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Incorporating Attachment Theory into Practice:
Clinical Practice Guideline for Clinical Psychologists
working with People who have Intellectual Disabilities

June 2017

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Foreword

The work of John Bowlby and attachment theory has informed my thinking in various ways throughout my career. Therefore, I am delighted to have been invited to write this foreword to the guidelines. At the start of my psychology career in the 1970s, A-level texts presented Bowlby's attachment theory beside the famous study by Harry Harlow, in which a Terry cloth-covered wire monkey was preferred by infant monkeys to a bare wire 'mother' with a feeding tube. At that time, Bowlby's work, summarised in the World Health Organisation (WHO) publication *Infant Care and Mental Health* (1951) was subject to strong feminist critique, characterised as reinforcing traditional gender roles for women. As a new father myself, I lamented the baby books and guides of the time, which were clearly aimed at mothers, not fathers. Thus, Bowlby's initial interpretation that early maternal deprivation could cause irreversible and long-term psychological damage may have been influenced by the times in which he was writing. His initial findings were largely based on 44 children in a relatively deprived orphanage (Bowlby, 1946), but his research was very carefully carried out and showed a definite association between lack of affection and delinquency – thankfully, it turns out that such damage is not as irreversible as Bowlby originally thought.

The umbrella construct of *primary maternal deprivation* caused a debate that unfortunately overshadowed Bowlby's ground-breaking development of attachment theory. By the time I had undertaken my PhD in child development, Rutter's (1981) revision of maternal deprivation in *Maternal Deprivation Reassessed* had concluded that discord and disharmony of family breakdown predicted poor mental health, rather than primary maternal deprivation. However, the developing and interacting bonds that people experience in their lives offer continuing risks and continual opportunities for improved psychological health, and attachments continually reflect current mental wellbeing.

But what about fathers? In my first book with Jaqueline McGuire entitled *Fathers; Psychological Perspectives*, we were rather upbeat about the changing role of fathers (Beail & McGuire, 1982). Disappointingly, my research at that time did not find much change in parenting roles (Beail, 1985). However, it would be fair to say that much has changed since then, and it is now accepted that children develop multiple attachments, which are developed into a hierarchy of strengths.

Thankfully, attachment theory became more prominent in the 1980s in the clinical understanding of psychological development. As a trainee clinical psychologist, I was taught by two psychoanalysts, Brian Lake and Dorothy Heard, who knew and, in the case of Dorothy, worked with Bowlby; Brian supervised some of my clinical work. At that time, Dorothy and Brian were working on the concept of the attachment dynamic in adult life (Heard & Lake 1986). Work such as this demonstrates that attachment theory is not just about child development, but about development across the lifespan.

Also at this time, I carried out an observational study of profoundly multiply disabled children living in a hospital for 'mentally handicapped people'. My observations found that the children spent over 80 per cent of their time not interacting with anyone (Beail, 1985). This was in sharp contrast to children with similar disabilities living with their parents

where the time spent in interaction was the complete reverse (Beail, 1988). Although my project had a behavioural focus, I was left wondering about the internal worlds and emotional development of these children.

When I qualified as a clinical psychologist in 1984, I began working in a joint post in child development and intellectual disabilities (ID). My placement had been in a large hospital for people who have ID, but service philosophies were changing from hospital to community care, and new posts appeared in community teams (see Beail, 2016). The client group was also different as the community team served the community rather than only those placed in hospital. Those in hospital were also being repatriated to their communities. I had come to the view that people who have ID were being offered a very limited range of interventions, often by indirect behavioural methods. I started to work psychodynamically with some of my clients. I came into contact with Pat Frankish and Valerie Sinason who were also offering this approach to people who have ID. It was not surprising that working with adults with developmental delays needed to be informed by the work of child psychotherapists and theorists. As well as the ideas of Klein and Winnicott, Bowlby's ideas were also playing a central role in the developing model of disability psychotherapy (Frankish, 2016).

In the mid-1980s, attachment theory became more prominent in our thinking in ID services due to the work of Jennifer Clegg (e.g. Clegg & Sheard, 2002) and then Carlo Schuengel and his colleagues (e.g. Schuengel et al., 2013). Over time, these ideas have been increasingly incorporated into clinical practice with people who have ID, and hence the need now for some clinical guidelines.

These guidelines focus on incorporating attachment theory into clinical practice. For those who are not familiar with attachment theory, the guidance provides a summary before it examines research in attachment with people who have ID. There are service user and carer accounts of the attachment issues in their own life journeys, and then clinical guidance on incorporating attachment theory into our practice. The guidance invites us to think about direct clinical work with individuals, but also more systemic applications.

I would like to congratulate the working group of the faculty for people who have intellectual disabilities for their dedication and commitment to this project. They have produced excellent clinical practice guidelines, which I hope will inform and develop the practice of clinical psychologists and others who serve people who have ID.

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Executive Summary

The aim of this guideline is to inform clinical psychologists and others about attachment theory and how it can be applied to the health and social care of people with intellectual disabilities (ID). Key information is summarised to inform practice.

Overview of attachment theory

Attachment theory, as proposed by John Bowlby and developed by others, has resulted in an evidence base for the essential premise that good emotional care in childhood and beyond is an important factor for later wellbeing. This is not a simple one-way process, and the individual's *attachment behavioural system* needs to work in conjunction with the primary carer's *caregiving behavioural system* in order for secure attachments to develop. Secure attachments in childhood are thought to lead to individuals developing a sense of themselves as acceptable, competent, and valued. As children become more independent they rely less on the physical presence of their caregivers, and instead utilise their internal working models of attachment to predict how others will respond to them. Realising that others also have their own needs, they negotiate a *goal-corrected partnership*.

A range of constitutional and environmental factors can affect the development of attachment relationships. Although 60 per cent of the general population develop Secure attachments, 10–15 per cent of children develop Avoidant strategies (not signalling their need for comfort to avoid rejection), and 8–10 per cent of children develop Ambivalent strategies (signalling distress at high frequency and amplitude to overcome intermittently available care). Many children (15–19 per cent) show signs of attachment Disorganisation, (where children become watchful and fearful, or 'frozen') where parental care is experienced as frightening. Research has linked (with some caveats) these categories of attachment responses in children to adult's current states of mind regarding their early attachment relationships. Avoidant, Secure, Ambivalent, and Disorganised classifications have been thought to correspond to Dismissing, Autonomous, Preoccupied, and Unresolved states of mind respectively.

Research has demonstrated that children who are not classified as Secure are more likely to show a range of cognitive and emotional deficits or delays and receive certain psychiatric diagnoses. In adulthood, a classification of Unresolved, Dismissing or Preoccupied states of mind is linked to many forms of distress and increased risk of being diagnosed with a psychiatric disorder.

Attachment and intellectual disabilities

Intellectual Disability does not preclude the development of Secure attachment relationships, although an ID may add challenges to the process. Children with Down's Syndrome have similar rates of Secure attachment to the general population, but may be more likely to show attachment Disorganisation when not Secure. Children diagnosed with Autism Spectrum Disorder (ASD) seem to achieve security in just over half of cases, but this is more likely in children with higher cognitive ability (implying that ID is a risk factor in itself in these children). An ID may increase the chance of disruption to caregiving

behaviours that promote security, and children with ID may be less able to manage emotional stressors by themselves, especially if attachment figures are less immediately available.

Some authors suggest that parental grief, loss and adaptation create a different pathway for the development of attachment behaviours; as the parents mourn the loss of the 'imagined' healthy child, the arrival of a child with an ID into the family evokes a 'grief reaction'. However, research suggests that most families adapt, possibly by being able to represent their child's actual abilities, rather than holding onto ideas of 'wished-for' abilities. Families may not identify their experience as a grief process and therefore to impose this would be unhelpful.

Being in receipt of life-long support may lead to difficulties in forming and maintaining attachments. Changes in placement, personnel, over-emphasis on 'personal independence', and boundary issues, may create particular challenges. However, research has demonstrated that using care staff as a *secure base-safe haven* is related to wellbeing and behavioural adaptation in adults with ID. People who live in paid care settings will differentiate their attachment behaviours across different carers, so that the behaviours that arise in each dyad will reflect individual relationships.

There are several challenges in the field of research into people with ID and attachment. There is as yet no gold standard assessment of attachment for people with ID, though the Adult Projective Picture System (AAP) may soon be fully validated. When using assessment tools, conceptual issues could lead to confusion about the use of 'attachment', particularly the use of 'attachment style' as developed in studies of adult romantic relationships. Psychologists should be very careful about the terminology and concepts that they use. Specific research studies on groups of people, some of whom have an ID (e.g. ASD or Down's Syndrome), may not be generalisable to the wider population.

