

Children's attachment needs in the context of out-of-home care

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Practitioners supporting children in out-of-home care are often faced with making difficult decisions about children's needs. These decisions include where the child will live and how often a child has contact with their family of origin. Children's attachment needs are one of the factors that are considered when making these decisions (Barth, Crea, John, Thoburn, & Quinton, 2005; Dozier & Rutter, 2008; Zilberstein, 2006). This resource is intended to provide an overview of what we know, and what needs to be better understood, about children's attachment needs in the context of out-of-home care. It focuses specifically on disorganised attachment, which is thought to be common in high risk populations (Shemmings & Shemmings, 2011), and looks at the practice implications of this.

What is attachment?

Children's attachment experiences are thought to be the foundation for their later social, emotional and cognitive development. The nature of a child's attachment experience is shaped by how consistently and reliably a caregiver responds to the child's distress signals. Consistent, reliable and responsive caregiving is associated with an optimal attachment experience (Cassidy, 2008). Ideally the infant comes to expect that their caregiver will be available when needed, and learns that they are able, through their actions, to control their needs being met (e.g., through attachment behaviours such as crying or holding out their arms). This attachment experience becomes internalised by the developing child and forms the basis for self-concept, self-esteem, and emotional, social and cognitive development, through the formation of an internal working model of self and others (DeKlyen & Greenberg, 2008).

Early experiments on attachment focused on young children's reactions to a temporary separation from their caregiver during times of mild stress. It was assumed that a child's behaviour during this experiment could be used to infer its expectations and underlying beliefs about the caregiver's reliability and availability (the child's attachment experience) (Ainsworth, Blehar, Waters, & Wall, 1978).

These experiments showed that children's reactions formed one of three predictable attachment patterns (see Box 1).

Box 1: The origins of attachment classifications in young children

Secure or insecure

Originally, Bowlby (1969) defined attachment as a strong disposition to seek proximity to and contact with a preferred caregiver, where an attachment figure was conceived of as one responsive to the child's needs. He later broadened the discussion to include not just the child's needs but also the responsiveness and emotional availability of the caregiver in times of need. By doing so, Bowlby began to use the idea of attachment more broadly to account for differences in infants' experiences of early parent-child interactions (McLean, 2013).

Mary Ainsworth and colleagues (1978) further broadened the original concept of attachment by highlighting the young child's internal representations of the world (self and other). This allowed her to take into account the infant's appraisal of whether or not the caretaker would be available at times of need.

The organisation of attachment (secure, insecure avoidant and insecure ambivalent)

Ainsworth observed children's responses to a structured, experimental setting, referred to as the "Strange Situation" (Ainsworth et al., 1978). In the Strange Situation, the child's reactions to a stranger, and to a very brief separation from, and reunification with, a caregiver were carefully coded (see Ainsworth et al., 1978 or Shemmings & Shemmings, 2011 for a description of the Strange Situation protocol).

In this structured experimental situation, Mary Ainsworth identified three distinct, predictable (or organised) patterns of attachment behaviour. She classified one set of behaviours as "secure" and two sets of behaviours "insecure" (insecure ambivalent and insecure avoidant). Each of these classifications was associated with predictable attachment behaviour within this prescribed situation and based on the child's interaction with the caregiver upon separation and reunification. The children's behaviour was taken to reflect internalised expectations, or "internal working models", regarding the availability of the caregiver under conditions of stress.

Secure attachment

The "secure" classification reflected an expectation of caregiver emotional availability. A secure attachment is thought to evolve when a caregiver is consistently available and provides responsive and attuned caregiving. A securely attached child learns to regulate distress, in the knowledge that they can get help from their caregiver when needed.

Insecure attachment

The "insecure" patterns reflected predictable (organised) expectancies about the caregiver's behaviour and availability in time of need.

The child with "avoidant" attachment has developed an expectation that expressing emotions and need for comfort will result in conflict or rejection. An avoidantly attached child learns to hide distress for fear that vulnerability or need will anger or drive their caregiver away. This child believes that by not expressing their needs, and thereby not angering the caregiver or risking rejection, they are able to maintain proximity to the caregiver.

The "ambivalently" attached child, uncertain of their caregiver's response to their needs, demonstrates angry resistant or passive behaviour towards her. The child learns to exaggerate their feelings to try and gain a response from the caregiver. They simultaneously feel angry and needy towards the caregiver.

