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# Use of Attachment Language by Professionals in Children's Mental Health Notes

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## Abstract

**Purpose:** Attachment theory and associated terms are drawn upon widely in clinical and social work practice with families. There is a notable gap in research exploring how the use of these concepts and terms influences care.

**Research Design:** This article describes a critical discourse analysis of child and adolescent mental health service (CAMHS) clinical notes exploring the use of attachment related discourses for a sample of 30 cases. The case notes typically documented intensive professional activity (meetings; correspondence; assessment; therapy) and cross service discussions about children who were at serious risk of harm due to social and psychological difficulties.

**Results:** We identified the following themes: 1) Lack of Assessment; 2) Conceptual Confusion; 3) Care Pathways; 4) Conversations with Children and Parents.

Attachment related language was used for multiple reasons: an attempt by professionals to call for action from another service (e.g. change of placement), giving more power to professionals who might not otherwise have access to terminology that describes their concerns from a "clinical" perspective; offering an explanation for chronic issues resistant to the interventions offered by services; a means of locating the cause of problems within actors not currently involved in the child's life; a shorthand way of describing complex presentations not easily described within a diagnostic framework.

**Conclusion:** The study identified concerns about how these terms are used in practice and the impact on care provided to children and families. We make recommendations for policy changes, further research, and for practitioners and academics to work collaboratively.

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## Introduction

Attachment terminology features frequently in health and social care literature regarding children and families, particularly for those children who are looked after and/or adopted. There are well documented concerns from academic and applied practitioners about the gap between academic studies, key theoretical concepts and how these ideas are used in practice.

From a clinical perspective, this is important for three main reasons:

1) This lack of clarity creates difficulty in care planning for children across teams and agencies when language is used inconsistently (talking past each other).
2) Over diagnosing attachment disorders or making assumptions about attachment security can delay access to effective, evidence-based treatments for children.
3) Incorrect assumptions may be made about the quality of care afforded to children by their caregivers based on their current presentation, and incorrect assumptions may be made about the children's needs based on their history rather than current assessment information.

This paper aims to explore these issues using qualitative data from Child and Adolescent Mental Health Service case notes. This approach has allowed the authors to track how attachment concepts have been applied in the notes of individual children over time, and how this may have shaped the care that was provided.

### *Policy and Guidance*

In the UK, attempts are being made to bring clarity to this area of clinical practice. In 2015 the National Institute of Clinical Excellence (NICE) published guidance regarding the identification, assessment and treatment of attachment difficulties in care experienced children aged 0–18, and those at risk of entering the care system (National Institute for Health and Care, 2015). The guidance sets out recommendations for tools that would contribute to the assessment of attachment difficulties and/or disorders as part of a comprehensive assessment. They emphasise the importance of being clear about use of language, for example distinguishing between attachment difficulties and attachment disorders. The guidance also highlights the importance of assessing for commonly occurring co-existing conditions such as conduct disorder, autism, social anxiety disorder and attention deficit hyperactivity disorder (ADHD).

These guidelines are an important step towards providing a way forward for clinicians working with children in complex circumstances. They describe the difference between attachment disorders and attachment difficulties. The guidelines highlight repeatedly the importance of education, health and social care staff having access to a basic level of training to increase their knowledge of attachment difficulties. They also recommend formal assessment tools to be used by health and social care professionals in the assessment of attachment difficulties.

Despite the attempt to bring clarity to this complex field, the text of the guidance does tend to blur together disorder, disorganisation, and insecurity in ways that are problematic and may also contribute to confusion within clinical practice. Furthermore, the assessments recommended by

NICE are rarely available within CAMH services and the quality of training for staff is highly variable.

The influence of attachment theory can also be seen in UK health and social care policy, in ways that have been identified as problematic. Academics and practitioners have highlighted some risks of applying these concepts to policy developments without careful attention to the limitations of the current evidence base. (Broer & Pickersgill, 2015; Critchley, 2020; Macvarish et al., 2015; Wastell & White, 2012; Woolgar & Baldock, 2015; Woolgar & Scott, 2014). There is also a risk that by foreshadowing attachment concepts, other important issues (housing, education, equality of access to services) are overlooked or minimised.

## Literature Review

In reviewing the relevant literature on attachment discourses in practice three main strands of work were identified; historical and sociological perspectives; child protection practice; clinical practice.

*Historical and Sociological Perspective.* Duschinsky (2020) offers a historical perspective on six key strands of attachment research, bringing clarity to the story of attachment developments from a developmental psychology perspective. This work highlights differences within the detail of theory and application between practitioners researchers and academics.