Client and carer accounts

Two cases illustrate issues with attachment that are related to the person's experience of living with an ID, as well as other issues. Steve's experiences in his family demonstrate how his ID may have interrupted the development of attachment relationships in his family, which later led to difficult dynamics with well-meaning paid carers.

Carol's account demonstrated the importance of accepting and supporting her son Harry's expression of emotional distress over a long period of time. It also highlights the need for Harry's carers to provide a secure base by which he could explore his environment and achieve some independence, but also provide a safe haven for him when he was distressed.

Applying attachment in clinical practice

Guidance for practice is provided within the structure of assessment, formulation, intervention and consultation which will be familiar to psychologists.

Assessment is likely to involve multiple sources of information including detailed history taking, review of clinical records, interviews, observations, formal assessments and sometimes exploratory therapeutic sessions. Identification of factors that may suggest attachment difficulties will be included in any formulation, and specific questions to guide clinical interviewing are provided in recent publications and summarised here.

Formal assessment tools may be used by appropriately qualified psychologists. More sophisticated assessment tools with established construct validity may require further training and certification. ‘Diagnosing’ on the basis of anything other than standardised developmental assessments should be avoided.

Formulation should be consistent with the recent definition provided by the Division of Clinical Psychology (DCP) when formulating attachment difficulties. Hypotheses should be tentative and subject to change on the basis of new information, avoid labelling or stigmatisation, and respect the dynamic nature of attachment relationships. Formulations should be completed collaboratively when possible and should be based on the principle of attachment as an adaptive process.

Interventions following from formulations that suggest attachment difficulties may include psychological therapy, e.g. Disability Psychotherapy, Cognitive Analytic Therapy (CAT) or psychodynamic psychotherapy, for which there is preliminary evidence of effectiveness. Positive Behaviour Support (PBS), for people whose behaviour is perceived as challenging, may be tailored to address identified attachment difficulties. Integrative Therapy for Attachment and Behaviour (ITAB) may be considered for carers, if psychologists are able to access the training that has been developed by researchers in the Netherlands. Staff support and education (the CONTACT system) is a similar methodology which now has training materials. Both ITAB and the CONTACT system have promising evidence of change in actual attachment behaviours in carers and recipients of care, but require further validation. Finally, new interventions that have not yet been evidenced for people with ID may be applied, such as Video Interaction guidance (VIG), Circle of Security, Infant-Parent Psychotherapy, Developmental Dyadic Psychotherapy (DDP), and the Heijkoop method. It is important that psychologists develop the evidence base of all of these approaches if they use them.

Interventions should consider the number and quality of beginnings and endings in the lives of people with intellectual disabilities. The attachment issues that arise with multiple placement breakdowns, moves, and loss of carer relationships, should be raised and addressed where possible, as awareness is often low. The ending of any valued relationship, including those with the psychologists themselves, may require special attention.

Specific additional considerations

Attachment difficulties may arise, or be complicated by, a range of additional considerations.

Dementia is the subject of previous DCP Guidance. It suggests that psychological intervention may be necessary for people with dementia to enable family, carers and the client to feel as emotionally supported as possible. Earlier attachment difficulties are likely to be exacerbated by the dementia process, or emerge for the first time in adult life following diagnosis. Confusion and cognitive decline inherent in dementia may affect a person’s internal working model so that they require physical proximity more than before to feel comforted and understood.

Autism Spectrum Conditions (usually associated with diagnosis of Autism Spectrum Disorder or ASD) can make a goal-corrected partnership difficult to achieve in some people, despite parents and others offering good responsiveness. However, research indicates that individuals

with a diagnosis of ASD are able to develop Secure attachment relationships with primary caregivers. Interventions to support attachment relationships might include Social Stories™, social skills training or play-based therapies.

People with profound and/or multiple disabilities may require more physical proximity throughout their lives, and psychologists should promote the interpretation by carers of behaviours that may be attachment-directed rather than seeming to meet an auto-sensory function (simply to achieve food, etc.)

Parents with intellectual disabilities frequently lose care of their children following child protection concerns being raised. Recent studies have shown that parents with ID can learn or develop existing skills to improve their caregiving, though more research is required.

People who have an ID and who receive a *diagnosis of a personality disorder*, or have a *forensic history*, show similar rates of early deprivation, abuse and trauma as do other offenders. This means that psychologists can expect a higher rate of attachment difficulties in these clients, and they may be resistant to enhanced attempts to provide care, leading to a risk of frustration, rejection and hopelessness in individuals who might help. In these instances, a higher level of social support and therapeutic intervention may have to be provided than the person's adaptive skill set would seem to require.

The importance of clinical supervision in supporting emotional security is emphasised.

Consideration is also given to organisational factors which may present challenges to the operation of clinical services. When services attend to the needs of their staff then this is likely to have a positive impact on staff wellbeing and the quality of services offered.

Recommendations for research

A comprehensive survey of the attachment needs of people with ID in the United Kingdom is required to reduce the reliance on extrapolations from studies of people without ID. Assessment measures need to be further developed and validated for people with ID. Extending the attachment-informed interventions using video feedback methodologies developed in the Netherlands within the UK, would potentially replicate and support these as empirically based interventions.

Psychological therapies that explicitly target attachment relationships require controlled outcome studies to develop the practice-based evidence base. The present evidence consists of case studies and multiple case series, but the need for more controlled trials is a general need in the field of psychological therapies in people with ID. Finally, the attachment representations of psychologists themselves may have an effect on the outcome of interventions, as research into psychotherapy suggests this is important.

1. The need for this guideline

Attachment relationships and attachment theory are not a new phenomenon, they are central to all aspects of our lives. Attachment theory is explicitly applied to the health and social care of many groups, especially children. Difficulties in attachment have been linked to a wide range of problematic clinical outcomes in both children and adults. However, many clinicians and professional carers continue to experience uncertainty as to how to work in an attachment-informed way with people who have intellectual disabilities. In part, this may be due to a lack of information.

The aim of this guidance is to provide information about the attachment needs of people who have ID for psychologists working in health and social care services. It should inform their work with clients, families, organisations which provide services, and commissioners.

The document may be useful to other professionals who are working to promote good psychological support for people with ID.

The guidance includes:

- An overview of attachment theory with consideration of the particular needs of people who have intellectual disabilities.
- Factors to consider during:
 - assessment,
 - formulation, and
 - interventions.
- Additional considerations for the following areas of work;
 - behaviours that challenge others,
 - people with dementia,
 - people with a diagnosis of Autism Spectrum Disorder (ASD),
 - people with multiple and profound ID,
 - parents who have an ID,
 - people with a diagnosis of personality disorders or a forensic history
 - supervision and self-care of psychologists.
- Useful online resources.
- A proposed self-assessment tool.

2. Overview of attachment theory

2.1 What is attachment theory?

Attachment theory was developed by John Bowlby to explain the importance of the quality of early relationships between children and their primary caregivers. He proposed that both physical and emotional care were key components of early caregiving and that early separations and losses led to later development of psychological problems. Bowlby's work is presented as a complete theory in three classic texts^{1 2 3}, and initiated a wealth of research into children's attachment behaviours and their caregiver's responses which has led to a well-established evidence base in relation to children and adults who do not have intellectual or developmental disabilities.

Attachment theory proposes that the child's attachment behavioural system promotes physical proximity between the child and parent in response to actual or perceived 'threats'. This serves a protective function in order to aid the survival of the child. The perception of a threat leads to the child engaging in one or more attachment behaviours such as crying, holding arms out, or running towards the parent. The child's *attachment behavioural system* needs to work smoothly in conjunction with the parent's *caregiving behavioural system* in order for a secure attachment relationship to develop. This means that the child's attachment signals are noticed, understood and responded to promptly in a sensitive and consistent manner. Children whose parents miss their cues or offer an insensitive, inconsistent or rejecting response adapt their attachment behaviours accordingly to best meet their attachment needs. Thus many children develop organised strategies (known as insecure strategies) which enable them to stay close to their parent without risking rejection or further distress.

