Chapter 8

ADULT ATTACHMENT AND CARE STAFF FUNCTIONING

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Box 8.1 Excerpts from Adult Attachment Interviews with Care Staff Members

Excerpt from the adult attachment interview with a care staff member with an autonomous-secure mental representation of attachment:

> My own attachment, of course, when I was five, with my parents, also did help me. That's why also – I can empathize with the clients, as in: well, yes, I know how it is to not live with your natural people and to be brought up in a large group. So I think that has all some advantages.

Excerpt from the adult attachment interview with a care staff member with a dismissing-insecure mental representation of attachment:

> So, I don't want to say that I am very strict, because the difference is, when I am here at work, then I am much more eh, eh more disciplined, towards them. I am the one who decides when things go too far for me. When, for example, a resident asks for something

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> three or four times, I would say, 'I have given you the answer, that's that.' You know, it's over now and then I would not listen any more. And then it is really finished for me.

Excerpt from the adult attachment interview with a care staff member with an unresolved mental representation of attachment:

> I think that it always – it will have influence – and that you always wish for doing things better than your parents, do it different than your parents – when you have your own children or the children you work with or the clients you work with…well, that you just – want to be a bit more caring than…I think that all of this has influence. On how one works now. I think it is very important how people look like, I think it's very important that they look clean. No, but eh, no, I think it's just very important, that, that just appearance is very important, how people look, I think, and well cared for. But I think that I have got that from home.

Care staff around the world make huge differences every day in the lives of people with intellectual disabilities (ID). Care staff provide support, advice and protection, and may scaffold the autonomous exploration and development of people with ID. By doing so, they enrich the network of meaningful social relationships that humans need to flourish (Uchino, Cacioppo and Kiecolt-Glaser, 1996; Schuengel *et al*., 2010). Similar to family relationships of young people with ID (Totsika *et al*., 2014), better quality relationships between care staff and people with ID have been linked with fewer challenging behaviours in services (Clegg and Sheard, 2002; Eisenhower, Baker and Blacher, 2007; De Schipper and Schuengel, 2010). In residential care, aggressive client behaviours have been found to be linked strongly with client–staff interactions, such as attention seeking and evasion of demands (McAtee, Carr and Schulte, 2004; Embregts *et al*., 2009). Despite the obvious relevance of a social relationship perspective on the quality of care provision for people with ID, the literature provides little guidance for training and supervision of care staff on the ways in which they manage their relationships with clients (van Oorsouw, Embregts and Bosman, 2013). Crucial questions remain unanswered as a result. Do services stimulate and support care staff enough in building good quality relationships, and what are the most important limitations that care staff need to overcome (Hermsen *et al*., 2014)? How do relationships with clients affect

care staff on a personal level? Do policies and service cultures always pull out the best of human qualities that care staff can give (Bell and Clegg, 2012)? The goal of this chapter is to make a case for including attachment among the perspectives that should be considered in research, policy and practice around client–staff relationships. The central message of this chapter is that in order to improve care interactions and relationships, attention is required to understand attachment processes in people with ID and attachment processes in care staff as well. Implications of the small body of research on this issue will be discussed with regards to: policy and quality control, service development and organization, care staff and clients.

THE ATTACHMENT THEORETICAL PERSPECTIVE

The British psychiatrist John Bowlby (1907–1990) theorized that attachment is an important aspect of human behaviour, affect, cognition and personality across the life span. As an evolutionary adaptation to the inherent vulnerability of human infants, a behavioural system develops that plays an important role in regulating our sense of security. The attachment behavioural system directs us towards specific persons who are perceived as wiser, stronger and (at that moment) more able to cope with the world, as well as willing to share their resources and wisdom with us. While this system is likely to be highly active in children, to the extent that many situations challenge their abilities to fend for themselves, the system is also supposed to be active in adults at times when life's challenges outstrip their perceived personal resources. The attachment behavioural system is conceptualized within control systems terms as an adaptive, self-learning system that incorporates feedback from the environment into internal working models or mental representations of the social environment (Bowlby, 1984). These mental representations are supposed to play an important dynamic role in development, as these representations influence perceptions and behaviours in new relationships and new settings, and are updated and differentiated through ongoing new experiences (Sroufe, Coffino and Carlson, 2010). Attachment is therefore relevant across social contexts, not just for the family of one's upbringing.