Verhage et al. (2023), building on the work in Cornerstones of Attachment, set out clearly the rationale for clarifying how attachment terminology is used in practice. The authors recognise that confusion about terminology is a longstanding issue in psychology generally but propose it is particularly problematic in the field of attachment. This body of work also led to the creation of a comprehensive guide published on the website of the society for Emotion and Attachment studies. The authors propose that the guide can be used as a reference for researchers and clinicians to support more effective collaboration.

*Child Protection Practice.* In recent years several scholars have provided critical reflection on the use of attachment theory in child protection practice and policy. Forslund, Granqvist, van IJzendoorn et al. (2022) provide a consensus statement covering the key issues of how attachment related concepts are applied in child welfare and set out ideas to guide future research. This work provides a comprehensive overview of the challenges and opportunities for researchers and clinicians working with families at extremely vulnerable moments in time, and the role attachment theory might play in securing the best outcomes for children.

White, Gibson, Wastell and Watson (2020) caution against the mis-use of attachment concepts to justify child welfare decision making and unjust interference by the state in family life. They critique the scientific validity of attachment related research findings, (e.g., the neurobiology of attachment) and the motivations behind the state's willingness to take this up and promote the ideas in practice.

Broer et al. (2020) analysed UK policy reports focused on the early years, adolescence and older adults. They examined how the documents employ neuroscientific concepts with a focus on the theme of individual responsibility, which can limit the extent to which contextual issues such as poverty and access to health care are given due consideration. They suggest that neuroscience is used to support and construct understandings of society which then shape and constrain what support is offered to families in difficulty. The authors considered attachment as a concept related to neuroscience, although this was not the primary focus of their research.

Granqvist, Sroufe, Dozier, et al. (2017) focus their work specifically on disorganised attachment. They set out the research underpinning this concept and outline the ways in which false assumptions may have influenced child welfare practice: for example, drawing inaccurate conclusions about individuals based on attachment measures and assumptions that disorganised attachment necessarily indicates parental child maltreatment.

There is also a small but growing body of work looking exploring empirical data from the field of child protection. Bjerre et al. (2023) describe an observational study of social work practice in Denmark. They identify theoretical confusions and a lack of specificity in how attachment concepts are applied. Nevertheless, workers were observed to use these concepts to guide their practice raising concerns about the quality of assessment and intervention work undertaken with families. The authors capture moments of dialogue between colleagues that highlight the difficulty social workers face when articulating in detail the principals of attachment theory and how this actually links to their own practice. They describe how one team used the term 'detachment" repeatedly to describe how the process of transition from birth to foster family for a baby might be negotiated, as though drawing on this pseudo – clinical term offered some comfort to practitioners tasked with making critical and highly emotive decisions in a context of uncertainty.

Hammarlund et al. (2022) also undertook a study to examine the application of attachment related terms in child protection social work practice. The authors concluded that most social workers in this sample made judgements about the attachment relationships of young children, although no systematic assessment procedures were used to inform these judgements, and participants tended to make assumptions about the aetiology of attachment difficulties, for example assuming a linear relationship between abuse/neglect and insecure attachment.

Further research by Broer et al. (2020) explored the impact of parenting programmes incorporating concepts from neuroscience and attachment. One interesting effect was the tendency for information about child development to increase patience and empathy as parents felt more able to see beyond the children's presenting behaviour at moments of stress. However, when participants knowledge of attachment was assessed in relation to the course content it was apparent that parents had come away with confused and inaccurate information about the key concepts. This illustrates the importance of assessing the impact of attachment related training as the intended outcomes may be different from what was expected, including how the information is taken up and understood by participants.

## *Clinical Practice*

There are very few published studies which directly explore attachment related concepts using data from clinical practice. Woolgar and Scott (2014) undertook a review of four cases referred to a national adoption and fostering service. This review looked at the risks of over diagnosing attachment issues, and how this impacted directly on the care afforded to young people. They caution against an over reliance on the application of attachment disorder when formulating the needs of children.

Woolgar and Baldock (2015) undertook a comprehensive exploration of attachment disorder diagnoses in community and specialist services. The findings indicate significant differences in conclusions drawn by specialist services as opposed to CAMHS and other community referrals regarding primary diagnoses. The authors acknowledge the challenges facing practitioners in busy community settings. They also comment on the possibility that referrers might feel a need to foreground particular information and use diagnostic language in order to access services in the best

interest of children. They concluded the current framework is insufficient for supporting effective clinical practice in the assessment and diagnosis of attachment disorder.

Allen and Schuengel (2020) build on this work comparing data from specialist and community settings in the US. Their findings support those of Woolgar and Baldock. The authors comment on the need for further clarification regarding Reactive Attachment Disorder, Disinhibited Social Engagement Disorder and attachment related terminology.

