes, 2008), psychotherapy with adults (Wallin, 2007; Daniel, 2015; Holmes & Slade, 2017; Johnson, 2019), family and systemic therapy (Dallos & Vetere, 2009; Crittenden, 2014), service design and delivery (Goodwin, 2003; Bucci, et al., 2015), parenting (Seares & Sears, 2001; Hughes, 2009; Newton, 2008), education (Geddes, 2006, Golding, et al., 2012), assessing disorganised attachment (Shemmings & Shemmings, 2014), child welfare assessments (Howe, 1995; White, 2020) and family courts (Hontree, 2017). Besides the limited case of a process evaluation of an intervention promoting positive parenting (Stolk, et al., 2008), there has been almost no research evaluating how current clinical or welfare practice has actually been shaped by this substantial body of literature. In particular, there is a paucity of empirical knowledge surrounding practitioners' understanding of attachment concepts, how they relate to each other

and to other related constructs (such as trauma, resilience and wellbeing), and how these get deployed in practice.

The lack of available research appraising current practice has not deterred a wealth of recommendations and guidelines being published and circulated. Some of these guidelines (e.g. Forslund, et al., 2020) are comparatively well grounded in the available empirical evidence. However, even within otherwise well-conceived guidelines, gaps in knowledge of how attachment theory and research may relate to applied practice have led to ill-judged proposals. To give one example, the team of experts recruited by NICE to develop the national guidelines for attachment (NG26) briefly considered implementing routine assessments of infant attachment as part of a national screening programme, demonstrating the potential of attachment concepts to be applied so widely as to include public health considerations of all children born in the UK. This was considered without adequate understanding of population vs individual level validity of the assessment tools, and was halted by researchers and professional bodies appealing to the NICE guideline committee in feedback on the first draft (Clinical guidelines for consultation, May 2015, p79-81). Internationally, attachment scholars involved in recent collaborative work to publish international consensus statements on key matters of disorganised attachment (Granqvist et al., 2017) and child protection and custody issues (Forslund, et al., 2020) have also acknowledged the lack of empirical evidence regarding actual practitioner knowledge on which to draw upon, and emphasise that these works of consensus were premised only on speculation regarding professional understanding and practice. They called explicitly for empirical research on professional understanding of attachment theory and research, and specification of lines of alignment and misalignment between the perspectives of researchers and practitioners.

The extent to which attachment theory features in professional training programmes varies across disciplines (Furnivall, et al., 2012) suggesting there may be also differences in understanding and application between, and perhaps within, professional groups. Indeed,

clinicians have raised concerns about inappropriate assessment (Allen & Schuengel, 2020; Woolgar & Baldock, 2015; Woolgar & Scott, 2013) and treatment decisions being made in the name of attachment theory (see Prior & Glaser, 2006; Zeanah, et al., 2016). Scholars too have acknowledged difficulty in maintaining the integrity of attachment concepts and methods when applying them meaningfully to practice (Oppenheim & Goldsmith, 2007), and social work practitioners in the UK have suffered from being trained in line with recommendations about the use of attachment theory for risk assessments of child maltreatment, which were then heavily criticised by the academic community (Granqvist, et al., 2017) and later retracted (Wilkins, 2020).

Some practitioners have warned against overemphasising attachment concepts and their relevance to applied practice. *The Psychologist* magazine published by the British Psychological Society, a key forum for practitioner reflection and discussion, featured Professor Elizabeth Meins' (2017) article *"Overrated: The predictive power of attachment",* which sparked discussion between researchers and practitioners. It drew on anecdotal evidence from clinicians about how attachment is frequently used as a generic explanation, popular but vague, deemed highly important but potentially at the expense of other important constructs such as resilience. Separately, White and colleagues (2020) have made similar claims, with particular reference to child welfare practice. Taken together, these critiques appear to express dissatisfaction with 'where the telescope has been tuned': a reference to Pickering's (2010/2015) concept of 'interactive stabilisation' brought to the discussion of attachment research by Reijman, et al. (2018). The authors propose that the attachment classification system constitutes the theory's machine for seeing/knowing, which has been used and tuned to a particular configuration that has proved useful for developmental science. However, they emphasise Pickering's counsel that several usable points of interactive stabilisation will exist and selection can be optimised to suit the particular contextual demands of the instrument. To follow Pickering's metaphor of a telescope, the examples above imply that practitioners find this framework has so far only allowed them to see a 'blurry picture'.

Another way to understand these concerns is de Regt's (2020) concept of intelligibility: a contextually determined and pragmatic value judgement, pertaining to the degree of fit between a theory's qualities and the ability to use the theory in fruitful ways. He argues that theories are intelligible when they can construct explanations that are acceptable to its users, who in turn can understand the phenomenon that the theory sought to explain. Meins' article suggests she (and others) has not found attachment theory to be intelligible, due to a lack of clarity in a number of areas that have limited its explanatory power (such as the buffering effects of resilience). Instead, she considers that the reason the attachment literature has attracted widespread attention is because of its apparent simplicity: that secure attachment leads to successful development, and insecure attachment leads to unsuccessful development, commenting that *'simple causal relationships are attractive because they are easy to grasp'* (p.24). In contrast, she argues, understanding the resilience literature, which proposes a broader and more complex set of developmental pathways, is *'considerably more difficult'* (p.24). In direct response, van IJzendoorn and colleagues (2017) urged Meins to distinguish between the public discourse and the scientific discourse on attachment, attributing several of her criticisms to claims that were made within the policy arena, where they recognise that these can be intentionally exaggerated to emphasise the importance of early experiences, in order to obtain public support and necessary funds for policies. In highlighting these important differences, what the researchers have perhaps underestimated is the extent to which practitioners are inherently embroiled in the interplay between the public and scientific discourses, and where the nature and remit of their work is increasingly shaped by political and policy-based agendas. Certainly, in Meins' (2017) response she cautioned that although attachment researchers understand the nuances within the literature and the need to differentially angle these to various audiences, many outside developmental science do not, warning that simplistic caricatures of attachment research have filtered through to practice policy for working with children and families in the UK. This public exchange between experts indicates that a) there are different discourses of attachment, driven by different desires, and

shaped by the intended outputs of particular contexts, b) there may be divergence in understandings of attachment theory and research outside of developmental science that warrants further examination and c) understandings of attachment theory within the domain practice is of relevance and interest to a number of key stakeholders, with important implications for public health.

Duschinsky has tackled the issue of multiple discourses around attachment theory through analysing the social distribution of knowledge, specifically the spread of attachment ideas across time and audiences. His newly published book, *Cornerstones of Attachment Research* (2020), is the result of a five-year historical study of key research groups that have been important for the development of the attachment research paradigm. It provides an analysis of the contributions of each group and the debates between them; curated, in part, for the purpose of clarifying key concepts and terminology within the field. Duschinsky makes reference to the different discourses of attachment in circulation and how these have largely gone undocumented, which led him to suspect extensive divergences in understanding between researchers and practitioners. Recognising that its analysis was limited by the available literature, *Cornerstones* concludes with a particular emphasis on the need for new empirical work examining applications to practice. Given the wealth of literature on hypothesised applications for practice, combined with the misconceptions and ambiguities in some domains of discourse, it is clear that attempts to understand the resulting impact on practitioner knowledge and understanding is especially important.

Very few published studies have examined practitioners working with children and families in context. Two interview studies with social workers reported only disparaging conclusions pertaining to insufficient knowledge of attachment theory and interventions (Lesch, et al., 2013; Botes & Ryke, 2011; see also White, et al., 2020). One attempt to interview residential childcare staff found participants lacked an explicit awareness of attachment theory and thus had difficulty articulating theory-practice links (Morison, et al., 2019). Instead, they

described their practice as 'natural' and 'common sense', focused on 'building relationships' with 'theory in the background' (p.9). Using Q-methodology, Wilkins (2016) found that ideas of attachment appealed to social work practitioners because they emphasised the importance of relational issues, emotion, the impact of early experience on anxiety and the experience of symptoms. Though pertinent to identify, these are issues typically addressed through clinical interventions within mental health services rather than within social care and thus point to the particular need for examining understandings of attachment theory amongst clinicians. Finally, within adult therapeutic literature, another interview study identified that therapists somewhat loosely herald its relevance throughout all elements of the therapeutic process as well as in service design and delivery, primarily via establishing a secure base element to the therapist-client relationship (Burke, et al., 2016). As this was the only specified mechanism identified by the researchers, belief in such wide applications appears only weakly supported and perhaps overstated. Regrettably, what these previous studies demonstrate is an inability to sufficiently capture practitioner-led understandings of attachment theory and research within clinical settings. In particular, the methods used suggest that attempts to ask practitioners about this directly have not proved especially fruitful and risk appearing as though practitioners have only 'naive theories' (Olsson & Ljunhill, 1997). In summary, the relative scarcity and poor quality research of practitioner understanding and experience has prohibited a more complete understanding of theoretical or research informed ideas that have real clinical utility.

Overall, these observations from literature, policy and practice forums indicate a significant breakdown in communication between research and practice that leaves the field vulnerable to further misunderstandings and potential misuses. As a result, there have been missed opportunities for identifying what exactly it is about attachment theory that may be useful for those directly involved in the care and wellbeing of children and families. The inclusion of attachment theory and research within school and university syllabi, core training programmes and professional guidance documents, alongside its established appeal and attractiveness for

pertinent issues of relationships, emotion and mental health, suggests practitioners perceive ways of applying the scientifically generated knowledge that are both valuable and consistent with the intended aims of literature and policy. As detailed below, where direct applicability of concepts has not been stated, provided or deemed immediately intuitive, practitioners may interpret these in divergent ways, perhaps by transforming or generating new knowledge and understanding in response to problems uniquely encountered in the practice context. Further empirical enquiries of practitioner understanding and behaviour will therefore benefit from greater consideration of the unique demands of the practice context and the nature of knowledge that is required to navigate this. In addition, the limitations of previous studies have shown the need to use methods that support practitioners to communicate theory-practice links with greater specificity and minimal rhetoric. The remainder of this chapter addresses these recommendations and describes the empirical study undertaken to examine practitioner understandings of attachment theory and research and how these relate to both the scientific literature and the perspectives of academic researchers.

1.2. Practitioner knowledge and understanding

In his book, *Developing Professional Knowledge and Competence,* the renowned professor of education Michael Eraut (1994) states, *'it is inappropriate to think of knowledge as first being learned then later being used. Learning takes place during use, and the transformation of knowledge into a situationally appropriate form means that it is no longer the same knowledge as it was prior to it first being used'* (p.20). On his account, what knowledge gets used and how depends on whether it is done so in the context of academia, policy or practice, with no guarantees that learning in one context transfers to another. Uniquely, he argues, the practice context demands the integration of *'complex understandings and skills into a partly routinised performance, which then has to be deconstructed and deroutinised in order to incorporate something new'* (p.20). He proposes that each new instance of use is an opportunity for an individuals' understanding of a concept to be expanded and potentially altered, which, over time,

leads to the development of internalised maps or theories of action (Argyris & Schon, 1974). On the one hand, Eraut considers this is necessary in a practice context in order to make the demands of professional life tolerable, yet on the other it can mean that the introduction of new knowledge threatens to deconstruct and reassemble certain behavioural routines in ways that are disorienting and overwhelming. In this space, there is in fact further potential for knowledge transformation and new knowledge creation. However, such practical knowledge is typically implicit and rarely afforded the high status of technical knowledge (Eraut, 1994), which has resulted in almost all discrepancies between research and practice experience to be attributed to a failure in translation between, and in the direction of, theory → practice.

In medical literature this is often referred to as the process of knowledge translation, or more generally as a theory-practice or research-practice gap. Greenhalgh and Wieringa (2011) argue that the idea of a theory-practice gap constrains the thinking, conceptualisation and study of the knowledge and practice link in clinical encounters, and also the management and organisation of healthcare, and the policy-making process. They attribute this to three problematic assumptions underpinning the knowledge-translation metaphor: 1) an objectivist epistemology; that knowledge is a set of objective research findings independent of the scientists who generate it and the practitioners who may use it; 2) that knowledge and practice can be cleanly separated both empirically and analytically, and that it is useful to distinguish in this way; and 3) that practice consists of a series of rational, empirically-based, decisions. These assumptions are addressed below within a broader discussion of practitioner knowledge and understanding, in an effort to provide context for considering influences on individuals' relationship with attachment theory and research, and to highlight different types of knowledge that are relevant to a practice context.

1.2.1. The nature of professional knowledge

Epistemology refers to the philosophical study of knowledge; the branch of objective epistemology predicates a separation between reality and consciousness, indicating that facts about the world exist independent of human beings who understand them. In this way, the knowledge-translation metaphor in medicine and other areas of clinical practice, implies that there exists objective knowledge about how best to conduct clinical encounters, and that the task of a clinician is merely to deliver or implement this. This objectivist position is untenable in such a domain, not least because it would require drawing on a different 'objective' knowledge base for every single clinical encounter. Evidence-based practice guidelines have been one attempt to systematically incorporate best research evidence into clinical judgement in an attempt to reduce inappropriate, unproductive and sometimes harmful variations of practice (Eddy, 2005). Yet, evidence-informed practice still cannot provide all the answers that practitioners need (White, 2011), because *'in every case, the practitioner must reason not from the general to the particular but from the particular to the general – abduction rather than deduction'* (Greenhalgh, 2013, p.36). Crucially, practitioners need to know, or at least make a judgement or decision about what action to take, even in the absence of objectively knowing what would be best to do. In his book on the sociology of medicine and applied knowledge, Freidson's (1971) writes, *'one whose work requires practical application to concrete cases simply cannot maintain the same frame of mind as the scholar or scientist: he cannot suspend action in the absence of incontrovertible evidence or be skeptical of himself, his experience, his work and its fruit. In emergencies he cannot wait for the discoveries of the future [...] By the nature of his work the clinician must assume responsibility for practical action, and in doing so he must rely on his concrete, clinical experience.'* (p.169). Such urgency of action means the range of available knowledge on which to draw upon in clinical interactions necessarily goes beyond that which has been empirically observed; thus attention is turned to other types of knowledge and learning that are required and recruited for practical application.

For Aristotle, knowledge consisted of more than just objective 'episteme' (facts); his understanding of knowledge included 'techne' (skills) and 'phronesis' (a form of practical wisdom). His framework appears immediately problematic for the delineation of knowledge and practice inherent to the concept of knowledge-translation. Since then, others have developed these components into concepts of codified (explicit) knowledge and tacit (implicit) knowledge (Polanyi, 1958). However, these typologies still fail to account for knowledge pertaining to aspects of theory rather than objective empirical findings, and neglect to consider the personal knowledge and relevant experiences that clinicians bring to their professional role and understanding.

A model proposed by Drury Hudson (1997) for social work practice more satisfactorily accounts for these short-comings, integrating five areas of knowledge by highlighting their shared contribution to what she calls 'professional knowledge' (see Figure 1). Though not claiming to be fully objective in nature, the contribution of empirical knowledge refers to evidence that has been systematically gathered via scientific method, and is separated in this model from knowledge of theoretically-based concepts that may hold phenomenological or explanatory power. In addition, procedural or skills-based knowledge are conceptualised here as knowing and navigating the contextual layers surrounding practice, which is undoubtedly skillful but not inclusive of all the skills required for clinical or social work practice. Lastly, the contributions of personal knowledge and practical wisdom reflect what Eraut (1994) has described as a *'semi-conscious patterning of previous experience'* (p.44) that sometimes are difficult to trace the source of or even clearly articulate.

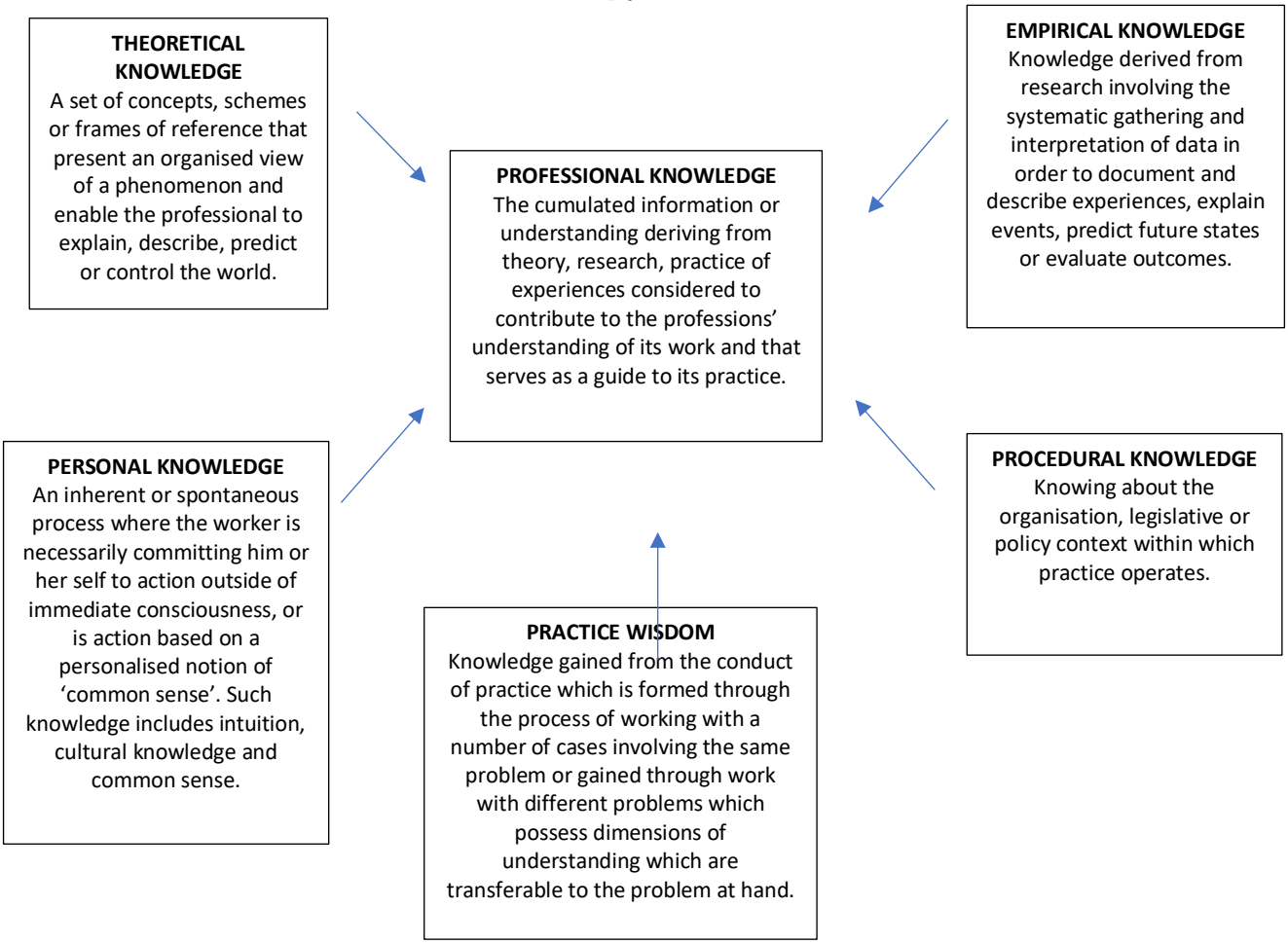

Figure 1: Model of professional knowledge for social work practice (Drury Hudson, 1997)

Though not perfect, this and similar models (e.g. Trevithick, 2008) ultimately demonstrate that knowledge equates to much more than objective, impersonal research findings that are implied by the knowledge-translation metaphor. Of greater importance to understanding the relationship between theory and practice is in fact the integration and utilisation of various forms of knowledge. The concept of transdisciplinarity was proposed by Büchner (2012) to capture what lies beyond multidisciplinarity and interdisciplinarity; to describe the task of combining various sources of knowledge from different disciplines and utilising it for practical application. In deciding what knowledge is useful for their practice, Askeland and Payne (2001) argue that practitioners do not necessarily base this on scientific or academic reasoning; rather scientific knowledge undergoes a process of adaptation and utilisation such that it becomes professional knowledge, or 'knowledge-for-practice' (Trevithick, 2009).

1.2.2. Knowledge-for-practice and mindlines

In the context of social work practice, Plafky (2016) examined how abstract concepts are translated and transformed into knowledge that can be readily applied by practitioners. She argues that practitioners do this in an attempt to own knowledge, not simply be users of knowledge. Her interview-based case study is of particular interest as it focused on the role of attachment and trauma theories as key agents in the translation process of complex neuroscientific messages. Plafky identified a 'pick and choose' approach that is limited to specific aspects that are useful for understanding and practice, arguably aligning with de Regt's (2020) proposition of intelligibility. In order to navigate the complex task of integrating theories and concepts into their work, she suggests practitioners develop nearly idiosyncratic tools to provide the best possible service. Gabbay and le May (2004) have previously described such tools as 'mindlines': *'guidelines-in-the-head, in which evidence from a wide range of sources has been melded with tacit knowledge through experience and continual learning to become internalised as a clinician's personal guide to practising in varied contexts'* (p.402). In recognising the value and constraints of practice guidelines, these authors propose that mindlines are preferential due to their flexibility and malleability to better the demands of clinical work. They described mindlines as *'a form of 'knowledge-in-practice-in-context' that accommodates the necessarily fuzzy logic that is part of everyday professional life'* (p.402). From ethnographic observations, the authors identified that a particular opportunity for mindlines to 'morph' was when clinicians found themselves out of line with respected colleagues. Within child mental health, one example of this may be attempts to resist the dominant medical model that some argue unnecessarily pathologises already vulnerable children or in disagreements around diagnoses and treatment options.

Attachment theory can be understood to offer a broad framework for understanding the impact of early childhood experiences on later life development, and supporters in multiple domains attribute high levels of optimism and hope to the potential it affords to intervention and society as a whole. For these reasons, and the shared need for transdisciplinarity across

clinical practice and social welfare, it is possible that the 'pick and choose' approach is also evident in clinical practice with regards to attachment theory and research. In her practitioner interview study, Plafky (2016) found evidence of personal preferences in practitioners' choices of relevant theory and research on which to draw upon, which were embedded in personal beliefs, attitudes, previous training and knowledge, and experience. This suggests that examination of practitioner-level factors could fruitfully elucidate relevant correlates of interest to the 'pick and choose' behaviours of practitioners and their developmental construction of personal mindlines. Other examples that may give rise to preferential selection of theory or the transformation of mindlines would be expected in new or ambiguous circumstances for which guidelines or mindlines are not yet available. This is somewhat inevitable, given clinical practice is a context that is ultimately characterised by uncertainty (Ghosh, 2004; Kim & Lee, 2018), and suggests that assessments of clinicians' dispositional responses to uncertainty and tolerance to 'fuzziness' may be relevant to their understanding of theory and its application to practice.

1.2.3. Uncertainty and clinical method

Greenhalgh (2013) offers a conceptual taxonomy of the uncertainty present in clinical practice, which gives this matter particular salience: uncertainty about the evidence (what do the research and guidelines show?), about the narrative (what is the patients' story?), about the case-based reasoning (what is best to do for this person at this time under these circumstances?) and about multi-professional working (how best to communicate and collaborate?) (Engebretsen, et al., 2016). National and professional guidelines, empirical research, service design, local needs and training priorities all contribute to the decision-making processes, but less is known about the contribution of individual level factors. Qualitative studies in medical literature certainly propose that clinicians vary in their ability to tolerate uncertainty and hypothesise that this influences medical decision-making (e.g. Wranik, et al., 2021; Kim & Lee, 2018), but this has not yet been formally assessed amongst health professionals. Within the anxiety literature, the concept of

intolerance to uncertainty has been widely examined using the intolerance to uncertainty scale (IUS; Freeston, et al., 1994). This measure captures the degree to which individuals' are bothered by the 'unknownness' of a situation, regardless of whether the possible outcome is positive, negative or neutral (Milne, et al.; 2019 Freeston, et al. 2020). The uncertainty distress model (Freeston, et al., 2020) suggests that under high uncertainty, individuals who are highly intolerant of uncertainty (IU) are driven to behave in ways that seek to reduce the degree of uncertainty. We would therefore expect that health professionals with high IU will find working in uncertain conditions distressing and are likely to engage in uncertainty-reduction behaviours.

A key part of the clinical method is reflexivity, which may include reflections on how clinicians operate under various conditions of uncertainty. This provides a notable challenge to the assumption of entirely technical or rational professional activity. Schön (1984) formulated that professionals use reflection to deal with the uncertainty that pervades their work, shape their thinking and actions and learn from experience. Greenhalgh and Wieringa (2011) proposed that ultimately the question facing practitioners during every clinical encounter is *'what is it best to do, for this individual, at this time, given these particular circumstances?'* (p.505), noting that *'clinical encounters are more than a collection of decisions: they are complex social accomplishments.'* (p.503). To illustrate what the authors were perhaps referring to, Drury Hudson's model of professional knowledge can be imperfectly overlaid on this question in the following way: 'what is it best to do (theoretical knowledge), for this individual (empirical knowledge), at this time (personal knowledge), given these particular circumstances (procedural and empirical knowledge). It is the experience of answering this question in clinical encounters, reflecting on the outcomes that follow and incorporating the learning gained into relevant future considerations that some consider to be the essence of practice wisdom. Inevitably, this is also what underlies practitioner-led understandings of clinical issues and the related intelligibility of available theory and research.

1.3. Rationale for proposed study

Attachment concepts now populate discourses of theoretical literature, scientific research, parliamentary proceedings, policy and guidance documentation and commerce, that combine to influence practitioners' knowledge, understanding and application to clinical and social welfare practice. Greenhalgh (2018) implies that this is to be expected, stating *'21st-century science is an intersectoral endeavour that necessarily occurs in dialogue with society'*. However, analysing the generation, circulation and sharing of knowledge across, between and within domains of academia, policy and practice will demand more than a critique that the integrity of concepts are *lost-in-translation*.

The recent collaborative effort of Forslund, et al. (2020) saw 78 attachment researchers calling for further inquiry regarding the spread and appeal of attachment concepts and methods. This dissertation reports on one study making an early response to this call. The overarching aim has been to examine how attachment theory and research is understood for the purposes of clinical practice, with a view to elucidating which features of attachment theory and research are considered of most clinical importance and where misunderstandings may be located.

Q methodology is a research method specifically designed to gain access to the richness and complexity of human subjectivity and to subtle differences within and amongst different understandings on a given topic. It assesses a variety of opinions, beliefs and perspectives, which are evaluated by participants according to a subjective criterion of judgement (e.g. utility in particular context). Q seeks to identify the range of viewpoints (*not* the spread of views across a population) particularly on topics over which there is debate – it then measures individuals' affinity with those views, as well as commonalities and differences between perspectives. The approach has been described as 'qualiquantilogical' (Stenner & Stainton-Rogers, 2004) as it brings together elements of qualitative and quantitative methods into one integrated mixed-method. This project seeks to complement the rich theoretical literature that proposes clinically significant and wide-ranging applications of attachment theory in addressing the needs of

children and young people, by specifying commonalities and differences in the understandings of its current knowledge-users through empirical enquiry using Q-methodology.

Alongside the Q-set data, Watts and Stenner (2012) encourage the collection of personal information that is likely to influence participants' viewpoints in some way. By nature of the different roles and concerns of different stakeholders, the personal information that would be considered relevant to the viewpoints also differed. Gabbay and le May's description of 'mindlines' was used to guide the selection of factors that might influence clinicians' viewpoints in this inquiry. They comment that *'clinicians acquire their mindlines over a lifetime' informed by their training, their own and each other's experience, their interactions with colleagues and patients, by their reading, their understanding of local circumstances and systemics, their experiences of handling the many conflicting demands, and a host of other influences..'* (2016, p.402). Therefore, additional data regarding clinicians' training backgrounds, familiar reading materials, relevant experience, individual differences and work context were collected. Some of the same considerations were deemed important information for contextualising the data collected from researcher participants, including their relevant experience, expertise and training backgrounds. In light of the above discussion, measures of clinicians' tolerance to uncertainty and comfortability with/resilience to the inherent uncertainty of clinical practice were included (see section 3.5 for further details). In addition, a self-report measure of clinicians' own attachment orientation was included, as previous research supports a relationship between adults' personal attachment representations and their ways of relating to others (Hesse, 2008), which could conceivably include how they understand and relate to others in their professional role though this has scantly been explored in previous research. No specific hypotheses were generated in relation to the demographic collected, but were intended to aid the interpretation and contextualise the results of the Q-sort data.

1.3.1. Research questions

This study sought to answer the following questions:

i) How do clinicians understand and regard the application of attachment theory and research within their routine clinical work in child mental health services?

ii) What factors relating to clinician demographics, background and service context correlate with their understanding and perspectives on attachment theory and research?

iii) Where do clinicians' understandings of attachment concepts align or misalign with those of researchers?

This project does not attempt to capture or address professional competence; rather the scope is focused on reporting understandings and perspectives held by relative stakeholders. Therefore, attention was directed to factors influencing knowledge and understanding, rather than detailing or evaluating how recommendations for practice have been made or taken up. The project has benefited from the input and supervision of experts in developmental science, social distributions of knowledge, Q-methodology and clinical practice, alongside discussions with key figures involved in the development of related policy and practice guidance.

Chapter 2

2

BACKGROUND LITERATURE

2.1. Concourse preparation: Review of relevant sources and discourses

The first step of Q-methodology is to develop a Q-set. This is a set of items, which typically take the form of statements, that aim to provide good coverage of the subject matter in relation to the research question. In other words, it must be *broadly representative* of the opinion, domain or population of interest and is often referred to as the 'concourse'. This chapter critically examines a variety of relevant literature materials that were necessarily reviewed in order to develop a representative set of stimulus items for how attachment theory and research may be understood for clinical practice. It is presented as a narrative literature review[1], outlining various attachment discourses to illustrate that attachment concepts are used in various ways across scientific, applied and popular domains, all of which may influence practitioner knowledge and understanding. Following each discourse description is a consideration of potential issues for translation to practice, which foreshadow some of the empirical results and discussion in this dissertation.

Duschinsky (2020) proposed that conceptual confusion in attachment research has been worse than in other areas of psychology. Certainly Bosman (2016) has observed better coherence in the use of concepts between researchers and clinicians in Cognitive-Behavioural Treatments

[1] An edited version of this review is published in Attachment and Human Development (Special Issue: February 2021).

(CBT), in part because of its grounding as a set of evidence-based therapies with ongoing monitoring, evaluation and refinement in line with the practice experience of clinicians who contribute as scientist-practitioners. There has not been a particular equivalent to this infrastructure within attachment research, though it is emerging: Steele & Steele's (2018) *Handbook of Attachment-Based Interventions*, outlines a range of upcoming and evidence-based treatment options directly informed by attachment theory. CBT literature often makes reference to 'first-, second- or third-wave' ideas and treatments, to illustrate the dynamic focus of change from behaviour, to maladaptive cognitions, to tolerating emotional distress, respectively. Duschinsky (2020) offers a familial metaphor to describe 'generations' of attachment researchers and how their goals and outputs have changed over time. However, it is far from clear the extent to which the different stakeholders in attachment theory are cognisant of such 'generational' changes. Duschinsky (2020) also argued for a discrepancy between the positions of contemporary attachment researchers (e.g. on monotropy) and other perceptions of attachment research, which remain dominated by Bowlby's less scholarly claims and their echoing and elaboration by non-researcher stakeholders. De Regt's (2020) work on intelligibility suggests that where theory is shared across different contexts, particularly involving domains with competing values, trade-offs in knowledge would be more or less inevitable in the pursuit of intelligibility. In appraising these trade-offs, it should not be presumed that the values of the research community are the only ones that are relevant. With this in mind, this chapter, and indeed this dissertation as a whole, is presented in the spirit of respecting all forms of knowledge, whilst also acknowledging that when evaluated on their ability to produce usable knowledge for professionals working in clinical practice, some forms of knowledge and discourse may have more utility and perhaps authority than others.

2.2. Aims and scope of review

The following discussion does not intend to be comprehensive, but rather to draw attention to the many angles and avenues in which clinicians are exposed to and influenced by ideas from attachment theory and research. Particular focus has been given to influences on clinicians in the UK, to best contextualise the forthcoming empirical study. This discussion will 1) offer thumbnail portraits of discourses in order to characterise salient features that are expected to influence clinicians; 2) speculate on the intended goals and constraints of each discourse which shape how attachment concepts are used therein; and 3) highlight potential ways in which the discussion of attachment concepts may create tension when applied to the context of UK clinical practice; not least because clinicians' task in drawing on attachment theory and research is in part to synthesise information from several, if not all, of the discourses described.

2.3. Attachment in academia: Developmental psychology

Attachment, as conceived by John Bowlby (1969), refers to the disposition of an infant to seek comfort and protection from a familiar caregiver when they are alarmed, not feeling well or following a separation. The attachment system is conceptualised as a bio-behavioural system that all infants are born with the capacity to develop, deriving from John Bowlby's integration of ethology and developmental psychology principles (detailed in his seminal trilogy, *Attachment and Loss*). His collaborator Mary Ainsworth was the first to operationalize the theoretical framework in the 1960s, offering a laboratory-based observational procedure called the Strange Situation. Ainsworth paid close attention to the behaviours of children under conditions of play with their caregiver, on separations and reunions with their caregiver, and in response to a stranger entering the room. Individual differences in attachment behaviours employed to manage proximity with caregivers and balance the competing demands of attachment and exploration were observed and used to develop the coding practices. Separation from the caregiver was considered the main attachment-activating event in this paradigm sequence, so the coding system placed particular

emphasis on behaviours occurring at the points of reunion. Ainsworth and colleagues reported their findings from these dyads in detail in *Patterns of Attachment (1978)*. This seminal work categorised the observed diversity into three identifiable repertoires of attachment behaviours: secure, insecure-avoidant and insecure-resistant. These are sometimes referred to as the 'Ainsworth classifications' or the 'ABC model' and has remained the dominant and gold-standard classification system for infant attachment.

A Secure pattern of attachment behaviour (B) indicated confidence in the availability of the caregiver through the successful communication of distress with the anticipation of receiving help: detailed home-observations of mother-infant dyads classified as *secure* indicated this confidence was grounded in a history of relatively sensitive, responsive care. What constituted sensitive care to Ainsworth had a technical meaning beyond the ordinary language definition of responding quickly to signals. On her account, sensitivity referred to the ability to quickly detect, interpret and appropriately respond to the presenting need of an infant (Ainsworth, 1969). To Ainsworth, a secure attachment constituted a high degree of *trust* in the availability of the caregiver. It was hypothesised that in the presence of such trust, attentional capacity could be afforded to exploration of the environment (Bowlby, 1969/82; Ainsworth, 1969.). This pattern of attachment was expected from the theory and found to characterise 60-65% of dyads in community samples (van IJzendoorn & Bakermans-Kranenburg, 1996).

The remaining two patterns of behaviour showed strategies for regulating distress in response to a history of much less sensitive and responsive care. For this reason, these patterns were termed *insecure*, characterised by attempts to either deactivate or hyper-activate signals of distress. Ainsworth (1978) considered these strategies to be effortful, reducing the capacity for infants to explore and learn from their environments. While more favourable circumstances would be optimal, these strategies were considered necessary for maintaining proximity to the caregiver regardless, due to the necessity of doing so to ensure survival. They were subsequently termed 'conditional strategies' underpinning non-secure patterns of behaviour.

The insecure-avoidant (A) classification reflected behaviour that minimised distress in pursuit of an attentional avoidance of both the source of distress and the caregiver. Home observations showed this pattern to be rooted in contexts of insensitive (and sometimes rejecting) responses to communications of distress and therefore operated as organised and intentional attempts to weaken the arousal of the attachment system and retain the availability of the caregiver. By contrast, the insecure-ambivalent/resistant (C) classification described an exaggeration of distress that compelled the attention of the dyad to both the source of distress and the need for the caregiver to respond. Home observations found the caregiving environments of these dyads were slow to respond to the infant's signals (e.g. crying), leading to a heightened communication of distress that necessarily functioned to draw and maintain attention to the infant's needs (Ainsworth, 1978/2015). On her account, 'A' dyads were characterised by attempts to minimise or reject attachment-related signals, compared with 'C' dyads which were typically 'imperceptive' of needs (Ainsworth, 1978, p.42); both of which ultimately reduced trust in the availability of a caregiver.