Bowlby proposed that children develop internal working models of attachment based on their day to day experiences with their caregiver regarding 'who his attachment figures are, where they may be found and how they may be expected to respond'². He suggested that a key issue for children is whether they develop an internal working model of their 'self' as being acceptable, competent and valued. This will relate to experiences of a caregiver who is predictably comforting and emotionally available when needed and also supportive of the individual's exploration. Where these responses have not been consistently available, Bowlby stated that the child is at risk of developing a sense of self as 'incompetent' and 'unacceptable to others', which leads to poorer outcomes psychologically.

As children grow older and are less in need of direct physical proximity to their parents, they begin to rely on their internal working models (IWM's) of attachment to predict how others might respond to them. It is thought that this typically happens at around 1 to 3 years of age whilst the child's language and motor skills are rapidly developing. At this stage children may begin to understand that their caregivers also have needs, and to be able to negotiate a 'goal-corrected partnership'⁴. The goal-corrected partnership

1 Bowlby, J. (1969) *Attachment and Loss. Vol 1. Attachment*. London: Pimlico.

2 Bowlby, J. (1973). *Attachment and Loss. Vol 2. Separation – Anxiety and Anger*. London: Pimlico.

3 Bowlby, J. (1980). *Attachment and Loss. Vol 3. Loss*. London: Pimlico.

4 Bowlby, J. (1980). *Attachment and Loss. Vol 3. Loss*. London: Pimlico.

strengthens the attachment relationship through a process of continual review and modification of behaviours which have been previously been unsuccessful in meeting the child's attachment needs.

Four attachment classifications have been defined in young children through assessment systems such as the laboratory based Strange Situation⁵. These are Avoidant, Secure, Ambivalent and Disorganised. The strange situation used a laboratory based environment to observe and classify children's responses to a series of separations and reunions with their caregiver. The resulting classifications have been studied extensively and found to link with specific patterns of caregiving behaviours in family home environments, thus providing ecological validity. For example, a meta-analysis of 2000 parent-infant dyads found a distribution of attachment classifications consistent with the distribution predicted by Ainsworth and colleagues.⁶

Avoidant – Children who are classified as Avoidant (10–15 per cent of the general population) maintain proximity to their caregiver by apparently 'self-managing' and not signalling a need for comfort, thereby avoiding rejection.

Secure – Children who are classified as Secure (60 per cent of the general population) are reported to experience their caregiver as a 'secure base' from which to explore and a 'safe haven' to return to for comfort when distressed. They are confident that their attachment needs will be met and return quickly to explore and play once they have been comforted.

Ambivalent – Children who have an ambivalent attachment (8–10 per cent of the general population) will maintain proximity to the caregiver by extensive use of attachment behaviours, which may be of high amplitude, and it may become difficult to reduce arousal levels at times of distress.

Disorganised – Where children's attachment behaviours are classified as Disorganised (15–19 per cent of the general population⁷) it is reported that children experience their parents as either frightening or behaving in frightened ways. During the strange situation children with a Disorganised classification seemed to experience a dilemma. They sometimes showed fear/apprehension when approaching their parent which led to them 'freezing'. They were also reported to appear confused and disorientated. These behaviours may be noted in children who also exhibit organised strategies (both secure and insecure) on the strange situation, leading to an additional classification of Disorganised as well as another classification.

Such Disorganised patterns of behaviour are frequently observed in children who have been maltreated (Main & Solomon, 1986). In addition children may also experience distress related to having parents with substance misuse, mental health problems and/or unresolved trauma regarding historical abuse and loss. Disorganised attachment is strongly linked to later negative outcomes for the child regarding increased distress, stress, dissociative and aggressive behaviours⁸.

5 Ainsworth, M.D., Blehar, M., Waters, E. & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, New Jersey: Lawrence Erlbaum.

6 Van Ijzendoorn, M.H. & Kroonenberg, P.M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange-situation. *Child Development*, 59, 1, 147–156.

7 De Wolff, M.S., van Ijzendoorn, M.H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development*, 68, 571–91.

8 Van Ijzendoorn, M.H., Schuengel, C. & Bakermans-Kranenburg, M.J. (1999). Disorganised attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology*, 11, 225–249.

A child may have a secure attachment with one primary caregiver and an insecure one with another: these classifications always refer to a particular relationship. By contrast, adults are classified on the Adult Attachment Interview (AAI)⁹ according to their state of mind with respect to attachment which emerges from their attachment history, and so the terminology used for adults is different. There is thought to be a correspondence between adult state of mind and childhood categories:

Child categories	Adult state of mind
Avoidant	Dismissing
Secure	Autonomous
Ambivalent	Preoccupied
Disorganised	Unresolved

Dismissing – On the AAI, Dismissing adults attempt to minimise the importance of attachment relationships and experiences. They may give brief and positive accounts of their family history which are either contradicted or unsupported by the content of their interview. They might also appear contemptuous or critical of their caregivers whilst stressing their own independence and ability to cope.

Autonomous – Autonomous adults will present as valuing of attachment relationships whilst being able to remain realistic and objective regarding their past experiences and relationships. They are able to speak coherently and to freely explore their views of their relationships and past. They also seem realistic about their own imperfections as well as those of their caregivers.

Preoccupied – Preoccupied adults present as confused and non-objective in their narrative on the AAI. They appear preoccupied with past family relationships and may present as passive and childlike, overwhelmed or conflicted and angry. During the interview they may refer to their current relationships with caregivers when being asked questions about the past. Interviews may be longer in length due to adults providing longer and more involved answers to the questions.

Unresolved – An Unresolved classification refers to previous experience of attachment related trauma such as loss or abuse from caregivers. The adult has not been able to reconcile or resolve the trauma in their current state of mind and this is indicated by unusual speech. An example of this might be talking as if a dead person is still alive. The adult may report having ongoing feelings of guilt or responsibility where there is no objective reason for this.

2.2. Attachment difficulties and later outcomes

A large body of evidence links problematic early attachment relationships to personal difficulties in childhood, adolescence and adulthood. In children without ID, the following are associated with insecure or disorganised attachment classifications:

- Less persistence in problem solving in preschool children
- Poorer theory of mind as children enter school

⁹ George C., Kaplan, N. & Main, M. (1985). *The Adult Attachment Interview*. Unpublished Manuscript, University of California at Berkeley

- Poorer recall of life events at age 11
- Difficulties in relationships with peers & associated low self-esteem
- Increased risk of receiving a psychiatric diagnosis (e.g. Reactive Attachment Disorder, Oppositional Defiant Disorder, Conduct Disorder)

In adults without ID, individuals who do not have an autonomous (Secure) state of mind are reported to be at increased risk of psychological distress including paranoia, distressing intrusive thoughts, depressive thoughts and feelings, and are more likely to receive formal psychiatric diagnoses including Depression, Obsessive-Compulsive Disorder, Schizophrenia, and a range of personality disorders. Some research also links diagnosis of eating disorders to attachment difficulties.

Appendix 1 gives more detail of mainstream research with key references and the level of evidence indicated.

This section has offered an overview of attachment theory including terminology and the classifications which are commonly used in the gold standard attachment assessments validated for non-ID populations. The next section considers attachment specifically in the context of the lives of people with intellectual disabilities and their families and carers.

Key points: Overview of attachment theory

- Attachment theory was developed by Bowlby to explain the importance of the primary caregiver offering both physical and emotional protection to their child to increase chances of survival.
- The strange situation procedure was developed by Ainsworth and colleagues which later led to four commonly used classifications of attachment in children: Avoidant, Secure, Ambivalent, Disorganised.
- Secure attachment relationships develop in the presence of parents who consistently notice their child's attachment signals, understand them and respond promptly in a sensitive and consistent manner.
- Children whose parents miss their cues or offer an insensitive, inconsistent or rejecting response adapt their attachment behaviours to develop strategies (known as insecure strategies) which enable them to stay close to their parent without risking rejection or further distress. Children who experience consistently frightening care experience a breakdown or 'disorganisation' of attachment strategies.
- Children typically develop 'goal-corrected partnerships' after three years of age with their primary caregivers where they learn that their caregivers have needs too which need to be balanced with their own attachment needs to get the best outcomes.
- Children later rely on internal working models (based on their learnt experiences) to predict how others will relate to them.
- Attachment strategies need to be constantly reviewed and updated in relation to the person's context.
- A history of problematic attachment strategies are associated with a range of childhood and adulthood psychological problems.

3. Attachment and intellectual disabilities

Evidence suggests that attachment relationships are important for individuals with intellectual disabilities. However, parents and caregivers may face particular challenges when caring for an individual with an intellectual disability. This is because, despite their best efforts to protect and care for them, the disability or health condition does not change. This can potentially lead to distress and disruption in the attachment and caregiving systems.