Both avoidant and ambivalent patterns of behaviour represent an organised (coherent) set of beliefs about the emotional availability of the caregiver, together with the behaviours needed to maintain proximity to the carer (McLean, 2013).

Disorganised attachment

Subsequent to these classifications, Main and Solomon (1990) identified a fourth group; those that lack an organised approach to addressing their attachment needs: the “disorganised” group. This characterises the attachment behaviour of the child who has not had sufficient consistency in caregiving to be able to develop a coherent (organised) attachment representation. A child with a disorganised attachment may be afraid to directly approach their caregiver because they cannot predict what the caregiver will do. This lack of a predictable, coherent attachment behaviour was reflected in inconsistent attachment behaviour in the Strange Situation (Main & Solomon, 1990).

The failure to develop an organised attachment expectation (internal working model) results from a relationship with a caregiver that is simultaneously a source of both comfort and fear; leaving the child in an impossible bind (McLean, 2013) or “fear without solution” (Shemmings & Shemmings, 2011). Because of this experience, a child seeks proximity and yet avoids it; exhibiting contradictory behaviour such as freezing and fearful apprehensive approaches toward their caregiver (Main & Solomon, 1990; Zilberstein, 2006). Children exhibiting disorganised attachment are thought to be at an increased risk of developing psychopathology over time—possibly due to an internalised representation of behaviour and emotions that remains dis-integrated and lacks coherence (McLean, 2010; Zilberstein, 2006) and an inability to meet their need for comfort and security.

Why is it important to understand a child’s attachment experience?

A child’s experience of attachment is believed to lay the foundation for later development in four main areas (DeKlyen & Greenberg, 2008):

- cognitive development (internal representations of self and others);
- emotional regulation (ability to experience, tolerate, express and regulate strong emotions);
- exploratory play and other behaviour (ability to show initiative to investigate the world through play and socialisation); and
- pro-social orientation towards others (motivated to please others and seek social rewards) (see McLean, 2013).

Optimal development occurs when children have had sufficient safety and predictability to develop a coherent set of beliefs about their caregiving experience.

Contemporary models of attachment all suggest that attachment is one of the formative experiences of childhood. Early writings tended to cast attachment as a *critical* experience of childhood (Shemmings & Shemmings, 2011). It is now thought that there are *sensitive* periods of development, during which key developmental milestones are more readily acquired (Schore, 1994; Shemmings & Shemmings, 2011). As such, early attachment experience is no longer considered to “determine” later development (Goldberg, 2000; Shemmings & Shemmings, 2011), although it does make a unique contribution.

There is a general agreement that disorganised attachment is strongly associated with the experience of child abuse and neglect (i.e., a fear inducing caregiver results in an incoherent internalised model of self and others, together with the inability to clearly signal distress to an unreliable and frightening caregiver). Unfortunately, attachment theory offers little guidance to child protection practitioners who need to make decisions about meeting the needs of children in out-of-home care. The remainder of this resource will focus on disorganised attachment, due to its significance for child protection practitioners.

Why is disorganised attachment significant?

Attachment involves developing behaviours to ensure the proximity of a caregiver in times of stress. There is no right or wrong way for a child to resolve this need; a child may meet their attachment needs in a range of ways, depending on their experience with a caregiver. Ambivalent, avoidant, and secure attachment styles are all appropriate (non-pathological) ways to resolve attachment needs, and they are all associated with reasonably consistent self-concept, signalling behaviours and ways of relating to others. In contrast, disorganised attachment is of concern because it means that a child has not been able to develop *any* consistent means of eliciting comfort and support from the caregiver (i.e., they have not been able to develop an organised, coherent strategy towards a caregiver).

Disorganised attachment appears to be more common in vulnerable populations. We know that atypical childhood experiences, such as extreme neglect in the absence of a specific caregiver, are linked to a risk of disorganised attachment. For example, children raised in institutional orphanages have higher than usual levels of disorganised attachment (see Rutter, 2008; Vorria et al., 2003). One study of 11–17 month old infants in a Greek institution found 66% displayed disorganised attachment, compared to 25% in a comparable community sample. A similar study of Romanian orphans found 65% showed disorganised attachment, compared to 22% of never institutionalised children (Vorria et al., 2003). Therefore, we know that the risk of experiencing disorganised attachment appears to be elevated in situations of extreme neglect and where there is no specific caregiver.