A student of Ainsworth's, Mary Main, working with Judith Solomon, noticed some infants showed unusual behaviours in the presence of their caregivers that obscured the identification of the previously established patterns. These observations were grouped together and labelled as a fourth classification, which has since been the focus of much speculation (see Granqvist, et al., 2017) and has been described as a highly attractive and potentially magnetising concept for practitioners (Reijman, et al., 2018; Wilkins, 2016). Main and Solomon's (1990) fourth classification, disorganised or disorientated attachment behaviour (D), captured attempts to approach and avoid the caregiver simultaneously or in quick succession, and confused, repetitive or stereotypic behaviours. In Main's formulation, the child is alarmed but unsure whether to direct attention towards or away from the caregiver, which results in a paradox or dilemma. It was theorised that these behaviours did not represent an additional strategy for emotion regulation in the manner of the Ainsworth patterns, but rather were stress behaviours

that signalled infants' conflict about approaching their caregivers for comfort. One antecedent for behaviour classified in this way is child maltreatment (van IJzendoorn & Sagi, 1999), however, there are several other kinds of associated behaviours by non-maltreating caregivers, many of which can be involuntary effects of parents' experiences of loss and trauma (Fearon and Mansell, 2001; Madigan et al., 2006) or accumulated adversities faced by the parent (Cyr, et al., 2010).

Another key part of the developmental discourse pertains to attachment in adulthood. The Adult Attachment Interview (AAI) schedule developed by Main and colleagues was designed to 'surprise the unconscious' (Hesse, 2008) through probing adults' autobiographical memory of early relationship experiences. This method was constructed to generate enough attachment-related stress so as to activate the attachment system, challenging interviewees to divide their attention between the interview task and the emotional weight of their memories. What is coded is the extent to which they manage to be collaborative yet contained speakers, able to provide a more or less balanced account of their experiences, independently of what these experiences are. In other words, what matters is the coherence and consistency in their narrative, rather than the content of answers given. This formulation proposed *states of mind* with regards to attachment in adulthood, strongly considered to be theoretically related to the previously identified patterns of attachment in infancy (Main, et al., 1985). This formulation of attachment in adulthood was described as a 'move to the level of representation' (Main, 1985), though it held that activation of the attachment system was required in order to observe such representations (Bowlby 1969/1982; George & West, 1999).

Goals and constraints. The developmental discourse of attachment originated and has remained within the wider terrain of academic developmental science. This discourse is rooted in ethology and evolutionary principles, highlighting proximity to, and later availability of, the caregiver as the set goal of the attachment system and necessary for survival. Here, ordinary English language terms (such as 'disorganised', 'sensitivity' and 'security') confer technical

meanings (see Reijman, et al., 2018), limiting accessibility to the knowledge from a wider readership. Though offering significant specificity about the first months and years of life, this discourse has been vague on details of later development regarding how attention is allocated in the face of increasing competing demands and how this framework relates to other constructs such as emotion regulation, personality, resilience etc. Perhaps one reason for this is that at times the developmental tradition of attachment theory has needed to align itself with the priorities of academic journals and funding bodies in order to establish and sustain itself within the broader field of developmental psychology. To this aim it has sought and sustained credibility partially through meta-analytic work supporting cross-cultural validity of the existing classifications and caregiver sensitivity as an important predictor of attachment quality (DeWolff & van IJzendoorn, 1997; Posada, et al. 2016), and through population-level predictive ability of classifications for a wealth of later life outcomes, including externalising behaviour (Fearon, et al. 2010), self esteem and academic attainment (Solomon & George, 2008). Similarly, the AAI protocol obtained credibility within the research paradigm in part due its ability to predict SSP classifications for children of adult interviewees (Main, et al., 1985; Fonagy, et al., 1991; see van IJzendoorn, 1995 and Verhage et al., 2016, for meta-analyses), thereby successfully establishing attachment theory to be a relevant framework for understanding the psychology of adulthood.

However, the developmental tradition of attachment research has also been somewhat of a secret trove of treasures. The majority of work has remained within the metaphorical walls of academia and behind the digital paywalls of publishing journals (Duschinsky, 2020). Some technical aspects of attachment research, such as how disorganised or unresolved attachment are actually operationalised, have been sustained by an *'oral culture of coding'* (Reijman, et al., 2018, p.56), to an extent limiting this knowledge to those who (or whose PI's) could afford the expensive and time intensive commitment to its pursuit. Attachment classification scales and manuals have typically remained unpublished and their laboratory-based observational paradigms with highly controlled environmental variables are rarely replicable, let alone scalable, outside of

formal science (exceptions include books by Dozier & Bernard, 2019 and Juffer, et al., 2008 that better detail the assessment practices used for their attachment-based interventions). With such restrictions for the other research groups to empirically test important metrics such as external and construct validity, the developmental tradition has relied on predictive and convergent validity between its instruments within a small lineage of researchers, which has produced a degree of functional legitimacy for their constructs.

Duschinsky's (2020) historical account notes that a particularly significant 'secret treasure' has been Ainsworth's technical concept of sensitivity, in part because she herself did not publish her sensitivity scale. Ainsworth found that sensitivity, not parental warmth, predicted security in the SSP (Ainsworth, 1988). More recently, researchers have found that it is mostly sensitivity to signals of infant distress predicted child attachment, conduct problems and social competence (Leekers & Zhou, 2018), as was theorised by Ainsworth to be most relevant to activation of the attachment behavioural system and the need for caregivers to provide a safe haven. This has been an important finding for the development of clinical interventions and helps to explain why the most effective interventions for promoting attachment security have been those that target parental sensitivity (see Bakermans-Kranenburg, et al., 2003). However, the restricted distribution of technical knowledge has arguably limited the intelligibility of the theory for those unable to access the necessary texts, tools and training in such training measures and technical concepts, which, broadly speaking, has been most audiences outside of developmental science.

2.3.1. Issues in translation to practice

Firstly, detailed descriptions of infant attachment classifications and associated caregiving behaviours constitute what is typically taught about attachment theory in academic and professional training programmes (see Furnivall, et al., 2012 for some discussion). However, tensions emerge when what is known or understood at a theoretical level is applied to elements

of clinical work and individual clinical interactions. For instance, though highly informative for the purposes of group-level analyses, the Strange Situation Procedure was developed and validated as a research tool rather than a psychometrically sound instrument for clinical assessment of individual caregiver or infant behaviours. As such, interpreting such observations as constitutive markers of individual diagnoses, developmental risk or predictive of later outcomes for individual parent-child dyads is not warranted (van IJzendoorn, et al., 2018a; Forslund, 2020), and the same concerns pertain to AAI classifications and related predictions for parenting behaviours (Steele & Steele, 2008). Alongside their resource-intensity, the lack of validation (or revalidation) of these research measures for clinical assessment has likely hindered their travel into applied contexts (Howe, et al., 1999; Rutter, 2009, though see Cooke, et al., 2020). Nevertheless, practitioners have access to a wealth of information about individuals' history, wellbeing and environment, alongside multiple other observations and measurement tools for children and families (Howe, et al. 1999). Conceivably, where researchers have prioritised obtaining sufficient *reliability* in the coding practices of attachment assessments, clinicians have needed attachment assessments to offer information that achieves case *validity* with individuals' experience, collateral information and other assessment tools. Considerations for practitioners then include determining how to use attachment-relevant information for individual case formulations, and how to assess and gather such information in the absence of being able to access the validated measures from the research literature.

Secondly, some technical distinctions of key concepts and theoretical underpinnings have been lost between research coders of attachment assessments and practitioners wishing to interpret these assessments (Reijman, et al., 2018). For example, Main's growing understanding of attachment behaviours as attentional processes throughout the 1980s and 1990s (see Main, 1995) is rarely cited in literature thereafter and thus may be invisible to practice communities (see Duschinsky, 2020 for speculative reasons why). This suggests that the role of attention as an indicative feature of the attachment system within subsequent theory, research and

understanding has largely been neglected and is unlikely to have filtered through to practitioner curriculums. Main's focus on attention as the observational variable of interest in attachment behaviour variation was revisited in her scrutiny of the expressed language used by adult interviewees in their attempt to regulate the emotional content of the conversation. However, such theoretical nuances have remained privileged knowledge only to those who attend specialist training institutes or have had the opportunity to interact personally with Main and her colleagues. One consideration for clinicians then is how to incorporate attachment theory when assessing and evaluating presenting issues with attention, as available treatment options will depend on whether clinicians formulate attention difficulties along the lines of attachment theory or as an indicator of a separate pathology such as attention deficit and hyperactivity disorder (ADHD).

A third challenge in translation to practice is that the experiences of early caregiving and the strategies employed to regulate arousal, distress and exploration have been widely considered relevant for later life emotional regulation, interpersonal relationship functioning and mental health, but their implications in this discourse have been greatly underspecified (Slade & Holmes, 2017). In the last decade, longitudinal studies have identified some longer term implications of attachment experiences, with meta-analyses finding that attachment security was associated with fewer externalising (d=0.31: Fearon, et al., 2010) and internalising problems (d=0,15: Groh, et al., 2012) in later childhood, and greater social competence (d=0.39; Groh, et al., 2014). Yet empirical knowledge about population effect sizes is still challenging to translate into individual case formulations or inform individual risk assessments and have mostly been unable to address mechanisms. This means clinicians are without the structure to use attachment theory and research to inform idiographic formulations of individuals' current distress, background history and development trajectories that they rely on for assembling suitable treatment plans. Therefore, the discourse ends by leaving the door open for practitioners to come to their own conclusions about how attachment experiences shape later life personality and

pathology via their own clinical experience and through other sources of literature. Here, there is an opportunity for the experiences of clinicians to inform directions for attachment research, by paying attention to how they decide to weigh the impact of attachment experiences alongside other influences on personality and pathology.

Points of consideration for the Q-sort from the developmental literature:

Beliefs about:

- Utility of assessments for individual formulations
- Use of validated measures in practice (including AAI with parents)
- Co-morbid presentations of attention difficulties
- Relative value of attachment experiences compared to other influences on personality and pathology

2.4. Attachment in academia: Social psychology

The introduction of the AAI established attachment classifications to be both observable and of relevance in adulthood, and social psychologists pursued the line of thinking that attachment patterns lay a foundation or template for adult relationships. Large portions of the social psychology and psychotherapeutic discourses (discussed below) emerged in response to the meaning of attachment in adulthood and its correlates with later life outcomes. Though developmental researchers did not conceive an association between attachment and love per se (Ainsworth, 1985), the attachment relationship later became described as a special bond and particularly an affectional one (in part due to connotations with the term 'sensitivity' (Waters, et al. 2013; see also chapter 2 of Duschinsky, 2020)). Most notably, Ainsworth's Strange Situation classifications were extrapolated by Hazan and Shaver (1987) to produce short, narrative descriptions that mirrored affectional bonds in adult romantic relationships, offering a further taxonomy of four attachment styles that bore some resemblance to characteristic observations of infant behaviour and AAI classifications. This shift in methodology somewhat reshaped the conceptualisation of 'attachment' as nearly synonymous with 'intimate relationship'.

Shaver and colleagues subsequently capitalised on self-report questionnaire methods frequently used within social psychology research to collect large datasets validating these attachment styles in adulthood, which tried to mirror aspects of the attachment classifications of infancy. This led to an explosion of research exploring associations between attachment styles and a wide range of cognitive, behavioural and emotional correlates. Rather than retaining the motivational and dynamic characteristics of an inherent, bio-behavioural drive needed for survival and implicated in the allocation of attention, when applied to adulthood attachment was transformed to resemble a hierarchy of cognitive schemas regarding beliefs, emotions and behaviours that organised information relevant to intimate relationships (Hazan & Shaver, 1987; Fraley, et al., 1998). As such, social psychology's formulation diverged from the developmental perspective here by de-emphasising the essence of attachment as a behavioural system. Work on self-report attachment style questionnaires thus proceeded largely without attempts to activate the attachment system (though Mikculiner and colleagues pursued experiments using *security priming,* a technique to temporarily activate individuals' felt sense of security, see Mikculiner & Shaver, 2007 for a review).

Psychometric investigations of attachment style questionnaire measures thus that followed proposed two latent variables: attachment anxiety and avoidance (Fraley, et al., 2000). This had the effect of reinforcing a sense of theoretical coherence with Ainsworth's discussions of anxious and avoidant behaviours, whilst raising the measure closer to standards of psychometric credibility that were gaining salience in social psychology. Fraley and Spieker (2003) then applied taxometric statistical analyses to the patterns of behaviour observed in the Strange Situation and found two functionally similar dimensions: variability in anxiety and resistance towards the attachment figure and in the willingness to use them as a safe haven or secure base for exploration. Duschinsky (2020) comments that this generalisation of attachment dimensions across the lifespan has helped convey the appearance of consistency between social and developmental approaches, and between self-report measurement strategies and the

observational/representational methodologies. In some measures, adult romantic attachment styles were attributed some of same descriptive labels as those used by the AAI (e.g. secure, dismissing), and social psychological researchers tend to treat their findings as equivalent in systematic reviews (most notably Mikulincer & Shaver 2010), despite meta-analyses reporting an average correlation of only .09 or .15 between the two measurement strategies (see Roisman, et al, 2007 and Crowell, et al., 2008, respectively). However, the wealth of available research and transparency of the self-report methodology has meant the two-dimensional model is now the dominant conceptualisation of attachment in adulthood, typically - though not exclusively - via the Experiences in Close Relationships scale revised version (ECR-R: Fraley, et al., 2000). The majority of research studies on adult attachment since have been largely experimental and cross-sectional studies, demonstrating replicable associations between low levels of attachment anxiety and avoidance with optimal outcomes relating to relationships, personality factors, health behaviours and performance on various tasks.

Goals and constraints. As has been true for developmental science, social psychology discourse on attachment has also sought acceptance from the wider field of social psychology by aligning with the priorities of journals and funding bodies as needed in order to sustain itself within academic life. Therefore, one goal of this discourse has been to use attachment to address issues within social psychology via the conceptualisation of romantic love, as this has been a vehicle for explaining how individuals interact with their social worlds and live harmoniously with each other. Though European social psychologists have typically paid attention to group-level phenomena, American social psychologists have traditionally focused more on the actions of individuals under particular social conditions (Moscovici, 2006), facilitating the overall interest in mental states and mental representations of attachment that were proposed, albeit with different theoretical meanings, by proponents of the AAI.

The shared lexicon of attachment theory and research within peer-reviewed psychological literature as a whole facilitated assumptions of construct continuity between the

developmental and social psychology fields. Several commentators (e.g. Jacobvitz, et al., 2002) have alleged that this has helped mask differences in theoretical underpinnings. It also facilitated the idea that early attachment relationships transcend into adult relationships, granting the developmental domain an

even greater degree of importance and influence whilst legitimising the social psychology domain as a credible branch of attachment research. Duschinsky's (2020) socio-historical analysis of attachment research groups from both domains describes how certain theoretical constructs became 'boundary objects'; information that is used in different ways by different communities, yet they provide a way to connect and communicate with each other in spite of this (Star & Griesemer, 1989). He identified that almost all the shared terminology between the two academic fields of attachment research has in fact been used differently (see appendix A for examples), yet recognition of such divergence appears to have been slight. For example, social psychologists use the term 'internal working models' 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. Whereas developmental scientists generally mean expectations about the availability of attachment figures. An exception are those developmentalists interfacing strongly with psychotherapy, who tend towards appeal to the ordinary language connotations of terms, which sometimes and incidentally tends to align them with social psychological uses of these terms.

Additionally, a perhaps unintentional effect of the use of factor analysis for identifying dimensions of attachment quality was the arguably reductionist transformation of the construct of security in this discourse. It came to refer to low levels of anxiety and avoidance within relationships, downplaying ideas of secure base, safe haven or exploration. This is markedly different to the developmentalist's definition of security as the perceived availability of a caregiver in times of distress and has become the prevailing conceptualisation of security in this discourse. However, regression analyses show that security predicts additional variance over the

two-dimensional model of attachment (Al-Yagon & Mikulincer, 2006; Gillath, et al., 2009), indicating instead that security constitutes a theoretically autonomous dimension of attachment quality. The extent to which security has then been understood by clinicians and others readers of attachment literature, to reflect either Ainsworth's technical definition or the absence of anxiety and avoidance as portrayed by this discourse remains unknown, but may importantly have various implications how interventions targeting this concept are delivered in practice. Moreover, disorganisation in this framework (high anxiety and high avoidance) is also markedly divergent from the developmental perspective regarding a failure to organise behaviour around the caregiver. Certainly it has been gross misunderstandings and misuses of disorganisation that first triggered the attempts to develop consensus between researchers (see Granqvist, et al., 2017). The impact of this work on clinician's understanding of disorganisation is therefore of critical interest.

Both the development and social psychological traditions of attachment theory have at times implied that attachment security may be equated with 'good' developmental trajectories and that indicators of anxiety or avoidance decreased the likelihood of favourable outcomes (see Waters, et al., 2005). Ein-Dor (2010), working with Mikculincer in social psychology, is among the few researchers who have conducted empirical work seeking to document the potential benefits of insecure attachment under specific circumstances, though there has been speculation along these lines from other quarters (e.g. Crittenden 2008/2016; Belsky, et al., 2010).

2.4.1. Issues in translation to practice

First, if introduced to attachment theory via literature that references it to explain adult relationship *styles*, it is possible to miss several of the technical meanings behind the ordinary language terms intended by developmental researchers. For instance, conceptualisation of the term 'attachment' in this discourse refers to a close relationship that functions to regulate emotions, signalling the extent of anxiety or avoidance in individual experiences of these

relationships. By comparison, conceptualisation of the term 'attachment' in developmental literature refers to the use of a caregiving figure as a safe haven, signaling the history of the caregiving relationship. With reference to this and broader uses of the term attachment, van IJzendoorn and Bakermans-Kranenburg (2010) described some uses of the attachment concept to have been stretched to the point of snapping. Duschinsky (2019; 2020) offers several other examples of terminology that have attracted various meanings over the last few decades, making a comparison between 'narrow' and 'broad' uses of key concepts across the research paradigm as a whole (p.473, contents reproduced in appendix A). Clinicians then are not only faced with differentiating between technical concepts and their ordinary language definitions but need also to navigate conceptual differences in terminology between researchers and research domains that use them to mean different things.

It remains unknown what impact these different conceptualisations have had on practitioner understanding of particular terms and concepts, and whether assessments of these would point to notable differences, consensus or idiosyncrasies. At best, this could enable or encourage communication between clinicians that capitalises on the function of such terms as boundary objects, drawing attention to aspects such as the caregiving environment, parent-child relationship or indicators of emotional regulation capacities within the family. Yet, at worst it may overfill terminology with potentially contradictory meanings, confusing practitioner understandings of attachment concepts and instead allowing them to talk past one another. Moreover, when driven by a pragmatic need to identify clinical cut-offs for pathology and suitability for treatment, clinician understandings of intervention efficacy for example may depend on how they understand the concept of parental sensitivity, and indeed their awareness of sensitivity as an importance predictor of attachment classification (de Wolff & van IJzendoorn, 1997) and effective treatment (Klein Velderman, et al., 2006).

Secondly, the perception of construct coherence with research in infancy implies a sense of stability and predictive validity of attachment constructs, which may be influential for

practitioners when weighing up the value of this framework against others. However, it remains unknown whether this is done with an awareness or understanding that the conceptualisation of attachment across these literatures and subsequent methodologies shifts from an explanatory model at the behavioural system level, to one of cognitive schema in conscious awareness. Moreover, the ability to freely access self-report measures on attachment enabled even those with no or little understanding of developmental attachment research to collect and analyse data quickly via such measures. Combined, the spread of attachment ideas and terms in this way runs the risk that differences in the formulation of attachment between the academic traditions get glossed over and lead to variations in clinicians' understanding in spite of a shared language.

Points of consideration for the Q-sort from the social psychology literature:

Beliefs about:

- Conceptualisation of attachment as a behavioural system
- Degree of attachment stability - how much might attachment change over time or in different relationships anyway/how much weight to place on classifications

2.5. Attachment in society: Policy, politics and popular science

Attachment theory has received particular attention in UK policy and politics, where multiple references to attachment language and concepts can be found. In 2009, the UK Government launched an early intervention and prevention public health initiative, *The Healthy Child Programme*, which aimed to identify and support children at risk of poor outcomes. A primary focus was *'the proactive promotion of attachment and the prevention of behavioural problems'* (p.15) and placed *'strong parent-child attachment and positive parenting'* (p.8) as its key outcome. The report claims to be driven by new evidence that *'early interactions directly affect the way the brain is wired'* (p.11), with a repeated focus on children's neurological development throughout, illustrating that a

neurobiological basis of attachment was a significant impetus for the overall initiative but failing to specify any such literature.

Six years later, the Building Great Britons Report (2015) followed the now retracted recommendation that the disorganised attachment classification could be used as a proxy or screening tool for assessments of child maltreatment and risk (Wilkins, 2020). That same year, NICE published national guidelines for children's attachment, which sought to primarily cover the identification, assessment and treatment of attachment difficulties in those under 18 in or on the edge of care, but stated it was also aimed at all *'children and young people with attachment difficulties and their families and carers'* (p.4). NICE offered recommendations for all healthcare, social care and educational staff; demonstrating a hugely significant degree of anticipated scope and relevance (NG26, 2015, p.4). However, the guidance was inconsistent in its definitions of attachment problems and/or difficulties, and more fundamentally, whether the specified interventions were recommended for attachment disorders and all forms of insecure attachment or solely the disorganised classification.

Shortly afterwards, a Government Green paper (2017) - a preliminary report of government proposals, published to provoke discussion - claimed to have since identified many children with attachment disorders in clinical services, and made a commitment to commission research for caregiver interventions to enhance attachment quality. Other policy documents emerged that contained a wide variety of claims regarding attachment – many reflecting a strong belief in the utility of the framework yet arguably mirroring the academic literature in its underspecification of direct applications. For example, a British Psychological Society briefing paper (BPS, no.26, 2007) argues for a range of interventions to improve traumatised children's resilience and capacities for relationships in the future, claiming *"attachment theory holds out the hope of a framework for developing such interventions."* (p.27).

This repeated focus on attachment in health policy is not wholly surprising; not least because topics of the family and parenting are perennial objects of public concern but also in

part perhaps because of the political landscape in which it has emerged. In a previous discussion of this policy literature, Duschinsky, Greco & Solomon (2015) identified a general conservative familialism that attachment can be aligned with, principally that attachment theory got anchored in the responsibilities of mothers, but recognised that this has intensified in the past decade. 2010 saw a new political era of a right-wing ideology in the UK Government, in which Andrea Leadsom arguably politicized attachment within a welfare state agenda; commenting, *"it is greatly in the interests of our society for sound relationships to have been built by the age of two so that we do not constantly have to deal with the consequences of failed attachment later in life"* (5.33pm, 14th June 2012) and that '*support for early attachment is the single greatest thing we can do to mend our broken society"* (HoC, 15th September 2008). For context, though the comments suggest welfare state support for families should be encouraged, they were instead purported at the same time as voting for reductions in state welfare across the board. In an earlier initiative, *Early Intervention: Good Parents, Great Kids, Better Citizens,* Allen and Duncan Smith (2009) highlighted the importance of intervention to ensure that children's attachment relationship with their mother is organised in a way that will produce obedient and self-sufficient citizens. They argued that the regulation of the infant's emotional life within the infant's attachment relationship with his or her mother must be regarded *'as a prime requirement for a citizen to be of the law-abiding "self-regulator" type'* (2009, p.61): *'focusing on the first three years of children's lives' means 'reducing dependence on the state' among the citizens who will be produced'* (2009, p.97). Allen and Duncan Smith specified that whilst the middle classes can generally be expected and trusted to enact the regulated attachment relationship which will produce well-regulated citizens, this cannot be expected from others. The potential role of poverty, debt, housing problems, domestic violence or chronic health and mental illness in making caregiving more difficult were however pushed out of view (Grover & Mason 2013).

Separately, references to attachment concepts have also featured widely in popular science literature, in part due to the appeal of ideas that came with the authoritative backing of science. Popular science books on attachment show the same tendency as some policy

documents to make reference to a body of neuroscientific findings implicating the brain development of humans at the earliest stages of their life (e.g. Siegel, 1999; Gerhardt, 2003). Similarly, social psychology's version of attachment theory has entered the popular discourse concerned with the formation and maintenance of intimate relationships, by promoting Hazan and Shaver's measure as a 'love quiz' in magazines and websites offering psychology-related content (e.g. PsychCentral.com and PsychologyToday.com).

Goals and constraints. As illustrated above, attachment theory in this discourse has been one of hope and relevance to society, but there has been a tendency for broad sweeping statements that make claims in excess of those that could be supported by existing research. Attempts of policy and popular science to find credibility to their claims came partially in references to psychiatric nosology, but also in the appeal to neuroscientific developments of early experiences and brain development (Schore, 2001; 2014). Nuance regarding the relative degree of progress made in neurobiological research is lacking in the political and popular science literature, yet claims are offered generously. Lacking too are references to meta-analytic findings, which demonstrate more moderate effect sizes of association and risk (Groh, et al., 2017); possibly as they fail to offer clickbait headlines or persuasive political messages. The nature of such claims made in the popular and political discourse have been nested and circulated through books, magazines, internet forums and social media, in addition to some scientific and therapeutic literature. White, et al. (2020) argue that reinforcement of key ideas and terminology from multiple sources can be expected to be received as confirmatory evidence by its consumers, within whichever ideology or belief systems are already held. Arguably this also makes it difficult for individuals to recall or trace the source of particular ideas or knowledge-bites, potentially blurring their own ability to separate speculation from scientific reasoning from political spin.

Of note in the aforementioned policy documents is the inconsistent use of terminology, and increasing tendency towards pathologising language; starting with the terms 'strong' (and 'poor') attachment (HCP, 2009), 'failed attachment' (HoC, 2010), 'attachment difficulties'

(NG26, 2015). Keddell (2017) has referred to this as 'quasi-attachment' terminology, which others have recognised as failing to offer any useful specificity about individual behaviour (White, 2020; Shemmings, 2018). Arguably this is in accordance with the desires of popularised and politicised discourse on any given topic; where discourse needs to retain resonance with ordinary language in order to be understood, presenting a quality of obviousness and intuitiveness whilst also appearing to offer something extra in terms of authority, depth or insight. Typically though, the promise of depth is rarely delivered. The politicised discourse in the UK has largely aligned with the broad definition of 'attachment' that became a 'bond' or 'relationship' and as such can be plugged into various narratives, or used as boundary object, as the speaker sees fit.

2.5.1. Issues in translation to practice

First, what is meant by the term 'attachment' has become markedly unclear in this discourse. Where Ainsworth and her students made reference to the 'attachment system', 'attachment security' and 'patterns of attachment', and early work in social psychology spoke of 'attachment styles', discussion in policy and popular literature has often been either abbreviated to just 'attachment' or used other quasi-attachment language as mentioned above. It is reasonable to consider that the spread of attachment terminology in political and popular discourses offers a sense that these terms can be understood by the general public, or at least those with little technical knowledge. In which case, the issue of conceptual conflicts with the ordinary language definitions of particular terms becomes more problematic, and the possibility of idiosyncratic interpretations more likely. For clinicians, inconsistent use of the terms 'attachment difficulties/problems' by the NICE guidelines (p.17) makes it difficult to ascertain whether they are being encouraged to prioritise attachment disorder and disorganisation only or all forms of attachment insecurity.

Second, there is an implication in the political and popularised discourse that early dysfunction can lead to qualities of individuals that are stable or even fixed throughout the lifecourse; at least in the absence of intervention. This is particularly pronounced by the claims made about neuroscience of attachment experiences and their role as determinate influences on brain development. Combined, these implications suggest that 'attachment' describes something akin to an individual quality, rather than describing the quality of a relationship or caregiving environment. All of these points can and should be tested by examining the beliefs of clinicians and what they have ultimately concluded from the wealth of literature available. Clinicians reading materials from this discourse are made aware of the arguably political and policy driven agendas that draw attention to individual pathology and emphasise the societal costs of not addressing associated attachment concerns, whilst also realising their role in distinguishing which elements of attachment-related experiences are amenable to intervention; all performed with a sense of urgency about doing so within a suitable window of brain plasticity. This task might be somewhat overwhelming, and contains several areas of uncertainty which likely give rise to decision-making that is more vulnerable to heuristics and biases (Tversky & Kahneman, 1974) or uncertainty reduction (Freeston, et al. 2020).

Points of consideration for the Q-sort from the policy, politics and popular science literature:

Beliefs about:

- Confusions in terminology and technical meanings of ordinary language words
- Potential dependency on (original) source of knowledge and subsequent confirmation bias
- How much to prioritise attachment insecurity against issues of attachment disorganisation or attachment disorder

2.6. Attachment in practice: Psychiatry and psychotherapy

The psychiatric discourse of attachment is narrow but influential, and focuses on diagnostic practices. Attachment was first mentioned in diagnostic manuals in 1980 by the Infancy,

Childhood and Adolescent disorders committee for the American Psychiatric Association's Diagnostic and Statical Manual (DSM) version III. Drawing on observations of institutionalised children, they introduced the diagnosis of 'reactive attachment disorder in infancy'. Symptoms of the disorder included weak infant growth, social responsiveness and emotional apathy as a result of substantially inadequate care. Duschinsky (2020) notes that this diagnosis was only applicable to infants under eight months of age, which makes it hard to see what resemblance it bears to Bowlby's conceptualisation of the attachment system that, he proposed, only gets fully formed by the age of nine months. Duschinsky goes on to identify that the primary member of the committee who wrote about introducing this diagnosis to the manual, did so without any reference to Bowlby's attachment theory at all (1969/82, 1973, 1980). Nevertheless, the diagnosis has been retained, altered and elaborated in subsequent editions of the DSM and featured in the International Classification of Diseases (ICD) manual which is used predominantly in Europe.

Its inclusion in psychiatric nosology has had the effect of downplaying the dyadic nature of the attachment system and reinforced the idea that it refers to a property of an individual (van IJzendoorn & Bakermans-Kranenburg, 2003). The most recent versions of diagnostic manuals (DSM-5 and ICD-11) now contain two types of 'attachment disorders', understood to arise from extremes of insufficient care and have a demonstrable onset before the age of five (APA, 2013): Reactive attachment disorder (RAD) and disinhibited social engagement disorder (DSED). The former is characterised by a cluster of internalising problems, such as emotionally withdrawn behaviour, mood disturbances and minimal comfort-seeking behaviour; whereas the latter is characterised largely by externalising presentations, such as non-discriminatory friendliness towards strangers and minimal use of their caregivers as a point of reference. These two formulations of attachment disturbances are largely distinct from the classification typology used within the psychological research literature. In an attempt to summarise the necessary details of the attachment classification system and attachment disorders for the benefit of General Practitioners in the UK, Turner, et al., (2018) emphasise that attachment insecurity is not a

diagnosis nor a particular pathology, but a label to describe most of what might be seen within general practice and may or may not require a referral to secondary care or social care for treatment. They also echo caution from other scholars, that attachment disorders are rare (Woolgar, et al. 2015; Zeanah, et al., 2016) and should only be considered once other more common disorders, including neurodevelopmental disorders, have been ruled out.

Interestingly, Bowlby ([1985] 2020) recalled his development of attachment theory as an attempt to provide a model for psychotherapy, more than the basis of a paradigm for psychiatry or empirical research. Various clinicians have since sought to develop attachment-based therapeutic models, which are ultimately too heterogeneous to capture sufficiently here. To highlight a few, approaches by Peter Fonagy (Mentalisation-Based Therapy, 2004), Patricia Crittenden (Dynamic Maturational Model, 2005) and Dan Hughes (Dyadic Developmental Psychotherapy, 2015) are among those that have travelled most into UK practice (outlined below), with varying degrees of supporting evidence. More recently, many other research groups, some in collaboration with clinicians, have conducted various stages of trialling attachment-based interventions (see Steele & Steele, 2018), which are, typically, though not exclusively, aimed at children, young people and their families. The most empirically established attachment-based interventions target caregiver sensitivity as the primary treatment target, via video-feedback and coaching of caregiver-infant dyads with specially trained clinicians. Most notably this includes the Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD: Juffer, et al., 2017; O'Farrelly et al., 2021 in press), the Attachment and Biobehavioral Catchup intervention (ABC: Dozier, et al., 2013), the Attachment Video-Feedback Intervention (AVI: Moss, et al, 2018, cited in Steele & Steele, 2018) and the Group Attachment-Based Intervention (GABI: Steele, et al., 2018, cited in Steele & Steele, 2018).

Peter Fonagy's work on mentalisation, packaged as Mentalisation-Based Therapy (MBT: Bateman & Fonagy, 2004) has its supporting evidence-base now primarily for the treatment of personality disorders in adulthood (see the Anna Freud Centre website). Developed from

observations of differences in adults' abilities to reflect on their own and others' internal experiences, Fonagy, et al. (1991a) re-coded AAI transcripts for capacities in 'reflective self-function', later referred to as reflective function (RF) (Fonagy, et al. 1998; Fonagy, et al., 2016), which was found to predict levels of attachment security in adults and their offspring (Fonagy, et al. 1991b; 1995, Slade, 2005). Fonagy's work has, on the whole, subsumed attachment theory; however, MBT does seek to operationalise the secure base function of attachment theory, by encouraging therapists to offer themselves as a secure base for clients to explore their thoughts and feelings about themselves and others, using techniques to increase their capacity for reflective functioning/mentalising about these internal states of mind. This use of the therapist to enact the key functions of a sensitive attachment figure ('secure base' and 'safe haven') is also often proposed by others writing on the role of attachment theory for therapeutic practice (most notably, Holmes & Slade, 2007). In the UK, MBT is not typically used in child clinical practice, but it is possible that some of its principles do guide attachment-informed work with parent-child dyads or filter through to how clinicians understand the role of themselves and their interventions in routine practice, particularly those who trained with an awareness of psychodynamic literature that similarly posits these functions of a therapist. Steele, et al. (2018) have employed reflective functioning as the hallmark objective of their Group Attachment-Based Intervention (GABI), to promote secure parent-child attachment, but this intervention has not yet travelled to the UK context.

Separately, Crittenden, who studied under Ainsworth, set out to elaborate on the differences in information processing that Bowlby alluded to in his trilogy, understanding these to develop in response to an individual's history and current environment. Crittenden's work has been popular in the UK, and the only university qualification specifically in the study of attachment has been the MA in Attachment Studies at the University of Roehampton, which focuses largely on Crittenden's work. Likewise most commercial training on attachment-related topics at the Tavistock Clinic in London has been in assessments developed by Crittenden (e.g.

Robson & Savage, 2001). In her invited address to the British Psychological Society's Division for Clinical Psychology Annual Conference in 2012, she sought to counter the increasingly pathological narrative of attachment insecurity to emphasise that adaptation to one's environment was more important than attachment security. In her view, attachment disorder and disorganisation needed to be reframed to refer to dysfunction within the system surrounding a child and that the role of therapy was to provide a new context with opportunities to practice new behaviour in safety and reflect on the outcomes. For these reasons, the proposed treatment model, the Dynamic Maturational Model (DMM: Crittenden, 2005), focused on expanding adaptation strategies organised around protecting the self from danger and focusing on the existing strengths of the child and its environment (Crittenden, 2008/2016); but her work has been met with significant critique from other developmentalist researchers (see below).

Finally, within specialist looked after children's service in the UK, some practitioners are trained in Dan Hughes' model of Dyadic Developmental Psychotherapy in part due to its promotion by the British Psychological Society (Casswell, et al., 2014) and also because it offers to guide support outside of therapy and it is typical for health and social care to jointly commission specialist services for looked after children that include the involvement of educational and broader welfare systems. DDP describes itself as an attachment- or relationship-focused therapy and considers itself unique for encouraging it's principles to be extended into 'therapeutic parenting' (Hughes, et al., 2015). Similar to video-feedback interventions, the caregivers and therapist work together in session with the child, seeking to offer a safe environment for experiencing increased sensitivity and availability of trusted others. Notably, Hughes, et al. (2015) emphasise that this intervention is not aligned to any particular diagnosis and nor does it desire to be; they instead express a particular preference for the term 'developmental trauma' to describe the development of difficulties that adoptive and foster children frequently present to clinical services with (p.359).