The prime demonstration of the salience of attachment across contexts and generations is provided by the robust finding that parents' own representations of attachment predict the quality of the attachment relationships with their own children (van IJzendoorn, 1995). This so-called intergenerational transmission of attachment has been

found to be partially mediated by sensitive responsive caregiving by parents of their children (Bernier *et al*., 2014). The explanation is that parents' mental representations of attachment facilitate or hinder accurate perception of children's signals and needs and adequate responses to those needs. This is because the mental representations that parents may have developed in adaptation to painful and distressing caregiving experiences from childhood onwards may bias or limit parental sensitive responsiveness. Their own children will therefore also have to resolve the ensuing feelings of rejection, anger or distress and adapt their own mental representations and behaviour within the parent–child relationship.

The impact of adult mental representations of attachment was discovered by Mary Main and her colleagues (Main, Kaplan and Cassidy, 1985) by studying parents' responses to semi-structured interview questions about their relationships with their own parents within the Adult Attachment Interview (AAI; George, Kaplan and Main, 1996). Questions about such affect- laden experiences are challenging for a speaker in two ways. Because the listener is completely unfamiliar with the speaker's background, the speaker has to present the experiences and evaluations in a way that the listener can understand. If the relationships with attachment figures have been difficult and complex, the story that the speaker needs to tell will be difficult and complex as well. At the same time, the topic of relationships with parents and the actual memories that are retrieved may be affectively arousing, setting self-regulatory processes in motion. Efforts on both these challenges may conflict, which may lead to confusing or incoherent narrative, unsuccessful regulation of affect, or both. Few difficulties are expected for speakers who have not had conflicting, confusing and distressing experiences which need to be incorporated in their mental representations of attachment. Relatively few difficulties may also be experienced by speakers who have extensively re-examined and reprocessed their more complex experiences, for example as a response to corrective experiences in new relationships (e.g., when a person who grew up in an emotionally cold family becomes involved with a loving, responsive partner, or when a person engages in psychotherapy). The interview may prove more difficult for speakers who have had relatively complex or unfavourable experiences, and who may not or only unsuccessfully have worked through those experiences. The problems and faults within the resulting narratives have proven to be a rich and powerful window into the complexity of human social functioning (Main, Kaplan and Cassidy, 1985).

In order to subject mental representations of attachment to quantitative empirical study, Main and Goldwyn (1994) developed a formal scoring and classification system based on verbatim interview transcripts, which is now used worldwide by researchers As a result, a burgeoning literature has developed on individual differences in attachment representations, as characterized by classifications into a number of adult attachment categories (see Bakermans-Kranenburg and van IJzendoorn, 2009 for a review of studies including data from 10,000 participants using the AAI). Most narratives in these studies (58% in North American samples of non-clinical mothers; Bakermans-Kranenburg and van IJzendoorn, 2009) indicate an *autonomous-secure representation*, which goes along with an open and realistic stance regarding the nature of their experiences and an open and valuing discussion of the importance of their attachment figures in their lives. *Non-autonomous dismissing representations* indicate a distance taken towards attachment and attachment experiences, often seen in idealization of relationships with parents, failure to recall concrete attachment experiences or negation of any possible hurt or negative impact of harsh or insensitive parenting. *Non-autonomous preoccupied representations* indicate a mental entanglement and involvement in conflicted relationships with attachment figures, as shown by current anger flaring up during the interview or vagueness surrounding ill-defined, negative experiences. Specific attention is paid to loss of attachment figures and experiences of traumatic abuse from attachment figures. Disorganization and disorientation in speaking or reasoning about these experiences go along with an *unresolved-disorganized representation of loss or trauma*.

The theoretical view espoused in this chapter regards the adult attachment categories of autonomous, dismissing, preoccupied and unresolved representations as developing patterns of affective-cognitive processing of attachment cues. This view differs from the approach that is often taken in social psychology to cast personality differences in attachment terms, speaking about secure or anxious *individuals*. While the latter approach stresses relatively fixed social behaviours and relationship styles, the developmental approach in the Bowlby–Ainsworth tradition provides psychological depth in understanding how social relationships shape, and are shaped by, relatively specialized affective-cognitive substrates. An important implication is that the impact of attachment representations on social relationships may be changed by understanding such processes and changing the social context, which will be demonstrated in the next section.