The rates of disorganised attachment are also much higher in high risk populations generally (between 25–50%, compared with 15% in low risk populations) (Bakermans-Kranenburg & van IJzendoorn, 2007; Hesse & Main, 2006; Rutter, 2008; Shemmings & Shemmings, 2011; van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999).

Disorganised attachment is linked to the development of later psychopathology (see Green & Goldwyn, 2002; Lyons-Ruth & Jacobwitz, 1999; Lyons-Ruth & Jacobwitz, 2008) and is thought to influence later mental health and adjustment (van IJzendoorn et al., 1999). Disorganised attachment has also been linked to later externalising behaviour (Fearon, Bakermans-Kranenburg, Lapsley, & Roisman, 2010; van IJzendoorn et al., 1999; Shemmings & Shemmings, 2011) and internalised, dissociative symptoms (Dozier, Chase Stovall-McLough & Albus, 2008; Shemmings & Shemmings, 2011; van IJzendoorn et al., 1999).

What causes disorganised attachment?

Disorganised attachment is specific to a particular caregiver. That is, a child can have disorganised attachment with one caregiver and organised attachment with another. This finding suggests that disorganised attachment doesn't reflect a temperamental or genetic vulnerability (Lyons-Ruth & Jacobitz, 2008; Shemmings & Shemmings, 2011). Therefore, there does not seem to be any support for the idea that genetics or gender influence susceptibility to disorganised attachment (Shemmings & Shemmings, 2011).

As we might expect, disorganised attachment is correlated with a range of parenting issues that can negatively affect parent–child relationships. These include parental drug and alcohol issues and parents who are frequently withdrawn or detached due to intrusive thoughts or unresolved trauma.

For example, a large meta-analytic study found that parental alcohol or drug problems were related to the likelihood of having a child classified as having disorganised attachment (van IJzendoorn et al., 1999). The same study, however, did not support the expected link between parental depression and disorganised attachment (van IJzendoorn et al., 1999), although complex forms of mental illness such as psychosis were not examined in this study (Shemmings & Shemmings, 2011).

While parental mental health *per se* has not been strongly linked to disorganised attachment, certain features of parenting behaviour have been linked. Parenting behaviours correlating to disorganised attachment *may* include:

- unresolved loss or trauma;
- parental insensitivity;
- parental reflective functioning; and
- unusual or frightening parental behaviour such as dissociation, withdrawal or rough handling (Bakermans-Kranenburg & van Ijzendoorn, 2007; Lyons-Ruth, 2003; Shemmings & Shemmings, 2011; van Ijzendoorn, 1995; van Ijzendoorn et al., 1999; van Ijzendoorn & Bakermans-Kranenburg, 2009).

At this stage, however, the relative contribution of parental unresolved loss and frightening parental behaviour to disorganised attachment is unclear (Madigan, et al., 2006; Shemmings & Shemmings, 2011). Some argue that disengaged parenting and poor reflective functioning are central to the development of disorganised attachment (Fonagy & Target, 2005; Shemmings & Shemmings, 2011).

Practice implications

How is attachment assessed?

The assessment of attachment requires specialist training and is undertaken in prescribed situations in which the child's responses to its caregiver is observed and coded; or by using specific tasks that ask the child to imagine a caregiver's response, thereby invoking a child's attachment representation (e.g., reading story stems in which a child is injured or needs help).

Apart from this kind of specialised and structured assessment, practitioners can only obtain an indication of the quality and nature of a child's relationship with their caregiver—a proxy indicator of the likely quality of the child's relationship with their caregiver. This can be done by observing both parent-child interaction, particularly in situations that heighten a child's attachment needs (situations where the child experiences uncertainty or mild distress). The practitioner will need to consider alternative explanations for children's behaviour, as well as the developmental factors that can influence the expression of attachment needs (i.e., are they at a critical age for displaying attachment behaviour or are other types of relationships (e.g., with peers) most age appropriate?).

Repeated observation can answer the following questions:

- How responsive is the parent to the child's emotional needs and needs for safety?
- How effectively does the child signal distress?
- Are there parental factors that are affecting capacity to provide emotional and physical safety? For example, does past trauma or current trauma and violence result in the caregiver being pre-occupied, self-absorbed, or “not present” for the child?
- Does the caregiver demonstrate reflective capacity; that is, an understanding of the child's needs (as separate from their own needs)?
- Does the caregiver demonstrate the ability to recognise the child's needs and soothe the child when needed (e.g., when distressed)?