Goals and constraints. Training in any of the approaches outlined above is typically offered to qualified professionals as part of their continuing professional development, rather than as part of core teaching curriculums. It therefore relies on the continued interest of clinicians and clinical organisations for sustained implementation within national health services, as only video-feedback interventions have so far been incorporated into national guidelines or funding priorities. Psychotherapy has been increasingly encouraged to align with the broader movement towards evidence-based practice, and calls for research to demonstrate the 'value added' by an attachment perspective and whether its integration into clinical formulations influences outcomes (Berry & Danquah, 2016). Other objectives of therapeutic models include the need to make sense of psychological distress in its complexity and to demonstrate clinical relevance by proposing thresholds for pathology and intervention. In contrast then to the psychiatric discourse on attachment, the psychotherapeutic attachment literature has been somewhat unique in offering models and interventions that are not disorder-specific, and instead attend to transdiagnostic mechanisms such as caregiver sensitivity and information-processing biases. In my experience as a clinician and clinical supervisor, the DMM and DPP models are often viewed by clinicians as depathologising and subsequently appealing to those with a desire to locate the source of the problem outside of an individual child's potential pathology. This interpretation of the DMM and DPP models can also be seen propounded by clinicians writing in academic journals (e.g. Stacks, 2010), especially *Clinical Child Psychology and Psychiatry*.

Several of the psychotherapy models have developed from clinical observations and interest, thus they convey a sense of intuitiveness, which may be further reinforced by a sense of credibility, in the form of appearing grounded in an established theoretical literature and empirical research base (Bennett & Nelson, 2008). Critics of this literature might nonetheless perceive a disjuncture between the claims of therapeutic approaches to be evidence based and the relatively weak evidence provided. For example, the array of subtypes in Crittenden's model appear to offer the potential for personalised treatment. This has had particular relevance for

clinical practice in the UK because personalised medicine is a topic that has been promoted wholesale by NHS England (2016), and thus has occupied increasing space in the minds of practitioners. In this case we might expect that targeting care to the individual needs of each vulnerable or insensitively parented child would resonate loudly with clinicians. Yet, developmental psychologists have cautioned strongly against the use of existing attachment assessment procedures for individual decision-making, stating that doing so produces *'the false semblance of scientific credibility'* (p.654), as they currently fail to offer sufficient levels of sensitivity and specificity required for application to individual cases (van IJzendoorn, et al., 2018a). They have described Crittenden's numerous categories as *"colourful confetti"* (van IJzendoorn, et al., 2018b, p.2) since they imply numerous idiographic characterisations that are too heterogeneous to ever be tested. Even the reduction of Crittenden's categories to just security, normative avoidance, normative resistance and two clinical categories has resulted in small group sizes in most studies to date, hindering the development of cumulative knowledge.

To take another example, Duschinsky' and Foster's (2021) forthcoming analysis of work by Peter Fonagy and colleagues identifies MBT as probably the attachment-based psychotherapy with the strongest existent evidence-base. Yet Duschinsky and Foster also raise concerns about the limitations of this evidence. Indications of the clinical benefits and cost-effectiveness of MBT are largely based on a randomised-controlled trial involving 37 hospitalised patients (Bateman & Fonagy, 1999), and effect sizes from subsequent studies have been weaker (see Cristea, et al., 2017; Fonagy, 2019). Moreover, there is as yet little evidence for the role of changes in attachment-related processing, or even mentalising, in mediating the effects of MBT on clinical outcomes.

Ultimately what much of therapeutic literature has in common are claims that attachment theory should feature in clinical practice, but without sufficient research on how it is being used. Moreover, despite a few passing discussions (e.g. Morrison et al 2019), there remains a major gap in the literature in understanding how the ideas and techniques of attachment theory and

research are used by practitioners outside of such frameworks. Finally, researchers working with the attachment disorder category have sought to establish a scientific basis for its sufficient retention as a psychiatric diagnosis, but as yet there is little scientific evidence pertaining to the treatment of attachment disorders. Rather it is the diagnoses themselves that have faced greater scrutiny, with recent scholarship promising to tighten the relationship between theory and diagnosis by, in the first instance, identifying that the disinhibited behaviour typifying DSED is less integral to the attachment disorder constructs than a failure to seek care or support (Zimmerman & Soares, 2019).

2.6.1. Issues in translation to practice

On the whole, the psychotherapeutic attachment discourse draws on the terminology of developmental attachment research; however, as discussed above, many of these concepts have perhaps become overfull of divergent and sometimes contradictory meanings, due to the uses in different discourses. Though we might expect Clinical Psychologists, for example, to be most influenced by the psychotherapeutic and developmental psychology discourses on attachment, with specially-trained skills in distinguishing more credible sources of information than others, they are often still exposed to and consumers of other discourses, as indeed may their colleagues. Of the many discourses outlined above, the psychiatric and psychotherapeutic discourses appear to have the most capital for translation to practice. However, a key translation issue for this discourse is that it has less guidance to offer clinical practice where there are barriers to working with other members of the child's support system - what then might be a pragmatic target for treatment? Perhaps, under such conditions, clinical focus is directed towards addressing problems associated with the lack of a secure attachment instead, or indeed, not at all.

Compared to academic uses of the same concepts, guidance of psychotherapy has perhaps aligned with the political discourse that portrays attachment insecurity as the mechanism of mental pathology, rather than a correlate. For instance, Fonagy & Alison (2012)

situate non-mentalising as the basis for most mental health disorders, attributing this to experiences of attachment system activation without access to the capacity to reflect on thoughts and feelings. Similarly, Crittenden interprets individual difference in attachment as the basis of information-processing strategies responsive to an individual's history and current environment, which is again treated as implicated in most forms of mental ill-health. The extent to which clinicians' understand attachment insecurity as a primary clinical focus remains unknown, though can be tested at the level of beliefs about the theory and its utility for clinical practice.

Points of consideration for the Q-sort from the psychiatric and psychotherapeutic literature:

Beliefs about:

- Value of clinical practice organised by individual categories
- Ability to intervene or change attachment quality
- Value of maternal sensitivity/caregiving environment as core target of treatment
- Degree of impact on brain development and subsequent priority for intervention
- Attachment as the property of an individual vs a relationship/dyad
- Prevalence and utility of attachment disorder diagnoses
- Value of intervening in the absence of caregivers
- Treatment targets
- Prioritising insecurity

2.7. Attachment in practice: Child Welfare

Crittenden's work on the DMM, and her book *Raising Parents*, has had a particular influence on child welfare services too. Many of the assessments and associated training promoted on her website are recommended for assessing care and child attachment. Otherwise, David's Howe's (1995) book, *Attachment theory for social work practice* has been the key text for this discourse and the recently published, *Reassessing attachment theory in child welfare,* by White et al., (2020) offers a much more critical account. Both reference both social work academics and policy documents that have encouraged welfare professionals to use the image of secure attachment as the point of comparison when making assessments of parenting capacity. This has proliferated to such an extent that, in a survey conducted by the UK Department for Education (2018) of organisations

working with children in need of help and protection, attachment theory was, by a large margin, cited as the most frequently used underpinning perspective.

David Shemmings was another key driving force behind the inclusion of attachment theory in child welfare practice, and did so in such a way that seemingly circumvented the need for practitioners to have undertaken specialist training in attachment classification assessments. He led the Attachment and Relationship-Based Practice programme (formerly known as the Assessment of Disorganised Attachment and Maltreatment project) which trained over 5000 child protection professionals across the UK in identifying signs of disorganised attachment and making assessments of risk and maltreatment accordingly. Other examples of commercial training include Attachment in Practice™ website offers 1, 2, or 3-day Attachment Disorder training course, priced between £1-5000 plus VAT, examining *'the concept of attachment disorder, the mechanisms behind it, and in particular, how to identify it and intervene in a helpful way'* (http://www.apt.ac/attachment-disorder.html). What both of these for-profit programmes promote, at least implicitly, is that they will sufficiently up-skill attendees to identify relevant features of attachment theory that can directly feed into clinical or social welfare decision-making. The training programmes are aimed exclusively at practitioners, tangibly operationalizing NICE's recommendation for assessing attachment in all children and young people engaged with these services, and thus convey a strong message for applying attachment theory to assessments and decision-making at the individual level, seemingly backed by the appropriate training qualifications to do so. However, it is important to note the lack of reference made to any accredited background of qualifications of trainers in either formal attachment assessment methods or diagnostics.

In 2012, David Wilkins, a social work practitioner and educator, and doctoral student of Shemmings, published an article in the *Journal of Social Work Practice,* proposing disorganised attachment behaviour in the home could be used to indicate child maltreatment. His later Q-sort study found that professionals working in safeguarding contexts did indeed find the construct of

disorganised attachment helpful for effectively identifying risk when assessing children and families (Wilkins, 2016). However, he has since published a letter to the journal editors to retract his claim and instead highlight the limits of what is currently known about this classification (Wilkins, 2020). He cites earlier work by Cyr, et al. (2010) that found the accumulation of socio-economic risks are equally likely to be associated with observations disorganised attachment behaviour and thus point to multiple routes to this classification, and also references current attempts to validate assessments of caregiving that may be in future be used for parenting assessments that do not offer attachment disorganisation as a reliable indicator (Cooke, et al., 2020). The extent of the impact on welfare practice and practitioners' understanding, resulting from the initial claim and, more relevantly, the prominent retraction, remain unknown. However, given there is a degree of multi-agency working across clinical and social welfare services, it is possible that some degree of influence on practice in social services was at least known about or circulated within clinical practice as well.

Goals and constraints. Overall, child welfare practice is orientated around assessments and related decision-making pertaining to children's welfare and best interests, delivering categorical judgements about the basis for action in predicting and preventing future harm (Forslund, et al., 2020). Again, attachment is used here as a way to make sense of complexity and minimise uncertainty, which together promise to specify risk and subsequently indicate the necessary next steps. In common with other proponents of the psychotherapeutic literature, this usage conflicts with the non-pathologising values of some of the children's welfare workforce. In light of this tension, attachment categories are typically deployed as quasi-diagnostic, in part because they are not regulated in the same way as clinical judgements (diagnoses or formulations) made by clinical professionals. However, attempts to do so are not always regarded as credible by family courts (see, for example, G.M. vs. Carmarthenshire County Council, 2018).

2.7.1. Issues in translation to practice

As is true for most clinicians, there is uncertainty about how social welfare practitioners are meant to use attachment concepts without specialist training in the attachment classification system. There is yet to be any evaluation of whether child welfare assessments informed by attachment is superior to assessment as usual, in part due to the weak networks linking child welfare practice and academic attachment research. Nevertheless, some practitioners seek further training in assigning attachment categories (e.g. Dallos et al., 2020), while other researchers advocate for a move from static diagnoses to assessments of the potential for enhanced parenting (e.g. van IJzendoorn, et al., 2018b). Another shared issue across the clinical and social welfare discourses of attachment theory is the lack distinctions made regarding whether concepts are drawn from popular, developmental, therapeutic or psychiatric discourses. White, et al. (2020) note the frequent use of quasi-attachment language used in welfare practice, as was identified above as a feature of the political and popular science discourses, which they argue risks perpetuating misunderstandings and potential misuses of the theory.

Encouragingly, the collaborative efforts of clinicians and researchers in Canada have now successfully validated the AMBIANCE-brief as an observational screening instrument for disrupted caregiving in community settings (Cooke, et al., 2020). An initial feasibility study found good interrater agreement amongst novice clinician coders across eight videotapes of parent-child interactions following a 2-day training course (Madigan, et al., 2020). Further validation and feasibility work using this tool is expected to make an important contribution to future practice policy, and may lead a shift in attention away from assessments of child attachment to assessments of caregiving environments for both clinical and welfare practice.

Points of consideration for the Q-sort from the child welfare literature:

Beliefs about:

- Attachment disorganisation and maltreatment/psychopathology
- The perception of colleagues understandings of attachment theory
- Assessment of attachment vs assessments of caregiving

2.8. Summary and conclusions

In discussing sociology's practice theories, Shove, et al. (2012) use a driving analogy to illustrate that *as cars became more reliable, less was required of the driver*. They attribute this to a process of 're-scripting' what it is to be competent, in order for driving to be *'mastered by many, not just by few'* (p.41). As more and different people/forums 'took the wheel' of attachment theory and research, so too the meaning of its core constructs were re-scripted by virtue of usage in different societal contexts. Some parts of the re-scripting process have been outlined in this chapter, though, unlike the driving analogy, it appears to have blurred rather than eased or refined understanding and skill. The forthcoming empirical study in this dissertation seeks to examine how clinicians and researchers have made sense attachment theory and research in these various discourses, with a view to elucidating which features of attachment theory and research are considered of most clinical importance and where misalignments of understanding may be located. This review of background literature has contributed to the investigation by identifying a number of issues in translation of attachment concepts to practice. In combination with discussions within the project steering group, the summary boxes from each section highlighted above formed the basis of identifying the initial themes and sub-themes, used to generate Q-sort items, summarised in Table 1 below. Further details of the development of the concourse can be found in Chapter 3.

Table 1 Initial themes and sub-themes for generating Q-sort items

Key constructs	Guides what I do	Explanatory potential	Associated problems	Controversies
• Secure base • Maternal sensitivity • Threat regulation • Proximity-seeking • Avoidance • Separation • Dyadic • Adaptive • Malleable • Care-giving environment	• Choice of terminology • Diagnosis • Assessment • Formulation • Intervention • Outcome • Decision-making	• Relationship functioning • Developmental trajectories • Co-morbidities • Treatment response • Parental attachment	• Anxiety • Trauma • Attention • Temperament • Callousness	• Underpinning neuroscience • Attachment disorganisation • Attachment disorder • Specificity of application • Consensus • Developmental disorders

Chapter 3

3

METHODS

'Q attempts' to analyse subjectivity, in all its forms, in a structured and statistically interpretable form' (Barry and Proops 1999, 338-9)

'The 'best-developed paradigm for the investigation of human subjectivity' (Dryzek & Holmes, 2002, p.20)

3.1. Design

3.1.1. Introduction to Q methodology

Q methodology is distinguished from the R methodology that is more typically used in psychology and social sciences by its offering of an inverted factor technique. Rather than concerning participants who are subjected to a range of stimuli and lend themselves to *by-variable* analysis, Q is concerned with its variables as they are measured or scaled by its participants, thus requiring a *by-person* analysis. In dataset terms, attention is directed towards the 'rows' rather than the 'columns' of data (the data-matrix is essentially rotated by 90°). The analytic process searches for correlations between participants; treating the participants as the variables and stimulus measures as the sample or population.

Q methodology requires participants to 'sort' a set of stimulus items that contain statements relating to the topic of interest, in an order of specified salience (e.g. agree/disagree or most likely/least likely). These statements are termed the 'concourse' and serve as a vocabulary for summarising observations. Initially, the researcher seeks to generate as many

possible statements as possible that reflect the range of expressed views surrounding a topic (van Exel & De Graaf, 2005), and can be created for any topic on which various views exist. Following a process of sampling and refinement to ensure adequate representation, participants organise the final 'Q-set' of items by assigning relative item weightings. It is the choice of dimension that helps to define and standardise the nature of psychological significance, e.g., agree/disagree, most characteristic of me/least characteristic of me (Watts & Stenner, 2012). This method is primarily used to answer research questions that are focused on either: i) representations of a subject matter; ii) understandings of it; or iii) conduct in relation to it (Watts & Stenner, 2012). Stenner (2009) claims, *"Q begins with the complexity of events and explores the ordering of such complexity by way of feeling".* This approach thus allows for the organisation of perspective according to a degree of personal significance (albeit conscious or unconscious), without requiring the underpinning explanation for significance to be identified, pinpointed or expressed. The resulting sorting patterns are quantifiable: each 'sort' is represented in numerical form and similarities and differences between completed 'sorts' are expressed as correlations. Correlations are then subject to by-person factor analysis, which identifies statistical clusters of individuals with similarly patterned sorts that are interpreted as sharing points of view.

The aim of Q methodology is not to make generalisations about populations. Instead, it seeks to capture, describe and explain patterns that are expressed within a small and strategically sampled cohort of participants. Such sampling is typically achieved theoretically, purposively or via non-random self-selection, according to criteria of interest, and - by virtue of using an inverted factor analytic approach - does not require large participant sample sizes in order to obtain insightful findings. Each participant is recruited because their viewpoint *matters* in relation to the subject at hand (Watts & Stenner, 2012), and it is in the researchers' interest for the final participant group to avoid being *'unduly homogeneous'* (p.71). Participation selection therefore seeks to balance relevance, sufficient variability and limited levels of bias. Q methodology can then be used for various purposes, including i) exploring how understandings interact and group

together, ii) identifying commonalities and differences in the perspectives held and iii) enabling an examination of potential moderating influences via adjunctive data collection and descriptive analysis. In its attempts to incorporate as much contextual information as possible, Q seeks to maximise the benefits of both quantitative and qualitative methodologies without the formalities that each approach would seek separately. Limitations of statistical power, rigour and use of adjunctive data are therefore features of the method (discussed again in section 5.5). Generalisations, it is argued, regarding *'concepts, categories, theoretical propositions and models of practice'* (Watts & Stenner, 2012, p.89) are nevertheless possible.

Q-sort data affords multiple scoring options and analytic strategies (see Waters & Deane, 1985). 'Criterion sorts' can be used to define and score constructs, by asking a group of experts to formalise their understanding of a construct by sorting the Q-set items to describe a hypothetical scenario or individual that would score highest on a target construct. These definitions are averaged to offer a consensus view of what is then considered to represent expert opinion and can serve as scoring templates to which other sorts can be compared. Criterion sorts therefore allow study and debate of experts' construct-understandings that usually remain implicit in work using traditional rating scales (Waters, unpublished), and offer nuanced insight behind associated labels and related rhetoric. Importantly, agreement in the context of Q does not establish that observations are *accurate* in a positivist sense, but rather that sorters have performed similarly in their organisation of information.

The centroid factor analysis typically employed is a data reduction technique that seeks to explain the full range of study variance. It searches for groups of participants who have ranked the items in a similar fashion. The number of 'groups' identified (i.e. the factor solution) involves a careful decision-making process (see Watts & Stenner, 2012, for guidelines). Once a viewpoint has been established as significant, it is not of particular importance how many participants endorse each point of view, though characteristics of participants endorsing each factor warrant close inspection as it can provide substantive meaning to the factor interpretation.

The interpretive task in Q methodology involves producing summarising accounts, much like the discussion emerging from a thematic analysis, each of which explicates the viewpoint being expressed by a particular factor. Qualitative comments gathered in the sorting task can be used to check and refine the initial interpretations of factors, alongside illustrations of item rankings from the exemplifying factor arrays to support the emerging narrative. Item-level analysis can be used for group comparisons to supplement interpretations and point to new hypotheses. These processes therefore utilise abductive logic in pursuit of potential explanations for observed phenomena. With regards to output, identified factor structures can be used to provide empirical support to existing theoretical frameworks, assist the development of new theory, or offer conclusions about relevant theoretical propositions and models of practice.

3.1.2. Rationale of Q methodology for the proposed study

As detailed in Chapters 1 and 2 of this dissertation, it is markedly unclear whether researchers and clinicians are united in their understanding of attachment theory and that research currently lacks an empirical assessment of understanding in either participant group. Q methodology is an appropriate choice for this enquiry for the following reasons.

Firstly, Q methodology is a helpful approach for unearthing perspectives without requiring participants to articulate these clearly. As scholars of professional knowledge tell us,*'when it comes to practical knowledge acquired through experience, people cannot easily tell you what it is that they know'* (Eraut, 1994, p.25). Rather than relying on a method which asks people to articulate what they are doing, the inverted design and analytic approach in Q methodology is favoured for its uniqueness in asking *constructs* what people are doing. This approach has been used effectively for the related purpose of identifying how child protection social workers use attachment theory with children who have been abused or neglected, and identified four distinct perspectives on such conduct (Wilkins, 2016). By contrast, an attempt to use semi-structured interviews to explore how residential childcare staff conceptualise and use attachment theory achieved less

tangible findings, noting that the majority of staff had difficulty articulating themselves when explicitly discussing attachment (Morison, Taylor & Gervais, 2019). Of particular advantage then is how the viewpoint expressed via the Q-sort stimuli can be subject to statistical analysis whilst retaining access to the richness and complexity of subjective constructions typically only afforded by qualitative methods.

Relatedly, a second advantage of Q is that participants are given the vocabulary by which to express themselves and that fixing this aspect of variance across participants offers increased methodological rigour. This is considered of particular advantage to an assessment of attachment understandings given the complexities and misconceptions in terminology and meanings found in various public discourses, that compound to influence practice and practitioners. In Q methodology, it is the researcher who is tasked with reviewing the discourses and condensing these ideas into a set of individual items about the subject matter. Waters and Deane (1985) claim that participants are then *'forced to clarify distinctions and ambiguities that are more easily glossed over in designing rating scales'* (p.52) by virtue of the sorting process.

A third advantage of Q-methodology is the reduction of potential response bias via the option to instruct that items are sorted into a fixed distribution. This is important given an anticipated tendency of participants towards social desirability, by virtue of being asked about their professional knowledge and particularly in light of doing so in the presence of a fellow health care professional. The use of a fixed distribution means i) participants remain unaware of the constructs that will be scored from the data they provide and ii) data from different samples can be compared directly because sample norms do not enter into the scoring. Typically, what participants consider to be 'often' or 'rare' when self-reporting in either quantitative and qualitative approaches can be subjective or unclear. Perhaps, then, the most important advantage of Q-methodology is that the salience of behaviour is distinguished from the frequency with which it occurs, i.e. each item is explicitly sorted *in context* of a well-defined set of other items

(that is fixed across all participants). Aptly, it may be argued this kind of contextual decision-making also mirrors the process of clinical reasoning and behavioural practice of clinicians.

Fourthly, participants (at this stage represented as 'sorts') that load onto one factor and not another reveal perspectives that are divergent and may be interpreted through reference to participant characteristics or associated variables of interest. In this study, correlates of interest relevant to the reasoning, practice behaviours and personalities of practitioners will be of value to the interpretative task that follows. The analysis of individual differences in these variables may identify other shared factors between participants and elucidate potential reasons for both shared and different understandings of applying attachment theory and research. An interpretation of why certain individuals may or may not share viewpoints with others can then be offered, enhancing the quality of enquiry and leading to more specific research questions for the future.

3.1.3. Study development

This project sought to explore the understandings and uses of attachment theory in the context of clinical practice. Initially, this project set out to focus primarily on clinician understanding and use of attachment theory and research in routine practice and considered recruiting a small number of expert attachment scholars to serve as criterion sorts. However, this enquiry differed from other uses of Q, such as an existing Attachment Q-sort (Waters, 1985), which utilised criterion sorts to define and assess key constructs and provide a gold-standard for other sorts to be measured against. The scope and flexibility of Q methodology allows for different applications to be pursued and is used here as an exploratory tool to capture and describe the nature of perspectives held by clinicians on the topic. To offer academic knowledge as a benchmark for the assessment of evaluation of practice knowledge was not considered appropriate and instead would fall into the trap of implying a theory-practice translation error. Therefore, no assumptions were made a priori in the context of practitioner research about who

the expert viewpoints of the research question belonged to, and the decision was made to analyse data from all participants together rather than utilise the criterion sort feature.

Of more interest to the broader inquiry then, is an understanding of how both participant groups understand attachment theory and research for the purposes of clinical practice, and the degree, and moderators of, consensus and divergence between those operating in the academic research community and those in clinical practice. Both are by definition users of a developing knowledge base, contribute to the relevant literature and policy that influence practice, and continue to learn and use the knowledge in different spheres for different purposes. It is hoped that in doing so the knowledge, experiences and contributions of each community inform each other. It is crucial therefore to understand the extent to which this knowledge is shared and the specific axes of agreement and disagreement. As a result, a full sample of academic attachment researchers were recruited to complete the Q-sort task and provide some additional demographic information.

The implementation of Q-methodology for this inquiry consisted of the following phases:

1. Collate a representative sample of claims about attachment theory and research as relevant to an applied clinical context by generating a concourse of statements drawn from the range of literatures that influence professional practice and discussion with experts.
2. Recruit a sample of attachment researchers and practicing clinicians working in child and adolescent mental health service and use a Q-sort task to explore the extent of consensus and divergent understandings of applying attachment theory to their work.
3. Use information relating to the demographics, professional backgrounds and current working contexts of the participants to assist the interpretation of the identified perspectives and explore potential moderating influences that may explain these.

3.1.4. Broader study context

This project was part of an overarching Wellcome Trust Investigator Award, entitled *Disorganised attachment in contemporary attachment research* (Duschinsky, 2014-2020), which traced developments in the study and conceptualisation of attachment concepts using historical perspective and sociological analysis. The researcher was therefore primarily supported by funds from the overarching grant (WT103343MA; Work package 2: Use of attachment research in clinical and child welfare practice) alongside additional project support funds from the National Institute of Health Research, School of Primary Care (Project 392). This project built on Dushinsky's critical examination of contemporary controversies in the field of attachment, to explore the nature of understanding that resulted in the minds of relevant stakeholders who have been influenced by the surrounding discourses (as discussed in Chapter 2). It sought to capture attachment knowledge at the level of belief and understanding, which implicates, but does not speak directly to, the intended or actual behaviour of clinicians in practice. Decisions made throughout the concourse development and refinement stages were in line with this focus of enquiry, whilst balancing the desire to avoid being a proxy knowledge-test. Other doctoral projects within the research group under this stream sought to capture assessment practices specifically through the use of case vignettes, regarding i) perceptions of risk and safeguarding issues or ii) reflecting on individual cases in a neurodevelopmental context that were perceived to be 'attachment-related'.

3.1.5. Study approvals and study set-up

All work pertaining to the project reported here was covered by the University of Cambridge Public Liability and Professional Indemnity insurance policy (see appendix C). This study was granted ethical approval from the Psychology Research Ethics Committee at the University of Cambridge (see appendix D). This approval included the international recruitment of academic attachment researchers with the view to initially serving as a criterion sort and the decision to over-recruit for a fuller sample was not deemed to necessitate a formal amendment. In the UK,

all project-based research involving the National Health Service (NHS) is required to undergo a comprehensive assessment of government and legal compliance from the Health Research Authority (HRA). Governance approval for this study was obtained by the HRA (see appendix E) and the lack of patient recruitment meant further review by the HRA Research Ethics was not warranted. The study was sponsored by the researcher's affiliated institution, University of Cambridge, and hosted by its local NHS organisation, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The study was adopted into the research portfolio of the National Institute for Health Research (NIHR) Clinical Research Network - Eastern hub, enabling access to local recruitment support from dedicated research staff from the local and neighbouring mental health Trusts. Potential participants were first approached by an E-mail circulated by local research staff, and initial expressions of interest and preferred contact details were then passed to the researcher to screen referrals to check inclusion criteria (described in section 3.4.1).

The EU General Data Protection Regulation (GDPR) was introduced to UK policy during this project, prompting changes to the law with respect to how data could be stored and handled. This only had a minor effect on this study as GDPR generally agreed with existing good practice guidelines for psychological research that this study already adhered to. Nonetheless, before recruitment began minor changes were made to the study documentation to explicitly state the joint study sponsors as the responsible data controllers.

3.1.6. Ethical considerations

Clinician participants were given a minimum of 48hours to read the Participant Information Sheet (appendix F) before providing written informed consent to take part. By virtue of recruiting practicing clinicians, study participation was anticipated as a likely time burden. Research appointments were arranged as convenient for the practitioners around their clinical schedules, and flexibility to participate during evenings or weekends was offered. Participants were offered the chance to participate in the study online, however face-to-face participation was

encouraged and no requests for online participating were made. Mostly, appointments took place at practitioners' place of work, during normal working hours; four appointments took place at Cambridge Institute for Public Health and one in a participant's home whilst working from home. Each appointment took place in a private space with only the researcher and the participant present.

All face-to-face appointments were audio-recorded (i.e. those conducted with clinician participants). The purpose and procedures for this were stated clearly in the Participant Information Sheet and discussed explicitly with participants at the start of the session. Consent for audio-recording was not a mandatory requirement of participating and so consent for this was sought separately. Participants were permitted to request the audio recording was stopped at any time but none of them did so.

It was not anticipated that participating in the study would elicit distress in the participants. The risk of identifiable or clinically relevant information arising from the study materials was considered low and guidance about this was given at the start in the Participant Information Sheet (see appendix F). Had the unlikely situation arisen that a participant disclosed information regarding harm to or by a child or other person then the researcher would have managed this appropriately in line with their Code of Practice and local Safeguarding policies. This is in accordance with the British Psychological Society Code of Human Research Ethics (BPS) emphasising the need to override the duty of confidentiality in exceptional circumstances in order to uphold the researcher's duty to protect individuals from harm. Participants were made aware of these limits of confidentiality and safe risk management procedures. All research activities were risk-assessed through the external approvals processes to ensure the safety of the researcher; however, none of the pertaining conduct was considered to be outside of that which is expected of and conducted routinely in the researchers' clinical role.

Due to their internationality, researcher participants completed the study online. Eligible researchers (see section 3.4.3) were contacted by E-mail with study information and offered a

chance to participate. Following an initial expression of interest, researchers were then sent a link to complete the study online and left to do so in their own time. One follow-up attempt was made to researchers who did not respond to the initial invitation to participate, and two follow-up reminders were sent to those who had given provisional agreement but not yet completed the study. Researchers used the online platform Q-assessor (https://q-assessor.com) to complete the Q-sort. Data was stored anonymously within the online program and could be downloaded in batches or at the end of the recruitment period.

3.2. Phase 1: Concourse Development

3.2.1. Generating the concourse

There is no gold-standard way to generate a Q-set (Watts & Stenner, 2019). Rather, researchers are instructed to do so idiosyncratically to ensure it is tailored to the requirements of the investigation and demands of the research question(s). The wealth of literature pertaining to attachment theory and research and the variety of policy, public discourse and popular texts for clinical application made representative coverage an ambitious aim - perhaps an impossible one. However, it also reflected the essence of the identified problem that applied practitioners face.

Themes for the concourse were generated through a review of relevant literature, an interview with a child Clinical Psychologist (appendix G), field notes from an attachment special interest group (appendix H) and a series of discussions held by the project steering group. The project steering group involved in initial brainstorming consisted of the following individuals and expertise:

1. Dr Helen Beckwith (Primary researcher) - Clinical Psychologist with 18 months experience working in child mental health services and specialist training in attachment assessments (Strange Situation Procedure; Adult Attachment Interview).
2. Dr Robbie Duschinksky (Primary supervisor) - Senior academic with Investigator Award for leading a sociological analysis of the history of attachment ideas and research.

Training in attachment assessments (Strange Situation Procedure; Friends & Family Interview).

3. Professor Marinus van IJzendoorn (Co-supervisor) - Professor of Human Development honoured with Lifetime Achievement Award by the Society for Emotion and Attachment Studies. Training in various attachment assessments including the Strange Situation Procedure and Adult Attachment Interview.
4. Dr Matt Woolgar (Co-supervisor) - Consultant Clinical Psychologist and Lead of two national child mental health services and established record of research in developmental psychology. Training in attachment assessments (Strange Situation Procedure; Preschool Assessment of Attachment).
5. Professor Mark Freeston (Co-supervisor and mentor) - Clinical Psychologist and Professor of Clinical Psychology, expert in uncertainty research and experience of using Q-methodology for psychological science.
6. Professor Paul Stenner (Expert consultant) - Professor of Social Psychology with over 30 years experience of using Q-methodology across a range of topics.

Concourse statements were generated and sampled alongside the literature review to refine this thinking (see Table 1 in Chapter 2 for initial themes and sub-themes).

3.2.2. Sources of information

Individual statements were generated from reflection on a range of sources pertaining to attachment discourses and applications. Source materials included academic literature, national guidance and policy documents, parliamentary discourse and other grey literature that discussed attachment theory and research. In addition, field notes I made during two gold-standard attachment training institutes: the Adult Attachment Interview (Berkeley 2017, delivered by Erik Hesse, Mary Main and Naomi Gribneau-Bahm) and the Strange Situation Procedure (London

2015, delivered by Judith Solomon) were reviewed for statements relating to beliefs about attachment or uses for clinical practice. Items were extracted from source material to generate a list of 146 possible Q-statements (see appendix I).

3.2.3. Refining the concourse

The process of refinement was conducted with the aim of retaining unique items that were most relevant, appropriately constructed and offered adequate coverage of the topic area. Inappropriate constructions included items containing very technical or complicated terminology (some terminology was permitted on the assumption participants had a degree of special expertise), double-barrelled items (containing two or more propositions and/or qualifications), and negative expressions that would demand a positive ranking to indicate disagreement (and vice versa). Ordinary, lay language was used as far as was possible for the construction of concourse statements. However, when specific terminology was necessarily used, it remained important to keep this to a minimum. Retention and rejection decisions were agreed with the primary supervisor. Two renowned attachment theorists and two clinicians working with children and families who were not part of the final sample conducted an early stage piloting of the study materials, as they were considered subject experts who could comment authoritatively on its overall coverage, obvious omissions, individual item phrasing and suitability for both participant groups. All four individuals involved in the piloting agreed on the suitability and range of coverage across the concourse; two minor wording amendments were recommended alongside one additional item.

A final Q-set containing between 40-80 items is typical (Stainton Rogers, 1995; Shemmings, 2006). The lower limit is favoured to make the sorting task less taxing for the intended participants. However, all participants in this study by virtue of their profession were familiar with managing high loads of information and complexity and thus considered able to handle the demands of the task. In addition, a number towards the upper limit was anticipated to

be needed given the varied and sometimes diffuse claims about attachment in circulation in academic and practice contexts. In the end, 65 items were retained for the final Q-set (see Table 2). These are presented below alongside example of available literature that inspired the items generated (NB: they are not citations of claims made; indeed, some items have been phrased to indicate the opposite of observed findings; but they are materials that may have been read by participants and shaped their understandings).