ADULT ATTACHMENT AND PROFESSIONAL CARE

The strong and robust associations between parents' mental representations of attachment and the quality of their caregiving behaviour and relationships with their children have spurred investigations into other domains that also present people with attachment-relevant cues. For example, in residential care for adolescents with severe behaviour problems, adolescents perceived their assigned group worker as more psychologically available if workers had an autonomous-secure attachment representation rather than a non-autonomous representation (Zegers *et al*., 2006). Also, the nature of interventions and working alliances between mental health workers and their clients were associated with workers' attachment representations (Dozier, Cue and Barnett, 1994; Tyrrell *et al*., 1999). A recent study found that when psychotherapists had dismissing attachment representations, their clients were more likely to rate the therapeutic relationship as avoidant-fearful (Petrowski *et al*., 2013).

In a study on the effectiveness of CONTACT, a video-feedback intervention to improve the relationship between support staff and people with visual and ID (Janssen, Riksen-Walraven and van Dijk, 2003; Damen *et al*., 2011), the role of the attachment representation of staff was included (Schuengel *et al*., 2012). Staff participated in a video-feedback programme to improve the sensitivity of their responsiveness to the sometimes difficult-to-read interactive behaviour of residential clients. Of the 51 care staff, 18% were male, and 65% had a higher vocational education degree. On average, staff members were 31.0 years old (SD 9.3) and had, on average, 8.6 years of experience in working with persons with disabilities (SD 7.5). The 12 clients in the study had a combination of visual and intellectual disabilities. Clients were between 13 and 54 years old (median 38 years). Seven clients were male. Severity of intellectual disability ranged from moderate (n=2), through severe (n=5) to profound (n=5). Five clients were partially sighted, the other clients were blind.

To study the effect of the intervention, an A–B design for single-case experiments (Barlow and Hersen, 1984) was used. Each client and his or her care staff completed a series of interaction sessions. During the baseline period, video recordings were made of the interaction situations with each of the participating staff members. Each staff member was videotaped and observed twice during baseline and no interaction coaching was given. During the intervention period, three recordings were made, resulting in two baseline recordings and three intervention

recordings for each client–staff dyad. Five minutes of each videotape were coded, using scales to measure the quality of the interaction in the form of: frequency of giving confirmation to the client, responsiveness (giving a reaction to initiatives of clients) and affective mutuality (high, moderate or low) (for more details, see Damen *et al*., 2011 and Schuengel *et al*., 2012).

The results showed that 28 staff members were classified as autonomous, 12 as dismissing and 11 as preoccupied with respect to attachment. In addition, seven participants received a primary classification as unresolved with regard to loss or trauma. Multinomial tests did not reveal significant differences between the sample distribution of AAI categories and the distribution found for general population samples of parents reported in the meta-analysis by Bakermans-Kranenburg and van IJzendoorn (2009). Care staff were no more or less autonomous-secure with regard to their attachment representations than the general population and no associations were found between attachment classification and gender, age or years of working experience of staff. However, caregivers with higher vocational training were more often classified with an autonomous attachment representation than caregivers with lower vocational training. Our CONTACT study also made it possible to clarify the linkage between attachment representations and the quality of the interaction and, even more importantly, the linkage with the intervention to improve the quality of the interaction between staff and clients (for detailed results, see Schuengel *et al*., 2012). The unresolved classification was disregarded in the statistical analyses, due to the small number of care staff within this group.

With regard to the associations between attachment representations and the indicators used for quality of the interaction, two significant patterns emerged. Staff members with dismissing attachment representations less often responded to signals of their clients with a confirmation that they had perceived the signal, compared to staff members with an autonomous classification or staff with a preoccupied classification. This leads us to question how the attachment representations of staff relate to intervention effects regarding improving the quality of the interaction they are involved in. Interestingly, no differences on the intervention effect by attachment representation group were found for the concept of confirmation. A significant improvement in the use of confirmation in general was found for all attachment groups in this study. Hence, despite an overall increase after interaction coaching in the rate with which staff responded with a confirmation of receipt of the clients' signals, care staff with dismissing classification continued

to show such confirmation at a lower rate than care staff with autonomous and preoccupied classifications. The lower rate of confirmation among care staff with dismissing attachment representations points to a more 'distant' interactive style that might reflect a general strategy to minimize exposure to negative affect in relationships (Kobak *et al.*, 1993; Roisman, 2006).