Morrison et al. (2020) undertook an exploratory study of how attachment theory is applied in residential childcare settings. The study also aimed to identify whether any components of attachment theory are particularly salient to staff and to what extent their conceptualizations draw upon contemporary attachment theory. They found that staff focused on a natural process of building relationships, rather than using attachment related concepts to guide their work. There is a strong imperative nationally for residential homes to invest time and money in attachment-oriented trainings for their staff. Furthermore, young people who are living in residential care are often identified as in need of therapeutic care or therapeutic parenting. It is therefore important to understand specifically what these placements offer and whether attachment-oriented trainings have a helpful impact in practice.

Beckwith et al. (2022) explored the perception of attachment related concepts among clinicians working with children and among attachment researchers. The study provides clear evidence of confusion within the field and highlights the knowledge gap between research and practice. Coughlan et al. (2022) carried out a qualitative study exploring how experienced clinicians differentiate between autism and attachment difficulties in clinical practice. The study highlighted how challenging it can be for practitioners to work with attachment related concepts in the absence of clear guidance or helpful training.

The relevant research to date clearly suggests that there is a problematic level of confusion about attachment theory in policy, clinical and social work practice. Nevertheless, attachment related concepts underpin practice with life changing consequences for children and families. The current study seeks to explore this further as a primary research aim, looking specifically at practice within UK Child and Adolescent Mental Health Services.

Clinical Record Interactive Search (CRIS) was commissioned by the National Institute of Health Research to permit research on anonymised CAMHS records from 2007 to the present. This project has been approved for secondary data analysis by the University of Oxford (Ref: 08/H0606/71+5).

To date, very few studies have looked at the use of attachment related concepts as documented in clinical case notes over an extended period. The present study has explored how attachment is represented in a random sample of anonymised clinical notes, to explore the following research questions:

1. How do practitioners draw on attachment concepts to inform their decision-making about children and young people?
2. How are attachment-related conceptualisations communicated, substantiated and negotiated in practice?
3. What evidence base do practitioners draw on to inform their use of attachment concepts?
4. How does the use of attachment concepts shape care planning/decision making for children and families?

## Methodology

This study uses data derived from a large-scale electronic health record system, the South London and Maudsley Biomedical Research Centre case register. The SLaM BRC case register was set up

in 2006 as a data resource, derived directly from the routine Electronic Health Records of the SLaM NHS Trust network. To facilitate research, a de-identified version of the SLaM BRC case register, referred to as CRIS, was developed. Researchers can systematically search CRIS for any combination of different fields available within the records, including date of birth, referral details, primary diagnosis and clinical notes (summary records made by clinicians after each contact with a patient). The case notes are produced by CAMHS professionals but also include notes from other involved professionals.

Inclusion criteria were age range (0-18 years), the child had been on a child protection plan, or looked after under section 20 of the children act, 1989, or had been identified as a looked after child; and at least one CAMHS event or correspondence included the term attachment. These criteria allowed us to study cases where attachment concepts were employed by professionals within both health and social care services. We were particularly interested in how different agencies would employ these terms and communicate with each other using attachment related discourses. Only case notes entered after January 1st 2010, were included in the sample, so that more contemporary practice was the focus of the analysis. A random sample of 30 cases was identified by the CRiS data administration team.

Data analysis was undertaken over an 18-months period up to and including October 2023.

Each case was reviewed in full by the first author, following approval. The term "attachment" was then searched for in correspondence and notes so that every use of the term attachment could be identified. Where the reference to attachment was not being used clinically the case was excluded.

## Sample

The study included 30 cases, 14 of which identified as male; 15 as female; 1 as other. The ethnicity of participants was documented as follows: 12 White British; 1 White Irish; 5 Black British-Other; 1 other ethnic group; 3 Black British Caribbean; 2 Mixed Race; 2 Black British African; 3 White Other; 1 Asian British – Pakistani.

12 children were in the care of at least one birth parent. 15 children were in foster care, kinship care or adopted. 3 children became looked after during the period covered in the CAMH notes.

## Analysis

The method used for analysing the cases selected in this study was Critical Discourse Analysis. Critical Discourse Analysis is associated with discourses of power and control and how these are manifested in day-to-day practices through an examination of the role of the speaker/author (Fairclough, 2003; Gee, 2014). Power and control in this study are operationalized as attachment related language, discursive practices and cultural ideologies as they appeared within case notes. The approach was informed by the authors' professional experiences and the work of Duschinsky, Greco and Solomon which offered a comprehensive description of how power and control are operationalized within social and clinical contexts (Duschinsky et al., 2015).

Berg and Bowker (1997) describe the importance of medical records as a focus for research. Taking a sociological perspective, they describe how multiple stories about patients and services are presented within clinical records. The clinical record does not simply give an account of the "case" but is crucial in shaping the narrative that develops and the care that is offered.