Table 2 Concourse details

Concourse item	**Example sources of inspiration**
1. Disorganised attachment can be used to identify child maltreatment	Shemmings/Wilkins (2012) and addressed in Granqvist (2017) consensus paper
2. Only validated assessments of attachment should be used in practice	Claim espoused in attachment training institutes ad Granqvist (2017 consensus paper
3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	Specific tool recommended to members of the research team
4. Attachment is only relevant for children in fostering and adoption services	Focus of NICE Guidelines NG26
5. Attachment language is more helpful for clinical practice than specific attachment measures	CP interview, clinical experience
6. Attachment assessments cannot be used for children with autism spectrum disorder	SSP training
7. ADHD symptoms make it difficult to interpret attachment assessments	SSP training, clinical experience
8. The adult attachment interview is helpful to use with parents of children in services	AAI training, Steele et al (2004; 2009)
9. Parent-child separations in a clinical setting can be used as part of an assessment	CP interview (see appendix G)
10. The best way to work with attachment problems is to try a short intervention and see what happens	Supervision discussion/VIPP principle
11. Attachment classifications over-simplify differences between people	Slade (2004), Critteden (2005)
12. Attachment theory could be used more precisely within mental health practice	Zenah (2016), Morison, Taylor & Gervias (2019)
13. Bowlby's ideas are outdated for current clinical practice	CP interview
14. Insecure attachment is a research concept with little-to-no clinical application	NICE guidelines
15. Too much focus is placed on attachment theory compared to other theories of child development	CP interview, Meins (2017), White et al (2020)
16. Attachment concepts are useful to provide a sense of family dynamics	CP interview, Dallos & Vetere (2009)

17. My colleagues understand what attachment is	Wilkins (2016)
18. Attachment research literature is difficult to translate into clinical practice	CP interview
19. There is a high level of agreement amongst researchers about what attachment is	Duschinsky (2020)
20. Childhood attachment patterns should not be used to predict adolescent outcomes	CP interview, literature, Meins article
21. It is impossible to develop a secure attachment to maltreating care-giver	Dozier & Bernard (2013)
22. Children with severe learning disabilities cannot develop secure attachments	Granqvist (2014)
23. The disorganised attachment classification is the most relevant for mental health	van IJzendoorn, Schuengel & Bakermans-Kranenburg (1999), Wilkins (2012; 2016)
24. Childhood attachment patterns are good predictors of adult relationship functioning	Minnesota longitudinal study
25. Callous and unemotional traits in children originate from their early attachment experiences	Supervision discussion, clinical experience
26. Children with anxiety problems always have poor attachment relationships	Implication from psychotherapeutic literature
27. Attachment insecurity in children is so common it is not problematic by itself	Supervision discussion
28. Attachment disorders are common in children	Woolgar & Baldock (2015)
29. It is rare that children develop secure attachments to parents with learning disabilities	Granqvist (2014)
30. Children's mental health problems are often attachment-related problems	CP interview
31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	Minnesota longitudinal study
32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	Multiple meta-analyses
33. Children show the same attachment patterns across all their relationships	dispute in literature, Main & Weston (1981)
34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad	Main/Hinde conditional strategies, Crittenden
35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	Woolgar & Scott (2014)
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	CP interview, parliamentary discourse, Building Great Britons report
37. After the first 1000 days attachment patterns are fixed for life	direct quote from 1000 days document
38. Good quality care throughout childhood is a better predictor of a future mental health than a child's early attachment pattern	Beijersbergen et al (2012)
39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	Clinical experience, Morison, Taylor & Gervias (2019)

40. Attachment problems and attention problems are often related	Main (1985), clinical experience
41. Attachment disorders are over-diagnosed at the expense of other disorders	Woolgar & Scott (2014)
42. Attachment theory is helpful for differential diagnosis in child mental health	Clinical experience, Crittenden (2008/2016)
43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	DSM-5
44. Knowing a child's attachment status determines the type of treatment they need	Implication from psychotherapeutic literature
45. The most effective attachment interventions target maternal sensitivity	De Wolff & van IJzendoorn (1999), Posada (2016)
46. Interventions should target parents' internal working models of relationships because this benefits their children	Steele & Steele (2008), Bakermans-Kranenburg et al (2003)
47. Clinical interventions should be adapted to suit different attachment patterns	Steele & Steele (2008)
48. Attachment theory is an important framework for making decisions about fostering placements and adoption	CP interview
49. Attachment behaviour only means something when a child feels threatened or anxious	SSP training
50. Attachment patterns provide information about the function of behaviour	Main/Hinde conditional strategies
51. Early attachment experiences determine how the brain develops	Healthy child programme (2009), Schore (2001; 2014)
52. Attachment is a property of a relationship rather than a child	Ainsworth (1978/2015)
53. The temperament of a child heavily influences the type of attachment they form	van IJzendoorn & Bakermans-Kranenburg, 2012)
54. Attachment assessments focus specifically on where children direct their attention	Main (1985)
55. Attachment disorders can be effectively treated with clinical intervention	NICE guidelines
56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors	Implication from psychotherapeutic literature
57. Attachment assessment tools are easily accessible to clinicians	CP interview, researcher experience
58. Attachment interventions work as well for adolescents as they do for younger children	Steele & Steele (2018), Facompré et al (2018
59. There is so much literature on attachment it is difficult to know which bits are most useful for practice	Clinical experience, supervision discussion
60. All children in mental health services who lack secure attachments need attachment-informed interventions	CP interview
61. Attachment concepts can be used to facilitate personalised care for children	Clinical experience, implication from psychotherapeutic literature
62. Childhood trauma lies behind all cases of attachment disorganisation	Shemmings/Wilkins (2012), Granqvist et al (2017)

63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	Clinical experience, Main/Hinde conditional strategies
64. Working in an attachment-informed way means providing a safe environment for children to explore	Lieberman & Zeanah (1999; 2008),
65. Working on a child's attachment cannot be done without the involvement of their caregivers	Lieberman & Zeanah (1999; 2008), Steele et al (2009)

3.3. Phase 2: Q-sort task

The conditions of instruction were as follows: *'We are asking clinicians and researchers about how they think about attachment concepts and methods and their relevance for clinical practice. Based on your knowledge and experience, to what extent do you agree or disagree with the following statements about attachment theory and research?'*. All the clinician sorts were completed face-to-face in a 90-minute appointment with the researcher, using a physical set of item cards and a Q-sort distribution mat (see Figure 2). Although completion of researcher sorts was not timed it is anticipated from piloting that this required a similar length of time.

Participants were provided with the Q-set of 65 items and asked to initially sort the items into three piles: 'largely agree', 'largely disagree', and 'not sure/no strong opinion'. Participants then proceeded to assign weightings to each item and sort them into the quasi-normal distribution grid below. They were informed that the specific order of items in columns was unimportant, rather focus should be given to assigning items a ranking that was reflective of their point of view based on their knowledge, understanding and experience. The online platform used by researchers for the sorting procedure mimicked these instructions, by first asking participants to sort the items roughly into the same three piles before assigning individual rank weightings. In both methods, all sorting decisions were preliminary and could be changed, meaning sorts were finalised only when the participant decided they were finished.

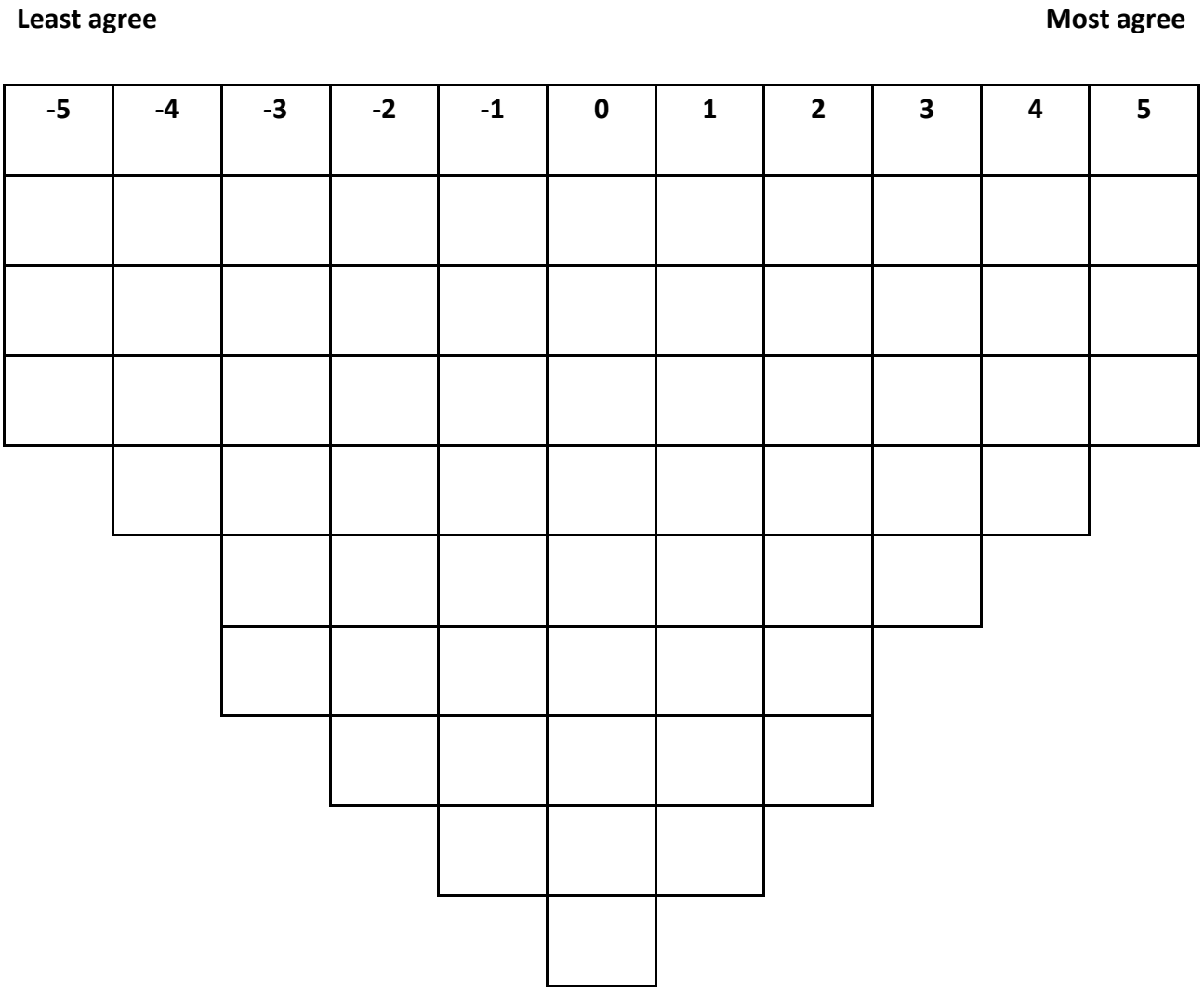

Figure 2 Q-sort distribution grid

Clinicians were encouraged to 'think aloud' throughout the sorting process, if they felt comfortable to do so. The uptake of this instruction varied, with some providing an almost constant commentary and others remaining largely silent. This commentary was audio-recorded and extensive notes were made; however, the data was not formally transcribed or analysed. It was however referred to throughout the process of analysis and interpretation. Researchers were also given the opportunity to provide written feedback on the sorting process though this tended to be very brief if at all.

3.4. Participant recruitment and characteristics

The final sample consisted of 30 practicing child health clinicians (six male, 24 female) in the UK, and thirty-one international experts in attachment research (10 male, 21 female). The appropriate number of participants needed for a Q-sort task is widely discussed, however it is generally agreed that the number of participants recruited should be smaller than the number of items in the concourse (Brouwer, 1999), typically between 20-60 participants (Stainton-Rogers, 1995; McKeown & Thomas, 2013).

3.4.1. Clinicians

The study was advertised to clinical staff within two mental health Trusts in the UK with the following inclusion criteria: participants must be a registered health professional with at least one year's clinical experience since qualification and be currently working psychologically (i.e., as a psychologist or delivering psychological interventions with children, adolescents and their families; see appendix B for recruitment leaflet).

51 clinicians responded to the advert and initially expressed interest in the study. Thirty-two of these gave consent and participated in the study, however two were excluded from analysis as it emerged during the research appointment that they did not meet the inclusion criteria (one was an unqualified member of staff and the other did not work in child services). Of the remaining 19 referrals, 11 were contacted but reported to not be working psychologically or delivering psychological interventions in their role, and a further eight did not respond to attempts to contact them further about the study. As mentioned earlier, it is ideal for a participant group in Q methodology to include a range of possible viewpoints; this was achieved purposively by selecting clinicians working in primary, secondary and tertiary care services across physical and mental healthcare. After data collection, it emerged that two participants did not in fact meet criteria and were removed from analysis ('C9' was not currently working in children's services and 'C14' was not yet a qualified health professional).

Clinical experience of the recruited practitioners spanned the range of 1-30+ years of professional practice. Clinical professionals worked across primary care (n=7, 23.3%), generic secondary care (n=11, 36.6%) and specialist services (n=12, 40%). 10 clinicians (33.3%) were qualified Clinical Psychologists, 12 (40%) were Accredited Therapists (7 Systemic therapists, 1 Art therapist, 1 Cognitive-Behavioural Therapist, 1 Counselling Therapist, 1 Play Therapist and 1 Integrative Therapist) and the remaining eight (26.6%) were other Allied Health Professionals (3 Nurses Practitioners, 3 Social Workers, 1 Wellbeing Practitioner, and 1 Occupational Therapist).

Two clinicians (6%) did not respond to the question about what attachment literature they were most familiar with. Nine (30%) reported being most familiar with the developmental attachment literature that constitutes core teaching in professional training. A further 10 clinicians (33.3%) denoted greatest affiliation with psychotherapeutic attachment literature written by clinician-researchers primarily for the purpose of translation to clinical practice. Of the remaining practitioners, three (10%) reported greatest familiarity with attachment theory via a combination of core teaching and further clinically focused professional development training, and a further three (10%) learnt of attachment theory predominantly via psychodynamic literature. See Table 11 for full details.

3.4.2. Academic researchers

Researchers were purposively recruited for their expertise in attachment theory and research and/or the application of attachment theory and research in clinical practice. This included researchers from both the developmental and social psychological traditions of attachment research (see Jacobvitz, Curran & Moller, 2002), in order to capture a variety of potential viewpoints. As active researchers within the field of attachment, the project steering group was already broadly familiar with the pool of potential participants and helped to compile a list of researchers to invite to participate in the study. They also advised on who to contact, utilising existing contacts, making introductions and supporting with reminders. A total of 77 invitations

were sent out to potential participants (52 were affiliated with the developmental psychology tradition, 24 were from social psychology and one was not considered to be particularly aligned with either research tradition). Forty researchers responded to the invitation expressing interest in participating, ten declined the invitation and 28 did not respond. Researchers were then sent a link to complete the study online and left to do so in their own time. One follow-up attempt was made to researchers who did not respond to the initial invitation to participate, and two follow-up reminders were sent to those who had given provisional agreement but not yet completed the study. 31 researchers proceeded to complete the study in full, one began the study but felt unable to complete the sort effectively due to not being a clinician, one failed to complete due to struggling with the online platform, and seven others were willing but unable to make time to complete the study. Of those who participated in full, 26 of those were developmentalists (50% take-up) and 5 were social psychologists (20% take-up).

The majority of recruited researchers had experience of working in clinical practice (n=17, 54.8%) and/or were involved in training clinicians (n=21, 67.7%). A large majority (n=25, 80%) were trained in at least one of the Strange Situation Procedure (Ainsworth, 1978) or the Adult Attachment Interview (George, Kaplan and Main, 1985), and a further nine (29%) were trained to deliver an evidence-based attachment-specific clinical interventions (as per Steele & Steele, 2017, *Handbook of Attachment Interventions*, e.g. ABC: Attachment Bio-Behavioural Catchup; GABI: Group Attachment-Based Intervention; or VIPP: Video-Interactions for Positive Parenting). Eleven (35%) of the recruited researchers had studied alongside either Mary Ainsworth, Mary Main or Patricia Crittenden. The majority of those who took part were considered to be affiliated with the developmental psychology tradition (n=26) and only five were affiliated with the social psychology tradition. See Appendix L for full details.

3.5. Phase 3: Contextual participant data

3.5.1. Demographic information

The demographic questionnaire was designed for use with the clinicians, as a tool for facilitating a conversational inquiry of pertinent background information. This included: gender, years of experience, role, service context, familiarity with NICE guidance, sources of attachment knowledge, continuing professional development via reading and training, confidence in theoretical understandings and geographical location (see Appendix K). Similarly, researcher participants were asked to indicate whether they had previous or current experience of clinical practice, expertise in specialist attachment assessments or interventions, and whether they studied alongside other key attachment researchers.

3.5.2. Self-report questionnaires

Following the Q-sort, clinicians completed a small battery of self-report questionnaires, described in the following sections. The measures selected assessed key variables of interest relating to clinicians' own attachment experiences and dispositional traits of tolerance to uncertainty and ego resilience.

Clinicians' own attachment style

The Experiences in Close Relationships – Revised (ECR-R, Fraley, Waller & Brennan, 2000) scale was used to assess clinicians' own levels of attachment anxiety (anxiety regarding the availability and responsiveness of others they have relationships with) and attachment avoidance (the extent to which people are uncomfortable being close to others). The measure consists of 36 items, half of which measure avoidance and half of which measure anxiety. Items are scored on a 7-point scale from 'strongly disagree' to 'strongly agree'. Sample norms demonstrate the following average item scores: anxiety (M = 3.56, SD = 1.12); avoidance (M = 2.92, SD = 1.19). Inspection of the factor structure of these subscales by Sibley & Liu (2004) found good evidence of internal consistency (>.90) and good test-retest reliability (>.86).

Tolerance to uncertainty

Intolerance of uncertainty (IU) is a well-established cognitive construct reflecting how an individual perceives, interprets and responds to uncertain situations at a behavioural, cognitive and emotional level (Dugas, Buhr & Ladouceur, 2004). Although IU emerged from clinical observations of individuals with generalised anxiety disorder (Freeston, et al., 1994), ample datasets from clinical and healthy adult populations now indicate IU is a normally distributed variable, considered to reflect a dispositional fear of the unknown (Carleton, 2012). Clinician tolerance for uncertainty has not yet been studied, however it is reasonable to expect both variation and relevance of this variable to the study of professional subjectivity. The Intolerance of Uncertainty Short Form questionnaire (IUS-12, Carleton, Norton, & Asmundson, 2007) was used, consisting of 12-items measured on a 5-point Likert scale (not at all characteristic of me – entirely characteristic of me), and correlates highly with the original (Freeston, et al., 1994) 27-item scale (.94-.96, Carleton, Norton & Asmundson, 2007; Khawaja & Yu, 2010).

Resilience

Finally, the construct of *ego resilience* proposed by Block refers to those who (at the high end) tend to be *"more competent and comfortable in the 'fuzzier' interpersonal world"* (Block and Kreman, 1996, p.43). If expressed as an ego-resilience continuum, the other end may be called ego-brittle, indicating a reliable difference in the degree of dynamic resourcefulness for adaptability (Block and Kreman, 1996). In an unpredictable or uncertain situation, ego-brittleness may place the individual at risk of anxiety, which may play a role in clinical decision-making. The ego-resilience measure consists of 14-items relating to characteristics of the self, assessed on a 4-point scale ranging from 'does not apply at all' to 'applies very strongly'. Total scores correspond to the following levels of resilience: Very low (0-10), Low (11-22), Undetermined (23-34), High (35-46), Very high (47-56).

3.6. Statistical analyses and abductive logic

PQmethod is a freely available, basic DOS package that runs on but does not use the Windows operating system. It is purpose-built for Q analysis, offering a choice of factor extraction and rotation methods that produce detailed statistical information. The two options for factor extraction are principal component analysis and centroid factor analysis. The latter is the oldest extraction technique available and is typically still favoured by Q methodologists for its simplicity and for permitting greater data exploration.

The first step in the statistical process of factor extraction is inspection of the correlation matrix. Each sort is intercorrelated with every other sort to provide a measure of similarity. The following factor analysis then seeks to identify distinct portions of common and specific variance from the correlation matrix. Centroid factor analysis searches the data for patterns of similar configurations and extracts these as factors until no more common variance can be detected. The end product is the unrotated factor matrix of factor loadings, i.e. correlation coefficients that indicate how typical each sort is of each factor. A number of best-practice guidelines can be used to decide the number of factors to extract, relating to factor eigenvalues and Humphrey's rule (Brown, 1980), the screen test (Cattel, 1966) and use of parallel analysis (Horn, 1965).

Conceptually, the next step is to inspect the factors as shared viewpoints by visualizing them in multi-dimensional space. This is because each sort represents an unique viewpoint or perspective, much like every seat in an auditorium. In this way, seats clustered in one corner of the auditorium have a degree of shared perspective, that is different to a cluster of seats in the front row. A two-factor solution enables sorts to be plotted along an x and a y axis to illustrate how similar or different each viewpoint is from each other. A three-factor solution introduces a third dimension in which to situate different sorts, and more than three factors ventures into multi-dimensional space. Using the above analogy, it is possible to look at the variety of sorts and factors within this space from any position in the auditorium, but it will of course look slightly different to someone standing at the back of the room to someone standing on the stage.

Importantly, Watts and Stenner (2012) note that the perspective of someone standing on the stage is one that is not shared by any of the audience (participants) and therefore may be somewhat non-optimal, particularly for viewing what these clusters of viewpoints have in common. Rotating around these axes to inspect the factors from different angles is the process of factor rotation. The aim of factor rotation is to find suitable positions within the conceptual space from which to view the subject matter, depending on the focus of the data collected. The position of sorts in relation to each other is fixed by their unrotated factor loadings, rather it is the position of the factors and their viewpoints relative to the sorts that changes.

Automated varimax rotations are standard in analyses of Q-sort data, as they strive for orthogonal factors; however, researchers can opt to employ alternative rotations by hand that can offer more oblique solutions. Varimax rotations maximise the amount of study variance explained, by positioning the factors such that as many sorts as possible have a high factor loading onto one factor. This rotation method therefore favours particular areas of consensus - points where multiple people have gathered - as its focus for patterning in the data. It is useful for offering a solution that is recognisable to most people and thus can be an important starting point for examining subject matters with little prior knowledge of understanding.

Abductive logic largely comes into play during factor interpretation (Watts & Stenner, 2012). Individual items and their interrelationships signpost the researcher to an understanding of the overall viewpoint that makes sense of the configuration as a whole. Demographic information and comments from participants regarding their experience of the sorting process can provide additional clues during this interpretive phase. The researcher therefore uses all available information to interpret the factor array, with the aim of providing a plausible hypothesis or theoretical explanation, that '*transforms a potentially surprising or unique experience into a commonplace example of some more general phenomenon'* (Watts & Stenner, 2012, p.39). It is this focus on seeking to explain observed phenomena which exemplifies the underpinning logic of

abduction in Q-methodology, in contrast to more familiar, bottom-up, inductive reasoning that describes phenomena, or top-down, deductive practices of hypothesis-testing.

Chapter 4

4

RESULTS

'Abduction is a logic designed for discovery and theory generation, not for testing and theory verification.' (Watts & Stenner, 2012, p.39).

4.1. Factor Analysis

61 completed sorts were entered into PQ Method (Schmolck, 2014). A by-person centroid factor analysis was conducted in order to identify of groups of participants who made sense of the set of items (i.e. 'sorted') in a comparable way. The following best practice decisions were used in a stepped process to select the most suitable factor solution from several potential options: First, the scree plot was inspected and only factors demonstrating an eigen value higher than 1 were considered. Second, factors with more than three loading sorts were considered meaningful enough to report, as per Brown's (2002) guidance. Third, the solution accounting for the highest total variance was favoured (Watts and Stenner, 2012). In this case, a two-factor solution excluded too many sorts and under-explained the diversity in understanding that this project sought to capture. By contrast, a four-factor solution included too much covariance rendering it statistically non-optimal and violating Brown's rule (2002). Expert advice on analytic decisions was sought from members of the project steering group when needed.

All options offered highly correlated factor solutions, indicating the data should not be interpreted as reflecting factors wholly distinct from each other. Stenner (2020, personal communication) advised that '*a highly correlated factor solution may instead indicate a broad consensus*

amongst participants, with identified differences pertaining to specific details of the subject matter'. This could be expected when examining a topic that is part of an established scientific discourse, and suggests the analysis offers a description of nuances in perspectives held within the population sampled. For the purposes of understanding how attachment is made sense of by various users of the knowledge, identifying areas of consensus and disagreement were considered to both be of high importance. This may be unlike other uses of Q-methodology that deal with public issues that are inherently more controversial or polarised and thus identify starker points of view. With this in mind, the results are synthesised below to offer a nuanced discussion of both convergence and divergence in the understandings of attachment theory and research held by a sample of its professional users'.

4.1.1. Factor Solution

A three-factor solution rotated by the varimax criterion best fit the data, with each factor demonstrating high reliability and low standard error. Many participants loaded onto more than one factor (known as co-loading and thus producing a highly correlated solution). However, there remains clear demographic differences across the defining sorts of each of the three-factors that offer an interpretable conclusion. In addition, most of the distinguishing items were highly significant $p<0.01$, indicating strong discrepancies between the factors on a number of specific items. This adds support to the above interpretation: that identified differences concern specific details of the subject matter rather than distinct variations in overall points of view. The three-factor solution explained 55% of the total variance; see Table 3 for descriptive data relating to the selected factor solution.

Table 3 Factor solution characteristics

	Factor 1	Factor 2	Factor 3
Defining sorts	13	17	17
Average reliability coefficient	0.80	0.80	0.80
Composite reliability	0.98	0.99	0.99
Eigenvalue	27.80	4.18	1.94
S.E. of factors	0.14	0.12	0.12
% Explained variance	17	19	19
Correlations	-	0.74	0.78
	0.74	-	0.62
	0.78	0.62	-

NB. Low-loading sorts pertained to eight researchers and six clinicians.

4.1.2. Factor loadings: statistical significance and defining sorts

Sorts can be considered to make a statistically significant factor loading, p <0.01 via the following calculation: 2.58 x (1/√Number of items in the Q-set). In this case, 2.58 x (1/√65) = 0.320. Factor loadings of each sort need to be squared in order to ascertain the proportion of variance explained by any given factor. For example, a sort with a factor loading of 0.32 means the factor accounts for 10% (0.32 x 0.32) of its variance.

In this study, 100% sorts (n=61) had at least one statistically significant factor loading (>.32), and 57% sorts (n=35) had two or more statistically significant factor loadings. Defining sorts were selected as those where the highest loading squared accounted for more than 50% of the sum of the three loadings. In other words, sorts could load across the three factors, but in order to be considered a defining sort, one loading must account for more than the others combined. Table 4 shows the final factor matrix loadings for the full dataset, including defining sorts in bold.

Using these standard criteria, 77% of sorts (n=47) were considered to be defining sorts, i.e. sorts that were included in the calculation of factor estimations (see Table 3). Of those which were not selected as defining sorts (n=14), all had multiple loadings (>.32); that is to say they were confounded. However, the majority of defining sorts were also confounded: 31 sorts (51% of total) had multiple significant loadings compared with 16 (26% of total) defining sorts that had uniquely significant loadings. This pattern was largely similar across the subgroups and

suggests a high degree of consensus. This supports the preliminary interpretation above, that different factors therefore represent differences in detail rather than fundamental disagreements in perspective. It also means that there is a large body of core understanding which is shared and is in part revealed by analysis of consensus (see section 4.3.)

Table 4 Factor Matrix

Sort	F1	F2	F3	Sort	F1	F2	F3
C1	0.43	0.30	0.44	R1	0.44	0.44	0.04
C2	0.50	0.16	**0.55**	R2	0.14	**0.53**	0.31
C3	**0.56**	0.36	0.38	R3	0.15	0.58	**0.65**
C4	**0.58**	0.36	0.22	R4	0.04	0.49	**0.63**
C5	**0.62**	0.33	0.45	R5	0.41	**0.66**	0.34
C6	0.48	0.27	0.41	R6	0.31	0.47	0.56
C7	**0.63**	0.48	0.21	R7	0.33	**0.61**	0.50
C8	**0.58**	0.20	0.41	R8	0.41	**0.64**	0.35
C10	0.30	0.27	**0.47**	R9	0.19	**0.70**	0.16
C11	0.28	0.16	**0.53**	R10	0.25	**0.78**	0.06
C12	0.34	0.40	**0.56**	R11	0.26	0.52	0.47
C13	0.22	0.28	**0.66**	R12	0.37	**0.58**	0.34
C15	0.29	0.14	**0.58**	R13	0.12	**0.53**	0.43
C16	0.56	0.28	0.55	R14	0.16	0.50	0.51
C17	0.46	0.37	0.50	R15	0.38	0.41	0.15
C18	-0.02	0.20	**-0.45**	R16	-0.13	**0.63**	-0.22
C19	**0.58**	0.15	0.52	R17	**0.57**	0.41	0.21
C20	**0.60**	0.10	0.35	R18	0.46	0.50	0.22
C21	0.44	0.23	0.39	R19	0.32	**0.72**	-0.16
C22	0.50	0.39	0.31	R20	0.43	0.07	**0.59**
C23	**0.55**	0.43	0.12	R21	0.13	**0.76**	0.27
C24	**0.54**	0.10	0.50	R22	0.47	0.45	0.32
C25	0.43	0.11	**0.65**	R23	0.46	**0.52**	0.23
C26	**0.41**	0.16	0.33	R24	0.46	**0.72**	0.20
C27	0.31	0.07	**0.68**	R25	0.26	0.31	**0.72**
C28	0.26	0.07	**0.67**	R26	0.13	0.50	**0.61**
C29	**0.62**	0.43	0.38	R27	0.56	0.37	0.43
C30	0.19	0.18	**0.72**	R28	0.43	**0.61**	0.09
C31	**0.65**	0.15	0.41	R29	0.35	**0.54**	0.32
C32	0.31	0.03	**0.62**	R30	0.40	**0.64**	0.22
-	-	-	-	R31	0.42	**0.52**	0.17

NB. Defining sorts highlighted bold, non-defining sorts shaded grey.
Significant factor loading ≥0.32, $p < 0.01$
Sorts labelled C# refer to clinician sorts and sorts labelled R# refer to researcher sorts.

4.2. Factor Characteristics

4.2.1. Factor overview

There were distinct differences in participant demographics across factor loadings, which suggest statistically significant differences in the perspectives of researchers and practicing clinicians. Broadly speaking, factors 1 and 3 were considered to reflect the range of clinicians' perspectives, as all clinician sorts (labelled 'C') loaded significantly onto at least one of these factors (>0.32). Seven clinicians also loaded significantly onto factor 2 but each made distinctly larger and subsequently defining contributions to either factor 1 or factor 3. In addition, factor 2 can be characterised as representing the defining factor for attachment researchers, as all but two (29/31) researcher sorts (labelled 'R') loaded significantly here (>0.32). Seventeen researcher sorts were selected as defining sorts for factor 2 - one researcher sort defined factor 1 and five researcher sorts defined factor 3.

4.2.2. Specific cases

A number of specific sorts stand out in Table 2. Speculations about such sorts are permitted by contextualising this information in line with demographic and observational data, though the need for participant anonymity remains. First, sort C18 produced a significant negative loading. Typically, a significant negative loading would indicate an inverse or mirror-image configuration of items and is suggestive of a highly opposing viewpoint. C18 was also the lowest significant loading of all defining sorts (i.e. it had low loadings across all three factors), meaning that it disagreed with all other sorts in factor 3 and with the other two factors. However, this sort was conducted in-person and the researcher noted at the time that the participant appeared chaotic in their sorting behaviour. Despite clarification of instructions and appropriate prompting, the researcher could not be sure whether participant C18 had fully understood the sorting task. Watts and Stenner (2012) recommend that an inclusive approach to selecting defining sorts is generally favoured to order to reduce error in the estimate and increase factor estimate reliability,

therefore this sort was not removed from analyses. However, this sort should be interpreted with caution, as what appears to be a highly divergent viewpoint may in fact be a measurement error.

Second, sorts R17, R20 and R25 appear to be atypical researcher sorts for different reasons. They all correspond to researchers who are also clinicians, though this was true of the majority of the researcher sample (17/31, see appendix L). R17 was unique in making a defining contribution to factor 1, whereas all other researcher sorts defined either factor 2 or factor 3. Of note, R17 was the only participant who worked as a psychiatrist whereas other researcher-clinicians were psychologists or psychotherapists. Sorts R20 and R25 stand out as the two researchers who did not load significantly onto factor 2 (<.32); of note, both participants actively conduct applied research of clinical practice, unlike most of the other researchers.

4.2.3. Factor estimates and factor arrays

Factor estimates provide an estimate of a factor's viewpoint on each item, which is expressed as a z-score. They are calculated using weighted averages of the defining sorts of each factor, meaning sorts with higher factor loadings contribute proportionally more to the factor estimates than those with relatively low factor loadings. To aid interpretation, factor estimate z-scores for each item are typically converted into item scores in a single factor array, configured to represent the viewpoint of a particular factor. Factor arrays conform to the same distribution used in the original data collection and are constructed using the rank order of the factor estimate z-scores.

The three factor arrays pertaining to this dataset are listed in full in Table 3 and expressed visually in Appendix M. Table 5 offers exemplar scores of each item within each factor. Distinguishing items have been highlighted to indicate item scores that were particularly characteristic of individuals loading onto that factor and thus are most similar to the raw item-rankings assigned by the defining sorts. There were 24 significantly distinguishing items for Factor 1, 30 significantly distinguishing items for Factor 2, and 23 significantly distinguishing items for Factor 3: these are used later to aid factor interpretation.

Table 5 Factor arrays (**Distinguishing statements** $p<0.05$ indicated in bold; ***** distinguishing statements $p<0.01$)

Statement	F1	F2	F3
1. Disorganised attachment can be used to identify child maltreatment	+1	**-4***	+1
2. Only validated assessments of attachment should be used in practice	-1	**+3***	0
3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	+1	+1	0
4. Attachment is only relevant for children in fostering and adoption services	-5	**-4***	-5
5. Attachment language is more helpful for clinical practice than specific attachment measures	**+3***	**+1***	**-2***
6. Attachment assessments cannot be used for children with autism spectrum disorder	-3	-3	-2
7. ADHD symptoms make it difficult to interpret attachment assessments	-1	-2	-1
8. The adult attachment interview is helpful to use with parents of children in services	**0***	**+3**	**+4**
9. Parent-child separations in a clinical setting can be used as part of an assessment	+2	**+5***	+2
10. The best way to work with attachment problems is to try a short intervention and see what happens	**-2***	**-1***	**-4***
11. Attachment classifications over-simplify differences between people	+2	+2	**0***
12. Attachment theory could be used more precisely within mental health practice	+3	+3	+3
13. Bowlby's ideas are outdated for current clinical practice	**-2**	-3	-5
14. Insecure attachment is a research concept with little-to-no clinical application	-4	**-2***	-4
15. Too much focus is placed on attachment theory compared to other theories of child development	**-2**	**-1***	**-4**
16. Attachment concepts are useful to provide a sense of family dynamics	+4	**+2***	+4
17. My colleagues understand what attachment is	**+3***	**+1***	**-1***
18. Attachment research literature is difficult to translate into clinical practice	0	+1	**-1***
19. There is a high level of agreement amongst researchers about what attachment is	**-1***	**+2***	**-1***
20. Childhood attachment patterns should not be used to predict adolescent outcomes	**0***	**+1***	**-2***
21. It is impossible to develop a secure attachment to maltreating caregiver	0	**-2***	0
22. Children with severe learning disabilities cannot develop secure attachments	**-5***	-3	-3
23. The disorganised attachment classification is the most relevant for mental health	**-1**	**0***	**-3***
24. Childhood attachment patterns are good predictors of adult relationship functioning	+2	**0***	+2
25. Callous and unemotional traits in children originate from their early attachment experiences	0	-1	0
26. Children with anxiety problems always have poor attachment relationships	**-4**	-2	-3
27. Attachment insecurity in children is so common it is not problematic by itself	0	0	**-5***
28. Attachment disorders are common in children	-2	**-3***	-2
29. It is rare that children develop secure attachments to parents with learning disabilities	**-4***	-2	-1
30. Children's mental health problems are often attachment-related problems	+2	**0***	+1
31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	-1	-1	**2***
32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	+1	+2	+1
33. Children show the same attachment patterns across all their relationships	-3	-4	-4

34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad	+5	+5	+5
35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	**-3**	-1	-2
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	**+2**	**-1***	**+2**
37. After the first 1000 days attachment patterns are fixed for life	**-5**	**-5**	**-3**
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	**+2**	**+4***	**0**
39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	0	0	0
40. Attachment problems and attention problems are often related	+2	**-1***	+1
41. Attachment disorders are over-diagnosed at the expense of other disorders	-3	**+1***	-3
42. Attachment theory is helpful for differential diagnosis in child mental health	+3	**+1***	+1
43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	**-3**	-2	-2
44. Knowing a child's attachment status determines the type of treatment they need	**-1***	**-2***	**1***
45. The most effective attachment interventions target maternal sensitivity	0	**+4***	+1
46. Interventions should target parents' internal working models of relationships because this benefits their children	**+1***	**+2**	**+3**
47. Clinical interventions should be adapted to suit different attachment patterns	+3	+2	+3
48. Attachment theory is an important framework for making decisions about fostering placements and adoption	+4	+3	+4
49. Attachment behaviour only means something when a child feels threatened or anxious	-2	-1	-3
50. Attachment patterns provide information about the function of behaviour	**+5**	+3	+3
51. Early attachment experiences determine how the brain develops	+5	**0***	+5
52. Attachment is a property of a relationship rather than a child	+4	+5	+5
53. The temperament of a child heavily influences the type of attachment they form	**0***	**-4***	**-1***
54. Attachment assessments focus specifically on where children direct their attention	-1	0	0
55. Attachment disorders can be effectively treated with clinical intervention	+1	+2	+2
56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors	-3	-3	**0***
57. Attachment assessment tools are easily accessible to clinicians	-2	-3	-2
58. Attachment interventions work as well for adolescents as they do for younger children	+1	0	**+2***
59. There is so much literature on attachment it is difficult to know which bits are most useful for practice	+1	+1	**-1***
60. All children in mental health services who lack secure attachments need attachment-informed interventions	-1	0	**1***
61. Attachment concepts can be used to facilitate personalised care for children	+3	+4	+4
62. Childhood trauma lies behind all cases of attachment disorganisation	**-2***	**-5***	**+2***
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	**-4***	**-5***	**-1***
64. Working in an attachment-informed way means providing a safe environment for children to explore	**+4***	+3	**+3***
65. Working on a child's attachment cannot be done without the involvement of their caregivers	+1	+4	+3

4.3. Convergence

First and foremost, this analysis showed a high degree of commonality across the three factors: a body of shared understanding amongst various users of the attachment knowledge base about its relevance and application to child mental health services. Statistical consensus was obtained across all three factors in 17/65 items, reflecting similarly assigned rankings that could not be explained within the context of one of the identified factors. Table 6 details the identified consensus statements, i.e., items that did not significantly distinguish between any pair of factors.