A second indicator of high quality of the interaction between staff and clients was the percentage of client initiatives responded to by the staff member ('responsiveness'). In general, the video-feedback intervention improved the responsiveness. A significant interaction effect between attachment category and recording occasion was also found. Figure 8.1 shows a drop in responsiveness from the first baseline recording to the second, and an increase from the last baseline to the first intervention recording for the care staff with non-autonomous attachment, while care staff with autonomous attachment showed an increase from the first to the second baseline recording, remaining stable thereafter. In other words, while care staff with autonomous classifications improved without support before the video-feedback intervention had started, staff members with preoccupied or dismissing classifications only showed improvement *after* they had received

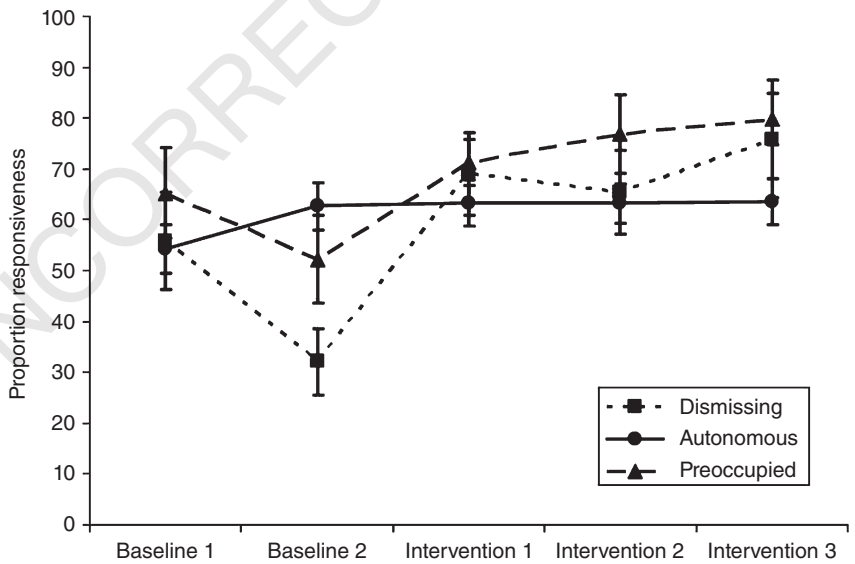

Figure 8.1 Mean proportions of responsiveness by interaction recording during baseline and intervention period for care staff in the three attachment categories.

interaction coaching. It is therefore encouraging that interaction coaching was effective in eliminating the emerging differences in responsiveness between care staff with autonomous and non-autonomous representations. However, the stronger dependency on the interaction coaching for non-autonomous staff might also make it more difficult to sustain their improvements in the long term.

A case example will now be used to describe the impact of the CONTACT intervention with a young boy called Tommie.

Case Example: Tommie

Tommie was placed out of his family home into a group home when he was ten years old, five years before the intervention. He had cerebral palsy and severe visual and intellectual disabilities, but generally few behaviour problems. He used some verbal communication, but his direct care staff had very little verbal interaction with him. They requested the CONTACT intervention in order to increase their verbal interaction with Tommie. They chose lunch time as an appropriate opportunity to video their interactions with him. After the intervention, the direct care staff evaluated the progress they had made in a group session. They concluded that the intervention helped them to learn that Tommie could understand simple messages within a relevant context, that they listened more and responded more and took conversational turns. They also reported gaining a better understanding of how Tommie's physical condition sometimes hampered communication, and that they became better in allowing Tommie more time to process cues and information.

It is recognized that supporting care staff through video-feedback interventions to interact with clients in ways that may be contrary to their natural inclination may cause psychological discomfort and strain for the staff. This study of video-feedback also explored staff's level of work experience and reported job satisfaction in relation to their attachment representation (Schuengel *et al.*, 2010). Staff with a preoccupied attachment representation had a lower overall job satisfaction than staff with autonomous or dismissing attachment. Staff members with autonomous attachment were most satisfied about the

work itself and their relationships with colleagues. Interestingly, the aspect that care staff members with dismissing attachment were most satisfied about was the autonomy that their job provided. Care staff with preoccupied attachment were most dissatisfied about the support they received from their colleagues and supervisors. They seemed to experience a misbalance between the support they provided their clients and the support they received from others.

This study provided evidence for the importance of attachment representations of staff working with vulnerable clients with visual and intellectual disabilities. Because of the importance of the relationships with significant others in the lives of people with ID, care staff must be reliable, stable and sensitive in their contacts. The above-mentioned results showed that care staff with non-autonomous attachment representations and, more specifically, care staff with dismissing representations need support and coaching to improve the quality of their interactions in working with children and adults with visual and intellectual disabilities. This support or coaching can ameliorate the at-risk character of the less-responsive interaction patterns in their natural social behaviour.