The process of data analysis involved the following steps: familiarisation with the data by reading each case in full; selecting the passages of text with direct references to attachment using CRiS to search for the relevant words; coding the text with reference to the research questions

outlined previously; looking for patterns and meanings in how the concepts were being used. The final stage then considered how the text was influenced by social, cultural, and political structures. Through discussion with the wider team, the first author then mapped, clustered and named data into final themes. Differences in interpretation were discussed until we reached a consensus. This process was fruitful given that the research team reflects a range of cultural and disciplinary backgrounds including academia, psychology and social work where the term attachment is often used differently.

The approach to identifying themes was both inductive and deductive. Following Fairclough's discourse analysis approach our analysis was informed by the wider discourses surrounding attachment on both a service-based practice level and the wider sociopolitical context (Duschinsky, 2020). As a team we reflexively discussed these discourses and acknowledged that some of these will have shaped our initial categories and patterns of meaning. However, we remained curious and alert to our specific data. As such we also utilised an inductive approach, closely scrutinising texts so that we identified additional themes from the data. In particular the theme of assessment was unexpected, grounded most firmly in the text and the initial step of Fairclough's analytical process.

Each clinically meaningful use of attachment related terms was documented and is reported in Table 1 to illustrate the attachment terminology used throughout the case notes.

## Findings

An initial analysis identified key characteristics of the cases. Table 1 includes the child's care status, reason for CAMHS involvement, attachment terms identified and co-morbid neurodevelopmental diagnosis for each child. Table 1 also summarises all the attachment related concepts found in this sample of case notes. Descriptions of attachment relationships included such terms as positive, strong, absent, good, normal, insecure, secure.

This data illustrates the level of conceptual confusion regarding the application of attachment theory and related terms observed within clinical notes. Professionals appear to use colloquial terms, alongside academic and clinical language, to describe their observations and formulations regarding patterns in relationships.

The findings from discourse analysis are presented below as overarching themes, with descriptions of specific cases to illustrate the themes that cut across each research question. The themes Assessment and Conceptual Confusion are significant for research question two. The research findings indicate that practitioners are using attachment related concepts in variable and unstructured ways. The theme "Care Pathways" speaks most directly to research question four.

Research questions one and three were most difficult to explore through analysis of these case notes, as this detail was not available in the recorded notes.

### *Assessment*

This theme highlights how attachment related concepts are used in clinical practice in the absence of documented formal assessment.

There were very few examples of structured or explicitly described attachment focused assessments. There was one exception to this whereby a national centre did set out what they meant by attachment related concepts and attachment disorder. Their conclusions were later challenged in writing by a paediatrician advocating strongly for an attachment-informed understanding of the child's difficulties, questioning the validity of the ADHD diagnosis that had been made. There was

**Table 1.** Care status, attachment terms and co-morbid neurodevelopmental diagnoses

| Care status | Primary diagnosis/ presenting problem | Attachment concepts referenced | ADHD diagnosis | Autism diagnosis |
|---|---|---|---|---|
| Birth parent | ADHD | Positive impact on attachment | Yes | No |
| Birth parents | Eating disorder and anxiety | Good attachment<br>Positive attachment<br>Attachment based family therapy | No | No |
| Child looked after (CLA) | Reactive attachment disorder | Normal attachment<br>Strong attachment<br>Good attachment<br>Complex and anxious attachment<br>Attachment difficulties | No | No |
| Birth parents | Self-harm<br>Anxiety<br>Depression | Attachment strategies | No | No |
| CLA (reunified with birth mother) | ADHD | Attachment difficulties | Yes | No |
| Birth family | Anxiety | Negative case example | No | Yes (private provider) |
| CLA | ADHD/Autism assessment<br>Behavioural difficulties | Attachment issues<br>The attachment "was not there"<br>Poor attachment<br>Attachment disorder<br>Stable attachment<br>Disorganised attachment disorder<br>Strong attachment<br>Family attachment | Yes | Yes (4 assessments) |
| CLA | Separation anxiety<br>LD, ADHD, autism, challenging behaviour | A bond and an attachment (description of relationship) | Yes | Yes |
| Became looked after | Affective disorder | Attachment difficulties & issues<br>Insecure attachments | No | No |
| Adopted from foster care | ADHD and autism | Attachment focused parenting course | Yes | Yes |
| CLA | Self-harm and low mood | Attachment style; avoidant, | No | No |
| Became looked after | PTSD | Nurturing attachment figure | No | No |