Table 6 Consensus statements: item scores and z-scores (rank order)

Item	F1	F2	F3	F1 z-score	F2 z-score	F3 z-score
34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad	+5	+5	+5	1.89	1.9	1.6
52. Attachment is a property of a relationship rather than a child	+4	+5	+5	1.74	2.09	1.78
48. Attachment theory is an important framework for making decisions about fostering placements and adoption	+4	+3	+4	1.49	1.26	1.32
61. Attachment concepts can be used to facilitate personalised care for children	+3	+4	+4	1.26	1.47	1.49
12. Attachment theory could be used more precisely within mental health practice	+3	+3	+3	1.03	1.09	1.2
47. Clinical interventions should be adapted to suit different attachment patterns	+3	+2	+3	1.28	0.91	1.14
32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	+1	+2	+1	0.44	0.75	0.76
3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	+1	+1	0	0.31	0.12	-0.05
55. Attachment disorders can be effectively treated with clinical intervention	+1	+2	+2	0.42	0.76	0.76
39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	0	0	0	0.03	-0.1	-0.18
25. Callous and unemotional traits in children originate from their early attachment experiences	0	-1	0	-0.1	-0.16	0.14
7. ADHD symptoms make it difficult to interpret attachment assessments	-1	-2	-1	-0.37	-0.61	-0.74
54. Attachment assessments focus specifically on where children direct their attention	-1	0	0	-0.24	-0.09	-0.09
57. Attachment assessment tools are easily accessible to clinicians	-2	-3	-2	-0.85	-0.95	-0.82
33. Children show the same attachment patterns across all their relationships	-3	-4	-4	-1.3	-1.56	-1.22
6. Attachment assessments cannot be used for children with autism spectrum disorder	-3	-3	-2	-0.97	-1.13	-0.79
26. Children with anxiety problems always have poor attachment relationships	-4	-2	-3	-1.37	-0.94	-1.00

Consensus items of particular interest are those with the same or similar item scores at the extreme ends of the rating scale [+4, +5, -4, -5]. Despite often being the easiest items for individuals to sort, agreement with others about which items are placed at the extremes is harder to achieve. For instance, table 4 shows items 34 and 52 are strongly endorsed by all the various clinicians and researchers sampled [+4, +5]. This highlights widespread agreement on the adaptive (attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad) and dyadic (attachment is a property of a relationship rather than a child) elements of the attachment concept and can be regarded as two of the most important features of attachment theory for this context of applied practice. Similarly, there is strong consensus with respect to the perceived value of attachment theory as a framework for decision-making around fostering and adoption placements (48) and personalised care (61), offering specificity to domains of practice considered to be of particular relevance. In addition, there is consensus regarding what the attachment concept is *not* [-2, -3, -4], i.e. not a trait characteristic across all of a child's relationships (33), not irrelevant to children with Autism Spectrum Disorder (6), and not always related to childhood anxiety (26).

Other consensus items also offer nuances on the shared perspective held by participants. For instance, there is moderate agreement [+2, +3] amongst clinicians and researchers alike that attachment assessment tools are not easily accessible to clinicians (57), that attachment theory could be used more precisely within mental health (12), and that clinical interventions should be adapted to suit different attachment patterns (47). Further, mild agreement is found [+1, +2, *'true a bit'*] surrounding the ability to predict a child's attachment pattern from knowledge of their parents' attachment pattern (32) and the effectiveness of clinical interventions for the treatment of attachment disorders (55).

All sorting decisions must be understood to have been made relative to other items in the concourse. Consensus items falling in the middle of distribution (i.e. those with item scores of 0, -1 and +1) can be harder to interpret as they may indicate what is agreed to be (relatively)

uncertain, unknown or unimportant, or merely items that participants struggled to evaluate or understand. The observed commentary from clinicians during the sorting process suggests that items pertaining to the relevance of early attachment experiences to the later development of callous and unemotional traits (25) and the degree to which attention is a specific feature of attachment assessments in children (54) were judged to be areas of the literature that remain uncertain/unclear/not yet known. By contrast, and despite piloting, items referring to the utility of the Coventry grid (3) and the tendency for attachment concepts to be discussed at times of diagnostic uncertainty (39), were described by participants as unknown areas of application that they felt unable to sort with sufficient meaning and, on reflection, it is expected that researchers may have similarly found these items challenging to sort.

4.4 Divergence

4.4.1. Factor labels

The three identified factors were assigned descriptive labels to help identify and distinguish between the factors in a memorable way for a reader. These are intended to be used as heuristics rather than definitive labels, chosen subjectively by the researcher to capture the main thrust of the viewpoint in a short but precise way.

Factor 1 emphasised understanding attachment pertaining to behaviours, interactions and relationships. Interpreting the factor as a whole revealed participants were somewhat hesitant to apply specific elements of attachment theory and research to clinical practice. Participants expressed a sense that there were indeed valuable and worthwhile aspects to draw on but remained characteristically unsure about the use of some concepts and measures, often due to the realistic constraints of doing so. This is typically a more pragmatic stance and demographic characteristics pertaining to these sorts revealed the majority of Clinical Psychologists sampled endorsed this viewpoint (see Table 11). Participants endorsing this point

of view referenced first learning about attachment theory through developmental psychology. For these reasons it was labelled the *pragmatic, developmental and uncertain perspective.*

Factor 2 emphasised understanding in line with key empirical findings and strong views on a number of recent controversies in the literature (e.g. neurobiological underpinnings, attachment disorganisation and attachment in the context of child maltreatment). There was solid endorsement of direct application of specific attachment assessments but widespread hesitancy to express strong claims about utility and application for other types of clinical tasks. In other words, the distinguishing features of this viewpoint predominantly reflected academic and empirical knowledge and a characteristic hesitancy to comment on professional or procedural knowledge (see Figure 1, Chapter 1). For these reasons it was labelled the *academic perspective* and was endorsed uniquely by researchers.

Factor 3 conveyed an understanding of attachment through strong expression of the detrimental nature of attachment insecurity and the ongoing relevance of addressing this in a therapeutic way. Participants emphasised the role of mental representations, internal working models and past experiences of attachment, with a particular predilection for using the adult attachment interview. In contrast to the other two factors, there was less expression of a behavioural systems-level understanding of attachment and a notably different perspective on matters of attachment disorganisation and childhood trauma. Participants endorsing this perspective were mostly clinicians but also a few clinician-researchers, of whom the majority attributed their learning of attachment to personal reading, continuing professional development and post-qualification training in specific modalities, rather than core professional training or traditional texts. For these reasons it was labelled the *autodidactic, therapeutic and enthusiastic perspective.*

Factor 2, *the academic perspective,* endorsed uniquely by researchers, is presented in detail first, followed by data discussing the divergence amongst clinicians.

4.4.2. Factor 2: Academic perspective

17 participant sorts defined Factor 2, accounting for 19% of the variance in this solution. Table 7 shows the statistically distinguishing features of Factor 2. Factor z-scores are a standardised unit of comparison indicating relationship to the mean of a group of values, with large z-scores reflecting greatest distance from the mean.

Table 7 Distinguishing items for Factor 2

Item	F2 rating	F2 z-score
9. Parent-child separations in a clinical setting can be used as part of an assessment	+5	1.48*
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	+4	1.43*
45. The most effective attachment interventions target maternal sensitivity	+4	1.39*
2. Only validated assessments of attachment should be used in practice	+3	1.14*
8. The adult attachment interview is helpful to use with parents of children in services	+3	0.92
46. Interventions should target parents' internal working models of relationships because this benefits their children	+2	0.89
16. Attachment concepts are useful to provide a sense of family dynamics	+2	0.85*
19. There is a high level of agreement amongst researchers about what attachment is	+2	0.58*
20. Childhood attachment patterns should not be used to predict adolescent outcomes	+1	0.50*
5. Attachment language is more helpful for clinical practice than specific attachment measures	+1	0.31*
42. Attachment theory is helpful for differential diagnosis in child mental health	+1	0.18*
41. Attachment disorders are over-diagnosed at the expense of other disorders	+1	0.19*
17. My colleagues understand what attachment is	+1	0.13*
51. Early attachment experiences determine how the brain develops	0	0.12*
24. Childhood attachment patterns are good predictors of adult relationship functioning	0	-0.11*
23. The disorganised attachment classification is the most relevant for mental health	0	0.06
30. Children's mental health problems are often attachment-related problems	0	0.03*
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	-1	-0.24*
15. Too much focus is placed on attachment theory compared to other theories of child development	-1	-0.19*
10. The best way to work with attachment problems is to try a short intervention and see what happens	-1	-0.18*
40. Attachment problems and attention problems are often related	-1	-0.13*
21. It is impossible to develop a secure attachment to maltreating caregiver	-2	-0.88*
44. Knowing a child's attachment status determines the type of treatment they need	-2	-0.76*
14. Insecure attachment is a research concept with little-to-no clinical application	-2	-0.46*
28. Attachment disorders are common in children	-3	-1.26*
1. Disorganised attachment can be used to identify child maltreatment	-4	-1.61*
53. The temperament of a child heavily influences the type of attachment they form	-4	-1.49*
4. Attachment is only relevant for children in fostering and adoption services	-4	-1.40*
37. After the first 1000 days attachment patterns are fixed for life	-5	-2.06
62. Childhood trauma lies behind all cases of attachment disorganisation	-5	-1.62*
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	-5	-1.92*

NB. All items are significantly distinguishing at $p<.05$ level; * $p<.01$

Factor 2 was characterised by a strong sense of what is important for childhood attachment; specifically, the consistency of good quality care throughout childhood (38, +4) and high levels of maternal sensitivity (45, +4). In addition, a clear idea about how to assess for attachment in clinical practice, i.e. using robust validated attachment measures (2, +3), which should include parent-child separations (9, +5) and the Adult Attachment Interview (8, +3). Researchers did not consider attachment disorders to be common in children (28, -3), nor did they consider the development of a secure attachment to a maltreating caregiver to be an impossible task (21, -2). They considered attachment classifications to be necessary but perhaps insufficient (14, -2) for identifying suitable treatment plans (44, -2), characterised by their endorsement of the vaguer notion that attachment concepts are useful for gaining a sense of family dynamics (16, +2).

Researchers were distinguished by their hesitancy to express strong claims regarding the utility of attachment theory for clinical tasks/dilemmas such as: differential diagnosis (42, +1); diagnostic overshadowing (41, +1); prioritising interventions for attachment insecurity in an attempt to prevent later pathology (36, -1); identifying co-morbid problems of attention (40, -1); and the relative importance of attachment theory for clinical work compared with other theories of child development (15, -1). This may reflect a lack of desire from academic researchers to comment on matters considered outside their expertise; however, several of these participants did have current or previous experience of working in clinical practice, in which case, the presenting reluctance to comment on such matters may better reflect their current participant role more than their beliefs or opinions on those items. Researchers were also hesitant to endorse the ability to predict adolescent outcomes (20, 1) or adult relationship functioning (24, 0) from childhood attachment patterns in the context of clinical practice.

Finally, researchers were distinguished by their strong opinions on the role and nature of the attachment disorganisation classification (see below for further details of this). Researchers also strongly rejected the idea that attachment patterns are largely fixed (37, -5) and definitive of

later life relationships. They also disagreed with the position that temperament likely played an influential role in the development of childhood attachment (53, -4).

4.4.3. Factor 1: Pragmatic, developmental and uncertain perspective

12 Clinicians and one researcher-clinician defined Factor 1, accounting for 17% of the variance in this solution. Table 8 shows the significantly distinguishing characteristics of Factor 1.

Table 8 Distinguishing items for Factor 1

Item	F1 rating	F1 z-score
50. Attachment patterns provide information about the function of behaviour	+5	1.81
17. My colleagues understand what attachment is	+3	1.13*
5. Attachment language is more helpful for clinical practice than specific attachment measures	+3	1.25*
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	+2	0.57
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	+2	0.56
65. Working on a child's attachment cannot be done without the involvement of their caregivers	+1	0.34*
46. Interventions should target parents' internal working models of relationships because this benefits their children	+1	0.23*
8. The adult attachment interview is helpful to use with parents of children in services	0	0.21*
53. The temperament of a child heavily influences the type of attachment they form	0	-0.01*
20. Childhood attachment patterns should not be used to predict adolescent outcomes	0	-0.02*
23. The disorganised attachment classification is the most relevant for mental health	-1	-0.35
44. Knowing a child's attachment status determines the type of treatment they need	-1	-0.17*
19. There is a high level of agreement amongst researchers about what attachment is	-1	-0.12*
15. Too much focus is placed on attachment theory compared to other theories of child development	-2	-0.95
13. Bowlby's ideas are outdated for current clinical practice	-2	-0.88
10. The best way to work with attachment problems is to try a short intervention and see what happens	-2	-0.79*
62. Childhood trauma lies behind all cases of attachment disorganisation	-2	-0.65*
35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	-3	-1.2
43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	-3	-1.18
29. It is rare that children develop secure attachments to parents with learning disabilities	-4	-1.53*
26. Children with anxiety problems always have poor attachment relationships	-4	-1.37
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	-4	-1.35*
22. Children with severe learning disabilities cannot develop secure attachments	-5	-1.86*
37. After the first 1000 days attachment patterns are fixed for life	-5	-1.65

NB. All items are significantly distinguishing at $p<.05$ level; * $p<.01$

This factor was characterised by strong endorsement [+5] of attachment patterns offering information about the function of childhood behaviour (50), and a strong rejection of the idea that attachment theory was an inapplicable framework for parents (29) and children (22) with learning disabilities [-5 and -4, respectively]. They were also characterised by sharing some similarities with the researcher factor, including strong rejections [-5] of attachment patterns as being fixed entities (37). Clinicians and researchers alike also rejected the idea that children with insecure attachment [-4] did not want to be close to their caregiver when ill or frightened (63). In contrast to researchers, they were less sure that consistency of care is a better predictor of future mental health than early attachment patterns (38). This suggests clinicians rate sensitivity as less critical than researchers, perhaps due to differential understandings about the concept of sensitivity or because Ainsworth's did not publish her sensitivity scale. Additionally, clinicians here disagreed [-2] that too much focus was placed on attachment theory at the expense of other theories of child development (15), often commenting that in their experience it wasn't considered enough within clinical settings. In particular, clinicians reflected that the attachment lexicon offered greater value [3] than formal attachment measures (5) (not least because they are largely inaccessible).

However, participants in this factor were also characterised by uncertainty [-1, 0, +1] about whether to actually use some aspects of attachment theory and research for applied practice, such as: internal working models (46), the adult attachment interview (8), identified attachment patterns in treatment planning (44), the emphasis on dyadic interactions and dyads as a key target for intervention (65) and the predictive ability for broader adolescent outcomes (e.g. emotional and social development, risk-taking behaviour, etc.). As previously stated, items ranked in the middle of the distribution can be difficult to interpret. For instance, these may reflect pragmatic constraints on their individual skillset, service provision, or client group. Alternatively, this may reflect a true sense of uncertainty that may be due to either i) an unawareness, ii) inability to recall or iii) lack of available empirical findings.

4.4.4. Factor 3: Autodidactic, therapeutic and enthusiastic perspective

17 participants defined Factor 3, accounting for 19% of the variance in this solution. Table 9 shows the significantly distinguishing characteristics of Factor 3.

Table 9 Distinguishing items for Factor 3

Item	F3 rating	F3 z-score
8. The adult attachment interview is helpful to use with parents of children in services	+4	1.33
46. Interventions should target parents' internal working models of relationships because this benefits their children	+3	1.23
64. Working in an attachment-informed way means providing a safe environment for children to explore	+3	1
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	+2	0.95
58. Attachment interventions work as well for adolescents as they do for younger children	+2	0.81*
62. Childhood trauma lies behind all cases of attachment disorganisation	+2	0.80*
31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	+2	0.78*
44. Knowing a child's attachment status determines the type of treatment they need	1	0.30*
60. All children in mental health services who lack secure attachments need attachment-informed interventions	1	0.63*
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	0	0.2
56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors	0	0.10*
11. Attachment classifications over-simplify differences between people	0	-0.50*
19. There is a high level of agreement amongst researchers about what attachment is	-1	-0.62*
17. My colleagues understand what attachment is	-1	-0.53*
18. Attachment research literature is difficult to translate into clinical practice	-1	-0.76*
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	-1	-0.66*
53. The temperament of a child heavily influences the type of attachment they form	-1	-0.65*
59. There is so much literature on attachment it is difficult to know which bits are most useful for practice	-1	-0.65*
5. Attachment language is more helpful for clinical practice than specific attachment measures	-2	-0.91*
20. Childhood attachment patterns should not be used to predict adolescent outcomes	-2	-0.82*
23. The disorganised attachment classification is the most relevant for mental health	-3	-0.97*
37. After the first 1000 days attachment patterns are fixed for life	-3	-1.2
10. The best way to work with attachment problems is to try a short intervention and see what happens	-4	-1.42*
15. Too much focus is placed on attachment theory compared to other theories of child development	-4	-1.35
27. Attachment insecurity in children is so common it is not problematic by itself	-5	-1.44*

NB. All items are significantly distinguishing at $p<.05$ level; * $p<.01$

Factor 3 was characterised by a strong sense [-5] that attachment insecurity is a key cause for concern in its own right (27) and did not believe [-3] the disorganised attachment classification was the most relevant for mental health (23). Interestingly, throughout the sorting process many clinicians spoke of their aversion to pathologizing language in general in the context of attachment, disregarding attachment disorder or disorganisation terminology. Participants who endorsed this point of view felt strongly [-4] that not enough attention in child services is given to attachment theory (15) and were unsure how to evaluate whether it offers an oversimplified framework (11). Participants also expressed a high valuation of the use of formal attachment assessment measures in their work (5).

Factor 3 perspective expressed uncertainty [-1] surrounding whether a child with an insecure attachment wished to be close to their caregiver when ill or frightened (63). From a theoretical point of view this appears to downplay the behavioural-systems-level understanding of attachment within this perspective. With respect to interventions for attachment insecurity, participants were hesitant [+1] to claim that an attachment-informed intervention was always required (60) but felt strongly [-4] that short interventions with these cases were inappropriate (10) (some additionally commented that this item implied a trial-and-error approach, which was also considered inappropriate).

Within this point of view, participants also felt very strongly [-5] that Bowlby's ideas were not outdated for clinical practice (13), and they were characteristically unsure [0] about the continuity of care being a better indicator of future mental health than early attachment patterns (38) despite overwhelming research evidence to attest to this (Beijersbergen, et al., 2012). In summary, this suggests a key feature of this perspective is concern pertaining to the adverse nature of early insecurity.

4.4.5. Key differences between perspectives

Table 10 shows the largest differences in z-scores between Factor 2 and the other two factors. In this analysis, those listed can be interpreted to broadly represent the most striking differences of opinion on specific items, between researchers and clinicians.

Table 10 Key differences between Factor 2 and both other factors (descending by z-score difference)

Item	Item scores		Factor z-scores		
	F2	**F1**	**F2**	**F1**	**±Diff.**
1. Disorganised attachment can be used to identify child maltreatment	-4	+1	-1.61	0.46	2.07
51. Early attachment experiences determine how the brain develops	0	+5	0.12	1.88	1.76
53. The temperament of a child heavily influences the type of attachment they form	-4	0	-1.49	-0.01	1.48
2. Only validated assessments of attachment should be used in practice	+3	-1	1.14	-0.13	1.28
45. The most effective attachment interventions target maternal sensitivity	+4	0	1.39	0.14	1.25
	F2	**F3**	**F2**	**F3**	**±Diff.**
62. Childhood trauma lies behind all cases of attachment disorganisation	-5	+2	-1.62	0.79	2.42
1. Disorganised attachment can be used to identify child maltreatment	-4	+1	-1.61	0.50	2.10
51. Early attachment experiences determine how the brain develops	0	+5	0.12	1.79	1.67
27. Attachment insecurity in children is so common it is not problematic by itself	0	-5	0.08	-1.44	1.52
20. Childhood attachment patterns should not be used to predict adolescent outcomes	+1	-2	0.50	-0.82	1.32

In line with, and perhaps reinforced by, the recent consensus statement led by Granqvist and colleagues in 2017, researchers strongly disagreed with the notion that disorganised attachment can be used to identify child maltreatment (1, -4). This item produced two of the four largest discrepancies in factor scores (difference >±2 in item z-scores) across the whole analysis and was a highly distinguishing aspect of the *academic* perspective. Relatedly, another key characteristic of this perspective was a sharp disagreement with the notion that childhood trauma lies behind all cases of attachment disorganisation (62, -5). In fact, responses to this item were relevant to distinguishing all three factors, indicating moderate disagreement in Factor 1 (-2) and moderate agreement in Factor 3 (+2).

Of similar magnitude was the discrepancy found regarding the role of early attachment experiences in determining brain development (51): while both Factors 1 and 3 gave equally

strong endorsement of this [+5], the researchers sorted this item firmly into the middle of the distribution [0], conveying a unique tentativeness about this claim. Finally, researchers strongly disagreed [-4] with the idea that child temperament heavily influences the type of attachment pattern formed, compared to Factor 1 [0] and Factor 3 [-1] who were unsure.

4.4.6. Differences between the predominantly clinician perspectives

Measures of clinicians' attachment style, intolerance of uncertainty and ego resilience were collected as exploratory variables of interest with potential influence on their perspectives. No direct hypotheses were made, thus the data is reported descriptively. Compared with sample norms (Fraley, 2012), these data show that the majority of clinicians reported low levels of attachment anxiety (<.3.56) and attachment avoidance (<.2.92), and, on the whole, clinicians reported high levels of ego resilience (35-46) and non-clinical levels of intolerance of uncertainty (using the clinical cut-off score of 28, Wilson, et al., 2020). There were some exceptions to this: six clinicians reported ego resilience outside the high range - one low (C29), four undetermined (C4, C12, C20 & C31) and one very high (C16); three of the low-loading sorts pertained to clinicians reporting higher than average attachment avoidance (C1, C17 & C21); one clinician reported high intolerance to uncertainty, and also high attachment avoidance (C3); finally, two clinicians reported above average levels of both attachment anxiety and attachment avoidance, both with sorts defining factor 3 (C12 & C27). Full demographic and psychometric data can be found in Table 11, where these exceptions have been italicised.

Table 11 Demographic and psychometric data for clinician participants

ID	Band	Profession	Years' experience	Additional attachment training	NG26 awareness	Attachment anxiety	Attachment avoidance	IU total	Ego Resilience
C3	5	Wellbeing Practitioner	1	No	Unfamiliar	3.5	*4.06*	*38*	38
C4	8	Psychologist	6	Yes	Irrelevant	2.28	2.89	25	*34*
C5	7	Therapist (Systemic)	30+	Yes	Unfamiliar	1.61	2.83	18	40
C7	8	Psychologist	20	No	Unfamiliar	2.67	2.72	22	39
C8	8	Psychologist	4	Yes	Unaware	2.11	*3.28*	20	39
C19	8	Psychologist	14	No	Familiar	2.61	2.06	16	43
C20	8	Psychologist	10	No	Irrelevant	2	2.11	21	*30*
C23	8	Psychologist	11	Yes	Familiar	2.17	2.22	16	36
C24	8	Therapist (Art)	4	No	Unfamiliar	1.67	2.78	17	42
C26	6	Social worker	5	No	Unaware	3.06	2.78	18	39
C29	8	Psychologist	5	No	Unaware	2.61	1.94	25	*21*
C31	7	OT	2	No	Unaware	3.06	2.72	22	*32*
C2	7	Therapist (Systemic)	26	No	Familiar	-	-	19	-
C10	8	Therapist (Systemic)	25	Yes	Unaware	1.89	2.11	22	44
C11	8	Therapist (Systemic)	30+	No	Unaware	1.28	1.5	28	41
C12	6	Nurse	5	No	Unfamiliar	*3.78*	*4.39*	23	*34*
C13	7	Therapist (Systemic)	19	Yes	Familiar	2.17	2.44	16	36
C15	7	Therapist (Counselling)	10	Yes	Unaware	2.39	1.44	19	46
C18	7	Therapist (integrative)	30+	Yes	Unfamiliar	-	-	-	-
C25	8	Therapist (Systemic)	30+	No	Unfamiliar	1.28	1.5	14	46
C27	5	Social worker	7	No	Unaware	*5.56*	*3.72*	26	42
C28	6	Social worker	4	No	Unaware	1.5	1.44	16	42
C30	7	Nurse	11	No	Familiar	1.33	1.83	20	36
C32	7	Psychologist	2	No	Familiar	-	-	-	-
C1	7	Therapist (Systemic)	5	No	Unfamiliar	2.56	*3.17*	15	41
C6	7	Therapist (CBT)	8	No	Unfamiliar	2.11	2.5	16	37
C16	7	Psychologist	1.5	No	Unfamiliar	1.5	1.22	25	*47*
C17	7	Therapist (play)	30+	No	Unfamiliar	1.39	*2.94*	18	40
C21	6	Nurse	16	No	Familiar	3.33	*3.17*	17	41
C22	8	Psychologist	4	Yes	Familiar	2.56	1.61	19	39

NB: Factor 1: yellow shading; Factor 3: pink shading; Low-loading: white shading.

^Cognitive-Behavioural Therapist (CBT); Occupational Therapist (OT); North American (NA); European (EU).

Regarding NICE Guidelines for Children's attachment NG26, *Unaware*: Didn't know NG26 existed; *Unfamiliar*: Aware NG26 existed but not familiar with the details; *Familiar*: Familiar with the details of NG26 and apply in practice as relevant; *Irrelevant*: Aware of NG26 but not deemed relevant for current role.

*Introduced in 2012 as part of NHS England's Agenda for Change Programme. Current pay scales available at: https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-scales/annual

ECR-R norms: Attachment anxiety (M = 3.56 SD = 1.12), attachment avoidance (M = 2.92, SD = 1.19). IUS-12 clinical cut-off = 28. Ego resilience = Very low (0-10), Low (11-22), Undetermined (23-34), High (35-46), Very high (47-56).

A two-tailed independent *t*-test found that clinicians loading onto Factor 3 had significantly more clinical experience working with children, adolescents and their families (M = 16.58 years), compared to those loading on Factor 1 (M = 7.45 years), $t(17) = 2.49$, p=.02. No statistically significant differences between the two factors were found with respect to clinician's core profession, pay band or exposure to additional attachment training or NICE guidelines. However, visual inspection of the data shows the Psychologists were largely aligned with Factor 1 and more of the psychotherapists were aligned with Factor 3.

Table 12 shows the largest differences in z-scores between Factor 1 and Factor 3. Those listed represent the most striking differences of opinion on specific items, between the *pragmatic and developmental perspective* and the *autodidactic, therapeutic and enthusiastic perspectives*. Items are listed in by magnitude of difference in descending order.

Table 12 Top ten differences between clinician perspectives (descending by z-score difference)

Statement	Item scores		Factor z-scores		
	F1	**F3**	**F1**	**F3**	**±Diff.**
5. Attachment language is more helpful for clinical practice than specific attachment measures	+3	-2	1.25	-0.91	2.17
17. My colleagues understand what attachment is	+3	-1	1.13	-0.53	1.66
62. Childhood trauma lies behind all cases of attachment disorganisation	-2	+2	-0.65	0.80	1.45
27. Attachment insecurity in children is so common it is not problematic by itself	0	-5	-0.10	-1.44	1.34
8. The adult attachment interview is helpful to use with parents of children in services	0	+4	0.21	1.33	1.12
11. Attachment classifications over-simplify differences between people	+2	0	0.60	-0.50	1.09
46. Interventions should target parents' internal working models because this benefits their children	1	3	0.23	1.23	1.10
59. There is so much literature on attachment it is difficult to know which bits are most useful for practice	+1	-1	0.28	-0.65	0.93
20. Childhood attachment patterns should not be used to predict adolescent outcomes	0	-2	-0.02	-0.82	0.80
50. Attachment patterns provide information about the function of behaviour	+5	+3	1.81	1.07	0.74

There were some striking differences of opinion amongst clinicians, which may be related to the nature of their professional training, the source of their reading and educational materials regarding attachment theory, and/or the degree of clinical experience they have acquired over time. On the whole, Factor 1 represented clinicians in the early – middle stages of their clinical

career working with children and adolescents, who had primarily come from backgrounds in psychology and learnt about attachment theory via developmental psychology literature (e.g. work by Bowlby and Ainsworth). By contrast, clinicians in Factor 3 had much more clinical experience working with children and adolescents, came from a variety of therapeutic modalities, particularly systemic family therapy, and attributed their knowledge base to a wider range of clinical literature (e.g. Crittenden, 2008; Hughes, 2008; Dallos & Vetere, 2009; Golding, 2012).

As described above, participants in these factors held moderate but distinctly different points of view about the role of childhood trauma on the development of disorganised attachment. Participants endorsing Factor 1 indicated a particular preference [+3] for using the lexicon of attachment theory and considered a behavioural level understanding attachment patterns (50) to be particularly helpful [+5], yet cautioned that the classification system (11) represented somewhat of an oversimplification [+2]. By contrast, participants in Factor 3 anticipated greater utility of specific attachment measures (5), in particular a strong optimism [+4] about the use of the adult attachment interview for routine clinical practice (8), and perceived value [+3] of therapeutically targeting parents' internal working models of attachment (46) that may indicate a preferential understanding of attachment at the level of cognitive representation. Finally, whereas Factor 1 participants didn't necessarily consider attachment insecurity to be problematic, Factor 3 participants felt very strongly [-5] that it should not be ignored and expressed uncertainty about how well their colleagues really understood attachment concepts.

4.5. Factor interpretation

Critical to the interpretation of Q-sort data is remembering that it is generated by participants rank ordering a set of items *relative* to one another – multiple items are therefore reduced to a single, gestalt configuration. There is large volume of available statistical information relative to individual items of the Q-set, which can make it easy to lose sight of the holistic character of the

factor arrays. While particular item rankings can be important for interpreting the factor as a whole, cross-factor item comparisons are not the primary aim of this procedure, it is instead the interrelationship of many items within a factor that should ultimately shape its interpretation. Watts and Stenner (2012) recommend generating crib sheets as a way to encourage engagement with the full set of items and understand a factor's overall viewpoint to deliver a final factor interpretation (see Appendix N). Using this technique, all items are evaluated in the context of one another and can help to bring the essence of the factor into sharper focus.

Chapter 4a

4a

INTERPRETATIVE SUMMARIES

Factor interpretations have been summarised below by constructing a narrative to illuminate the viewpoints identified. This has been done by drawing on information from a number of sources; as much as was available, though they are of course primarily assembled around the factor array estimates and demographic data available.

The interpretive summaries can be read as either a 'shared voice' or a singular perspective, but either way it is necessary to foreground the consensus in order to bring the differences in sharper relief. Had the consensus not been as high, the presentation and interpretation of results would have been different.

Reference to item numbers and scores are provided to support the narrative where appropriate, however, where the +/- sign of an item score does not fit with particular phrasing used in the narrative, scores have been removed to avoid confusion. For example, when using the phrase 'Bowlby's ideas are still relevant' this is constructed from a negative ranking of item number 13 'Bowlby's ideas are outdated for clinical practice'. To present 'Bowlby's items are still relevant (13, -3) obscures comprehension in this interpretative narrative and so is expressed simply as (13). Care was taken throughout the analysis to avoid interpreting negatively ranked items as meaning the inverse of the item, unless clearly indicated as in the example above. As described above, Original item phrasing and item scores for all items can found with reference to Table 2.

Consensus statement

Attachment patterns represent a child's best attempt to adapt to their environment (34) – they describe something important about the relationship an infant has with their caregiver (52). This is a really important framework for thinking about looked after children and in making decisions about fostering placements and adoption (48). Ideally, we should adapt clinical interventions to suit the individual needs of children with different attachment patterns (47) and offer personalised care (61). At the moment, this level of precision is not used enough (12). One reason for this is that attachment assessment tools are not easily accessible to clinicians (57). It is also complicated by the knowledge that children show different attachment patterns with different caregivers (33). But, if made possible, attachment assessments could be used with children across the neurodevelopmental spectrum (6).

There are some elements of attachment theory that we don't yet have a good understanding of. For example, it's not clear whether attachment assessments focus on where children direct their attention (54) and what implications this has for interpreting co-occurring symptoms of ADHD (7). We are not sure how well children's attachment patterns can be predicted from knowledge of their parent's attachment patterns (32). We are also unsure how well attachment disorders can be treated with clinical interventions (55) or whether this framework is more helpful for non-diagnostic considerations (39). Finally, we don't know whether callous and unemotional traits in children originate from their early attachment experiences (25).

Pragmatic, developmental and uncertain perspective

Attachment theory was taught as part of my core professional training, primarily via the early work of John Bowlby and Mary Ainsworth. Done well, thinking about this carefully can help us tailor our approach to the individual needs of children (61, +3), but we probably do this in a slightly vague way (12, +3). It is tricky because children can have different sorts of attachment to different caregivers (33). Although I know attachment is about the relationship between a parent and child (52, +4), we don't always get the opportunity to work with the relevant caregivers (65, +1) so we just do our best and talk about attachment generally. I understand that children with insecure attachments still want to be close to their caregivers when they are ill or frightened (63) they just show this differently to securely attached children.

My colleagues understand what attachment is about (17, +3) and being able to talk about child behaviour and family dynamics (16, +4) with them in this way is helpful (5, +3). People used to worry about whether children (22) and/or parents (29) with learning disabilities could still develop secure attachments, but in my experience they absolutely can. Parents tell us some children seem to be born temperamentally different, and maybe that affects attachment but I'm not sure how (53, 0). But attachment patterns are definitely not fixed for life (37, -5) and good quality care throughout childhood is probably more important overall (38, +2). I am certain, though that early attachment experiences shape how the brain develops (51, +5) and this is partly why Bowlby's ideas are really relevant (13).

One of the most useful things about attachment is that it helps us to understand child behaviour (50, +5), but other concepts are less obviously applicable. For example, I don't how relevant parents' internal working models are to their children's attachment (46, +1) and without understanding this or having access to specific assessments tools (57, -2) I couldn't say whether the adult attachment interview is useful or not (8, 0). Sometimes we can work out a child's attachment classification (even without the validated measures), but this doesn't necessarily help to identify what intervention they need (44, -1), and, unfortunately, even an attachment disorder diagnosis doesn't necessarily ensure that a child gets access to specialised interventions (35, -3). Not every child, for example, with anxiety problems also has poor attachment relationships (26, -4), so we consider attachment alongside other theories of child development (15) and mental health. Sometimes addressing attachment insecurity looks like the clinical priority, (36, +2) but we are not really commissioned to do that kind of work in our services so we are limited in how much we can really focus on it routinely.

Academic perspective

The most important thing for child development is good quality care throughout childhood (38, +4). This means that interventions must focus on improving parental sensitivity as the active ingredient (45, +4).

Bowlby proposed that all infants are biologically disposed to seek and maintain proximity to the caregivers in the face of potential or real threat (63) but that there are individual differences in how this is achieved and expressed behaviourally. Only the validated assessments of attachments should be used to assess this (2, +3) and observing parent-child separations are key to this (9, +5). Not just assessments of child attachment, but the adult attachment interview too can be also be helpful for understanding the needs and challenges of parents of children in services (8, +3).

Some areas of attachment research remain unknown or haven't been very convincing. For instance, we really don't know to what extent early attachment experiences impact on brain development (51, 0), though lots of people have tried writing about this. We also don't really know if childhood attachment patterns are good predictors of adult relationship functioning (24, 0). However, I want to be very clear about the attachment disorganisation classification. It should not be used to identify child maltreatment (1, -4) and is absolutely not an inevitable consequence of trauma, abuse or neglect (62, -5). In fact, it is possible to have a secure relationship with a maltreating caregiver (21). It is also important to remember that attachment disorders are rare (28).

I can't be very specific about what is helpful about attachment theory for clinical practice. For example, I don't know how it plays out or should play out in key tasks such as differential diagnosis (42, 1) or treatment planning. I also don't know what sorts of attachment problems are most prevalent in services (23, 0), or how much attention should be given to attachment relative to other theories of child development (15, -1). I am unsure whether attention problems are related to attachment (40, -1) or how attachment problems should be prioritised over other concerns (36, -1).