3.1 Attachment classifications in intellectual disabilities

Some studies suggest that the proportion of attachment security is broadly equivalent between people with and without ID¹⁰. Research has reported that where children with Down's Syndrome (DS) are classified as having insecure attachment, they are disproportionately more likely to be classified as Disorganised, at rates similar to children without ID who have been maltreated, traumatised, or institutionalised¹¹. The study suggested that parents of children with DS may find it harder to read their child's emotional signals, and that this may lead to difficulties understanding and responding to attachment cues.

In a meta-analytic review of 16 studies using the Strange Situation in children diagnosed with ASD, just over half of the children (53 per cent) were classified as Secure. There was variation across samples in levels of ID. This meta-analysis suggested that attachment Disorganisation was more likely in those children who had a greater degree of ID, suggesting that ID was a bigger risk factor for attachment Disorganisation than ASD alone¹².

The presence of ID may increase the risk of disruption to caregiving behaviours that promote security¹³. In addition 'fright without solution' may be more likely in children with ID due to a reduced ability to manage emotional stressors by themselves coupled with a potential lack of available attachment figures to gain support from¹⁴.

3.2 Cognitive effects on reciprocity in children with Down's Syndrome

Research into attachment and ID has attempted to explore the relationship between cognitive impairments and attachment behaviours to explore whether the impairment has a direct effect on attachment classifications. A study of infants with Down's Syndrome suggested that children showed delay in emotional expression, with more 'blunted' responses, which made it more difficult for the adult carer to adequately interpret the meaning of the behavioural signals¹⁵.

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- 10 Larson, F., Alim, N. & Tsakanikos, E. (2011). Attachment style and mental health in adults with intellectual disability: Self-reports and reports by carers. *Advances in Mental Health and Intellectual Disabilities* 5, 15–23.
 - 11 Schuengel, C., de Schipper, J.C., Sterkenburg, P.S. & Kef, S. (2013). Attachment, intellectual disabilities and mental health: Research, assessment and intervention. *Journal of Applied Research in Intellectual Disabilities*, 26, 34–36.
 - 12 Rutgers, A.H., Bakermans-Kranenburg, M.J., van Ijzendoorn, M.H. & van Berckelaer, I.A. (2004). Autism and Attachment: A meta-analytic review. *Journal of Child Psychology & Psychiatry*, 45, 6, 1123–1134.
 - 13 Marvin, R.S. & Pianta, R.C. (1996) Mothers' reactions to their child's diagnosis: Relations with security of attachment. *Journal of Clinical Child Psychology* 25, 436–445.
 - 14 Schuengel, C. & Janssen, C.G.C. (2006) People with mental retardation and psychopathology: Stress, affect regulation and attachment; A review. *International Review of Research in Mental Retardation*, 32, 229–260.
 - 15 Cicchetti D. & Serafica F.C. (1981). Interplay among behavioural systems: illustrations from the study of attachment, affiliation, and wariness in young-children with Downs syndrome. *Developmental Psychology*, 17, 36–49.

3.3 Parental grief, loss and adaptation

Parents commonly experience distress on learning that their child has a disability or chronic health condition¹⁶. Marvin and Pianta (1996) described this as a grief reaction which requires a process of adaptation and resolution. Bowlby wrote extensively about grief processes following the loss of a loved one. Marvin and Pianta¹⁷ suggested that his theory was relevant whether the parent was grieving an actual loss or an imagined loss of the ‘healthy child’ they had expected to arrive. Parents who find it difficult to accept the reality of their child’s condition may continue to search for a reason or alternate diagnosis as part of the grieving process. They may also feel responsible for causing their child’s disability even if doctors have informed them that this is not the case.

Parents whose children have ID may also need extraordinary sensitivity to overcome the difficulty that their children have with expressing their attachment signals¹⁸. In addition, if parents are not able to develop an internal representation of their child’s actual abilities rather than the *wished for abilities*¹⁹ then this may impede their ability to parent sensitively and develop a secure attachment with their child²⁰.

Despite the considerable challenges reported by families, it is important to note that the majority of families adapt to their child’s disability, ‘resolving’ their initial grief and loss. Experiences of recent family stress and levels of social support from family members appear to be important for parents who present as unresolved in relation to their child’s intellectual disability²¹. However, each family culture is unique and the idea of loss or grieving in relation to their child’s disability may not always be relevant or helpful for parents.

3.4 Specific risks related to receiving life-long support

Many individuals with ID receive life-long support from paid carers throughout their education, home living environments and day services. In addition to this, individuals may also receive care from a number of health and social care professionals meaning that a large network of people will be involved in a person’s care at any one time. This poses particular risks to the psychological wellbeing, emotional safety and quality of care of people with ID due to:

- frequent changes of staff personnel
- high workload of staff
- discontinuity in staff presence
- limited opportunities for individual support

16 Waisbren, S.E. (1980). Parent’s reactions after the birth of a developmentally disabled child. *American Journal of Mental Deficiency*, 84, 345–351.

17 Marvin, R.S. & Pianta, R.C. (1996) Mothers’ reactions to their child’s diagnosis: relations with security of attachment. *Journal of Clinical Child Psychology*, 25, 4, 436–445.

18 Schuengel, C. & Janssen, C. (2006). People with mental retardation and psychopathology: stress, affect regulation, and attachment. *International Review of Research in Mental Retardation*, 32, 229–260.

19 Barnett, D., Clements, M., Kaplan-Estrin, M. & Fialka, J. (2003). Building new dreams: Supporting parents’ adaptation to their child with special needs. *Infants and Young Children*, 16(3), 184–200.

20 Atkinson, L., Chisholm, V.C., Scott, B., Goldberg, S., Vaughn, B.E. & Blackwell, J. (1999). Maternal sensitivity, child functional level and attachment in Down syndrome. *Monographs of the Society for Research in Child Development*, 64, 45–66.

21 Fletcher, H. (2016). Attachment relationships between parents and their children: The impact of ‘The Loss of the Healthy Child’. In H. Fletcher, A. Flood & D. Hare *Attachment in Intellectual and Developmental Disability: A Clinician’s Guide to Practice and Research*. New York: Wiley.

- organisational cultures which value service users' development of independence from staff rather than the mutual interdependence which is observed in typical attachment relationships
- lack of support for paid carers in negotiating relationship boundaries with service users who have a limited social network

Research suggests that using direct-care staff as a 'secure base-safe haven' is positively related to wellbeing and behavioural adaptation^{22 23 24}. Clegg and Sheard²⁵ suggested that clients in paid care settings will differentiate their attachment behaviours across professional caregivers indicating that each attachment relationship is specific to the relationship dyad and not part of a more general presentation of behaviours. These findings were also supported by a larger study of people with ID in day care settings²⁶. While staff turnover in paid care settings is high and generally considered to be problematic in relation to quality of care²⁷, currently there is a paucity of research evidence linking this to client wellbeing.

'Quality management systems and institutional culture may selectively reinforce care patterns associated with insecure, dismissing attachment, while failing to reward the positive contribution that sensitive, affectively attuned caregiving makes to wellbeing of persons with disabilities.'

People who need people: Attachment and professional caregiving. Schuengel et al.²⁸

3.5 Challenges to research into attachment and ID

3.5.1 Assessment tools

At present there is no measure of attachment which has been empirically validated for use with adults with ID, and leads to reliable and valid classification. Research into attachment and ID uses a variety of assessments which may be tapping different psychological constructs and this presents challenges to those interpreting the data. It is important not to confuse research into attachment 'styles' using self-report methods focusing on romantic adult relationships, with research that explores the internal working model of attachment using assessments such as the Adult Attachment Interview (AAI)²⁹ and the Adult

22 Clegg J. & Sheard C. (2002). Challenging behaviour and insecure attachment. *Journal of Intellectual Disability Research*, 46, 503–506.

23 De Schipper, E.J., Marianne Riksen-Walraven, J. & Geurts, S.A.E. (2006). Effects of child-caregiver ratio on the interactions between caregivers and children in child-care centers: An experimental study. *Child Development*, 77, 861–874.

24 De Schipper, J.C. & Schuengel, C. (2008). Less secure attachment behaviour to specific caregivers is associated with maladaptive behaviour in day care. *Journal of Intellectual Disability Research*, 52, 726–726.