*(continued)*

**Table 1.** (continued)

| Care status | Primary diagnosis/ presenting problem | Attachment concepts referenced | ADHD diagnosis | Autism diagnosis |
|---|---|---|---|---|
| Birth parents | PDA<br>Autism | Report heading FCAMHS: Attachments | No | No |
| Adopted | ADD autism | Attachment trauma<br>secure attachment<br>healthy attachment | Yes | Yes |
| Became looked after | Self harm | History of attachment difficulties and trauma<br>Diagnosis: Attachment difficulties & PTSD<br>Ambivalent attachment to services | No | No |
| Birth parents | ADHD and autism | Attachment - description of a relationship | Yes | Yes |
| CLA proceedings | Behaviour and attachment concerns | Attachment and bonding<br>Parents attachment to X<br>Transfer of attachment | No | No |
| CLA kinship | Attachment difficulties and emotional wellbeing | Attachment difficulties | No | No |
| Birth family | Gender identity and neurodevelopmental issues | Bonding | No | Yes |
| Birth family | Autism and challenging behaviour | Strong attachments | No | Yes |
| Birth family | Eating disorder | Attachment relationships | No | No |
| Birth family | ADHD and behavioural issues | Attachment issues<br>Lack of attachment<br>Insecure attachment<br>Good bonding and attachment | Yes | No |
| CLA | Therapeutic support | Ambivalent attachment style<br>Less ambivalent attachment<br>Attachment needs | No | No |
| Birth family | Autism challenging behaviour self harm | Attachment was fine<br>Strong attachment and bonds | No | Yes |
| CLA | ADHD | Attachment based method, activities, intervention<br>Attachment needs | Yes | No |
| Birth family | ASD challenging behaviour | Attachment issues | No | Yes |
| Adopted | Not specified | Attachment focused therapy | No | No |

*(continued)*

**Table 1.** (continued)

| Care status | Primary diagnosis/ presenting problem | Attachment concepts referenced | ADHD diagnosis | Autism diagnosis |
|---|---|---|---|---|
| CLA | Mixed disorder of conduct and emotions | Building attachment<br>Attachment and trauma course<br>Broken attachments<br>Anxious attachments | No | No |
| CLA | Childhood emotional disorder | Strong attachment<br>Disrupted attachment<br>Foundations for attachment group<br>Attachment difficulties | No | No |
| CLA kinship | ADHD | Attachment difficulties | Yes | No |

also one clear example of a service assessing trauma symptoms using standardised measures, as part of an ADHD assessment, with specific attention to differential diagnoses.

One child had four separate, documented assessments for autism before a diagnosis was made. The young person was described as having attachment difficulties throughout the case notes. There were different ideas within the professional network as to whether the child's presentation could most helpfully be understood from an attachment or neurodevelopmental perspective.

Even in the absence of documented or formal assessment, decisions were sometimes made based on "attachment needs". One case note documents the decision making to move a child to a new foster placement, in a different borough, on the basis that the child needed therapeutic care to address attachment issues. This plan was carried out although no formal assessment of attachment was documented.

The example below illustrates how this confusion can impact on care planning for children, with multiple professionals and agencies involved. A therapist based in an education setting had recommended Theraplay (Booth & Jernberg, 2010) and Filial therapy (Guerney, 1964) for a looked after child. Theraplay is a dyadic form of relational play-based therapy. Filial therapy is a play-based family intervention in which parents are supported to offer child centred play, with a view to strengthening family relationships. This provision was sourced by the involved professionals, and it was agreed that the Local Authority would fund a private provider. The provider was then unable to complete the agreed work. CAMHS offered a Cognitive Behaviour Therapy (CBT) informed intervention instead. This resulted in dispute within the network, including accusations against the local authority of withholding resources and failing to meet the child's "attachment and trauma needs". In this case, private therapy was sourced and would have been carried out in the absence of a documented, structured assessment of either attachment or trauma symptomatology, which may have clarified the highest priority for intervention.

Another case example covered five years of documented clinical activity citing possible neurodevelopmental issues, attachment difficulties, trauma and behavioural problems, as contributing factors to a child's difficulties. The mental health service in this case was unable to complete a planned assessment to aid differential diagnosis, towards the end of their involvement, as the young person then struggled to attend scheduled appointments, in the context of housing,

financial and social barriers. The young person's "ambivalent relationship" to services was cited as a barrier to completing this work, with the author of the clinical note making a connection between this ambivalence and the young person's attachment relationship with his mother. There was significantly less documented evidence in the notes of other factors having been considered (e.g., organisational skills, competing demands, literacy, anxiety, lack of adult practical support, financial constraints, lack of flexible working arrangements, location of the service). The young person was discharged before the planned assessment was completed as he was considered too old for CAMHS at that point.

Children were described as having attachment difficulties, without formal assessment, at times when the case notes indicate they were living in very painful, challenging circumstances. Considering the presenting issues from other perspectives, for example as problems of grief or adjustment, might offer an alternative framework for developing social and psychological interventions to support the child. The diagnostic overshadowing resulting from assumptions about attachment, may have resulted in less timely, effective and targeted interventions for children.