ADULT ATTACHMENT AND STAFF MANAGEMENT

Overcoming the effects of care staff's attachment representations on interactions with clients, as demonstrated in the CONTACT project, may be important but not sufficient in order to intervene in problematic staff–client relationships. In some cases, care staff may choose to continue with limiting confirmation of client signals as a strategy to avoid problematic overinvestment of clients in relationships with staff (Clegg and Sheard, 2002) and to discourage clients from becoming 'overly fond' of the staff member, which is reported as the most frequent challenging behaviour (Larson, Alim and Tsakanikos, 2011). Box 8.2 illustrates the strained interactions that may sometimes occur.

In attachment theory, the excessive attachment behaviours of some people with ID towards their care staff indicate a failure to develop an adaptive goal-corrected partnership with the attachment figure. Of the several possible pathways towards this relationship pattern, attention has focused on under-developed person permanence, especially for persons with intellectual and visual disabilities (den Brok, Sterkenburg and Schuengel, 2012). A person who lacks person permanence and develops an attachment relationship is bound to be vulnerable to

Box 8.2 Excessive Attachment Behaviours

The person with ID searches for and talks about a particular member of staff, finds out about when she will be on shift, follows her around, including waiting outside the toilet for her to re-emerge, takes her photograph off display boards, and so on. These behaviours feel deeply intrusive and disturbing to the staff member. It feels as if the person is trying to crawl inside her skin. Incidents of aggression are easily provoked, as the person experiences intense jealousy when 'his' member of staff talks with a peer, particularly somebody similar who may be construed as a competitor. Having to work in locations away from the person makes the staff member feel, and resent feeling, that she is being prevented from doing her job properly.

anxiety during separations. To stimulate the development of person permanence and thereby to lessen anxiety when the attachment figure is out of sight or out of earshot, a mobile application was developed to facilitate communication independent of time and place. Care staff may employ these or similar strategies to lessen distress and attachment behaviour during separation, thereby not only increasing client wellbeing but also decreasing care staff burden.

As clinicians and researchers, we are all aware of policies that manifestly fail to limit turnover of direct care staff or that promote staff 'churn' so as to prevent special relationships developing between staff members and clients (De la Fosse and Baron, 1995; Leaf, 1995). There may even be attempts to justify such policies by reference to the anxiety that clients may experience around the inevitable separations and transitions that occur in non-family, professional care arrangements. Yet, this strategy has been implicated in the problems of people with ID intermittently over the years. King, Raynes and Tizard (1971) were the first to identify and express concern about up to 50 different staff caring for young children in any given week, an issue also raised by parents (Buntinx, 2008) and the current authors.

The concerns that managers and policy makers may have regarding support staff's lack of responsiveness to attachment behaviours of clients may be alleviated by attending not only to building secure relationships but also to the way in which such relationships are brought to a completion. Care staff may not only be a positive model for human

connection, responsiveness and trustworthiness, but also for preparing and managing the disconnections that are inherent in any human relationship. Completing professional staff–client relationships in ways that promote emotional security and confidence in future relationships requires that care staff and clients are allowed time to prepare themselves and each other for such transitions. Within this transitional period, the security invested in the current relationship may be used to explore new relationships that may replace the current one (Schuengel and van IJzendoorn, 2001). Such a display of respect for relationships that have been developed over time, whether close and enduring or perfunctory and limited, may generalize to other relationships that might be affected, for example with group members and neighbours during a residential move.

Awareness that their support contributes to the wellbeing of people with ID might be lower in care staff with non-autonomous representations (Schuengel *et al*., 2012). However, the intervention study of Schuengel and colleagues on video feedback indicates that there is the potential to make care staff more aware of their role in understanding and supporting people with disabilities. Furthermore, care staff appear to become capable observers of attachment behaviour in people with ID after a short 15-minute introduction to the Circle of Security diagram, which can be found on the Internet: circleofsecurity.net (De Schipper, Stolk and Schuengel, 2006; Hoffman *et al*., 2006; De Schipper *et al*., 2009). Hoffman and his colleagues developed their diagram for use with parents of non-disabled infants, who are portrayed wearing nappies. The principles depicted in the diagram are, however, also highly relevant to long-term care and support relationships with adults who have IDs.