25 Clegg J. & Sheard C. (2002). Challenging behaviour and insecure attachment. *Journal of Intellectual Disability Research*, 46, 503–506.

26 De Schipper, J.C. & Schuengel C. (2010) Attachment behaviour towards support staff in young people with intellectual disabilities: associations with challenging behaviour. *Journal of Intellectual Disability Research*, 54, 584–596.

27 Buntinx, W. (2008) The logic of relations and the logic of management. *Journal of Intellectual Disability Research*, 52, 588–597.

28 Schuengel, C., Kef, S., Damen, S. & Worm, M. (2010). People who need people: Attachment and professional caregiving. *Journal of Intellectual Disability Research*, 54, Suppl 1:38–47.

29 George, C., Kaplan, N. & Main, M. (1985). *Adult Attachment Interview*. Unpublished manuscript, University of California, Berkeley, USA.

Attachment Projective Picture System (AAP)³⁰. There are no reported studies using the AAI with people with ID, probably due to the high level of verbal ability required. Nevertheless, the AAP has been successfully used with individuals with ID in pilot studies with promising results³¹. Research to validate the AAP for use with people with ID is ongoing³².

The utility and limitations of assessment tools is discussed more fully in section 5.1 below (Assessment).

3.5.2 Terminology and concepts

Schuengel et al.³³ describe the different terminology and phenomena which attachment researchers may describe or purport to be measuring in their research. These include:

- **Behaviours:** the seeking and maintaining of proximity to achieve protection & support; e.g. proximity seeking, contact maintaining, avoiding, resisting, disorganisation of these.
- **Relationship:** description of the dyadic history of attachment behaviour and response.
- **Bond:** affective concern with a relationship perceived as stable, including desire for contact, dislike of separation and the need for comfort during separation.
- **Representation:** unconscious internal rules relating to attachment; e.g. coded as: Dismissing, Autonomous, Preoccupied, Unresolved.
- **Style:** the internal judgement that one feels comfortable getting close to others, and depending on them, or not; comfortable with intimacy and autonomy (secure), preoccupied with relationships, dismissing of intimacy and fiercely independent, or fearful of intimacy and actively avoidant³⁴. See section 3.4.1 regarding the use of the term 'style' in attachment assessment.
- **Disorder:** specific patterns of atypical behaviours in the context of pathogenic care; inhibited, withdrawn, or indiscriminately social³⁵.

A sufficient understanding of the different concepts and terminology used in attachment focused research is required in order to effectively incorporate attachment theory into everyday practice. It is possible that the complex and multiple terminologies act as a barrier to attachment being confidently utilised by clinical psychologists.

3.5.3 Generalisability

There are a number of factors to consider when interpreting the evidence base. A significant proportion of the studies focusing on attachment and ID have been carried

30 George, C. & West, M. (2012). *The Adult Attachment Projective Picture System*. New York, NY: Guilford Press.

31 Gallichan, D.J. & George, C. (2014). Assessing attachment status in adults with intellectual disabilities: The potential of the Adult Attachment Projective Picture System. *Advances in Mental Health and Intellectual Disabilities*, 8(2), 103–119.

32 Gallichan, D.J., & George, C. (2014). Assessing attachment status in adults with intellectual disabilities: The potential of the Adult Attachment Projective Picture System. *Advances in Mental Health and Intellectual Disabilities*, 8(2), 103–119.

33 Schuengel, C., de Schipper, J.C., Sterkenburg, P.S. & Kef, S. (2013). Attachment, Intellectual Disabilities and Mental Health: Research, Assessment and Intervention. *Journal of Applied Research in Intellectual Disabilities*, 26, 34–36.

34 Bartholemew, K. & Horowitz, L.M. (1991). Attachment Styles among young adults: A test of a four-category model. *Journal of Personality & Social Psychology*, 61, 226–224.

35 Minnis H., Reekie J., Young D., O'Connor T., Ronald A., Grayand A. & Plomin R. (2007) Genetic, environmental and gender influences on attachment disorder behaviours. *British Journal of Psychiatry*, 190, 490–495.

out with children who have Down's Syndrome, and therefore the results may not be generalisable to children with ID who do not have DS. In addition there may be difficulties in classifying the attachment behaviours of children with ID due to the ambiguity about the reasons for their observed behaviour. This may reflect the ID itself, physical conditions associated with the ID, or communication difficulties, rather than the attachment behaviours *per se*.

In summary, there is an emerging evidence base pertaining to attachment in people with ID, which indicates that it is a valid and important phenomenon to study and incorporate into clinical work. The next section focuses on the stories and experiences of clients and carers, including their testimonials.

Key points: Attachment and intellectual disabilities

- Attachment relationships are important for people with ID. There is no current research to suggest that attachment strategies differ significantly between people with ID and the general population
- Parents of children with ID may experience a number of challenges to developing secure attachment relationships including emotional distress, difficulty understanding the child's communications and developmental level and increased levels of stress. These may influence the sensitivity of their responses.
- Each family culture is unique and ideas of loss and grieving in relation to disability may not always be helpful or relevant. Therefore clinicians need to be mindful not to make assumptions and to offer an individually tailored approach.
- Being in receipt of life-long support may pose particular risks to the psychological wellbeing, emotional safety and quality of care of people with ID due to frequent changes of staff, overload of work and limited opportunities for individual support.
- There are some significant challenges to conducting and interpreting research in attachment and ID. These include the lack of valid and reliable assessment tools, the range of different terminology used and problems with generalisability. It is important to be aware that the literature may be referring to separate constructs as 'attachment'.

4. Client and carer accounts

Illustrative client and carer accounts are included here to demonstrate how attachment issues may present in practice. While attachment issues are not the only factors determining the symptomatic and personal outcomes for both Steve and Harry, they are an important part of the accounts given.

4.1. Client account: Steve³⁶

Steve is a 24-year-old man who accesses specialist learning disability services. His cognitive profile is very mixed, with low average verbal comprehension offset by clinically significant difficulties in perceptual skills, working memory and speed of processing information. Throughout his development, Steve's language skills were interpreted as predictive of his other skills. This seems to have created a negative feedback process at home and during his time at school.

He was referred to the community learning disability team for a course of psychological therapy at the age of 21 which addressed anxiety and related symptoms, but also raised longstanding issues of ambivalence towards his family members. Initially, he wished to remain living with them, but the family stated that this was very stressful for them because he would follow them around the home, resisted separation from his mother, and was very anxious about being asked to remain at home alone. This seemed to worsen as he left school and became an adult. Attempts at manualised 'anxiety management' were not successful and indeed, being asked to do these tasks by his family led Steve to either protest by shouting or swearing, or acquiesce, and then to sit on his own and start to cry. The family's perspective was that they had spent a lot of time trying to promote self-esteem and independence, but that on learning steps of a task, Steve would not do the task independently; it would lead to a 'mess' or a breakage, or he would want the other person to do it for him.

A high risk incident at home led the family to ask the local authority to find an independent living placement. This placement was highly individualised and supported, with a strong ethos of personal empowerment and independence through the learning of key living skills. Steve soon started to have difficulties with particular members of staff, with flashpoints based around new learning tasks where he was meant to develop personal and domestic living skills in order to move to less supported accommodation in future.

Steve's formulation suggested that his cognitive difficulties had interacted with a family situation where both parents had to work and sometimes had other major challenges. Steve and others would expect him to be successful at learning tasks, only to find these more difficult than expected, even when supported by others. It was as though he built all of the parts of the particular joint task, but could not put these together and do them on his own. This would often seem like a matter of choosing not to do something, or wanting the other person to do it for him. Steve became increasingly avoidant of new learning tasks and could become hostile if confronted with a task that was cognitively effortful, such

³⁶ Steve (not his real name) wishes to remain anonymous. He gave his express consent to the wording of the section that is relevant to him.

as learning independence skills. Sometimes, Steve would state that he was a ‘superhero’ and had special powers, which may have helped him compensate emotionally for feelings of failure or where he felt criticised for a mistake.

A referral to the psychology team was made, for support with problematic behaviours such as shouting and swearing at staff. It was noted by the psychology team that only particular staff experienced difficulties of this kind.

An initial psychology-led workshop with carers led to a formulation identifying some key factors in Steve’s presentation. While certain factors were associated with the behaviours, such as being explicitly corrected during a learning task, or when he wanted to buy items that could cause financial difficulty, it was the presence of particular staff that most consistently predicted an incident.