## *Conceptual Confusion*

This theme highlights how attachment related terms are used loosely in clinical practice, without a clear theoretical grounding.

The terms attachment issues, post-traumatic stress disorder (PTSD), complex PTSD, trauma and attachment disorder were often used interchangeably within the clinical notes. This was also the case for attachment-informed descriptions of relationships (e.g. secure, insecure, avoidant, good, normal, positive, strong). It was not clear from the available notes why terms were changed and if there was a clinical rationale behind these changes.

As children entered adolescence there was a general trend to name issues as trauma or PTSD in the care experienced population. Younger children were more likely to be described as having attachment difficulties or avoidant attachment styles.

There were also examples, as illustrated below, of formulations evolving in very helpful ways over time. There was one clear example of a move from "ambivalent attachment" as the dominant narrative within care proceedings, to a complex PTSD formulation offered by CAMHS as the young person became looked after and more settled in foster care. The initial treatment recommendation from care proceedings by the expert witness had been play and art therapy. There was no evidence in the notes of this having been commissioned. However, the young person was offered trauma focused CBT through CAMHS with excellent reported outcomes. The treatment was offered within a systemic frame. The foster carer's role in advocating for this treatment was clearly documented and appears to have had a significant impact on the treatment plan and outcomes for the young person.

There was some evidence of attachment related concepts being used to make predictions about a child's future development, in the context of making decisions about family contact. The quote below is an extract from a professional's letter, requesting an opinion from CAMH services about family contact.

> "Research states that secure early bonding is the difference between a baby that grows up to be a secure emotionally capable adult, and a baby that will become a depressive anxious child, who will not cope well with life's ups and downs"

The use of attachment concepts in this instance seems to represent an attempt to activate concern about a child's experience in the here and now, by drawing on attachment theory to highlight potential future risk. This is a clear example of conceptual confusion and excessive certainty about the role of early caregiving experiences in child development.

### *Care Pathways*

This theme highlights how decisions about children's care pathway can be based on their background or experiences rather than assessment of need.

Children who were looked after or adopted at the time of referral were usually supported by specialist services, and/or neurodevelopmental teams. The specialist services for children in care were oriented to work from an attachment and trauma perspective. From the time of referral, consideration was given to the role of attachment-related concepts in the child's presenting issues. The interventions offered were oriented towards meeting attachment needs. This typically included a combination of individual psychotherapy or play therapy for younger children; psychoeducation and parenting support for foster carers (training in attachment and/or consultations) and individual therapy for adolescents (CBT/Dialectical Behaviour Therapy). Children in care were also likely to be receiving therapeutic input from therapists employed in school settings.

Attachment related discourses were less dominant in the care planning and assessment process for children who were in the care of their birth parents, except for those children with very extensive social care involvement.

### *Conversations With Children and Parents*

This theme explores how attachment related concepts are shared with children and parents.

Of the 15 cases where children were living with birth parents for some or all the time covered in the case notes, there were only two examples of the term attachment being used openly with birth parents. There was a notable example of services being ordered by a family court judge to share information with birth parents. In this case information about the child's autism diagnosis was shared, but not the attachment related hypotheses documented within the file.

There was one example of the term "attachment issues" being used in correspondence sent directly to a young person. Within the letter, there was no explanation of this term for the young person, no reference to how this was assessed, or what intervention was offered. There were two examples of attachment-related terms being used directly in clinical work with young people, as part of a therapeutic intervention. In these cases, attachment terms were being used to support young people to understand patterns in how they relate to other people.

The absence of open dialogue about attachment concepts was also observed in a case where a history of early abuse and trauma was clearly documented in the child's initial assessment, and the child remained in the care of their parents. There is no record of direct conversations with birth parents about the impact of such adversity on their child's development in this, or any other case material reviewed as part of this study. However, based on the data reviewed for this study, it is highly likely that attachment and trauma-informed discourses would have shaped the child's care plan had they become looked after and been directed to the CAMHS pathway for children in care.

For children living with their birth parents, clinical notes on the assessment of attachment relationships were limited to what the involved parents reported. There were no examples of observational tools or structured assessments of attachment for this group of children.

## Discussion

Data examined as part of this study indicates that the purpose and impact of using the language of attachment theory is complex. Professionals could choose to substitute the word 'attachment' with the word 'relationship' in most instances when it arose in the clinical notes. So, why use "attachment"?