See Boxes 8.3 and 8.4 for ideas to aid the introduction of the Circle of Security model of attachment to staff.

Attachment theory and research also suggest that there should be a focus on *all* staff members, because each staff member appears to contribute to the wellbeing of people with ID. Young persons with moderate to severe ID who showed secure attachment behaviour to more caregivers also showed less withdrawal and stereotypic behaviour (De Schipper and Schuengel, 2010). Although this association might be explained by client characteristics, the patterns of associations provided evidence that direct staff brought characteristics with them that influenced their relationship with each successive client. Second, the studies reported here have identified the role of support staff attachment representations and their engagement across varying groups of

Box 8.3 Topics for First Discussion of Circle of Security with Staff

- Explain how mature, competent adults help vulnerable individuals to grow and develop in two distinct ways: by encouraging them to explore the world and by being warm and responsive when they seek support.
- Explain that some people are able to do both of these well, but that most of us find one of them a bit easier than the other. Ask staff if they remember if their parents were more likely to encourage them to try new things and activities, or more likely to be warm and responsive when they approached them for comfort or reassurance.
- Ask staff to think about themselves and their colleagues at work. Ask if they are more likely than other people to encourage clients to try exploring new things and activities, or are they one of the available ones who respond warmly when clients approach?
- Discuss what it would be like to swap these different ways of working with a colleague who uses a different approach.

Box 8.4 Topics for Second Discussion of Circle of Security with Staff

- Explain that people with insecure attachments often *miscue* others about what they need.
  - Those who are very dependent on other people need sensitive encouragement to try some exploration, even though that seems to be the last thing they want.
  - Others may need emotional warmth to affirm that they are valued human beings, even though they seem unapproachable.
- Deciding not to follow the cues a person gives all the time has to be considered ethically, and done slowly and sensitively.
  - When people are preoccupied by getting their emotional needs met, they tend to 'tune out' the rest of the world, so may well find exploring something new very anxiety-provoking.
  - Similarly, people who have learned to avoid emotional closeness may need very low-key approaches to start with if they are not to feel overwhelmed by too much intensity of contact with staff.
- So it is worth staff carefully taking the risk of interacting in ways that run counter to the person's cues if they do it carefully, thoughtfully and at low intensities, because it can initiate a radical improvement in the person's wellbeing.

people ranging from mild to profound ID with and without additional disabilities, suggesting that the framework of caregivers' attachment representation and behaviour applies to diverse services.

Taken together, these research studies suggest that management need not consider selective recruitment of support staff based on attachment representations, because staff with insecure attachments can become more flexible in the way they interact with their clients. Their specific attachment background may indicate that some ways of relating may go against the grain somewhat, but training, supervision and support can facilitate growth-promoting connectedness with clients who have ID.

ADULT ATTACHMENT AND PROFESSIONAL RISK AND RESILIENCE

In addition to direct linkages that may be found between care staff's own attachment issues and quality of care and interpersonal relationships with clients, adult attachment also has been found to influence other domains that affect the functioning of care professionals. Whilst a complete review of the adult attachment literature is outside the scope of this chapter, several findings will be highlighted that are particularly relevant to the quality of care staff's functioning with persons with ID.

Mental Health

The linkages between attachment representations and mental health are complex. Both constructs may contribute to adult functioning independently, and to a considerable extent. However, a meta-analysis of 200 studies (N=10,000 participants) found over-representations of non-autonomous attachment representations in samples of people with clinical psychological problems (Bakermans-Kranenburg and van IJzendoorn, 2009). Preoccupied representations were over-represented among people with internalizing disorders, and in particular among people with borderline personality disorder. Preoccupied representations were also over-represented among partners involved in domestic violence. Depression was, however, associated with dismissing representations. People with dismissing representations may have a higher risk for suffering across a longer time, due to their reluctance to report

their symptoms, despite the heightened severity of their symptoms in the eyes of professionals (Dozier and Lee, 1995). Given the psychological burden that carers often have to endure, including scenes of violence and human suffering, attention to attachment representations of staff may also be justified given their proneness to persistent mental health problems.