A series of further workshops with Steve and his team led to an understanding of what he found to promote his emotional security and decrease his reliance on hostile responses to make sense of his social world. There was an existing model of good practice with his key worker, Toni, who was able to model a method of correcting Steve without seeming to ‘sharpen’ her tone, or become overly directive. However, the relationship with two other members of staff had deteriorated to the point where they could not envisage working positively with Steve, and chose to end their work supporting him. This reflected an established vicious circle, where hostile responses from Steve led to attributions that he was disrespectful of these individuals, and in response, they would back off and speak to him more formally, sometimes avoiding him. Steve then perceived a lack of warmth in the working relationship, creating more anxiety and further feeding the spiral and breakdown of these bonds. Steve was genuinely mortified following any incidents where he expressed hostility, which also fed ongoing anxiety.

Steve’s reports indicated that his carer’s responses were sometimes perceived as austere and corrective when they were trying to be clear and direct, particularly where he was failing to learn independence skills. This resulted in severe anxiety and hostility, which was reported as incidents of ‘verbal aggression and threatening others’.

Staff who were predictably warm, like Toni, had fewer difficulties and were able to support him to access the community successfully. The attunement, or the lack of attunement, therefore reflected both his preferences and his particular interpretation of well-meant responses, as well as the responses of staff, of whom some felt able to change their approach – by adopting a consistently warm tone and easy-going approach to the domestic skills that acted as trigger points – and some of whom felt they could not. Therefore, allowing for a degree of ‘selection’ of preferred carers can be beneficial for both parties and does not imply fault or blame.

Three questions were asked of Steve to elicit his views for the guidance:

Could you say how Toni helps when you have a difficulty?

It’s really good. Toni and I get on great, I have no difficulties. She never tells me off, like [other staff member] makes me feel happy. She says ‘oh I am glad I am working with you today, we have fun’ [Steve smiles]... Toni is like a mam, when I have a problem, she helps sort it out.

What causes the difficulties?

Like when other staff make me feel stupid, [staff member]. Like when I went near the cooker, she says 'oi what are you doing, burn yourself, stop'. So I told her to [swears]. I apologised, I am sorry, I will be better... my behaviour is a disgrace. I told my mam by text. She came down and took me out for a bit, but I have to come back don't I?

What makes things better?

When Toni comes on. We have a laugh and do baking, I can do baking now. I make a mess and she laughs, and says 'no honey, like this'. When Toni's on I don't get stressed. I do my routine, but we go out, go swimming, have a laugh. Toni is great company.

Steve referred to his fear of being reprimanded, which he associated with earlier rejections, and his perception of the disappointment of others. He also showed how pleased he was to see Toni, whom he perceived to be understanding, reliable, and comforting at times of stress. Toni was able to engage Steve in activities that other staff members had refused to attempt due to perceived risks, such as Steve walking away from support staff or being stigmatised.

4.2 Carer account: Carol and Harry

Carol has had a long-term fostering relationship with Harry who has chronic epilepsy due to early brain damage. She was asked to discuss what are the most important features of caring for children like Harry, and what has been difficult.

I've been a full time carer for this truly wonderful young man, this is some of our journey together. He arrived when he was 18 months old with a history of abuse involving physical attacks that were the likely cause of his learning difficulties. I was shocked to be told by a consultant that I should accept that he would be in a "vegetative state". My husband and I were determined that we would bond with him without regard for any disability.

For several very tough years, most of our parental relationship with Harry involved providing love and reassurance to him, physically and emotionally. He showed much screaming and frustration, which we took to be an expression of earlier emotional pain. It was as though we needed to let him know he was safe from harm now. Over time, this paid off; he learned to chew, smile, walk and talk. We learned Makaton to help our connection with him. There was respite support for us, which helped us cope. Though, I have always wondered why professionals in the health service talk "at" Harry, and don't form a real relationship with him. What are they afraid of?

He wasn't free from further trauma – some of his peers have sadly died, and members of his family also passed away. Harry has had periods of low mood, but this doesn't mean he is "ill", it just fits with his early and later losses. He is now in his 30s and doing brilliantly. You can see that people light up when he smiles at them. He has been able to express his feelings and his wondering about his parents – I have always felt that he should be able to express his feelings to us, never spare us by being compliant or "good".

I can't say for certain that our love, care and resilience in the face of great difficulties have been a major cause of his success. Services can be unresponsive, patronising, and avoidant; or they can be helpful and supportive. It's been way too variable.

But I look at Harry now, moving to living semi-independently in a group home (done carefully over a six month period), forming adult relationships, and having a romantic life, and with us now stepping back with mixed feelings as parents do when their children move out. He still has

weekends with us, and we meet up for a meal. Just like any parents and their adult child. I would say never write any child off – no child should be without protection, a parent who listens to their feelings, helps them cope with these, and helps them get out there and enjoy life.

My word for Harry is “brilliant”.

Carol’s account makes very clear what the emotional needs of children with ID are, and that their carers need:

- to provide physical safety,
- to provide emotional safety and predictability,
- to offer emotional warmth consistently even (or especially) when the child presents in distress or anger,
- to take joy in the child and enjoy spending time with them,
- to provide shared exploration based on mutually enjoyable and rewarding activities and new learning.

Key points: Client and carer accounts

- Steve’s account demonstrates the value he experiences in his relationship with a carer that is consistent, lighthearted and supportive of his needs.
- Steve’s experience illustrates the differences frequently observed in relationships between individuals and different staff members.
- Staff were able to benefit from psychological intervention leading to an increased understanding of Steve’s emotional needs, informed by his existing positive relationship with Toni.
- Carol’s account about her life with Harry shows the importance of accepting and supporting his expression of emotional distress over a prolonged period of time.
- Services were reported to be variable in their response to Harry with some professionals being negative about Harry’s future abilities and talking ‘at’ Harry and not forming a relationship with him.
- Carol’s account emphasises the importance of primary caregivers providing emotional warmth and safety, consistency, predictability, mutual enjoyment and shared exploration in childhood.

5. Applying attachment in clinical practice

This section describes the ways in which attachment theory can inform the work of clinical psychologists. Drawing on the general evidence base and findings from studies of people with ID, the section is structured in terms of assessment, formulation, and intervention. In addition, specific clinical considerations are outlined.

5.1. Assessment

Psychological assessments will typically involve a range of approaches and data gathering in order to develop clinically useful formulations and interventions. Assessing attachment relationships is likely to require detailed history taking and review of clinical records, interviews and observations, formal assessments and individual therapeutic sessions which can explore attachment issues.

5.1.1 Identifying the need for attachment-informed work

During assessment, the following factors may indicate the need to draw upon an attachment-informed framework:

- Exposure to abuse and/or neglect,
- Early separations and school/placement breakdown,
- Hospital admissions for severe emotional or behavioural concern,
- Socioeconomic risks³⁷,
- Difficulties coping with transitions and ending relationships (e.g. saying goodbye to family/carers and ending work with professionals),
- Intense preoccupation with the whereabouts of attachment figures,
- Self-injurious behaviours,
- Onset or increase in challenging behaviours in response to loss,
- Reports of hostility between the individual and their support staff or carers,
- Previous diagnoses of mental health or personality disorder,
- Early parental death or experience of serious physical or mental health problems.

Psychologists should not assume that the above factors are necessarily associated with early attachment difficulties, as each individual responds to life events differently, depending on the resources available to them internally and externally. However, major life changes will naturally cause increased anxiety. Therefore an increase in attachment behaviours may serve an adaptive and protective function for the individual rather than indicating a clinical presentation which requires intervention. There may be a requirement for input to facilitate risk management of particularly challenging behaviours during periods of adaptation.

37 Cyr, C., Euser, E.M., Bakermans-Kranenburg, M.J. & Van Ijzendoorn, M.H. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*, 22(1), 87–108.

5.1.2 Clinical interviewing

In order to effectively assess attachment, Fletcher³⁸ suggests that psychologists should consider the following in their assessments and clinical interviews:

- Parental reactions to their child's diagnosis and resolution of loss and grief,
- Family's culture and religious beliefs concerning disability,
- Experiences of early separations, losses or traumas of parents/carers,
- Intergenerational attachment experiences of parents/carers,
- Parent's mental health and emotional distress,
- Social support available to parents from their own families/support for carers within their teams,
- Parent-child interactions and attunement,
- Need for training for parents and carers to increase their understanding of attachment behaviours and identify helpful ways to respond (possibly using video to review their interactions).