Autodidactic, therapeutic and enthusiastic perspective

The more I work in child services the more I have learnt about attachment and realise how relevant it is to our understanding of children. Above all, insecure attachment is big problem for child mental health (27, -5), perhaps especially for children of parents with learning disabilities (29). Yet this big problem is not adequately recognised since attachment theory isn't given enough focus and attention to in services (15, -4). Part of working in an attachment-informed way means providing a safe environment for children to explore (64, +3). As well as seeking to contribute to children's sense of access to a secure base and safe haven, we should also use the adult attachment interview (8, +4) and use interventions that target parents' internal working models of attachment (46, +3).

I have to work really hard to help my colleagues understand (17) and think about attachment. I've read some really good books about attachment in psychotherapy over recent years, so I get it and actually don't find it hard to incorporate into my practice. It is quite intuitive when it comes down to it. I haven't read Bowlby's work, but I know he's the founder of attachment theory, so his ideas are definitely not outdated (13, -5). All behaviour is attachment behaviour really (49, -3) and it's relevant to think about for everyone. We need to be able to assess it properly (5, -2) as addressing attachment insecurity is a clinical priority (36, +2). Early attachment experiences determine how the brain develops (51, +5), tell us about how children will get on in adolescence (20) and how they will function in their adult relationships (24, +2). But that doesn't mean it is too late; attachment interventions can work for adolescents as well as children (58, +2). Not everyone needs an attachment-informed intervention (60, +1), but for those who do it is really important, so I have taken it upon myself to learn more.

Childhood trauma, abuse and neglect prevent children from developing secure attachments (31, +2) and lead to huge problems. Some children's behaviour shows that they don't always want to be close to their attachment figures when they are ill or frightened (63, -1) and we have to work with them very carefully to re-establish this. It is not appropriate to use short interventions for these children (10, -4) as they need longer term work. You could call such severe attachment problems disorganised, but I don't like to use that term (23, -3). I don't believe attachment can really be disordered as children ultimately adapt to their caregiving environment (34, +5) so I'm not keen on that diagnosis either and I don't really know what it means (43, -2).

Chapter 5

5

DISCUSSION

The overarching aim of this study was to examine how clinicians and researchers understand attachment theory and research in the context of clinical practice, with a view to elucidating which features of attachment theory and research are considered of most clinical importance and where misalignments of understanding may be located. The study set out to answer the following questions: i) How do clinicians understand and regard the application of attachment theory and research within their routine clinical work in child mental health services? ii) What factors relating to clinician demography, background and service context correlate with their understanding and perspectives on attachment theory and research? iii) Where do clinicians' understandings of attachment concepts align or misalign with those of researchers?

Q methodology was used to capture the points of view held about attachment theory and research, to identify areas of convergence and divergence, and interpret commonalities between those holding shared perspectives. Users of this knowledge base were recruited from two groups: i) healthcare workers from a variety of child clinical health services and ii) academic researchers from both the social and developmental traditions.

Three shared perspectives were identified by data collected from 61 Q-sorts. Each viewpoint was condensed into a particular sorting pattern of the 65 statements (see Appendix M) and were then interpreted and reported in detail in Chapter 4. This discussion chapter highlights the main findings and reflects on key points of similarity and difference between the three

viewpoints identified, and comments on potential tensions and implications for research and practice.

5.1. Summary of key findings

Results from this study offer three main contributions to the wider literature: 1) there is a substantial set of shared understanding amongst researchers and clinicians with regards to attachment theory and research; 2) there are some particular axes of significant differences in the understandings of researchers and clinicians; and 3) there are some differences of opinion among clinicians, which may vary according to duration of clinical experience or factors relating to this (e.g. time spent thinking/reading around the topic, opportunities for commercial training, development of a therapeutic style or preferred orientation, etc).

5.2. Shared understanding

Based on his analysis of published texts, Duschinky (2020) argued that there are many versions of attachment theory in circulation, and that several key terms are used in different ways by different stakeholders. He documented failures to recognise divergent uses of attachment language, concepts and methods and argued that this has contributed to the observed obscurities in communication and understanding between researchers, practitioners and the general public outlined in Chapter 1. Similarly, White, et al. (2020) drew a sharp distinction between researchers' and practitioners' understandings of attachment theory. Yet notably, they acknowledge their claims were based on limited data and were instead mostly anecdotal. To our knowledge, this is one of the first studies to empirically investigate the attachment knowledge and understanding of either clinicians or researchers, and it found a great deal of commonality in the viewpoints of these professional groups, particularly on matters of theoretical and empirical knowledge.

Participants were mostly in strong agreement that attachment patterns are shaped in response to experiences of caregiving and are adaptive to these environments. Additionally, there

was clear consensus that attachment patterns are dyadic in nature, vary across different relationships and are not fixed for life. These findings demonstrate solid agreement on these core theoretical aspects of an attachment relationship, as detailed in Bowlby's original trilogy, *Attachment and Loss*. However, when considering how these perspectives manifest in clinical practice and professional knowledge, further interpretation of the gestalt configurations is needed. For instance, attachment behaviour towards a caregiver describes something that happens between two individuals, i.e. it is *dyadic* in nature. However, dyadic constructs are somewhat foreign to the current set up and design of health services. This study found clear agreement that attachment had this quality, that is to say it describes a property of a relationship rather than an individual. Yet whilst consensus here may be viewed favourably, the UK healthcare system arguably struggles to meaningfully integrate dyadic or relational concepts in its current set-up.

With the rare exception of the DSM-5's Munchausen syndrome by proxy (also known as factitious disorder imposed on another in ICD-11), there are no other diagnostic categories in physical or mental health that refer to symptoms or characteristics pertaining to more than one individual, and only a couple of other clinical descriptions. The system is therefore without the necessary structures in place to identify, manage or treat dyadic presentations. The American Zero to Three diagnostic classification manual (1994) was designed specifically for the purpose of assessing relationships, mental health and development of young children and offers a potential exception to this, but it does not have the standing or institutional support of other more commonly used diagnostic manuals (e.g. cannot be used in health insurance claims in the US, and - to my knowledge - is not referenced in the UK).

The lack of attachment descriptions as formal diagnostic labels potentially renders this type of knowledge less likely to be understood or retained by the psychiatric or healthcare systems, which are ultimately organised around individual categories. A parallel could be drawn with the psychoanalytic notion of 'splitting'; a psychological mechanism that individuals use to

tolerate overwhelming emotions by perceiving others as either idealised or devalued. This is another psychological concept that can refer to the dynamic or relationship between two people, though is more typically attributed as originating in the individual assigned a confirmed or suspected diagnosis of personality disorder, rather than any of the other individuals or relationships they encounter. Similarly, appeals to 'splitting' can be seen circulating in a similar fashion to attachment constructs within UK health service culture - largely outside of formal systems of practice but amongst the dialogue between some groups of health professionals (Gallop, 1985; Crittenden, 2008/2016).

The international community of attachment researchers have recently engaged in a debate related to the question of how a dyadic concept can fit with diagnosis-based healthcare, after Lyons-Ruth and Jacobvitz (2016) argued for the revalidation of Ainsworth's classification system, particularly the disorganised classification, into the currency of diagnostic categories for ease of application to practice. However, others in the field have argued strongly against such a solution (see Zeanah & Lieberman, 2016) and, as it stands, these proposals have not been taken forward. This debate signals the difficulty of utilising the dyadic construct within the rigidity of current service structures and practices. As a result, there may be limits on the applicability, and therefore the intelligibility, of the research paradigm in this environment.

Another proposal (e.g. Forslund et al. 2020) has been to focus on formative assessments of caregiving to guide the provision of support, rather than assessments of attachment in judgements about risk or best interests. This may be a more mutually satisfying solution and would certainly align well with the evidence-based treatments focused on sensitivity that are recommended by NICE guidelines (e.g. VIPP-SD, Juffer, et al., 2008; 2017) and recent longitudinal finding that caregiver sensitivity predicts disorganised vs organised attachment better than insecure vs secure in preschoolers (O'Neill, et al., 2021). On this note, recent work validating the AMBIANCE-brief as an observational screening instrument for disrupted caregiving in community settings (Cooke, et al., 2020) looks remarkably promising for improving

such practices, by directly offering a practice measure for monitoring and evaluating caregiving environments. One benefit to this shift may be a clearer opportunity to operationalise the dyadic view of attachment that this study had found is shared between clinicians and researchers.

Interestingly, the dyadic view is primarily located in attachment literature on infancy, where the attachment and caregiving systems are interwoven (Bowlby 1969; Ainsworth et al. 1978). The idea of attachment as still, to an extent, a dyadic construct across the lifespan has been maintained by attachment researchers in the developmental tradition. However, by adulthood, the major assessments and conceptualisations by attachment researchers focus on either internal states of mind (e.g. Main, 1985) or styles of interpersonal relations (see Hazan & Shaver, 1987; Bartholomew & Horowitz, 1991), even if neither is a direct measure of the attachment behavioural system per se but rather of related constructs (Duschinsky 2020). From review of books offering guidance to psychotherapists on how to think about attachment, Duschinsky (2020; Duschinsky & Foster 2021) observed that infancy serves as the overriding perspective or metaphor both for attachment theory and for the application of attachment to clinical practice. Aligned with this observation, strong consensus regarding the dyadic nature of attachment may, like Duschinsky's review of published texts, suggest that clinicians and researchers alike hold a model of infancy in mind when organising information about attachment theory and research. Of note, in the UK, only clinicians employed in perinatal or paediatric services would actually work directly with infants; the majority of participants in this study were clinicians from child services that support children aged 5 years and older. Nevertheless, an infancy model of attachment theory and research appears to be one commonality in the self-organisation of attachment knowledge by both clinicians and researchers. Future research may therefore wish to consider the cognitive processes involved that facilitate applying a model of infant attachment understanding when working with an individual at later stages of development, as well as the strengths and limitations of this perspective.

This study also found that all participants aspired to better, more precise use of attachment theory in mental health practice and agreed one way of doing this would be to adapt clinical interventions to suit different attachment patterns. Collectively, participants hope and expect attachment theory to help support personalised care. However, awareness of the specific needs of individuals/individual dyads is necessarily required in order to tailor specialised treatments, and participants collectively indicated that one of the factors currently preventing this was poor accessibility of attachment assessment tools. One attempt to offer assessments for use in clinical practice has been Crittenden's approach to identifying multiple sub-types of attachment, most of which are immediately clinically intuitive and enable practitioners to quickly relate them to examples of individuals they have encountered. There are regular opportunities offered to UK clinicians to be trained in using the assessment tools that have followed this approach and certainly clinicians in this study referred to additional professional development courses stemming from this approach in their pre-sorting discussions. However, this assessment framework, whilst popular with many UK clinicians, is held by most researchers to be ultimately too idiographic to be reliably reproducible (van IJzendoorn, et al., 2018a). Therefore, there is perhaps a misalignment regarding the degree of precision that would actually be of value. Nonetheless, these findings indicate both clinicians and researchers recognise that *precision of understanding* is crucial, but that clinicians also desire *precision of assessment*. The lack of pertinent research on this to date makes this request difficult to satisfy but may prove to be imperative for continued alignment of researcher and clinician perspectives. This predicament has been explicitly acknowledged by Madigan and colleagues as one of the primary reasons for their work on the AMBIANCE-Brief, which was prompted by their conversations with clinicians about their desire for a measure of attachment that reflected both precision of understanding and some precision of assessment (Madigan, 2019; Haltigan, et al., 2019).

One surprising finding was the consensus result that current attachment tools are fit-for-purpose when assessing attachment in children with autism spectrum disorders. Mary Main, Erik

Hesse and colleagues have advocated for this position, but in a context of perceived lack of consensus (Rozga, et al., 2018). During her training institute on the Strange Situation Procedure (2015), Judith Solomon expressed particular caution about the validity of the scoring scales when observing the behaviour of children with known or suspected neurodevelopmental difficulties. Presentations of attachment and neurodevelopmental problems are not mutually exclusive yet differentiating between neurodevelopmental difficulties and problems with other origins is a key diagnostic task in routine practice for children in the UK (Coughlan, et al., 2020). The Coventry Grid (Moran, 2010) is a clinician-developed tool designed to guide practitioners in differentiating between child behaviours that present similarly but are better understood as resulting from either ASD or attachment problems. Reference to the Coventry Grid is not the only way of approaching this, but it is encouraged in some clinical training programmes across the country and used by the Clinical Psychologists in London who piloted the item set for relevance. Despite national curricula for Psychology, it is fairly underspecified and local tradition heavily influences what is taught and used (see BPS, 2019). The Coventry Grid was largely unknown to participants in this study; the lack of familiarity amongst participating clinicians from the East of England suggests regional variations in its use within routine practice (see also Coughlan, et al, *in press*). Of note, concerns regarding the application of theory to case formulations involving known or suspected neurodevelopmental difficulties have been widespread. Mckenzie and Dallos (2017) observed the lack of practice guidance available to help clinicians in distinguishing between indicators of autism spectrum conditions and attachment problems. Meanwhile clinicians (Woolgar & Scott, 2014) and researchers (Coughlan, et al., 2019) have encouraged extra thoughtfulness and caution in the application of attachment theory to such case formulations, given the current state of knowledge. Yet, it is also important to note that children with autism spectrum disorder do demonstrate the full spectrum of secure, insecure and disorganised attachment patterns alongside neurodevelopmental differences (Rozga et al., 2018; Rutgers, et al., 2004; Teague, et al., 2017). It was perhaps with this in mind that participants in this study

supported the use of attachment assessments for children with Autism Spectrum Disorder, alternatively it may reflect a general sense of optimism about the attachment classification framework and a desire for inclusivity across typical and atypical development.

Relatedly, participants were hesitant to comment on whether symptoms of Attention Deficit Hyperactivity Disorder (ADHD) complicate the interpretation of attachment assessments. This finding was also surprising, given empirical work by Stoerbø and colleagues that demonstrates the clear but complex association between ADHD and attachment insecurity (Stoerbø, 2016). They found children classified as disorganised who then received pharmacological treatment for ADHD were assessed as organised at follow-up (Stoerbø, et al., 2014). The authors struggled to explain this finding, but one interpretation is that the medication masked the capacity of participants to exhibit disorganisation in their narratives on the Child Attachment Interview (CAI: Shmeuli, et al., 2008; Target, et al., 2003). When considering this alongside the observed uncertainty about whether attachment assessments focus on the allocation of attention, it perhaps implies that Main's (1995) theoretical conceptualisation of attachment behaviour as attentional processes is indeed invisible to practice and research communities, as suggested by Duschinsky (2020).

Finally, this study found strong consensus that attachment theory is acknowledged as an important framework for making decisions about fostering placements and adoption, but crucially, that the framework is also of relevance outside of specialist fostering and adoption services. This is of particular importance given national treatment recommendations for UK practice are currently only outlined for 'children and young people who are adopted from care, in care or at high risk of going into care' (NICE, 2015: NG26). Evidence to show that both these participant groups of available experts understand the scope of attachment theory to be broader than this should be thought about in the next revision of clinical guidelines. Not least because the recommended attachment-based interventions have since demonstrated effectiveness in

populations beyond those at risk of care (see Steele & Steele, 2018, O'Farrelley, et al., 2021, in press).

5.3. Different perspectives

Overall, this study found clinicians and researchers alike share the same sense of hopefulness about the value and relevance of attachment theory that is apparent in national guidance and policy documents for child mental health practice. Yet, how they understand this and how they use this knowledge was captured by three distinct but overlapping viewpoints. The findings expand on the recent proposals of Duschinsky (2020) and White, et al. (2020) by offering empirically derived models of how attachment concepts are organised according to the available and varying experts. The identified viewpoints represent coherent positions in the discussion and hold their own as contextual narratives. It would not make sense to discuss them in terms of their constituent parts, as it is their contextualised configuration as a whole that makes sense and tells us about how attachment theory is understood and used.

However, they can be seen to reflect different combinations of knowledge-types, as per Drury Hudson's (1997) model of professional knowledge (see Figure 1, Chapter 1). Broadly speaking, interpretation of the factors identified that the factor labeled '*pragmatic, developmental and uncertain perspective'* predominantly reflected a combination of theoretical, procedural and empirical knowledge, and practice wisdom. The '*academic perspective'* reflected theoretical and empirical knowledge only, with a notable reluctance to comment on matters of practice wisdom, and reflected the views of developmental but not social psychology researchers. By contrast, the '*autodidactic, therapeutic and enthusiastic perspective'* reflected fewer expressions of theoretical and empirical knowledge, more notably reflecting practice wisdom, personal knowledge, and some procedural knowledge.

Assessments of professional knowledge might expect to identify different forms and combinations of these knowledge-types. In this study, the professional and occupational

demographics of participants were especially pertinent to the viewpoints identified, as was the perception of their current occupational role. Participants' may have expressed viewpoints that reflected how they saw their contribution to the topic, perhaps responding in line with the tasks and preferred solutions of their ordinary occupational life as much as what they believe or understand about attachment theory. Despite observed individual differences between factors, the viewpoints identified were not wholly distinct from each other, in part due to the high degree of consensus found amongst participants around some key principles but also on agreed areas of uncertainty. Within the viewpoints identified, researchers and clinicians were distinguished by their perspectives on several key issues.

5.3.1. Differences on key issues

The most striking difference of opinion related to claims made about attachment disorganisation and trauma. Allegations that trauma experiences underpin attachment disorganisation and the use of the latter as a proxy for the former were strongly rejected by the research community. By contrast, clinicians on both factors expressed a lack of strong opinion about identifying maltreatment in this way. This was the largest identified area of divergence across the perspectives, and though significant, may be an 'isogenic effect' of an earlier part of the wider Wellcome Trust project on disorganised attachment (Duschinsky, 2014-2020) that funded this research. Significant work has been done in the last five years to analyse the literature surrounding disorganised attachment and table it for discussion with the international research community. The Berkeley conference, January 2017, brought over 40 academics together to review what was known about disorganised attachment and clarify implications for clinical and welfare practice. The resulting consensus statement published later that year (Granqvist, et al., 2017) cautioned strongly against both propositions included in this study. This work was done precisely because of observed controversies in how the available literature was being misinterpreted and misused and required some within the community to actively change their

mind in light of the conceptualisations of child mental health at stake. Thus, the result observed here may in fact reflect the ability of the research community to respond to such consensus-building attempts, as well as suggesting that there is still some way to go in sharing this updated understanding with practice communities. It is important to note that this data was collected prior to the publication of Wilkins (2020) whereby a formal retraction of the claim regarding disorganised attachment as a proxy for maltreatment was made by one of the leading former advocates for this position.

Perhaps, in part, in response to the tension arising from applying a dyadic construct to healthcare systems structured to manage individual pathology, this study identified that some clinicians attempt to avoid implying that attachment problems are located within children themselves by using less- or non-pathologising language in their communication of these concerns. Participants endorsing the *autodidactic, therapeutic and enthusiastic perspective* described attempts to reject the validity of the value-laden term 'attachment disorder' and the disorganised attachment classification, primarily due to the negatively perceived connotations and potential to stigmatise already vulnerable children. This demonstrates an attempt to resist the system's constraints linguistically to some extent but potentially at a cost: such participants felt that attachment knowledge and lexicon wasn't enough for clinical practice, desiring more use of assessment and intervention methods, and often felt their colleagues failed to accurately grasp the concepts and importance of attachment theory for the children and families they work with. In addition, the *autodidactic, therapeutic and enthusiastic perspective* appeared to hold a different theoretical understanding of the key developmental principle of proximity-seeking. This point of view was characterised by a particularly heightened concern about attachment insecurity, so much so that the desire of children with insecure attachments to still want to be close to caregivers when ill or frightened was significantly underestimated compared to the other perspectives. It is not the purpose of this study to judge whether the points of view observed are right or wrong, but it should be noted that this position diverges from the majority of Bowlby's

written conceptualisation of attachment insecurity and conditional strategies (chapter 4, volume 3 is the exception, 1980). Instead, it seems to align better with Crittenden's conceptualisation of attachment strategies as adaptations that have implications for information processing. By contrast, the *pragmatic, developmental and uncertain perspective* appears to better integrate the idea of attachment as a behavioural system, pointing perhaps to an ontological difference between the two, predominantly, clinician-endorsed perspectives.

Views about the implications of early attachment experiences on children's brain development were also markedly different between researchers and clinicians. Though here, the tendency for a clear opinion was reversed: clinicians expressed strong agreement for these claims and researchers were characterised by their wariness to draw conclusions in either direction. Perhaps, as some have speculated (e.g. White, et al., 2020), emphasising associated neurobiology appears to offer scientific credibility to the observations and intuitiations of practitioners working with, and needing to make decisions based upon, children's attachment. Alternatively, neurobiology may appear to characterise something affecting the very 'core' of individual experience and potentially point to a mechanistic explanation, relevant to practitioners. Both implications can be drawn from the work of Schore (2001; 2014), which has been popular with clinical audiences. Certainly, researchers have made significant headway in exploring attachment and neuroscientific correlates. For example, Long, et al. (2020) recently presented a neuro-anatomical model of human attachment from their summary of the available neuroscience data. Yet generally researchers acknowledge that, overall, science has *'only just scratched the rather impenetrable surface of this elusive association'* (van IJzendoorn, et al., 2020 in press, p.200).

Relatedly, researchers strongly rejected the role of temperament in attachment, whereas clinicians expressed a degree of uncertainty or indifference. A review advocating for interaction effects of genes and the environment reported that temperament is a moderator of importance but without a main effect on attachment (van IJzendoorn & Bakermans-Kranenburg, 2012). This nuance was perhaps insufficiently captured by this item and may be responsible for the

divergence in views. There are few other relevant items to aid interpretation here, other than a consensus result that participants lacked an opinion in either direction on whether callousness and unemotional traits in children can be attributed to environmental, specifically attachment, influences. Overall, the findings are limited in what they can offer our understanding of how practitioners make sense of significant character differences in children they encounter and indicate a possible avenue for future research.

Finally, discrepancies regarding suitable treatment targets were identified. The *academic perspective* was strongly in favour of maternal sensitivity as the most effective target for attachment-based interventions, whereas clinicians did not endorse this. Based on analysis of published texts, Duschinsky (2020) has concluded that, outside developmental psychology, Ainsworth's technical use of the concept of sensitivity is little recognised (see section 2.3). Without this insight, he suggests, the ordinary language connotations risk portraying sensitive caregiving as a fluffy 'extra' rather than a crucially determining factor linking caregiving to child socioemotional development and mental health. Instead, the *autodidactic, therapeutic and enthusiastic perspective* favoured using the AAI and targeting parents' internal working models as a target of treatment for their children's wellbeing. This was a common position among attachment researchers in the 1990's (Duschinsky, 2020) and features throughout the psychotherapy-orientated books directed to clinicians. As Duschinsky also notes, meta-analyses are excluded from this literature and thus the finding from Bakermans-Kranenburg, et al. (2003) that interventions targeting internal working models were less effective than those targeting behaviour is unlikely to be known by these clinicians but will have been salient to researchers.

5.4. The role of clinical training, experience and reflective practice

The two identified factors differentiating factor 1 and factor 3 were clinicians' professional occupation and years of clinical experience. The majority of Clinical Psychologists endorsed the *pragmatic, developmental and uncertain perspective*, whereas it was mostly Systemic and other therapists

who gravitated towards the *autodidactic, therapeutic and enthusiastic perspective*. This was true too of the few researchers that loaded on these factors: an academic psychiatrist aligned with the first perspective, and the clinician-researchers aligned with the latter also came from cultures favouring systemic approaches.

Of note, the latter factor consisted of participants with significantly more clinical experience that the former: an additional 9 years on average. Two hypotheses for these findings are considered here. One is that the specific literature and teaching on attachment theory that professionals are exposed to as part of their professional training programs differs and heavily influences their subsequent perspectives about its application for practice. A second hypothesis is that more years of experience may entail more opportunities to encounter the work of other therapists writing about, and offering commercial training on, the psychotherapeutic implications of attachment. The findings suggest the latter is more likely, supported by the supplementary information offered by participants, including the specific texts they were especially familiar with. Many made reference to therapeutically orientated sources of literature from authors such as Patricia Crittenden, David Howe, Dan Hughes, Rudi Dallos, Miriam Silver, Peter Fonagy, Dan Siegel and Kim Golding. This literature appears to be both appealing to and targeted at systemic and other psychotherapists, more than Clinical Psychologists, and generally featured in post-qualification training courses rather than on undergraduate or postgraduate curriculums. This implies a later point of exposure to attachment theory and research and may be a result of clinicians teaching clinicians. These texts and models typically portray attachment insecurity as the underlying mechanism of mental ill-health in general and so offer recommendations for working with many of the problems associated with insecurity, e.g. behavioural problems, misattunement with caregivers, difficulties with play, and positive communication. This may well explain the preponderance of expressed concern for attachment insecurity in the *autodidactic, therapeutic and enthusiastic perspective*.

Alternatively, or additionally, perhaps this perspective incorporates reflection on the totality of professional experience, which may be conceived as a form of wisdom based practice. Råbu & McLeod (2018) interviewed 12 highly experienced, Norweigan psychotherapists, largely from psychodynamic backgrounds. All had experience of research and teaching alongside their therapeutic work and had between 35 and 52 years experience as a therapist. The researchers set out to investigate wisdom within this sample, though framed this to participants as an interest in how being a therapist had influenced their personal lives. In their analysis of how therapists use theory in psychotherapy, they identified the following three themes: 'psychotherapy theories become more helpful as you really get to know them', 'there is always another truth' and 'being clever is not the same as being helpful'. These reflect what scholars of professional knowledge and competence have detailed elsewhere, namely a necessary reliance on concrete experience over scholarly thought. Eraut claims that for practitioners, *'the aim is not knowledge but action. Moreover they also have to believe in what they are doing, rather than question it, because they take responsibility for the consequences. The result is an essentially pragmatic orientation which stresses first-hand experience in preference to abstract principles. So there is a certain subjectivism in the approach, a scepticism about 'book learning' and a belief in the individuality of each distinct case.'* (1994, p.52). With this in mind, we can conceive a pragmatically developed process of practitioner behaviour: decide, believe, act. Reflection-in-action and reflection-on-action (Schön, 1984) then take place, which informs the next round of decisions, beliefs and actions. By cutting into that cycle at a particular point in time and asking individuals to organise a set of information to express their current point of view, we can access snapshot understandings that are underlying their current practice behaviour. This certain subjectivism is part of what this Q-methodology study sought to capture, and the findings suggest that the personal significance of accumulated clinical experience may be part of what brings together and distinguishes clinicians' perspectives from each other. Perhaps from this study we might hypothesise that the more experienced participants came to *believe* in attachment literature the better they got to know it and found it helpful. By contrast, the

researchers and other, generally less experienced but more psychologically trained, clinicians seem to be still deliberating and yet to decide on many matters of applications to practice.

Though much of this part of the discussion is speculative, we can perhaps safely assume that more clinical experience entails greater exposure to clinical uncertainty and complexity, and in turn more opportunities for developing and evolving various 'mindlines' for practice (Gabbay & le May, 2004). Over time, strategies for keeping uncertainty at a manageable level will necessarily develop (see Freeston, et al., 2020) in order for practitioners to feel safe enough to continue facing emotionally demanding work. Writing on the limits of reflective practice in social work, Ferguson (2018) highlighted the need to take account of how practitioners might defend themselves from the sensory and emotional impact of the work. It was with this in mind that brief measures of clinicians' own attachment-related experiences, intolerance to uncertainty and ego resilience were considered of potential relevance and can be followed up in future studies designed with enough statistical power to test the moderating influence of individual factors.

5.5. Strengths

This project was oriented by the premise that clinicians have other ways of knowing and learning things alongside traditional 'book learning', (i.e. through personal and professional experience and critical reflection of practice), and wished to give increased if not equitable status to these other forms of knowledge. A key strength of this work has been the choice of Q-methodology - selected primarily for its ability to empirically capture areas convergence and divergence in understanding. Survey methodology ran the risk of serving as a proxy knowledge-based test, which would have been a poor attempt at evaluating the intelligibility of attachment theory. However, it perhaps remains an attractive option for future research in other contexts, such as investigating the knowledge-base of foster carers or educational professionals and could be a useful tool for evaluating training initiatives with these groups. Attempts to gather the viewpoints of attachment researchers and clinicians using narrative methodologies have been pursued by

other members of our research group, and some publications are forthcoming. However colleagues have found repeated problems and difficulties for participants in characterising their knowledge. This is of course interesting in itself, but it leaves open the research questions that have organised the present project. The decision was therefore taken to a) provide participants with a vocabulary and linguistic structure in order to avoid vaguish rhetoric b) adopt a Q-methodological approach that instructs participants to self-organise their knowledge, rather than hoping for organisation to emerge thematically from the data.

This study built on the limitations of Wilkins' (2016) Q-sort study with child protection social workers, by addressing the need to i) include a more diverse pool of participants and ii) consider how their perspectives are influenced by personal and professional factors. It has been able to examine and compare clinician understandings with those of researchers, with no prior assumptions about who held the authority on recommendations for practice. Crucially, this was done by collectively analysing the perspectives of clinicians and researchers together; as analysing one or other of these stakeholder groups would have resulted in participations imposing their own understanding onto carefully phrased propositions in ways that couldn't be detected. This study has also generated some hypotheses about the impact of specific training opportunities, reading materials and clinicians' professional life courses as mediating factors for the perspectives that they hold, which offer interesting avenues for future research.

A second key strength of the present research was the recruitment of over 30 attachment researchers, which made comparisons between and within participants' perceptions possible. The researchers recruited have demonstrable expertise and include the most widely published contributors in the field. As such, their view is ultimately the academic authority on attachment and can be considered as a good reflection of the views of attachment research. The primary attempt to capture this previously has been Duschisnky's (2020) qualitative impressions from his extensive analysis of the available literature. His work identified several constructs with varying apparent meanings to different stakeholders of attachment knowledge, including distinct

variation between, but also within, developmental and social psychological traditions of attachment research. The results from this Q-sort don't appear to show convergence between the psychological traditions, though this perhaps in part due to differential take up (50% of invited developmentalists vs 20% of invited social psychologists) and the relatively small number of social psychologists who completed the study (n = 5). It is possible that this study identified more with the developmental perspective, as it frequently aligns itself with clinical concerns and psychopathology. By contrast social psychological paradigm has typically had less of a clinical orientation, though, more recently, security priming as an intervention has started to be circulated within clinical practice (see Mikculincer & Shaver, 2007 for review). As a point of comparison, a recent interview study conducted by Spies and Duschinsky (2021, in press) invited 39 researchers across both traditions; 15 of whom accepted the interview, all of whom were developmentalists. In any case, the successful recruitment of international researcher participants was in-part made possible due to the previous work of my primary supervisor, Robbie Duschinsky, to bring together the different corners of the field, and also likely attributable to the increased interest in clinical implications of attachment theory in recent years (Schuengel, et al., 2021, in press).

5.6. Limitations

This doctoral thesis was undertaken whilst working within a small research group with the majority of its members working on projects linked to the same overall investigation of attachment in clinical and social welfare practice, led by Duschinsky. It is possible that by using existing contacts with attachment researchers, the study was immediately identifiable as being connected to the wider project, making some items in the concourse especially salient for colleagues and perhaps leaving participation vulnerable to demand characteristics. Two of the items relating to attachment disorganisation may have been particularly impacted by this, regarding the role of childhood trauma as a causal factor and the use of the classification to

identify maltreatment. It is possible that some degree of social desirability contributed to the degree of difference observed on the latter item, but, more likely, it illustrates that the community of attachment researchers had been influenced by work towards and the publication of Granqvist et al. (2017). In addition, the differential take-up of researchers to participate in the study suggests a potentially striking demand characteristic that may have been an effect of the perception of the research group within the field.

As was anticipated, none of the clinician participants recruited to this study were familiar with the methodology, compared with most of the researchers who were. It was therefore particularly important to conduct the clinician sorts in-person, so that accurate understanding and completion of the task could be supported, and where consistency of item interpretation could be monitored. One necessary item amendment emerged from these observations: some clinicians rejected item #45 - *the most effective interventions target maternal sensitivity* - based on the word 'maternal' rather than because they disagreed with the sentiment of sensitivity as a key treatment target. Although this wording was taken specifically from the meta-analytic findings on this matter, the reality of clinical practice is such that clinicians are often working with other types of caregivers and thus felt unable to sort the item appropriately. Stipulating 'caregiver sensitivity' instead would have resolved this specific issue. A couple of other items were considered by some to be unclear: for example #27 - *attachment disorders are common in children* - wherein clinicians sought clarification as to whether this meant common in general or common in their services; also #38 - *good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern.,* which several participants felt was a tautology. Despite, best attempts to construct a concourse of unique items, using clearly constructed and unambiguous language and void of double propositions, the result is inevitably imperfect and several items may benefit from rephrasing (see appendix J for some suggestions). Q-methodology is generally robust enough that by capturing the personal significance imposed on the items provided and analysing the gestalt configuration, valuable observations can still be interpreted. At this early

exploratory stage of research, this study was able to make a contribution to the literature in spite of linguistic flaws or potential reconstructions of the concourse.

Although the clinician and researcher participant groups used different methods to complete the Q-sort task (physical card sorting vs an online platform, respectively) this is not considered to have had any notable or systematic impact on the observed results. Two clinicians and two researchers agreed to complete the study via both methods to allow for cross-checking between their sorts. Only data from the first sorting attempt was included within the analysis to retain consistency with data collected from the rest of the sample. However, the data obtained from these individual's second sorts were scrutinised by the primary researcher. Alternative-method sorts were not considered to be significantly different from the original sorts because they were very highly correlated and loaded in similar ways onto the identified factor structure. In addition, inclusion of these second sorts in place of the original data did not alter the proposed factor solution or the behaviour of any other sorts in the analysis. As a point of interest, a few researchers who were familiar with Q-sort and completed the study online did report feeling less connected to the items than in previous experiences of physical sorting in other work, but only one researcher felt unable to complete the study due to the method chosen. Overall, the impact of using different data collection methods in this case was considered minimal.

Q-sort data ultimately offers a one-time snapshot of participants' relationship with discourse. What this study is unable to account for is how these identified perspectives may play out in examples of case discussion, clinical reasoning and practice behaviour; it may be, for example, that different points of view come to the forefront under different circumstances. However, practice behaviour is specific to a given case and therefore investigations of this would have to choose whether to examine clinicians working on different cases or to provide a standard case-vignette. In both scenarios, other sources of knowledge (e.g. context, practical experience, etc, as per Figure 1, Chapter 1) become relevant and extend what is being observed outside of

the focus on attachment theory. Likewise, academic researchers do not 'behave' in clinical contexts, meaning studies aimed at the level of belief are one of the only ways to discern knowledge and understanding between researchers and other participants groups. Assessments of vignette-based reasoning (see upcoming work by my colleagues Foster, et al., and Coughlan, et al., for examples) and actual observations of practice will nonetheless contribute further insights to the study of practitioners. Indeed, such work will usefully link observations of understanding with actual use of attachment theory and research.

5.7. Future directions

The results of this study suggest examining regional variations in understanding across the UK would be important. Clinical networks are likely regional more than they are national because at a local level they are led by individuals who work in the area and contribute to training others in the area. This is particularly true for regions outside of London and the South East, where there is little travel in or out (only within) for training and conferences (in part due to relative travel costs), whereas there is greater mobility for professional development within the rest of the country. This would be especially interesting for identifying and sharing aspects of best practice. It may also be able to better demonstrate the role of local and national policy in shaping practice priorities. International investigations of perspectives and practice behaviour would also offer valuable insights to this aim but may rely on future research to establish robust associations between understanding of attachment theory and individual factors, otherwise direct comparability will be limited by the strong influence of contextual factors.

The section of this chapter discussing differences on key issues points to a number of issues that could be explored in future research. Perhaps most crucially, the tension arising from the desire for individual level assessment measures and implications for case conceptualisations is unlikely to dissipate spontaneously, given the classification framework has continued prominence in academia, practice literature and policy. The 'treatment utility of assessment' is a

concept from the behavioural literature used to describe *'the degree to which assessment is shown to contribute to beneficial outcome'* (Hayes, et al., 1987, p963). Examinations of the treatment utility of attachment assessments, across clinical and social welfare practice, would likely be illuminating and influential for the perceived intelligibility of attachment theory and research for all relevant stakeholders.