Support Seeking

Adult attachment representations are associated with seeking support within relationships, in marital couples (Crowell *et al*., 2002) as well as in adolescent–parent relationships (Kobak *et al*., 1993; Allen *et al*., 2003). Adolescents with more autonomous attachment representations were perceived as seeking support more effectively (Zegers *et al*., 2006). An Israeli study found that young adults with preoccupied representations were less satisfied with the support they derived from their parents, which provided an explanation for the difficulties they experienced in dealing with the stresses of entering military service (Scharf, Mayseless and Kivenson-Baron, 2011). Similarly, studies have found that the transition from home to college life was more difficult for young adults with preoccupied representations (Bernier *et al*., 2004). Together, these findings provide grounds for speculating that some professional carers may seek and find support more effectively when faced with challenging situations at work because of their autonomous attachment representations. Failure to seek and find support may be especially detrimental for new care staff. With ever-limited training and supervision on the job, care staff with non-autonomous attachment representations may be less likely to seek out or welcome advice and help, which diminishes the opportunities for adjusting to the job situation, enjoying it and developing the necessary skills.

Mindset

Care staff working within services which exclusively use behavioural approaches may find that attachment-informed practice requires a different mindset. Although both approaches are firmly rooted in behaviourism as a psychological methodology (building theory on the basis of observable phenomena), behaviourism as a theory of functioning and behaviour change is exclusively based on learning

principles whereas attachment theory is composed of tenets from ethology, evolutionary biology, cybernetics, systems theory and psychodynamic theory. Put into practice, it may often appear as if attachment interventions focus on invisible phenomena such as bonds between people, and on the way past relationships affect the expectations each individual brings to meetings with new people. As a result, it may often not be transparent how researchers and clinicians within this orientation perceive attachment phenomena within case material (Clegg and Lansdall-Welfare, 1995). However, similar to the behaviouristic tradition, attachment-oriented scholars and practitioners train to become astute observers of interactive behaviours and astute readers and listeners of verbal behaviour in narrative form in order to infer quality of both attachment relationships and mental representations of attachment. This has two implications for clinicians working with care staff within an attachment framework. First, staff members will need help to understand this way of seeing their clients and work out how this influences any difficulties the client may have. In addition to this, they will also need ongoing support to maintain a grasp on this learning and find ways to combine this with existing protocols or behavioural therapeutic approaches already in place. Reminders in the form of Circle of Security diagrams have been shown to be helpful, but integrative approaches may also be developed (Schuengel *et al*., 2009).

Secondly, research indicates that the attachment histories of staff influence how open they may be to trying out new ideas, because security of attachment fosters exploration, learning and perseverance. For example, college students with dismissing and preoccupied representations reported the least positive dispositions towards learning (Larose, Bernier and Tarabulsy, 2005). Mothers with autonomous attachment representations showed an open and flexible mindset concerning the emotions they and their infants experience (DeOliveira, Moran and Pederson, 2005), while the general personality trait of openness to experience was found less among persons with dismissing attachment representations (Roisman *et al*., 2007). Since a mindset of openness to expressions of individuality of clients, appreciation of differences and assuming that people might learn and change have been proposed as essential to personalized, high-quality care (Schuengel *et al*., 2010; Meppelder *et al*., 2014;), these positive personal qualities might be more strongly in need of stimulation and support among care staff who have non-autonomous attachment representations.

CONCLUSIONS

Relative to the external, structural forces that limit overall improvement of professional care for people with ID, the attachment representations of the care staff themselves might appear to be a relatively minor, secondary problem. However, research to date indicates that some of the efforts to improve care may be done more efficiently by identifying the care staff members who need such support the most. For example, relatively intensive and expensive video-based coaching from the CONTACT programme may be offered in a more differentiated way, so that it reaches the care staff with non-autonomous attachment representations who benefit the most (Schuengel *et al.*, 2013). In an ideal world, efficient screening methods would perhaps exist to identify candidates for such interventions. Until that time arrives, we might employ the attachment theoretical framework as one of the tools for understanding some of the problems experienced by care staff who fail to deliver the qualities that people with ID require and deserve. The attachment theoretical perspective supports a fundamental trust in the opportunities for people, despite psychosocial liabilities developed over years, to learn and develop new response sets and inner understanding. This perspective may be an important component of the culture and climate of organizations that provide professional support for people with ID, promoting a mindset not only oriented towards social functioning of clients with ID, but also towards the capacity of care staff to change relationships with their clients for the better. Becoming aware of one's own vulnerabilities and limitations and those of others may be an important step towards sympathizing with the needs and vulnerabilities of even the most difficult clients with ID, and to recognizing how care staff can shape the interpersonal world of these clients.

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