One of the common difficulties in seeking this information with adults is that often the information is not available and the person themselves may not be able, or only partially able, to present their story. Perry and Flood³⁹ offer an additional set of questions focused on the current presentation of the individual which may help gather clinically useful information:

- How does the individual interact with the people around them?
- What expectations do they appear to have of those interactions?
- If supported by paid carers, how does the person respond to support staff beginning and ending shifts, taking absences from work, having sick leave, or leaving the job?
- Does the person show a strong preference for a particular caregiver? Does this cause any difficulties or concerns?
- How do they seek support from others during times of distress, anxiety or discomfort? Do individuals around them recognise these as support seeking behaviours?
- Does the person develop trust in those who support them and respond positively to reassurance in unfamiliar situations?
- How does the person respond to events which would be expected to be highly distressing for them – do they communicate an emotional response or appear outwardly unaffected?

In addition it is recommended that the individual's response to separating from and being reunited with relatives who have had primary caregiving roles is considered.

5.1.3 Formal assessment tools

Some commonly used formal assessments of attachment are summarised in Appendix 2 and 3. Information is provided as to whether the assessment is intended for use with children or adults, applicability to people with ID, the need for standardised training,

38 Fletcher, H. (2016). Attachment relationships between parents and their children: The impact of 'The Loss of the Healthy Child'. In H. Fletcher, A. Flood & D. Hare. (2016). *Attachment in intellectual and developmental disability: A clinician's guide to practice and research*. New York: Wiley.

39 Perry, E. & Flood, A. (2016). Autism Spectrum Disorder and attachment: A clinician's perspective. In H. Fletcher, A. Flood & D. Hare. (2016). *Attachment in intellectual and developmental disability: A clinician's guide to practice and research*. New York: Wiley.

research or clinical function, the mode by which assessment is undertaken, and the conceptual focus of the tool.

Some aspects of formal assessment are problematic in people with intellectual disabilities. Psychologists should be aware that the instruments that have driven the seminal findings in research are highly sophisticated; the Strange Situation Procedure (SSP) and the Adult Attachment Interview (AAI) require rigorous training and certification before use, which therefore limits their use in routine clinical practice for the majority of psychologists. Given the issues of conceptual divergence in what is meant exactly by 'attachment', clinicians should exercise caution in interpreting the meaning of such instruments and avoid relying on one assessment tool.

While clinical psychologists are well placed to describe attachment behaviours in their clients and consider the strategies they use to maintain proximity to those close to them, categorical 'diagnosing' on the basis of limited information carries risks of misclassification and should be avoided.

Key points: Attachment in clinical practice

ASSESSMENT

- Assessing attachment relationships is likely to require a range of approaches including: detailed history taking, review of clinical records, interview, observations, formal assessments and individual therapeutic sessions.
- Certain factors may indicate the need to draw upon an attachment-informed framework e.g. a history of repeated placement breakdown, difficulty separating from primary caregivers and/or paid carers, preoccupation with the whereabouts of attachment figures, severe challenging behaviours.
- There may be an increase in adaptive and functional attachment behaviours following the experience of stressful life events.
- Clinical interviews should consider the person's early history as well as their current relationship patterns. This should include family culture, history of attachment relationships, current experience of social support and current stressors.
- Established valid assessments of attachment classification can only be used after rigorous training and certification. Other clinician based observations and rating scales may contribute usefully to clinical formulations and intervention, but caution is needed to prevent these being misinterpreted as a formal classification of attachment behaviours.

5.2 Formulation

The Division of Clinical Psychology has recently defined formulation in an information leaflet for clients who may see clinical psychologists in the UK⁴⁰, as follows:

Formulation is a joint effort between you and the psychologist to summarise your difficulties, to explain why they may be happening and to make sense of them. It may include past difficulties and experiences if these are relevant to the present... The pieces of the “jigsaw” are pieces of information such as:

- *How you feel at the moment;*
- *What’s going on in your life now;*
- *When the difficulties or distress started;*
- *Key experiences and relationships in your life;*
- *What these experiences and relationships mean to you.’*

It is important to ensure tentative hypotheses are constructed when using clinical judgement, history, or interpreting formal assessment measures. The psychologist should have a clear view of the psychometric basis of any scale or other tool used in relation to assessing attachment.

This definition of formulation is highly concordant with this guideline. Formulations should not apply an attachment ‘label’ to a particular person (X is ‘clingy’, Y is ‘secure’, Z is ‘fearful’) as this risks over-simplification of an individual’s emotional life and actions, a failure to consider that attachment reflects and varies according to individual relationships⁴¹, and stigmatisation.

Notwithstanding these cautions, the identification of potential or actual difficulties in attachment relationships in an individual formulation has a number of implications for any intervention or further assessment that is offered. The person may:

- find separation and loss more difficult,
- find it more difficult to benefit from interventions,
- blame themselves for losses,
- struggle to express their feelings (if they tend to dismiss their emotions),
- misidentify therapy for friendship or a potential sexual relationship,
- be more vulnerable to distress,
- find it difficult to make decisions that oppose parents or figures of authority,
- find the experience of meeting professionals upsetting or even frightening (if Unresolved state of mind is indicated),
- struggle to engage in a therapeutic relationship, or
- avoid help partially or completely.

Formulations should make clear that attachment strategies were developed as an adaptive response and identify cases where the individual’s strategies are no longer current and appropriate (therefore requiring updating) versus those situations where the person’s social context means that the attachment behaviours remain adaptive (and the environment or system of support needs adaptation).

40 Division of Clinical Psychology, British Psychological Society (2015). *Working with a psychologist: Understanding Formulation*. www.bps.org.uk/dcp

41 De Schipper, J.C. & Schuengel C. (2010) Attachment behaviour towards support staff in young people with intellectual disabilities: associations with challenging behaviour. *Journal of Intellectual Disability Research*, 54, 584–596.

Formulations should ensure that the individual's developmental level is clearly described along with their current attachment strategies. Where families, staff or professionals present with expectations of independence which are developmentally inappropriate for the individual, this should be considered with the system and appropriate interventions planned. The interventions should be aimed at increasing awareness and understanding of the individual in their system of support and differentiate between functional independence and emotional independence.

It is recommended that psychologists include potential attachment factors within their formulations and explain the nature of attachment with their client in a supportive and non-blaming way when collaborating to produce their formulation.

Where joint formulations are more difficult (often where the ID is severe or profound), it is equally important to share a formulation that draws on attachment theory with the entire system of support.

Key points: Attachment in clinical practice

FORMULATION

- Attachment history should be included in individualised formulations.
- Formulations should make it clear that attachment strategies were originally developed as an adaptive response even where these strategies are identified as outdated and problematic in the individual's current context.
- The individual's developmental level should be clearly described along with their current attachment strategies within formulation. Where families or staff present with unrealistic expectations, this should be considered with the system and interventions planned to increase understanding of the individual's abilities and needs.
- Formulations should be shared with individuals and their system of support in a supportive and non-blaming way.
- Difficulties in attachment relationships may impact on the type of intervention and length of input needed for the individual and their wider system of support.

5.3 Interventions

Whilst it is not possible within this guideline to demonstrate the full range of psychological interventions that are available to people with ID⁴², an overview is provided of selected approaches, which have focused on issues pertinent to both historic and current attachment relationships.

5.3.1 Psychological therapy

Psychological therapists strive to provide a safe and consistent therapeutic space to interact with the person with unconditional positive regard. They will engage in a joint learning

42 Division of Clinical Psychology, British Psychological Society (2016). *Psychological therapies and people who have intellectual disabilities*. Leicester, UK. BPS publications.

process, where the intention is for severe distress to decrease and/or to discover how to improve wellbeing.

There is not yet evidence that psychological therapies with a relational focus have any more or less success than psychological therapies which focus on symptom reduction and coping skills (e.g. mindfulness-based cognitive therapy). However it may be that the therapeutic relationship/alliance may account for much of the success of psychological therapy in people both with and without ID.

A particular approach, Disability Psychotherapy, developed and clearly summarised by Pat Frankish⁴³ and demonstrated in case studies⁴⁴, has the explicit goal of overcoming trauma and developing the individual's ability to develop attachments with and trust in others, which then improves their future experience of relationships.

Attachment theory has also been applied to Cognitive Analytic Therapy (CAT) with people with intellectual disabilities. A small pilot study⁴⁵ linked the reciprocal roles of 'overwhelming – overwhelmed' and 'unloving – unloved' to individual's previous experience of attachment relationships. Another initial study of 44 cases of psychodynamic psychotherapy suggests that clinicians may be able to determine which clients will have high initial symptom severity, and perhaps require more sessions, by rating client narratives on a 20-item scale and considering if these suggest secure or non-secure attachment representations⁴⁶.