Chapter 6

6

CONCLUSIONS AND REFLECTIONS

Despite generations of literature proposing what clinicians should do with attachment theory and research, there has been almost no empirical investigation of how this has shaped practitioner understanding. This study used Q-methodology to capture the perspectives held, but the viewpoints identified were highly correlated and thus do not reflect distinct entities. We can conclude therefore that practice-based conceptualisations of attachment theory are not operating as entirely different types but neither do they form a single whole: that is to say, there is a set of shared understanding between research and clinicians, and amongst clinicians themselves, but also some distinct axes of divergence.

Previous historical work on the emergence of attachment concepts suggests that one reason for this is that it has not been a priority of researchers to make much of the technical knowledge accessible outside of empirical science (Duschinsky, 2020). This means clinicians have struggled to access specialist knowledge and measurement instruments, and this study found evidence that researchers are aware of this. It may be that it has not been in the interests of the research community to share these tools widely with practice communities, in part because the nuances of coding practices cannot be grasped without deep and continued immersion in the manuals. Nevertheless, the result is that some niceties of the paradigm subsequently remain both pervasive and niche; the resulting gaps in understanding appear to have been filled in by other sources of information, most notably guidance texts written for audiences of psychotherapists,

which frequently depart in marked ways from the positions of academic researchers on attachment. Another factor shaping the reception of attachment research is also likely the service contexts that public healthcare workers operate in, set-up to treat individual pathologies and stipulating for instance that interventions are only available to those with formally diagnosable mental health problems; whereas at other times, the search for additional learning materials and ideas is driven by personal interests or clinical hunches (e.g. tacit knowledge). Such variations in the way practice knowledge is acquired and integrated can produce differences in understanding on important aspects of this topic. In particular, correlates associated with having more years of clinical experience indicated a degree of mindline-evolution that was more reflective of learning from clinical experiences and the pursuit of psychotherapeutic models that offer face validity with these experiences, than from theoretical or empirical knowledge-bases.

This study hoped to elevate the status of practice-based knowledge and not to condemn it from a positivist standpoint of alleged accuracy, though without abandoning accuracy as a criterion of evaluation and reflection. Research theories are of course just that: theories, subject to hypothesis-testing and various tests of validity, and which in the context of practice should include evaluations of intelligibility (de Regt, 2020). However, as Tversky and Kahneman highlight, some biases in judgement reveal heuristics used in decision-making under uncertainty, and it is possible that clinicians with more experience also have greater exposure to uncertainty and are at greater risk of such biases.

In sum, while the search for gaps, misunderstandings and divergences between and within researchers and clinicians appears to return some real results, many of these are understandable with some awareness of their different experiences, interests and expertise. It is the commonalities that are in fact much larger and, on the whole, were less anticipated by others in the field. In a forthcoming paper in *Attachment and Human Development Special Issue (February, 2021),* Dagan & Bernard (2021) propose that the research field needs to do more *"'in-house cleaning' before trying to relay any unified messages to clinical practitioners and the public regarding what*

attachment can tell us about mental health and well-being" (p.4). It is hoped that the field will be particularly interested in the results of this study and perhaps find it reassuring that many of the central tenets of attachment theory are understood similarly by researchers and clinicians.

6.1. What can we see through the telescope now?

Chapter 1 proposed that clinicians' 'machine' (previously conceptualised as a telescope) for knowing about attachment theory was tuned to a degree that offered only a 'blurry picture' to clinicians. Certainly, the first factor identified in this study - *the pragmatic, developmental and uncertain perspective* - seems aligned with this idea, as it was partially characterised by an unknownness regarding what to actually do with much of the knowledge and ideas purported in the literature, and a sense that many claims made about the use of attachment concepts in clinical practice could not be clearly supported nor rejected. Similarly, the second factor - *the academic perspective* - was also, in-part, characterised by a hesitancy to comment on many of the proposed applications for clinical practice, perhaps because those with this perspective perceived less authority to comment on such matters, or perhaps because they too struggled to be specific about implications for practice.

To reiterate Pickering's (2010/2015) conceptual illustration, Reijman, et al., (2018) argued that the point of interactive stabilisation in the knowledge-base was settled upon by the academic communities - namely that the classification systems of attachment patterns in infancy (Ainsworth, 1969) and adulthood (Main, 1985) operationalised Bowlby's theory to a sufficient enough degree that enabled substantive research programs. Traditionally, outputs from these have been population-level analysis of hypothesised causal factors regarding caregiving environments, much of which has helpfully focused on developmental sequelae and, more recently, begun the development of evidence-based caregiving interventions with beneficial outcomes for children and their caregivers (Steele & Steele, 2018). Though these interventions have been prioritised within developmental attachment research, clinically-useable assessment

tools have not, leading to muddled recommendations in the UK about how to identify families in need of these (e.g. NICE guidelines, 2015). We might then conclude that the lack of precision in expressed applications for clinical practice was successfully detected by the first two factors, and suggests that: *to see a blurry picture clearly is to see a blurry picture.*

6.2. Last words from a clinician-researcher

It is clear from this study that all participants aspire to greater precision of understanding and application, with clinicians especially favouring greater precision in assessment. However, both research programmes and clinical services are bound in part by priorities that are set at a national level for these domains, sometimes (perhaps more directly in the latter case) with overt governmental influence such as the distribution of public funding aligned to these priorities. Currently, the UK guidelines recommend all healthcare practitioners assess attachment in children in or on the edge of care and offer video-feedback interventions where appropriate (NICE, 2015). Yet, little funding for training in such assessments or interventions is offered and nor are they actually aligned with the commissioning and outcome evaluations of such services. Moreover, in the absence of clinically-usable assessment tools disseminated to, or developed with, clinicians from robust empirical work, clinicians use their toolbox of reflective practice, supervision, continuing professional development and personal experiences to develop their own mindlines for assessing attachment and interpreting what it means. In the case of ASD, for example, this has included clinicians' developing their own instruments to achieve this, but with regional variation in uptake. There will undoubtedly be other examples of this available in practice, as clinicians innovate and ultimately pursue what is helpful rather than - necessarily - what is 'right'.

One question arising from this thesis that faces both the research and clinical communities, is to what extent are we happy with the current point of stabilization? As previously stated, it is - at least, conceptually - possible to re-focus the parameters of this

'picture', to best suit different priorities or demands of the instrument. On the one hand, recognising that research and practice communities have different needs and priorities might foster a broader acceptance that in order to navigate these different domains there will necessarily be elements of conceptual or attitudinal divergence. (Of course, some divergences have been grievous misuses that were rightly contested and condemned - such as, the use of disorganised attachment in child welfare risk assessments, and in previous interventions that used non-contingent physical restraint or coercion, known as 'holding' therapies; see Zeanah, et al., 2016). On the other hand, some arguably exaggerated claims may serve a purpose - such as offering hope or containment in the face of high emotional distress and challenging interpersonal dynamics. For instance, when encountering numerous barriers to offering care and intervention to vulnerable children and families, clinicians may find valuable meaning in persevering on the proviso such that early attachment experiences can shape brain development and thus their attempts - although challenging - will be significantly impactful.

There are perhaps functional benefits to claims that are vague, left open to interpretation, or that unintentionally serve up boundary objects. Though feared initially that overfull terminology would enable stakeholders to talk past each other - with each party imposing their own understanding on key concepts and translating subsequent communication in line with their idiographic conceptualisations - perhaps the use of polyvalent constructs also enable stakeholders, and perhaps a more diverse range of stakeholders, to talk *to* each other in ways that previously required specialist language or certain occupational status to do so. Certainly, Duschinsky (2020) illustrated how widespread conceptual imprecision is within the attachment research paradigm, and the findings reported here offer some evidence of the same in clinical circles. Yet, maybe this has helped attachment theory to travel and inhabit corners of policy and popular science to the degree that it has. Nevertheless, while imprecision may have benefits for overall discourse and general utility it is less helpful for individual case conceptualisation, and indeed it is this juncture that seems to act as a nodal point for diverging and morphing

mindlines. Unfortunately, this prohibits agreement around which assessments can and should be used, and for what purposes; it also limits the identification of best practice and, in turn, a degree of standardisation in best practice delivery. Imprecision of attachment concepts parallel the conditional strategy of the avoidant attachment classification in this way: in the immediate term, it 'keeps the show on the road' (i.e. it maintains proximity to the caregiver or sustains attention to attachment principles) but in the long-term it prohibits genuine opportunity for engagement and perhaps falls short of being able to deliver the degree of personalised care that clinicians and researchers aspire to.

Personal reflexivity

This work is conducted from my perspective as both a doctoral researcher and as a qualified and practicing clinician. As a Clinical Psychologist, I was trained in the "scientist-practitioner" model (credited in the US to Boulder, 1949, and in the UK to Shapiro, 1985), to take a scientific approach to clinical psychology and to conceptualise such practice as a branch of psychological science.

I approached the topic of understanding and applying attachment theory both as a trainee clinician and through previous research exploring potential developmental origins of the transdiagnostic anxiety mechanism, intolerance of uncertainty (Freeston, et al., 1994).

In line with a scientist-practitioner model, the construct intolerance of uncertainty (IU) emerged from clinical observations when seeking to identify the key cognitive feature of Generalized Anxiety Disorder, and the associated IU scale is now used frequently as a measure and predictor of clinical symptoms across a range of psychopathologies (McEvoy, et al., 2019). Having identified from longitudinal work that attachment classifications at aged 6 predicted IU at aged 20 (Zdebik, et al. 2017), and cross-sectional evidence that suggested IU mediates the relationship between attachment and worry in young adults (Wright, et al., 2017), I became

interested in the role of early attachment experiences in the development of IU and how such knowledge could be optimally applied to developing psychological treatments.

In speculating what secure attachment offers that may be relevant to IU, my supervisor Mark Freeston and I considered the following: i) opportunities for exploration that inevitably lead to encounters with (presumably developmentally appropriate levels of) uncertainty, ii) opportunities to learn skills of emotional self-regulation (that can become internalised), iii) non-catastrophic appraisals of and corrective feedback (particularly pertinent within a cognitive-behavioural framework), and iv) a safe haven to return to if or when things go wrong (Beckwith, 2016, unpublished thesis, supervised by Freeston & Duschinsky). These aspects of attachment security may offer proportional salience to experiences of uncertainty and the potential to experience uncertainty in a way that fosters curiosity, approach and positive appraisals, rather than as cognitively, emotionally and physiologically aversive or intolerable. One way to specifically operationalise this knowledge for clinical practice, we thought, could be to develop compensatory solutions, as prevention or intervention, by providing opportunities to learn things as an adolescent or adult that were not learned early on.

Given the particular focus on cognitive-behavioural therapies for psychopathology in UK practice, we questioned, 'if attachment is a problem how do our current treatments e.g. CBT work?'. These broader questions relating to how clinicians currently understand and use attachment theory for clinical practice gained traction in my attempts as a trainee to penetrate the rhetoric of colleagues, services and applied literature in order to learn. I grew increasingly frustrated by frequent references to attachment language and concepts, with some claiming this knowledge and understanding distinguished clinical psychology from our medical colleagues in psychiatry but were all-too-often offered only in generic and non-specific ways.

Whilst attachment-specific interventions do exist, these are not generally considered within the remit of the public health service in which I was training. Instead, my colleagues were attempting to integrate their knowledge of attachment theory into other types of work, yet

apparently without recognition that they were having to do the heavy-lifting of translating terms and ideas on their own, and, perhaps more importantly, that they seemed to be doing so in different ways. Despite frustration and confusion, the volume of associated literature and pervasive enthusiasm from colleagues (and indeed lay public) around the topic of attachment theory and its utility for clinical practice, retained my curiosity enough to embark on this project.

It was in an early discussion of this project (2017) that Mark, Robbie and I tried to describe IU in attachment terms, and settled on 'feeling unsafe in the absence of threat'. Mark and colleagues have taken this conceptualisation forward in programmatic work at Newcastle University, and most recently applied this to developing their model of uncertainty distress in the context of the coronavirus pandemic. Meanwhile, I have focused on deep-diving into the attachment field with Robbie and learning about sociology along the way.

I have continued to work in clinical practice alongside conducting this work. A key challenge has been the swapping of hats (clinician and researcher) and sometimes, being unsure which hat I've got on as I'm speaking/thinking/writing. Reflecting on and hypothesising about my own clinical experiences with colleagues and services was encouraged by my research supervisors, and the choice of using Q-sort offered a methodological way to integrate these ideas with scholarly permission for ipsative decision-making. Given the early stage of this research area, it was not difficult to find the academic gap in which to situate this study, and I haven't had to fight for why I was a good person to conduct it.

In writing the introduction chapter, I sought to reflect the interdisciplinary position I found myself in: an applied psychologist, in a research institute for public health, primarily supervised by an expert in sociological theory (amongst other things) and parented by an expert in professional education pedagogy. Reviewing and synthesising relevant literature for Chapter 2 and development of the concourse was the most academically challenging and felt furthest away from the other parts of me trying to establish myself as a newly qualified clinician in adult secondary care. As a result, some aspects of the reporting remain, unapologetically,

impressionistic: they are my impressions, as a clinician reading the variety of literature, whilst juggling other things, and trying to make sense of it in order to apply it to practice or understand how others are. In addition, they are informed by Robbie's impressions, as a sociologist analysing the historical development and function of ideas using attachment theory as a case study but finding himself limited by a lack of empirical data on which to draw upon.

The methods and results chapters were more familiar ground to me as a researcher due to previous experience in quantitative empirical work, but the methodology was new and these sections were hugely enhanced by the support of Marinus van IJzendoorn. He was able to hold in mind and offer insight of both Q-sort data and attachment research, which provided a necessary safe haven when straddling disciplines and embarking on exploratory work felt overwhelming disorientating. Fortunately, I was also able to draw on the professional experiences and wisdom of Matt Woolgar, psychological lead of two national children's services in London, and his extensive knowledge about this topic gleaned from training multitudes of professionals, foster carers and third-sector organisations on matters of attachment. Matt's input into the concourse and in recognising the viewpoints that emerged from the data offered precious face-validity.

I floated initial ideas about the data at the International Attachment Conference in Vancouver, 2019 and was encouraged to keep going by the warm reception I received for this kind of work. With renewed confidence I had fun interpreting the results using all the information available to me. Articulating the discussion chapter has been a whole team effort, as the increased labour needed in the healthcare service due to the ongoing coronavirus pandemic, and looming threat of redeployment, has demanded much of my energy and brainpower.

I understand that the aim of clinical research, and one part of being a scientist-practitioner, is to move from clinical observation to more systematic data, and back again to patient care. What my previous experience of this in professional training taught me was that the outcome of research is generally not answers but better questions. The widespread under-

recognition of framing attachment behaviour as processes of attention is of particular interest to me, as it seems the most easily transferable to our existing treatment paradigms centred on cognitive and behavioural theories - this was, after all, my starting point for this work. I was pleased to see that Dagan & Bernard (2021, in press) also highlighted this in their commentary piece on clinical conundrums and engaging with adjunct disciplines, and it suggests there may be a place for me in the next steps of this work. Finally, I notice I have developed empathy for the imprecision that first frustrated me. I have a greater appreciation of how it has emerged from the perspective of attachment research, and I now consider that for clinicians it may help to keep uncertainty at manageable levels that feel 'safe enough' to make decisions and act; as this, ultimately, is our job.

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Appendices

APPENDIX A

[Reproduced Table 5.1 from Duschinsky (2020), p.473]

	Broad meaning Used by social psychologists + a few developmentalists like Cassidy and Fonagy	**Narrow meaning** Used by Main, Waters, and the large majority of other developmental psychologists
Safe haven function of attachment	The orientation to seek physical or symbolic comfort from close relationships under conditions of perceived threat.	The capacity to trust in the physical and attentional availability of discriminated familiar individuals under conditions of perceived threat.
Secure base function of attachment	The capacity of close relationships to provide felt security.	The capacity to trust that attention can be turned to exploration, given the expectation of the availability of discriminated familiar individuals.
Conditional strategies	The hyperactivation or deactivation of the orientation to seek physical or symbolic comfort from close relationships.	A species-wide repertoire made available by evolutionary processes, for manipulating the activation of the attachment behavioural system through the direction of attention vigilantly towards or away from cues about the availability of familiar caregivers or potential threats. This repertoire evolved because it has the predictable outcoming of increasing the availability and support provided by attachment figures who may others be unavailable. Other ways of manipulating or overriding the output of the attachment behavioural systems exist and become increasingly available with developmental maturation. They can also be described as strategies. However, they are not conditional strategies in this technical sense unless - like the redirection of attention- they can be considered to express a specie-wide repertoire, made available by evolutionary processes.
Internal working models	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.	Variously: 1) Expectations about the availability of attachment figures 2) Elaborated symbolic meanings and images held by humans about attachment figures and their availability 3) A synonym for attachment representations, as used by Main in the 1980s (but subsequently abandoned).

Department of Public Health and Primary Care
Helen Beckwith [EMAIL REDACTED]

APPENDIX B: Recruitment leaflet

Are you a clinician working with children and adolescents?

Take part in our research study!

Researchers working with The Wellcome Trust are looking to investigate how and when clinicians use their knowledge of attachment theory and research in clinical practice.

To take part you must:

- Be a qualified healthcare professional
- Have been in professional practice for at least one year
- Be working psychologically or delivering psychological therapies with clients
- Willing to spend up to 90minutes participating in a research study

Participation can be done face-to-face with a researcher at a time and location that is convenient for you, including at your place of work. Alternatively the study can be completed online if you prefer.

This project has been approved by Cambridge Psychology Research Ethics Committee and is covered under the insurance of University of Cambridge.

For further details, please contact:
Dr. Helen Beckwith [EMAIL REDACTED]

APPENDIX C: Proof of insurance

UNIVERSITY OF CAMBRIDGE
Finance Division

Gill Armstrong
Head of Insurance

To Whom It May Concern

1st August 2018

Dear Sirs

University of Cambridge – Confirmation of Insurance

This letter together with the attached certificates confirms that the following insurance covers are arranged for the University of Cambridge for the period 1st August 2018 to 31st July 2019.

Public Liability	£50,000,000 any one occurrence
Professional Indemnity	£10,000,000 any one occurrence and in the aggregate

The cover provided is subject to the relevant insurance policy terms and conditions.

Yours faithfully

[redacted]

Gill Armstrong
Head of Insurance

Greenwich House
Madingley Rise, Madingley Road
Cambridge
CB3 0TX

Tel: +44 (0) 1223 339659
Fax: +44 (0) 1223 765988
Email: @admin.cam.ac.uk
www.cam.ac.uk

UNIVERSITY OF CAMBRIDGE
Finance Division

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Head of Insurance

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Yours faithfully

[redacted]

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Head of Insurance

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www.cam.ac.uk

APPENDIX D: ETHICAL APPROVAL

Karen Douglas
Secretary

Dr R Duschinsky
Department of Public Health and Primary Care
University of Cambridge

UNIVERSITY OF CAMBRIDGE

CAMBRIDGE
PSYCHOLOGY RESEARCH
ETHICS COMMITTEE

16 May 2017

Application No: PRE.2017.002

Dear Dr Duschinsky

How and when do Clinical Psychologists use attachment theory in clinical practice?

The Cambridge Psychology Research Ethics Committee has given ethical approval to your research project: "How and when do Clinical Psychologists use attachment theory in clinical practice?" as set out in your application dated 12 January 2017.

The Committee attaches certain standard conditions to all ethical approvals. These are:

(a) that if the staff conducting the research should change, any new staff should read the application submitted to the Committee for ethical approval and this letter (and any subsequent letter concerning this application for ethical approval);
(b) that if the procedures used in the research project should change or the project itself should be changed, you should consider whether it is necessary to submit a further application for any modified or additional procedures to be approved;
(c) that if the employment or departmental affiliation of the staff should change, you should notify us of that fact.

Members of the Committee also ask that you inform them should you encounter any unexpected ethical issues.

If you would let us know that you are able to accept these conditions, we will record that you have been given ethical approval.

Please note that there have been changes to the procedures regarding amendments. Full details are given on the REC website.

Yours sincerely

pp [redacted]

K S Douglas

cc Dr H Beckwith

APPENDIX E: HEALTH RESEARCH AUTHORITY APPROVAL

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS Health Research Authority

Dr Robbie Duschinsky
Department of Public Health and Primary Care
Box 113 Cambridge Biomedical Campus
Cambridge
CB2 0SR

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

07 September 2018

Dear Dr Duschinsky

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Clinical applications of attachment theory**
IRAS project ID:	**222833**
Protocol number:	**6**
Sponsor	**Cambridgeshire and Peterborough NHS Foundation Trust and the University of Cambridge**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

Department of Public Health and Primary Care
Helen Beckwith [EMAIL REDACTED]

APPENDIX F: PARTICIPANT INFORMATION SHEET

Participant Information Sheet v1.1
Clinical applications of attachment theory

Who are the researchers involved in this project?
The researchers involved in this project are Dr Helen Beckwith [EMAIL REDACTED] and Dr Robbie Duschinsky (supervisor; [EMAIL REDACTED].

What is the purpose of this study and why have I been given this information?
The purpose of this study is to find out how attachment theory is being used and understood within clinical practice. We know that Clinical Psychologists and other practitioners have knowledge of attachment theory from their teaching and training in areas such as child development and psychopathology. You have been given this information because you work in clinical practice with children, adolescents and their families, and we are interested in how and when you use this knowledge in your work.

What will happen to me if I take part?
If you decide to take part, you will be asked to provide written consent to do so before proceeding. You will then be asked to complete some questionnaires, followed by a card-sorting task focused on elements of your own work and practice. The whole process will take no more than 90 minutes. The task will require you to sort a number of statements based on the extent to which you agree or disagree with regards to your practice. You are encouraged to discuss the process of sorting the cards as you go with the researcher, who is particularly interested in your thinking, reasoning and decision-making processes. With your permission, the researcher will make an audio recording of this process and the resulting conversation between you because it can provide valuable insights into the complexities the area. If you not wish not to be audio-recorded you can indicate this on the consent form and still take part in the study. Alternatively, you can complete this study online via the platform Q-assessor which offers opportunities for providing written feedback about your reasoning process.

Do I have to take part?
No, you do not have to take part. Participation in the study is entirely voluntary, it is up to you whether or not you decide to take part. If you do decide to take part and give written consent to do so you are still free to change your mind and withdraw your data from the study, without giving a reason. This will not affect any aspect of your employment, professional registration or participation in future research studies.

What are the advantages and disadvantages to taking part?
By taking part in this study you will contribute to the understanding of how attachment theory is applied to real-life clinical work. It is expected that understanding this from practitioners' viewpoints will identify examples of best practice, identify theory-practice gaps and have implications for policy recommendations and treatment development.
The researchers do not anticipate any disadvantages to taking part; however, it is possible that reflecting on your professional work could elicit some distress or unease. You will have the opportunity to discuss any concerns with the researcher before taking part. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Jonathon Mant at [EMAIL REDACTED] who is the Professor of Primary Care at University of Cambridge.

Will taking part in the study cost me anything?
Taking part in this study will not incur any direct financial costs; it will only involve your time. You will be offered a £30 voucher by the researcher in recognition of the time given to participating in this study.

Who will know that I am participating in the study?
Only members of the research team will know about your participation in this study, alongside anyone else you wish to tell.

Will the study require any clinical information and what is the confidentiality agreement for this?
The researchers do not anticipate that any clinically relevant information will arise from the study. Participants will be made aware of the limits of confidentiality - in the unlikely circumstance that a practitioner discloses information regarding harm to a child or other person; this information will be shared to appropriately manage the risk. This is in accordance with the British Psychological Society Code of Human Ethics p.22) emphasising the need to override the duty of confidentiality in exceptional circumstances in order to uphold the researcher's duty to protect individuals from harm
(http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf)

Who will have access to information collected about me during this study?
The University of Cambridge and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) are joint-sponsors for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controllers for this study. This means that we are responsible for looking after your information and using it properly. The University and CPFT will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting the research team.
The Windsor Research Unit in CPFT will use your name, and place of work details to contact you about the research study, and make sure that relevant information about the study is recorded, and to oversee the quality of the study. Individuals from these sponsor organisations and

regulatory organisations may look at your research records to check the accuracy of the research study. The Windsor Research Unit will pass these details to the University of Cambridge and CPFT along with the information collected from you. The only people in the University of Cambridge and CPFT who will have access to information that identifies you will be people who need to contact you to organise participation in the study or audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or work contact details.

Who is organising this research?
Dr Helen Beckwith (Clinical Psychologist) is conducting this study, supervised by researchers from University of Cambridge, King's College London, and Newcastle University. Any concerns or complaints about the study can be directed to Jonathon Mant, [EMAIL REDACTED].

Who is funding this research?
This project is funding by The Wellcome Trust via a New Investigator Award held by Helen's supervisor Dr Robbie Duschinsky at University of Cambridge (Grant WT103343MA) and supported by The School of Primary Care Research Funding Round 15 (Grant 392).

What will happen to the results of the research?
The results of the study will be collated, analysed, written up and submitted for publication in an academic journal and in partial fulfilment of a PhD dissertation to the University of Cambridge. The results may also be presented at scientific conferences. Direct quotes from interviews may be included alongside general findings, however all quotes and findings will be anonymised, and you and the data you have provided will not be personally identifiable in any outputs. If you would like to receive a summary of the results of the study you can make this known to the researcher by indicating so on the consent form.

Thank you for taking the time to read this information sheet.

Department of Public Health and Primary Care
Helen Beckwith [EMAIL REDACTED]

Participant Consent Form v1.0

How and when do practitioners use knowledge of attachment theory and research in clinical practice?

Research team: Dr Helen Beckwith (primary researcher) and Dr Robbie Duschinsky (supervisor).

Please initial each box to indicate your agreement with the following:

1. I confirm that I have read and understood what this study will involve and the Participant Information Sheet v1.1 provided. I have had the opportunity to ask questions and am satisfied with the answers I have been given. ☐

2. I am aware that my participation is voluntary, and that I am free to withdraw from the study at any time. If I want to withdraw, I know that I can do so without giving a reason, and that this will not affect any aspect of my employment or participation in future research studies. ☐

3. I agree to take part in the study. ☐

4. I give consent for the research appointment to be audio-recorded. I am aware that the recording will be stored securely and anonymously. I understand that appropriate measures will be taken to protect my identity and that the recording will be used for the purposes of this study only. [face-to-face only] ☐

5. I would like to receive a summary of the results of this study and am happy to provide my E-mail address for this purpose. ☐

Participant Name:	Researcher Name:
Participant Signature:	Researcher Signature:
Date:	Date:

APPENDIX G: BRIEF INTERVIEW WITH CLINICAL PSYCHOLOGIST

Interview with Clinical Psychologist working across two services: Perinatal Mental Health and a Looked After Children's (LAC) service.

Please reflect on your recent casework where principles of attachment theory were central to your understanding of the child/family, and/or the work you carried out with them.

In the LAC service it underlies all the work. We mainly use a DDP approach to therapy as all behaviours are stemming from insecure attachment. But I also use attachment in consultation with foster carers and in formulation. We also run attachment groups based on Kim Golding's book nurturing attachments.

How does knowledge of theory and research inform you work with regards to your assessment, formulation, intervention or evaluation? Which area of your clinical work do you most/least consider ideas from attachment theory?

I don't know really. I haven't been doing anything in terms of evaluating – but need to for commissioning purposes. I wouldn't ever intentionally create a separation and reunion, but we look at that stuff throughout. It's just in everything really.

Please tell me about a case that is relatively typical or representative of the people you work with on a regular basis where attachment was relevant but not of primary importance to your understanding or the work you carried out with them.

Attachment is always of primary importance for LAC. It is a bit different with perinatal – for example, we may focus more on risk or OCD, and we can only work with them for up to 12months, so it is not appropriate to focus on their own trauma then.

How often do you refer to attachment with your colleagues and/or families and what language might you use to discuss this?

Try to use language that is as simple as possible. Neuro-stuff and importance of early years. Secure base, safe place to refer to/safe haven. Avoidance, exploration, sensitivity, attachment patterns, hyper-vigilance, emotion regulation.

What do you understand by terms such as attachment problem, attachment disorganisation, attachment disorder?

I would speak about attachment difficulties mostly. Most of the kids we see and the behaviours that come with them are disorganised – very "push and pull". I probably use this word [disorganised] interchangeably with difficulties, or high-level attachment behaviours. Disorder is more diagnostic, more medicalised, we get people referred with that but it's not formally assessed or recorded. I'd always be wary about using the term 'disorder'.

What problems do you associate with the lack of a secure attachment?

Cognitive issues – brain development and high-level functioning, making friendships, social issues, most/all close relationships, conduct disorders, lying/cheating/stealing, manipulative behaviours, getting their own way, controlling behaviour, risk-taking behaviours, self-harm/suicidal thoughts – sexual exploitation and vulnerable positions, early pregnancies, housing (later life conduct problems), abandonment, "everything, it affects everything", also education – ability to concentrate, and settle in a class and manage the frustrations of going through school, and impact on employment.

APPENDIX H: NOTES FROM FOCUS GROUP

Some points made on the feedback forms in response to the question 'what is one thing you could do in your role as a result of the seminar' were:

· Be more confident in challenging the language of some clinicians and/or being more understanding of what the discussions mean.

I ran an attachment group session today where we used your 'John Bowlby and contemporary issues of clinical diagnosis' paper as the basis for the discussion.

There were 32 attendees, and – after summarising key points from the paper – I provided the following as suggested topics for discussion:

Your use of and views on labelling in your practice:

- Do you ever use diagnoses and/or other terms such as 'attachment problems' or 'disorganised attachment' to label children's expressions of distress? Which do you use? How do you use them?
- Why do you/don't you? What are the benefits and challenges?

The level at which you focus in your practice interpretations:

- How valuable for your practice is the use of classifications (including diagnoses) to compare one child to others, versus an individual approach (such as formulation) to consider what is unique about the child?
- Is there some value in a combination of the two?

Your views on when attachment is most useful:

- Is attachment theory and research most useful in practice when classifying and comparing, or when adopting an individual approach, or both?

The discussion from the group that I was able to capture is as follows. Whilst I have written these points in the first person, they should be considered paraphrased rather than verbatim. Points in brackets are my reflections. Where I knew their profession I have noted this too:

· A Clinical Psychologist: I don't use diagnoses in practice, despite some pressure to do so, but there is another type of general pattern that can be drawn on in practice, and this is what I often drawn on : 'patterns that we develop ourselves, based on our clinical experience'.

· A Clinical Psychologist: the paper doesn't mention ADHD as one of the possible diagnoses for the behaviour of Bowlby's first patient, but that's the path I would have been investigating (there were quite a few nods from others).

· When I get a referral that states 'attachment problems' I think, well what does that mean? It scratches the surface only. I think it is used when people aren't sure what's going on.

· We ask is it ADHD or attachment, or is it autism or attachment. We tend to talk in either/or terms rather than about diagnoses and attachment together. (Such a shame/wasted opportunity when we know they interact).

· A Clinical Psychologist: we have system that require definitions, and they justify resources and also make us feel safe. Not knowing is seen as unprofessional. (This was said with a smile and nod to the issues with this statement/view).

· Labels/diagnoses provide access to funding for those in schools.

· An Assistant Psychologist working in a secure unit: people come to us with lots of diagnoses, often with 'suspected' in front of them and we work hard to try to get them away from the labels. We tend to try to get them away from the labels by using the term 'attachment disorder'. (I found this comment fascinating in the sense that this implied that they were not seeing the term attachment disorder as a problematic label in the way they were seeing diagnostic labels as problematic). I hadn't realised attachment disorder means something different to what I thought it meant. (Again, fascinating!) A Clinical Psychologist replied: But you are using it to try to be

helpful. The Assistant Psychologist replied: But is it? (So nice to see someone questioning something for the first time!)

- I was thinking about the seeking of a diagnosis and who does that. Sometimes it is families driving that. (This led to a discussion about how a diagnosis and situating the problem in the child can feel less threatening to parents than attachment and considering their own role in the behaviour).
- Attachment can help open the discussion with parents. Another person: But attachment can also lead to guilt/shame/blame so I try not to use the term even when I am thinking in attachment terms. The guilt can be really bad and can open more wounds and compound the problems. A Clinical Psychologist: The response to the term attachment feels starkly different depending on whether I am talking to birth parents or foster/adoptive parents. The latter are very open to it, because they view it as all about the past. (I think it is really interesting how foster/adoptive parents may therefore only be getting half the benefit of the insight attachment theory can give them – i.e. they are using it to understand the past origins of their children's behaviour, but not to understand the impact of their own behaviour).
- I tend to use the word attachment and then the word disorder gets added to the word attachment by someone else and I think 'where did that come from?'
- There are people carrying labels with them and they make no sense to them. Another: A lot of people tell me the labels don't explain how they feel. A Clinical Psychologist: But diagnoses weren't intended to. Their purpose is just to describe, not explain. Another: Diagnoses don't tell us the why but the what. (I think this point nicely supports the point in the paper that it is important to recognise which level we are working at, and that the issue is not with diagnosis but when we are using diagnosis with the goal of formulation).
- I try to help people understand that attachment is about interactions and not something bad.
- (In response to the point about terms like 'attachment problems' being fuzzy) A Clinical Psychologist: Is there a problem with wooly and fuzzy? (My thought on this is that fuzziness can have a purpose but the problem is when people don't recognise the fuzziness, and think they are using an uncontested/precise term. I highlighted that a professional could have developed their own very clear definition of 'attachment issues' and always use the term in a very considered and consistent way, but that if they only communicate the term 'attachment issues' and not all their thinking about how they understand and define it too, other people could be reading that term in a very different way).
- I find it useful to use an attachment label to start to explain, unpick and manage behaviour, it gives me guidance.
- A Counselling Psychologist: diagnosis should be part of formulation, but formulation can get lost in the pressures.
- In the current climate it is about commissioning and diagnosis has more currency in this.
- A Clinical Psychologist: we need to challenge the artificial view that diagnoses are so discrete.
- A Clinical Psychologist: I have started seeing 'attachment' being used to keep people out of clinical services. I.e. saying, this is an attachment issue not a mental health issue, so this is a matter for social care not CAMHS. (I asked if others had seen this and there were quite a few nods).
- A Clinical Psychologist: the issue of power is always missing from articles like this, but power is critical to this discussion. (Someone else highlighted that the BPS has developed a power-threat-meaning framework and this might help for thinking about power).
- A Counselling Psychologist: I think we need to remember and think about the voice of the child and whether some of the language we use really reflects the experience of the child.
- A Clinical Psychologist: in the Bowlby quote on page 44 of the paper, I think when Bowlby is talking about theory this is different from diagnosis.
- Consider attachment in formulation more consciously.
- Continue to hear what the story is behind the people I work with rather than allowing service criteria to dictate my working.

- Think more about the use of terms and how it can affect a person's future.
- Be more aware of what level I am thinking at – diagnostic or individual.
- Be careful about using the term 'attachment disorder'.
- To consider even more how I use the term attachment in my practice and formulations – it must be individualise to each and every child to actually be meaningful.
- Thinking about terminology and what happens to it when it is out of my hands.
- Go back and discuss with the psychology team what/how we interpret 'attachment disorder' and that actually we might need to challenge that and how we use it.
- Consider use of language and don't always group children with 'labels' into one box.
- More thought about how 'attachment' is considered and understood within services.
- Separate diagnosis and formulation more.
- Keep championing the importance of formulation to defy simplistic interpretations of what's going on.
- Open up this type of debate amongst people I work with to encourage reflection and development and understanding of what attachment means in the services that I work in.
- Think about my use of the term
- Be clear about what we are talking about and what level.