Drawing on the work of Star and Griesemer (1989), perhaps we could helpfully consider attachment and related concepts as boundary objects. Star and Griesemer (1989) define boundary objects as follows:

> Boundary objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain common identity across sites. They are weakly structured in common use and become strongly structured in individual-site use. (p. 393)

If we apply this idea to the cases reviewed for this study, it suggests that the language of attachment and related concepts may function as a placeholder, used to refer to children whom professionals believe may have experienced maltreatment by their primary caregivers. The terms are recognisable enough across disciplines to allow for communication about the children, without overtly blaming parents/carers. This means we do not have to navigate the complexities of evidencing and articulating such harm, but it can still be communicated within the professional networks. However, the findings of this study, and those of related research, raise further questions as to whether the concepts have moved beyond being "plastic enough" into concepts so flexible they may create risk for children in the care planning process.

Attachment concepts may have become code for chronic, resistant to change; an umbrella term that can encompass a wide range of issues (sexualised behaviour, aggression, anxiety, attentional problems, self-neglect, sadness), making assessment of specific outcomes very difficult. However, ultimately, this means expectations of real change may be low for some children, and we may be at risk of not holding high enough aspirations for our services.

The findings offer support to the ideas posited by Rutter and O'Connor (1999) who used the term "conceptual confusion". The pathway to this confusion over time was described by Duschinsky (2020). This is an important observation from the current study, as we consider the question of coherence across clinical and academic practice/discourse, in the service of improving outcomes for children.

Using the framework of critical discourse analysis (Fairclough, 2003) these findings suggest that attachment related discourses may support professionals to perform a particular identity (and set expectations of others) advocating for a non-blaming and accepting stance towards the child, while calling others to act. This description may align more closely with the values of practitioners than using terms such as conduct disorder or PTSD, as diagnoses might be seen as locating systemic issues within an individual child, even if this might offer a clearer pathway to intervention. However, connecting with the work of Coughlan et al. (2022), the attachment related terms are used with such a lack of specificity that speaks to a hesitation and limited confidence on the part of practitioners to state their views about attachment with clarity and transparency.

There are implications for foster carers, adoptive parents and education staff who are increasingly expected to be the agents for therapeutic change when children are identified as having been subject to maltreatment by primary carers. Therapeutic parents/carers may be at risk of experiencing blame and guilt if the hoped-for change does not occur, even if they have engaged with the offers of training and consultation generally offered by services for care experienced children.

This is particularly problematic when the formulation and interventions offered are not grounded in assessment and evidence-based practice, as discussed by Woolgar et al., (2014). Likewise, there may be an implicit blaming of birth parents when attachment discourses become the dominant explanatory narrative, particularly when those parents are no longer primary carers for the child or involved in the clinical conversations. White, Gibson, Wastell and Watson (2020) offer a framework for understanding the function of this blame for services and for wider society.

The findings from this study are broadly consistent with those of Woolgar and Scott (2014) in their review of case files from the National Service for Adoption and Fostering. Discussion of attachment overshadows case formulations where there has been early trauma, and/or a child becomes looked after. This occurs in the absence of formal assessment for attachment difficulties, with some services specifically stating their assumption that all referred children who are looked after will require attachment-oriented interventions and support, before they have met or assessed the children.

Consistent with the work of Beckwith et al. (2022), it seems likely that the clinicians and practitioners who documented the notes reviewed as part of the study were acting with the best interests of the child in mind in the absence of information, resources and clear frameworks to support their practice. In fact, there was a great deal of professional activity around the children whose case notes were reviewed, often in the form of advocating across services for interventions, changes in placement, school support or diagnostic assessment. There were even clearly documented conversations about how services could work outside of what they were commissioned to provide so that young people's needs could be met.

It is concerning that there was a lack of documented coherence between clinical assessment, formulation and the subsequent interventions offered by services. Perhaps this reflects a lack of clarity about agreed frameworks for professionals to make clinical assessments of attachment. It is also possible that the available guidelines are not realistic in the context of current CAMH service pressures. The assessment processes recommended by NICE (2015) require specialist training, time and resources.

Professionals would benefit from clarity about what frameworks they are expected to use in the assessment of attachment, so they can confidently document their conclusions or identify gaps in assessment information, regarding the aetiology of a presenting issue for any child. It is interesting to note the absence of references to NICE within the case notes reviewed, or indeed references to any local practice guidance. It would be interesting to explore with commissioners, clinical leads and service managers how they conceptualise the issue of children's attachment needs/difficulties, building on the work of Beckwith et al. (2022). It would be helpful for local services to describe assessment and treatment pathways for children who may need attachment-based assessments and interventions. This would support practitioners to have transparent conversations with parents/carers and provide a clear evidence based option for commissioners.