Note that many of these questions involve assessment of parental qualities other than the parenting ability *per se*. An inability to discipline effectively through instruction and appropriate consequences does not equate to poor attachment quality—the child may nonetheless have a high quality attachment to the caregiver (although harsh and inconsistent parenting may be experienced as distressing to the child).

Cultural and other considerations

Some aspects of attachment are consistent between cultures while some differ. Although there is ample evidence that the distribution of attachment classifications is consistent between cultures (i.e., 60% secure, 40% insecure), it is important to recognise that the *expression* of attachment (in terms of parent and child behaviour) varies between cultures.

For example, the expression of sensitive and responsive parenting can vary (van Ijzendoorn & Sagi-Schwartz, 2008) with some cultures promoting independence and some inter-dependence (van Ijzendoorn & Sagi-Schwartz, 2008). Similarly, there are cultural differences in the way a child's behaviour is evaluated. In Western culture, attachment security and social competence is viewed in terms of the child's initiative and capacity for self-expression. In other cultures *inter*-dependence, rather than independence, may be more valued and the expression of some strong feelings may be discouraged. Therefore, it is important to recognise that "successful" child rearing is determined by cultural and social values.

In addition, most research has explored attachment between a child and one parent; there has been very little exploration of the child's ability to form multiple attachments from a very early age (Rutter, 2008). Although early attachment writing emphasised an infant's preference for a primary caregiver, subsequent reviews have challenged this idea (e.g., Lamb (2012) suggests that very young children can form attachment bonds to multiple caregivers simultaneously. The literature on cultural expression of attachment (Ryan, 2011), on shared caregiving (Howes & Spieker, 2008), and on attachment in middle childhood (Kobak, Rosenthal, Zajac, & Madsen, 2007; Laible, 2005) also questions the notion of a primary attachment figure.

When considering the attachment needs of Aboriginal and Torres Strait Islander children and their caregivers, it is important to look beyond the dyadic model of attachment and consider the broader importance of multiple attachment relationships for children, and the significant importance of extended family and kinship networks for children. Therefore, it is important to be aware of cultural values and ideals regarding parenting when considering if a child's attachment experience has been compromised.

Can disorganised attachment "improve" over time?

There is every reason to assume that children with disorganised attachment can be helped to develop more organised and predictable internal working models. The majority of children adopted from even extremely deprived environments (e.g., institutionalised orphanages) go on to form specific attachments to their carers once placed in foster care (Dozier & Rutter, 2008).

While we don't really know much about which children are more vulnerable to disorganised attachment and which children are more resilient, we do know that disorganised attachment is a specific response to a poor caregiving relationship (with one parent or both). We can assume, therefore, that exposure to safe, reliable and responsive caregiving as early as possible in children's lives will help them develop a more organised internal working model and a more consistent and predictable set of signalling behaviours directed towards caregivers.

The following can be helpful for children in out-of-home care who have experienced poor quality caregiving:

- Recognise that ambivalent and avoidant attachment styles are adaptive responses to less reliable or consistent caregiving. While these attachment styles may not be ideal, they do not reflect disordered or disorganised attachment.
- Expose the child to consistent, safe, responsive and predictable caregiving in a stable care environment, and as early as possible.

- Foster care can offer an alternative experience of caregiving for children. Under these circumstances a child can develop a more consistent way of relating to others, and a more organised and predictable set of behaviours to signal need at times of distress.
- Support biological parents to address poor reflective capacity, intrusive or disjointed parenting and to address unresolved trauma and grief that interferes with being present during parenting.
- Early attachment writing emphasised an infant's preference for a primary caregiver. However, subsequent reviews suggest that even very young children can form attachment bonds to multiple caregivers simultaneously (e.g., Lamb 2012). It is important to acknowledge that it is possible for children to maintain contact with birth parents or other caregivers without compromising the development of an attachment bond with a child's foster parent. In reality, there can be extended periods of uncertainty regarding whether and if children placed in out-of-home care will be reunited with their family; as such, the worker's role may be to acknowledge, support and strengthen children's multiple attachments during this time.
- The social networks of children in care can be impoverished for a range of reasons including family isolation and frequent moves. Peer relationships can act as important attachment relationships for school-aged children and every attempt should be made to foster children's social relationships where these are positive and nurturing.

How useful is attachment theory in child protection practice?