APPENDIX I: FULL ITEM SET

1. Consideration of attachment theory helps decisions about permanency planning
2. Attachment theory helps to understand children's intense reactions
3. Attachment refers to a child's ability to explore
4. Insecure attachment refers to a child's capacity for managing life stress
5. Attachment theory helps inform the development of symptoms and conflicts in the parent-child relationship
6. Attachment theory helps the therapist's conceptualisation of child and parent work (i.e. identify targets for treatment)
7. Knowledge of attachment helps to predict adjustment in social, psychological, developmental and behavioural domains
8. Attention to children's attachments is essential for increasing the likelihood of positive outcomes for children in the welfare system
9. Acknowledgement of attachment between maltreated children and their birth parents is essential when making placement decisions
10. Framework for understanding and evaluating parent-child relationships
11. Placing children early is important for the forming of attachments
12. Critical for understanding both the child's and the parent's reactions around separation (and reunion?)
13. Theory is helpful for education of foster parents about the kinds of behaviours to expect from children who have been maltreated/poor attachments
14. Attachment theory helps invite foster parents on board as co-therapists
15. Awareness of attachment theory helps to stay in tune with child's needs and make referral to therapy when appropriate
16. Highlights importance of parent's developing empathy for child/awareness or insight of needs
17. I am familiar with the details of the NICE guidelines for attachment
18. The NICE guidelines for attachment are relevant to the work I do
19. I consider an 'insecure attachment' to be an 'attachment problem' or 'difficulty'
20. I consider a disorganised attachment to be an 'attachment problem' but not a disorder
21. An attachment problem refers to a negative parent-child relationship
22. An attachment problem refers to an inability to form any kind of attachment to another person (i.e. the problem is the lack of any attachment)
23. An attachment problem refers to a reduced ability for a child's needs to be met
24. An attachment problem means an insecure attachment
25. An insecure attachment (either avoidant or anxious-ambivalent) is an adaptive and helpful way for a child to survive in their current environment/maintain proximity with their caregiver
26. Knowledge of a child's attachment experiences helps to predict adjustment in social, psychological, developmental and behavioural outcomes
27. Knowledge of the critical period (0-24 months) for child development and wellbeing leads me to weight information from this period during my assessment
28. I use attachment theory when evaluating the quality of the parent-child relationship
29. Attachment theory helps me understand a child's response to a novel situation

30. Knowledge of attachment theory enables me to predict a child's willingness to engage in something where the outcome is uncertain
31. I use knowledge of attachment patterns to understand how a child expresses their distress within their relationship
32. I use attachment theory to educate foster parents about the kinds of behaviours to expect from children who have been maltreated
33. Attachment difficulties, where severe enough, reach threshold for an attachment disorder
34. I use attachment-related language to highlight to other professionals that there are problems in the parent-child relationship
35. Insecure attachment is an example of an attachment problem
36. Attachment concepts are useful to provide a sense of family dynamics
37. Attachment assessment tools are easily accessible to clinicians
38. Parent-child separations in a clinical setting can be used as part of an assessment
39. All family dynamic problems are attachment problems
40. Attachment language is more helpful for clinical practice than specific attachment measures
41. Assessments of attachment disorganisation identify the presence of maltreatment effectively
42. The adult attachment interview is a useful tool to use with the parents of children in services
43. Insecure attachment is a research concept with little-to-no clinical application
44. Children's mental health problems are often attachment-related problems
45. Callous and unemotional traits in children originate from their early attachment experiences
46. Individuals who lack a secure attachment relationship have maladaptive help-seeking behaviours
47. Attachment behaviour is only significant within a threatening or anxiety-provoking context
48. After the first 1000 days attachment patterns are fixed for life
49. Current attachment assessments help to identify suitable clinical interventions
50. Ainsworth's ABC classifications fail to capture most children in mental health services
51. Bowlby's attachment theory is outdated for current clinical practice
52. The disorganised attachment classification has the most relevance for clinical practice
53. Attachment is a property of a child rather than a relationship
54. Children with severe learning disabilities will never achieve attachment security
55. All children who lack secure attachments require attachment-informed interventions
56. The best attachment interventions target maternal sensitivity
57. Attachment interventions work best if targeted at both parents
58. Children typically have the same attachment patterns as their parents
59. Attachment interventions should always aim to increase security
60. Childhood maltreatment makes developing a secure attachment impossible
61. Attachment disorders are over-diagnosed at the expense of other disorders
62. Attachment theory is helpful for differential diagnosis in child mental health
63. Early attachment experiences determine how the brain develops

64. Attachment assessments are void for children with autism spectrum disorder
65. Attachment assessments are only useful for children in fostering and adoption services
66. Attachment assessments are void for children with ADHD conditions
67. Attachment assessments enable practitioners to clearly separate
68. Children are unable to form secure attachments with parents with learning disabilities
69. Too much focus is placed on attachment theory compared to other theories of child development
70. Attachment concepts offer personalised treatments for children
71. Attachment patterns provide information about the function of behaviour
72. An insecure attachment pattern is a big problem
73. Attachment concepts have little relevance in adolescence
74. Children's attachment patterns are heavily influenced by their innate temperament
75. Trauma of any kind will inevitably disrupt a child's ability to form a secure attachment
76. Children who lack a consistent care-giver have the most problems later in life
77. Children show the same attachment patterns across all their relationships
78. Strategies that children develop to try and keep themselves safe in unsafe families are dysfunctional in the long-term
79. Strategies that children develop to try and keep themselves safe in unsafe families lead to psychological disorders
80. A diagnosis of attachment disorder should only be given to children who are unable to form an attachment relationship of any kind
81. Attachment disorders are common in children
82. Attachment insecurity is common in children
83. Clinical interventions should be adapted to suit different attachment patterns
84. There are no clinical interventions to effectively treat attachment issues
85. Knowledge of a child's attachment pattern or strategy is a pre-requisite for an attachment-informed intervention
86. Crittenden's Dynamic Maturational Model of attachment strategies provides a valid understanding of child behaviour
87. Childhood attachment patterns predict adult relationship functioning very well
88. Childhood attachment patterns predict adolescent relationship functioning
89. The allocation of the child's attention is the at the core of every attachment assessment
90. Children with poor attachment relationships always have problems with anxiety
91. Children with anxiety problems always have poor attachment relationships
92. Attachment problems and attention problems are often confused
93. Attachment problems and attention problems refer to the same thing
94. Attachment interventions must focus on increasing the responsiveness and sensitivity of the caregiver
95. If it is not possible to improve sensitivity then children should be placed with a different caregiver
96. Interventions should target parents' internal working models/parenting behaviours/parent's behaviour
97. There are no clinical interventions to effectively treat attachment issues

98. The allocation of the child's attention is the at the core of every attachment assessment
99. Attachment interventions must focus on increasing the responsiveness and sensitivity of the caregiver
100. If it is not possible to improve sensitivity then children should be placed with a different caregiver
101. Good clinical judgement is key to attachment assessment
102. Attachment theory is commonly used when children don't clearly fit a diagnostic category
103. Adaptive attachment strategies capture complexity better than attachment pattern classifications
104. There is so much literature on attachment it is difficult to know what knowledge is most useful for practice
105. There is a high level of agreement amongst health care professionals about what attachment is
106. Improving attachment security is a key priority for every child with an insecure attachment
107. Assessments of attachment disorganisation identify the presence of maltreatment effectively
108. Attachment concepts could be used more effectively in psychological treatments
109. Other theoretical frameworks are more applicable to clinical work with children
110. Attachment ideas are typically discussed only when children don't clearly fit a diagnostic category
111. A diagnosis of attachment disorder should only be given to children who are unable to form an attachment relationship of any kind
112. Clinical interventions are easily adapted to individuals with attachment insecurity
113. I worry about the tendency to pathologise atatchment
114. Some people might not like it but attachment disorders are a real thing
115. Professionals should be more careful when diagnosing attachment disorders because the evidence shows they are routinely over-diagnosed
116. We don't admit it enough but there is a lot of subjective judgement at play in assessment attachment status
117. A lot of the training in attachment theory needs to be updated with more recent theory and research findings
118. Those who are more inclined to consider attachment concepts are more psychologically minded
119. Professionals need to get away from the idea that attachment patterns are fixed for life
120. I will take attachment theory seriously when there is an evidence-based intervention available for it
121. More clinically accessible assessment tools are required to really exploiut the potential applications of attachment theory in practice
122. The value of the attachment framework lies in the freedom of expression it affords to professionals

123. The primary advantage of an attachment assessment lies in its ability to predict treatment response
124. For me, attachment concepts are about 'understanding' rather than 'prediction'
125. I know how to adapt my clinical interventions to suit someone who has insecure early attachment experiences
126. Attachment scholars have done enough theorising: it is time they tested out their ideas with substantial empiricism
127. Professionals usually make reference to attachment concepts to redirect vulnerable children away from diagnostic-based pathways of care
128. The existing attachment classifications fail to capture the complexities of children I work with
129. Practitioners turn to attachment concepts when they fail to identify an appropriate medical treatment
130. There is a gulf between the ways theorists intended for attachment to be used in practice and how clinicians are using it in practice
131. Attachment concepts have an important explanatory role to play in differential diagnosis
132. Uses of attachment theory should be left to Psychologists who are taught it as part of their training, rather than other practitioners who may have some training or interest in it
133. Practitioners who used attachment theory are more attuned to interpersonal dynamics than those who don't use it
134. Using attachment constructs in therapeutic interventions should follow a manual
135. It is very important to resist labelling children with attachment diagnoses
136. An good attachment-based intervention will aim to change an individuals' attachment pattern
137. I think attachment theory is routinely misused by professionals
138. For me, the disorganised attachment classification is most relevant to my work
139. To be honest, I don't know much about recent findings in attachment research, but I use the language and concepts because it is helpful for highlighting the relational aspects of a family dynamic
140. Attachment is only useful if you have information about specific ways a child responds under threat
141. Too much reliance on attachment problems means other commoner and more treatable problems are overlooked
142. Interventions that target specific attachment constructs would be helpful clinically
143. Sharing attachment-related ideas and language helps parents/carers feel they are being listened to
144. Using attachment concepts and language helps practitioners understand what is really going on for the children they work with
145. Most of the difficulties that children present with in mental health services are related to their attachment status

APPENDIX J: Expert commentary on the concourse (received after data collection)

Comments from Everett Waters (2019):

4. Attachment is only relevant for children in fostering and adoption services

Maybe a couple of issues here that allow for a couple of items.

E.g., Attachment-based therapies are primarily relevant for treating children who are adopted or in foster care.

And: Attachment assessments are primarily useful in making decisions about adoption and foster placements.

37. After the first 1000 days attachment patterns are fixed for life

Strongly worded. May not have much variance. Reword?

E.g., Prospects for the development of secure child-attachment relationship decline sharply after the first three years.

28. Attachment disorders are common in children

Some raters might take this to mean general problems with attachment relationship while others think you are asking about the attachment disorder diagnosis. Not clear what you would learn by asking about the base rate of the D diagnosis. Perhaps more useful to use this item to ask about how often attachment insecurity is comorbid with other childhood problems.

27. Attachment insecurity in children is so common it is not problematic by itself
Logically, the fact that something is common does not mean that it is not a problem (e.g. malaria in the subtropics or vitamin deficiencies in poor countries in general)

Better (?) Even in clear cases, insecure attachment classification is better of ordinary individual differences than as a clinical problem that requires treatment.

17. My colleagues understand what attachment is

It is important to distinguish between the presence /absence of attachment bonds and individual differences in the sense of security within a bond. As phrased, item seems to ask whether colleagues know what it means to have/lack a bond. But absence of bonds is very rare

compared to insecurity wthin an established bond. And theorists have long ago given up conceptualizing either developmental trends or clinical problems in terms of the strength/quantity of bonds per se. Moreover, most therapies are aimed at security not nond formation. Indeed, mot of attachment theory is about security/insecurity. Has very little to say about mechanisms underlying bond formation. It may be more relevant to ask whether they think their colleagues know what is entailed in different dgrees of security.

Maybe: Today, broad, detailed understanding of attachment theory and its clinical applications is the norm among mainstream child therapists.

12. Attachment theory could be used more precisely within mental health practice
Precise use is generally desirable. Therefore an item like this is likely to sort primarily at one end of the sort.
Also, item somewhat conflates the rater's ideas about whether attachment-based therapy is desirable with the rater's evaluation of how well so-called attachment theorists agree of the principles of their approach. Perhaps ask in one item whether the rater is positive toward attachment-based interventions in general. And in another item as whther they find that attachment oriented clinicians are all reading from the same book.

34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
I take it the issue here is the notion that insecure patterns are not pathological in the snse that they are sensible adaptations to a child's particular circumstances. This is a bit of a sore point for me in that the claim is more rooted in a relativist social philosophy than in data. Even if an insecure pattern were a useful or inevitable accommodation to current environment, it is not clear that there would not be a cost later on. And as far as I can see, no one is looking for relvant data.

Perhaps better: Insecure attachment patterns are better thought of as understandable adaptations to prevailing care than as maladaptations that can lead to later problems.

30. Children's mental health problems are often attachment-related problems
Are you asking whether attachment problems are common among child clinical problems or whether attachment problems are often the cause of clinical problems?
Perhaps better: Attachment problems are often at the root of other kinds of clinical problems.

3. The Coventry Grid is helpful for distinguishing between attachment-related behaviours and autism-related

Not familiar with the Coventry Grid. Maybe too specific a question.

19. There is a high level of agreement amongst researchers about what attachment is

This seems likely to elicit broad attitudes about attachment in general rather than anything

specific. Thus for different raters it may be asking (implying) "I don't like attachment theory (and thus will attribute this generally bad qualitiy to its practitioners) vs. Fuzziness of key concepts has been a significant obstacle to translation of attachment theory into practice.

57. Attachment assessment tools are easily accessible to clinicians

I think the issue here is, more specifically, whether training in the clinical use of attachment assessments is readily accessible. Probably implied. Maybe make it more explicit.

48. Attachment behaviour only means something when a child feels threatened or anxious
Better: Observing child-parent interactions in ordinary (i.e., not stressful) contexts provides little information about the status of the child's attachment.

47. Attachment patterns provide information about the function of behaviour

As phrased, this item asks about the function of behavior in general. Not clear what you are asking about.

Better (?): Attachment patterns are a useful starting point for understanding how a child uses a parent as a resource in everyday life.

46. Early attachment experiences determine how the brain develops

This seems sort of trivially true - as it would be of most any experience. Could be more pointed. I.e., asking whether effects on brain development are such that they can impose later costs.

E.g., The effects of early attachment on brain development are significant enough to influence emotion, cognition, and behavior in later childhood.

51. Interventions should target parents' internal working models of relationships because this benefits their children

Jack Block called this a "double barreled item". First part (should intervene on IWM) can be true while the second part (for the reason that it benefits child) may be less so.

50 Clinical interventions should be adapted to suit different attachment patterns

Most things are better if they are adapted (i.e., adaptation is more or less unconditionally desirable). Perhaps better: Children with different attachment patterns require different intervention strategies.

45. The most effective attachment interventions target maternal sensitivity

Is this a claim about available attachment based interventions - the effective ones are the ones that focus on sensitivity? Or is it a statement of principle - that the best target for intervention is going to be maternal sensitivity? Also, is the issue focusing on sensitivity vs. other targets or is the issue focusing exclusively on mother as opposed to a wider range of caregivers?

Department of Public Health and Primary Care
Helen Beckwith [EMAIL REDACTED]

APPENDIX K: DEMOGRAPHIC INFORMATION

PARTICIPANT DETAILS

Gender

Male Female Prefer not to say

Which of the following best reflects your job title? Please circle.

Trainee Clinical Psychologist Band 6 Therapist Band 7 Clinical Psychologist

Band 7 Therapist Band 8a Clinical Psychologist Consultant Clinical Psychologist

Child Psychotherapist Managerial role Primary mental health worker

Other_____

On the following scale, please give confidence ratings in your theoretical understanding of the following areas:

0 = no confidence in understanding – 10 = very high confidence in understanding

Attachment theory _____
Cognitive-behavioural theory _____
Models of resilience _____
Child temperament _____
Developmental trauma _____

PROFESSIONAL AND SERVICE DETAILS

I qualified professionally in the year _____.

Since I qualified I have worked professionally for _____ years total.

I have worked with children and families for ____ years.

I have completed further post-qualification training:
Course_____ Qualification_____
Year_____

Course_____ Qualification_____
Year_____

Course_____ Qualification_____
Year_____

I currently work in the London/Cambridgeshire/North East/Other area [please circle one].

What sort of service do you work in? e.g. CYP-IAPT, Tier 3 CAMHS/Specialist LAC Team/Forensic Adolescent Inpatient services, etc.

_____

_____

Please state with other types of service you have previously worked in:

_____

_____

Please state a key reason why you now work in the service that you do:

_____

_____

Department of Public Health and Primary Care
Helen Beckwith [EMAIL REDACTED]

FAMILIARITY WITH ATTACHMENT

How familiar are you with the NICE guidelines for Children's Attachment (NG26, 2015)?

□ Not at all – I did not know they existed
□ I knew they existed but am not familiar with the details of the guidelines
□ I am familiar with the details of the guidelines and make reference to them/work in accordance with them within my work
□ I am familiar with the details of the guidelines but none of the content is relevant to my work
□ Other, please specify

_____
_____

Where have you gained knowledge of attachment theory and research? Please tick all that apply.

□ GCSE Psychology
□ A-level Psychology
□ Undergraduate Psychology
□ Clinical Psychology training
□ Other core professional training
□ Postgraduate training (Please specify……..)
□ Additional (short course) attachment training
□ Specialist training for an attachment-specific assessment measure
□ Specialist training for an attachment-specific intervention
□ CPD events
□ My own independent reading
□ Research as a PG student
□ Research as an investigator
□ Research as research associate
□ Research as assessor
□ Research as trial therapist
□ Providing training in attachment theory
□ Other, please specify

_____
_____

Which areas of attachment literature and research are you familiar with? Please tick all that apply assign rank order, e.g. 1 = most familiar with/influenced by, 2 = second most familiar with/influenced by, etc.

□ John Bowlby's theory rank_____
□ Mary Ainsworth's classification system of infancy rank_____
□ Mary Main's adult attachment interview rank_____
□ Main and Solomon's disorganised attachment classification rank_____
□ Patricia Crittenden's Developmental Maturational Model (DMM) rank_____
□ Dan Hughes' Dyadic Developmental Psychotherapy (DDP) rank_____
□ Video-feedback Intervention for positive parenting (VIPP) rank_____
□ Circle of Security rank_____
□ Attachment Bio-behavioural Catch-up (ABC) rank_____
□ Other, please specify rank_____

_____
_____

APPENDIX L: Full demographic information for researcher participants – indicators of expertise

ID	Psychological tradition	Previously worked in clinical practice	Currently work in clinical practice	Involved in training clinicians	Trained in at least one specific attachment measure (AAI/SSP)	Delivered training on at least one specific attachment measure (AAI/SSP)	Trained to deliver at least one attachment-specific intervention (e.g. ABC, GABI, VIG/VIPP)
R1	Developmental						
R2	Developmental			X	X	X	X
R3	Developmental			X	X	X	
R4	Developmental			X	X	X	X
R5	Developmental				X		
R6	Social	CHOSE NOT TO ANSWER					
R7	Developmental			X	X	X	
R8	Developmental			X	X	X	
R9	Developmental					X	
R10	Developmental	X		X	X		X
R11	Developmental			X	X	X	X
R12	Developmental	X			X		
R13	Developmental			X			
R14	Developmental	X	X	X	X	X	
R15	Developmental	X		X			
R16	Developmental			X	X		
R17	Social	X	X	X	X		
R18	Developmental	X		X	X	X	
R19	Developmental	X			X		
R20	Developmental	X	X	X	X	X	
R21	Developmental	X	X	X	X		X
R22	Social				X		
R23	Social		X	X			
R24	Developmental	X			X	X	
R25	Developmental		X		X		X
R26	Developmental	X	X	X	X	X	
R27	Social	X		X	X	X	X
R28	Developmental	X	X		X	X	
R29	Developmental	X		X	X	X	X
R30	Developmental			X	X	X	X
R31	Developmental	X	X	X	X	X	

NB: Factor 1: yellow shading; Factor 2: blue shading; Factor 3: pink shading; Low loading sorts: white shading.

APPENDIX M: Visual Factor arrays

Factor 1

-5	-4	-3	-2	-1	0	1	2	3	4	5
37. After the first 1000 days attachment patterns are fixed for life	29. It is rare that children develop secure attachments to parents with learning disabilities	35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	10. The best way to work with attachment problems is to try a short intervention and see what happens	31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	25. Callous and unemotional traits in children originate from their early attachment experiences	3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	9. Parent-child separations in a clinical setting can be used as part of an assessment	42. Attachment theory is helpful for differential diagnosis in child mental health	48. Attachment theory is an important framework for making decisions about fostering placements and adoption	34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
22. Children with severe learning disabilities cannot develop secure attachments	14. Insecure attachment is a research concept with little-to-no clinical application	6. Attachment assessments cannot be used for children with autism spectrum disorder	13. Bowlby's ideas are outdated for current clinical practice	Only validated assessments of attachment should be used in practice	8. The adult attachment interview is helpful to use with parents of children in services	32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	24. Childhood attachment patterns are good predictors of adult relationship functioning	5. Attachment language is more helpful for clinical practice than specific attachment measures	16. Attachment concepts are useful to provide a sense of family dynamics	50. Attachment patterns provide information about the function of behaviour
4. Attachment is only relevant for children in fostering and adoption services	26. Children with anxiety problems always have poor attachment relationships	33. Children show the same attachment patterns across all their relationships	15. Too much focus is placed on attachment theory compared to other theories of child development	7. ADHD symptoms make it difficult to interpret attachment assessments	18. Attachment research literature is difficult to translate into clinical practice	1. Disorganised attachment can be used to identify child maltreatment	11. Attachment classifications over-simplify differences between people	12. Attachment theory could be used more precisely within mental health practice	52. Attachment is a property of a relationship rather than a child	51. Early attachment experiences determine how the brain develops
	63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	41. Attachment disorders are over-diagnosed at the expense of other disorders	28. Attachment disorders are common in children	19. There is a high level of agreement amongst researchers about what attachment is	20. Childhood attachment patterns should not be used to predict adolescent outcomes	55. Attachment disorders can be effectively treated with clinical intervention	30. Children's mental health problems are often attachment-related problems	17. My colleagues understand what attachment is	64. Working in an attachment-informed way means providing a safe environment for children to explore	
		43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	49. Attachment behaviour only means something when a child feels threatened or anxious	23. The disorganised attachment classification is the most relevant for mental health	21. It is impossible to develop a secure attachment to maltreating caregiver	65. Working on a child's attachment cannot be done without the involvement of their caregivers	36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	61. Attachment concepts can be used to facilitate personalised care for children		
		56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors	57. Attachment assessment tools are easily accessible to clinicians	44. Knowing a child's attachment status determines the type of treatment they need	27. Attachment insecurity in children is so common it is not problematic by itself	46. Interventions should target parents' internal working models of relationships because this benefits their children	38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	47. Clinical interventions should be adapted to suit different attachment patterns		
			62. Childhood trauma lies behind all cases of attachment disorganisation	54. Attachment assessments focus specifically on where children direct their attention	39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	58. Attachment interventions work as well for adolescents as they do for younger children	40. Attachment problems and attention problems are often related			
				60. All children in mental health services who lack secure attachments need attachment-informed interventions	45. The most effective attachment interventions target maternal sensitivity	59. There is so much literature on attachment it is difficult to know which bits are most useful for practice				
					53. The temperament of a child heavily influences the type of attachment they form					

Factor 2

-5	-4	-3	-2	-1	0	1	2	3	4	5
37. After the first 1000 days attachment patterns are fixed for life	4. Attachment is only relevant for children in fostering and adoption services	56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors	7. ADHD symptoms make it difficult to interpret attachment assessments	10. The best way to work with attachment problems is to try a short intervention and see what happens	24. Childhood attachment patterns are good predictors of adult relationship functioning	3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	50. Attachment patterns provide information about the function of behaviour	45. The most effective attachment interventions target maternal sensitivity	34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
62. Childhood trauma lies behind all cases of attachment disorganisation	1. Disorganised attachment can be used to identify child maltreatment	13. Bowlby's ideas are outdated for current clinical practice	14. Insecure attachment is a research concept with little-to-no clinical application	31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	23. The disorganised attachment classification is the most relevant for mental health	17. My colleagues understand what attachment is	11. Attachment classifications over-simplify differences between people	Only validated assessments of attachment should be used in practice	38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	52. Attachment is a property of a relationship rather than a child
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	33. Children show the same attachment patterns across all their relationships	6. Attachment assessments cannot be used for children with autism spectrum disorder	21. It is impossible to develop a secure attachment to maltreating caregiver	15. Too much focus is placed on attachment theory compared to other theories of child development	27. Attachment insecurity in children is so common it is not problematic by itself	5. Attachment language is more helpful for clinical practice than specific attachment measures	16. Attachment concepts are useful to provide a sense of family dynamics	8. The adult attachment interview is helpful to use with parents of children in services	65. Working on a child's attachment cannot be done without the involvement of their caregivers	9. Parent-child separations in a clinical setting can be used as part of an assessment
	53. The temperament of a child heavily influences the type of attachment they form	22. Children with severe learning disabilities cannot develop secure attachments	26. Children with anxiety problems always have poor attachment relationships	25. Callous and unemotional traits in children originate from their early attachment experiences	30. Children's mental health problems are often attachment-related problems	18. Attachment research literature is difficult to translate into clinical practice	19. There is a high level of agreement amongst researchers about what attachment is	12. Attachment theory could be used more precisely within mental health practice	61. Attachment concepts can be used to facilitate personalised care for children	
		28. Attachment disorders are common in children	29. It is rare that children develop secure attachments to parents with learning disabilities	35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	20. Childhood attachment patterns should not be used to predict adolescent outcomes	47. Clinical interventions should be adapted to suit different attachment patterns	48. Attachment theory is an important framework for making decisions about fostering placements and adoption		
		57. Attachment assessment tools are easily accessible to clinicians	43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	51. Early attachment experiences determine how the brain develops	41. Attachment disorders are over-diagnosed at the expense of other disorders	46. Interventions should target parents' internal working models of relationships because this benefits their children	64. Working in an attachment-informed way means providing a safe environment for children to explore		
			44. Knowing a child's attachment status determines the type of treatment they need	40. Attachment problems and attention problems are often related	58. Attachment interventions work as well for adolescents as they do for younger children	42. Attachment theory is helpful for differential diagnosis in child mental health	55. Attachment disorders can be effectively treated with clinical intervention			
				49. Attachment behaviour only means something when a child feels threatened or anxious	54. Attachment assessments focus specifically on where children direct their attention	59. There is so much literature on attachment it is difficult to know which bits are most useful for practice				
					60. All children in mental health services who lack secure attachments need attachment-informed interventions					

Factor 3

-5	-4	-3	-2	-1	0	1	2	3	4	5
27. Attachment insecurity in children is so common it is not problematic by itself	10. The best way to work with attachment problems is to try a short intervention and see what happens	22. Children with severe learning disabilities cannot develop secure attachments	5. Attachment language is more helpful for clinical practice than specific attachment measures	18. Attachment research literature is difficult to translate into clinical practice	3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours	30. Children's mental health problems are often attachment-related problems	24. Childhood attachment patterns are good predictors of adult relationship functioning	46. Interventions should target parents' internal working models of relationships because this benefits their children	48. Attachment theory is an important framework for making decisions about fostering placements and adoption	34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
13. Bowlby's ideas are outdated for clinical practice	14. Insecure attachment is a research concept with little-to-no clinical application	23. The disorganised attachment classification is the most relevant for mental health	6. Attachment assessments cannot be used for children with autism spectrum disorder	7. ADHD symptoms make it difficult to interpret attachment assessments	Only validated assessments of attachment should be used in practice	1. Disorganised attachment can be used to identify child maltreatment	9. Parent-child separations in a clinical setting can be used as part of an assessment	12. Attachment theory could be used more precisely within mental health practice	8. The adult attachment interview is helpful to use with parents of children in services	51. Early attachment experiences determine how the brain develops
4. Attachment is only relevant for children in fostering and adoption services	15. Too much focus is placed on attachment theory compared to other theories of child development	26. Children with anxiety problems always have poor attachment relationships	20. Childhood attachment patterns should not be used to predict adolescent outcomes	17. My colleagues understand what attachment is	11. Attachment classifications over-simplify differences between people	32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns	31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment	47. Clinical interventions should be adapted to suit different attachment patterns	16. Attachment concepts are useful to provide a sense of family dynamics	52. Attachment is a property of a relationship rather than a child
	33. Children show the same attachment patterns across all their relationships	41. Attachment disorders are over-diagnosed at the expense of other disorders	28. Attachment disorders are common in children	19. There is a high level of agreement amongst researchers about what attachment is	21. It is impossible to develop a secure attachment to maltreating caregiver	42. Attachment theory is helpful for differential diagnosis in child mental health	36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life	50. Attachment patterns provide information about the function of behaviour	61. Attachment concepts can be used to facilitate personalised care for children	
		49. Attachment behaviour only means something when a child feels threatened or anxious	35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need	29. It is rare that children develop secure attachments to parents with learning disabilities	25. Callous and unemotional traits in children originate from their early attachment experiences	40. Attachment problems and attention problems are often related	55. Attachment disorders can be effectively treated with clinical intervention	64. Working in an attachment-informed way means providing a safe environment for children to explore		
		37. After the first 1000 days attachment patterns are fixed for life	43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver	53. The temperament of a child heavily influences the type of attachment they form	38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern	44. Knowing a child's attachment status determines the type of treatment they need	58. Attachment interventions work as well for adolescents as they do for younger children	65. Working on a child's attachment cannot be done without the involvement of their caregivers		
			57. Attachment assessment tools are easily accessible to clinicians	59. There is so much literature on attachment it is difficult to know which bits are most useful for practice	39. Attachment concepts are usually discussed when children don't clearly fit a diagnostic category	45. The most effective attachment interventions target maternal sensitivity	62. Childhood trauma lies behind all cases of attachment disorganisation			
				63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened	54. Attachment assessments focus specifically on where children direct their attention	60. All children in mental health services who lack secure attachments need attachment-informed interventions				
					56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors					

APPENDIX N: Crib sheets for analysis

Factor 1

Items ranked at +5 by F1

34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
50. Attachment patterns provide information about the function of behaviour
51. Early attachment experiences determine how the brain develops

Items ranked higher by factor 1 than any other array

5. Attachment language is more helpful for clinical practice than specific attachment measures 3
13. Bowlby's ideas are outdated for current clinical practice -2
17. My colleagues understand what attachment is 3
30. Children's mental health problems are often attachment-related problems 2
33. Children show the same attachment patterns across all their relationships -3
40. Attachment problems and attention problems are often related 2
42. Attachment theory is helpful for differential diagnosis in child mental health 3
53. The temperament of a child heavily influences the type of attachment they form 0
64. Working in an attachment-informed way means providing a safe environment for children to explore 4

Items ranked lower by Factor 1 than any other factor array

2. Only validated assessments of attachment should be used in practice -1
8. The adult attachment interview is helpful to use with parents of children in services 0
26. Children with anxiety problems always have poor attachment relationships -4
29. It is rare that children develop secure attachments to parents with learning disabilities -4
35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need -3
43. A diagnosis of attachment disorder means the child has been unable form any kind of attachment relationship to a specific person/caregiver -3
45. The most effective attachment interventions target maternal sensitivity 0
46. Interventions should target parents' internal working models of relationships because this benefits their children 1
52. Attachment is a property of a relationship rather than a child 4
54. Attachment assessments focus specifically on where children direct their attention -1
55. Attachment disorders can be effectively treated with clinical intervention 1
60. All children in mental health services who lack secure attachments need attachment-informed interventions -1
61. Attachment concepts can be used to facilitate personalised care for children 3
65. Working on a child's attachment cannot be done without the involvement of their caregivers 1

Items ranked at -5 by F1

4. Attachment is only relevant for children in fostering and adoption services
22. Children with severe learning disabilities cannot develop secure attachments
37. After the first 1000 days attachment patterns are fixed for life

Factor 2

Items ranked +5 by F2

9. Parent-child separations in a clinical setting can be used as part of an assessment
34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
52. Attachment is a property of a relationship rather than a child

Items ranked higher by factor 2 than any other array

2. Only validated assessments of attachment should be used in practice 3
4. Attachment is only relevant for children in fostering and adoption services -4
9. Parent-child separations in a clinical setting can be used as part of an assessment 5
10. The best way to work with attachment problems is to try a short intervention and see what happens -1
14. Insecure attachment is a research concept with little-to-no clinical application -2
15. Too much focus is placed on attachment theory compared to other theories of child development -1
18. Attachment research literature is difficult to translate into clinical practice 1
19. There is a high level of agreement amongst researchers about what attachment is 2
20. Childhood attachment patterns should not be used to predict adolescent outcomes 1
23. The disorganised attachment classification is the most relevant for mental health 0
26. Children with anxiety problems always have poor attachment relationships -2
32. Children's attachment patterns can be predicted from knowledge of their parent's attachment patterns 2
35. An attachment disorder diagnosis ensures children access the specialised attachment interventions that they need -1
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern 4
41. Attachment disorders are over-diagnosed at the expense of other disorders 1
45. The most effective attachment interventions target maternal sensitivity 4
49. Attachment behaviour only means something when a child feels threatened or anxious -1
65. Working on a child's attachment cannot be done without the involvement of their caregivers 4

Items ranked lower by factor 2 than any other factor array

1. Disorganised attachment can be used to identify child maltreatment -4
7. ADHD symptoms make it difficult to interpret attachment assessments -2
16. Attachment concepts are useful to provide a sense of family dynamics 2
21. It is impossible to develop a secure attachment to maltreating care-giver -2
24. Childhood attachment patterns are good predictors of adult relationship functioning 0
25. Callous and unemotional traits in children originate from their early attachment experiences -1
28. Attachment disorders are common in children -3
30. Children's mental health problems are often attachment-related problems 0
36. Addressing attachment insecurity is a clinical priority because it leads to mental health problems later in life -1
40. Attachment problems and attention problems are often related -1
44. Knowing a child's attachment status determines the type of treatment they need -2
47. Clinical interventions should be adapted to suit different attachment patterns 2
48. Attachment theory is an important framework for making decisions about fostering placements and adoption 3
51. Early attachment experiences determine how the brain develops 0
53. The temperament of a child heavily influences the type of attachment they form -4
57. Attachment assessment tools are easily accessible to clinicians -3
58. Attachment interventions work as well for adolescents as they do for younger children 0

Items ranked -5 by F2

37. After the first 1000 days attachment patterns are fixed for life
62. Childhood trauma lies behind all cases of attachment disorganisation
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened

Factor 3

Items ranked +5 by F3

34. Attachment patterns represent a child's best attempt to deal with the caregiving environment, whether good or bad
51. Early attachment experiences determine how the brain develops
52. Attachment is a property of a relationship rather than a child

Items ranked higher by F3 than any other factor array

6. Attachment assessments cannot be used for children with autism spectrum disorder -2
8. The adult attachment interview is helpful to use with parents of children in services 4
29. It is rare that children develop secure attachments to parents with learning disabilities -1
31. Experiencing parental abuse or neglect will inevitably disrupt a child's ability to form a secure attachment 2
37. After the first 1000 days attachment patterns are fixed for life -3
44. Knowing a child's attachment status determines the type of treatment they need 1
46. Interventions should target parents' internal working models of relationships because this benefits their children 3
56. Attachment assessments enable practitioners to clearly separate innate factors from environmental factors 0
58. Attachment interventions work as well for adolescents as they do for younger children 2
60. All children in mental health services who lack secure attachments need attachment-informed interventions 1
62. Childhood trauma lies behind all cases of attachment disorganisation 2
63. Children with insecure attachments don't want to be close to their attachment figures when they are ill or frightened -1

Items ranked lower by factor 3 than any other array

3. The Coventry Grid is helpful for distinguishing attachment-related behaviours and autism-related behaviours 0
5. Attachment language is more helpful for clinical practice than specific attachment measures -2
10. The best way to work with attachment problems is to try a short intervention and see what happens -4
11. Attachment classifications over-simplify differences between people 0
15. Too much focus is placed on attachment theory compared to other theories of child development -4
17. My colleagues understand what attachment is -1
18. Attachment research literature is difficult to translate into clinical practice -1
20. Childhood attachment patterns should not be used to predict adolescent outcomes -2
23. The disorganised attachment classification is the most relevant for mental health -3
38. Good quality care throughout childhood is a better predictor of future mental health than a child's early attachment pattern 0
49. Attachment behaviour only means something when a child feels threatened or anxious -3
59. There is so much literature on attachment it is difficult to know which bits are most useful for practice -1

Items ranked -5

4. Attachment is only relevant for children in fostering and adoption services
13. Bowlby's ideas are outdated for current clinical practice
27. Attachment insecurity in children is so common it is not problematic by itself