Further empirical research on attachment discourses in clinical practice is greatly needed. This is a small study of a snapshot in time, relying on what clinicians have been able to document in the pressured environment of busy CAMH services. There is a need to look broadly at outcomes for children who are offered attachment-oriented interventions within CAMHS to understand how effective this form of help is. Furthermore, there is a need for all specialist services for children to be resourced to undertake audit processes looking at assessment, formulation and intervention work, to explore how care and treatment aligns with the current and developing evidence-base.

There is a need to address the gap between core child and adolescent mental health services, and attachment-oriented services, so that families can access support based on clinical assessment and need, rather than care status. Central to this will be a manageable and effective assessment

and triage system to ensure children, and their families, can access the most appropriate pathway for their needs, and ongoing work to assess outcomes for children.

Attachment theory clearly serves an important function within the CAMHS clinical community. This function must be understood and articulated to support developments in attachment informed practice. Guidance, audit and policies may produce first order change, and important work is already underway to support this change (Forslund et al., 2022; Granqvist et al., 2017; Verhage et al., 2023) In practice, first order change might involve practitioners using attachment terminology carefully with birth parents, and more coherently in correspondence with professionals. As described by research participants in Duschinsky's Cornerstones (2020) practitioners may think about attachment related concepts in their assessment of families but avoid using this language in written reports. However, unless the function of using attachment concepts is also addressed, change at the level of beliefs that guide practice will be much more difficult to achieve. In a stressed health and social care system we must think about how professionals can practice safely, transparently and collaboratively in the presence of risk and complexity, and how attachment related concepts can accurately and transparently contribute to children's care and treatment.

### *Strengths and Limitations*

The findings of this research study are limited due to size of the sample and the limitations of relying on case note searches to understand clinical activity. With regard to sample size, we included a wide age range, children with different diagnoses and genders. There may be very distinct issues arising for groups within the sample. This requires further exploration. There is a need for larger scale work to assess the impact of attachment-oriented interventions over time in applied settings.

Very few studies have accessed clinical material to explore the question of how attachment discourses are used in practice. This study contributes to the literature by using clinical material from CAMH services. The qualitative nature of the study has allowed for a fuller understanding of how the concepts have been applied, and how they have shaped services for children and their families. The research process and findings were shared with experts by experience, who kindly offered feedback regarding how the themes resonated with their experiences. They also offered guidance regarding patterns and meanings that could be significant within the data.

## Conclusion

We hope it has been possible to convey in this article our respectful and appreciative position for the work of practitioners in health and social care. This work is not intended to be critical of practice, but an analysis of how attachment concepts support or constrain clinical work with families. The analysis has highlighted issues with conceptual confusion, lack of transparency with birth parents regarding attachment related practice, and very limited specialist resources, particularly in the assessment of attachment to support differential diagnosis and intervention planning.

To address these issues, it will be important to engage in conversations across disciplines and services. There is a need to engage in dialogue with families, including birth parents, regarding how we talk about family relationships, including those aspects of relationships that might harm a child's development. This has been possible in interventions such as Circle of Security (Powell et al., 2009) where concepts are shared openly with parents who are then supported to reflect on their parenting and their relationships generally.

Most importantly, this research highlights the importance of well documented, thorough assessments in clinical practice with children and families. Case records should include meaningful

clinical formulations, evolving over time. We advocate for the increased availability of evidence-based interventions, in line with NICE guidance, unless there is an assessed reason to deviate from these. Without this specificity, there is a risk that children's needs will not be well understood, and that our interventions will not adequately address the issues that have such a profound impact on children's lives. Interventions should have specific, clearly stated goals from the outset, that can be monitored over time, with regular, documented reviews. We hope that this will not only improve outcomes for children but also help them to understand their journey through services as it unfolds and later in life.

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## Ethical Considerations

This study was conducted using anonymised mental health records accessed through the Clinical Record Interactive Search (CRiS) system at South London and Maudsley NHS Foundation Trust (SLaM). CRiS provides researchers with access to de-identified electronic health records under a robust governance framework. This project has been approved for secondary data analysis by the University of Oxford (Ref: 08/H0606/71+5).

## Consent to Participate

Individual informed consent was not required for this study because it involved secondary analysis of de-identified electronic health records accessed through the South London and Maudsley NHS Foundation Trust Clinical Record Interactive Search (CRiS) system. Data were made available for research within the established CRiS governance framework, which includes service-user information materials, mechanisms for opting out of research participation, and oversight through NHS research governance and research ethics procedures.

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## Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Data Availability Statement

Data are owned by a third party, Maudsley Biomedical Research Centre (BRC) Clinical Records. Interactive Search (CRIS) tool, which provides access to anonymised data derived from SLaM electronic medical records. These data can only be accessed by permitted individuals from within a secure firewall (i.e. the data cannot be

sent elsewhere), in the same manner as the authors. For more information please contact: cris.administrator@slam.nhs.uk.

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