Attachment has been an extremely influential construct in child development and in child protection (Barth et al., 2005). Unfortunately, the quality of the research evidence on attachment is not commensurate with the popularity of the theory in the out-of-home care sector (Barth et al., 2005; McLean, Riggs, Kettler, & Delfabbro, 2013; Zilberstein, 2006). In reality, attachment theory does not offer much clinical guidance about the needs of children who may have already formed a specific attachment to parents prior to entering care (Crittenden, 1985; Dozier & Rutter, 2008; Egeland & Sroufe, 1981; Rutter, 2008; Zilberstein, 2006), meaning that an attachment to a foster carer will be a subsequent attachment relationship. We know little about whether subsequent attachment bonds offer the same protective features as attachments with family of origin. In particular, there is little nuanced knowledge about the attachments of children who are fostered.

In addition, the attachment experiences of children placed in foster care can vary considerably:

Children experience a range of conditions prior to placement in foster care and adoptive care. At one end of the continuum are children who have lacked a caregiver altogether and experienced minimal stimulation. Although privation at this level is most often associated with institutional care, it is also sometimes seen among children reared with birth parents or foster parents. At the other end of the continuum are children who have been cared for by loving, committed caregivers who for some reason (e.g., death, imprisonment) were not able to continue parenting. Many children who enter surrogate care fall between these two extremes; they have not been starkly deprived, nor have they received consistently nurturing care. (Dozier & Rutter, 2008, p. 699)

We have very little evidence about the different and intersecting pathways of children in out-of-home care and the relative contribution of attachment and other factors to children's outcomes.

In addition, there can be confusion about what attachment is and what it means for a child. This difficulty was highlighted 10 years ago in a comprehensive review of attachment theory (Chaffin et al., 2006), in which the lack of clarity around the concept of attachment disorder was emphasised. As they state:

The terms attachment disorder, attachment problems and attachment therapy, although increasingly used, have no clear, specific, or consensus definitions. (Chaffin et al. 2006, p. 77)

The problem of poor conceptual clarity has not yet been resolved. In reality, it is a term that appears to be used more broadly to refer to aspects of the caregiver relationship or to a child's behaviour, relationship or social difficulties (Kerns, 2008; McLean, 2013; McLean et al., 2013)—all of which are inconsistent with the intention of attachment theory (McLean et al., 2013). It is important to remain clear about terminology and meaning in discussing children's "attachment" needs with other practitioners.

Attachment research clearly indicates that disorganised attachment, reflecting a lack of a well-integrated working model of self and other, is related to increased risk of poor mental health later in life. This tells us that we should endeavour to ensure children experience predictable caregiving that allows them to develop a set of expectations about themselves and others. Beyond this, it is important to realise that attachment insecurity (avoidant or ambivalent attachment styles) should not be considered as synonymous with any form of attachment disorder (Ainsworth et al., 1978; Rutter, 2008).

Conclusion

Attachment is one of the formative influences on child development. Other factors, such as ineffective parenting, temperament and family adversity also influence development. For children placed in care, significant trauma or neglect may also affect the developmental course.

Attachment theory does not provide clear directions for practitioners in terms of how or when to intervene to address attachment needs. Children in care are especially likely to be managing multiple loyalties and we have little information about how to handle these multiple attachments.

Research on the attachment needs of children in care is limited. Children who are placed in care are likely to have formed a specific attachment to one or more of their parents, and we know very little about the nature, quality and protective capacity of these and subsequent attachment relationships (Rutter, 2008).

Attachment may mean different things to the different people in children's lives. When working together on case planning to support children in care, it is important to clarify the assumptions made about children's attachments. In discussions about children's attachment needs, clearly communicate what is meant and what outcome is sought.

The relationship between attachment and behaviour has been well described for very young children. Caution should be applied, however, when using behaviour to infer attachment status in older children, or children from diverse cultures or childrearing contexts.

In light of this, and the fact that children in care often experience extended periods of uncertainty about whether or not they will ultimately return home, it is important to acknowledge, support and strengthen children's multiple attachments to both foster/kinship carers, siblings and biological parents.

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Child Family Community Australia

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The **Child Family Community Australia** (CFCA) information exchange is an information and advisory unit based at the Australian Institute of Family Studies, and funded by the Australian Government Department of Social Services. The CFCA information exchange collects, produces and distributes resources and engages in information exchange activities that help to protect children, support families and strengthen communities.

The Australian Institute of Family Studies is committed to the creation and dissemination of research-based information on family functioning and wellbeing. Views expressed in its publications are those of individual authors and may not reflect those of the Australian Institute of Family Studies or the Australian Government

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