Whilst little has been written about attachment theory in relation to other psychotherapeutic models for adults with ID, the theory is considered to be applicable whatever the approach being used, although research is required to confirm this.

5.3.2 Challenging behaviour and Positive Behaviour Support

Within Positive Behaviour Support (PBS) the individual's emotional and behavioural responses may be conceptualised in a way which overlooks the important function of these in terms of the individual's attachment relationships with others. For example, existing challenging behaviours may be helpfully formulated as a continued expression of Ambivalent attachment strategies which were adaptive during childhood. This would be in contrast to the more typical paradigm of focusing on cognition-emotion-behavioural responses⁴⁷. Whilst this latter approach is practical and useful within PBS approaches, as well as evidence based, it may constrain the psychologist to see problems as 'factors' to be 'influenced' or 'altered', to the benefit of the client rather than recognising the mutual and interdependent attachment relationships which connect individuals and their caregivers.

43 Frankish, P. (2016). *Disability Psychotherapy: Innovative Approaches to Trauma-Informed Care*. London: Karnac.

44 Frankish, P. (1989). Meeting the emotional needs of handicapped people: A psycho-dynamic approach. *Journal of Mental Deficiency Research*, 33, 407–414.

45 Psaila, C.L. & Crowley, V., 2006. Cognitive analytic therapy in people with learning disabilities: An investigation into the common reciprocal roles found within this client group. *Reformulation*, Winter, 5–11.

46 Skelly, A. & Burman, H. (2015). Forty-four worthwhile interventions: Clinician-rated attachment style and outcome of psychodynamic psychotherapy for people with intellectual disabilities. *Bulletin of the Faculty for People with Intellectual Disabilities*, 13(1), 20–29.

47 Allen, D. (1999). Mediator Analysis: an overview of recent research on carers supporting people with intellectual disability and challenging behaviour. *Journal of Intellectual Disability Research*, 43, 4, 325–339.

The purpose here is not to undertake a critical review of PBS but rather to support the integration of attachment theory within PBS. There are a number of ways in which this can be achieved:

- The NICE (2015) challenging behaviour guidelines are clear that family, environmental and developmental factors should be considered during initial assessment, prior to functional assessment.
- A mediator analysis should be completed, which takes into account the skills and availability of the network.
- Within Behaviour Support Plans, psychologists can promote the need for clients to be considered as persons with histories, and consider whether behaviours of concern reflect attachment related anxieties about separation and loss.
- There will also be a current ‘constellation’ of attachment relationships that require careful understanding. For example, if a member of paid care staff strongly reminds a person of an abusive parent, their working relationship may be unlikely to follow the same course as that of a staff member who reminds them of a loving and supportive parent.

How behavioural guidelines are implemented will vary according to such perceptions in an evolving way. There are attachment-based methods of working with ‘behaviour’ that allow the integration of these factors in a formal and systematic way^{48 49 50}, should practitioners wish to develop a method of working with behaviour where attachment is the primary focus.

However, the guideline recommends that when PBS is implemented, it includes clear and explicit accounts of past and current attachments and endeavours to promote:

- Ongoing stability in the physical environment and a minimisation of unnecessary moves, especially where these are based on service philosophy or ideas about ‘independence’ that are not consistent with the person’s cognitive and emotional readiness for such moves,
- The physical, emotional and sexual protection of people with intellectual disabilities who may be vulnerable to abuse,
- Challenging disrespectful care especially where the carer withdraws positive regard in response to difficulties the person may demonstrate,
- Identifying and intervening where poor quality relationships are evident although physical needs may be being adequately met,
- Development of and learning from naturally-occurring attachment relationships where the carer is warm, predictable, and resilient to behaviours negatively affecting the relationship (as with Carol and Harry),

48 Shackleton, A. (2016). Have a heart: Helping services to provide emotionally aware support. In H.K. Fletcher, A. Flood & D.J. Hare (Eds.) *Attachment in intellectual and developmental disability: A clinician’s guide to practice and research*. New York: Wiley.

49 Skelly, A. (2016). Maintaining the bond: Working with people who are described as showing challenging behaviour using a framework based on attachment theory. In H.K. Fletcher, A. Flood, & D.J. Hare (Eds.) *Attachment in intellectual and developmental disability: A clinician’s guide to practice and research*. New York: Wiley.

50 Schuengel, C., Clegg, J., de Schipper, J.C. & Kef, S. (2016). Adult attachment and care staff functioning. In Fletcher, H.K., Flood, A. & Hare, D.J. (Eds.) *Attachment in intellectual and developmental disability: A clinician’s guide to practice and research*. New York: Wiley.

- Supporting participation, new activities and skills training by promoting mutual enjoyment,
- Supporting regular new learning that involves the person and the caring individual in joint venture,
- Promoting relationship building and maintenance as part of ongoing review of progress, e.g. in periodic service reviews.

None of these recommendations are inconsistent with PBS in any way but may not be the focus to date.

5.3.3 Integrative Therapy for Attachment and Behaviour (ITAB).

A specialist intervention was developed by Sterkenburg and colleagues in the Netherlands⁵¹, initially reported as a single case and then a case series⁵², in order to address challenging behaviours in children with multiple disabilities. The approach involves adding the development of an attachment relationship between therapist and child prior to engaging in behaviour modification. The authors suggest that the reinforcement from the positive relationship creates an advantageous set of contingencies during behaviour change, and allows the child to regulate their emotions more successfully. Importantly, the authors included a control condition where the relationship was not developed prior to behavioural intervention. On modifying the behaviour directly, the therapist then moves to support daily caregivers to develop secure relationships with the child as well, before withdrawing. This approach is an explicit method of augmenting behavioural approaches and the initial evidence suggests that it is an effective methodology that may be superior to behaviour modification provided by unfamiliar therapists. However, a study with more participants, random allocation to ITAB or control condition, and widening the approach to children without multiple disabilities, or adults with ID, would allow the findings to be generalised to other groups.

5.3.4 Staff support and education (The CONTACT system).

Another specific intervention involves specialised training, but seems to offer clear evidence of effectiveness. Damen and colleagues⁵³ developed the CONTACT intervention within group homes for children and adults with visual impairment and moderate to profound ID. In the system, professional caregivers refer a client whose relationship with them they consider to require improvement. The caregivers then review videotaped interactions with their client and are encouraged by a therapeutic coach to identify ways in which they could improve their relationship based on the principles of attachment theory as well as ‘inter-subjectivity theory’⁵⁴. A large group of 72 caregivers of 12 clients

51 Sterkenburg, P.S., Janssen, C.G.C. & Schuengel, C. (2008) The effect of an attachment-based behaviour therapy for children with visual and severe intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 21, 126–135.

52 Schuengel, C., Sterkenburg, P.S., Jeczynski, P., Janssen, C.G.C. & Jongbloed, G. (2009) Supporting affect regulation in children with multiple disabilities during psychotherapy: A multiple case design study of therapeutic attachment. *Journal of Consulting and Clinical Psychology*, 77, 291–301.

53 Damen S., Kef S., Worm M., Janssen M.J. & Schuengel C. (2011) Effects of video-feedback interaction training for professional caregivers of children and adults with visual and intellectual disabilities. *Journal of Intellectual Disability Research*, 55, 581–595.

54 Janssen M.J., Riksen-Walraven J.M. & Van Dijk J.P.M. (2003). Contact: effects of an intervention program to foster harmonious interactions between deaf-blind children and their educators. *Journal of Visual Impairment & Blindness*, 97, 215–229.

demonstrated that staff became more skilful at perceiving and responding to emotional signals from clients. The ‘mutuality’ – similar to the idea of ‘attunement’ – of the relationships demonstrably improved. Interestingly, although initially the caregivers’ own attachment representations were associated with the quality of initial interactions between service users and carers, following intervention these differences were not evident. The study reported that there were in fact increased gains in quality of response for those carers classified as insecure versus the carers classified as autonomous secure⁵⁵. Again, this is reason to be optimistic that carer’s own states of mind regarding attachment do not preclude them benefitting from interventions focused on improving their responses to services users. Preliminary results suggest that challenging behaviour may be reduced where caregivers follow the modelled relationship skills⁵⁶, but further research is required. It has been acknowledged that this kind of training is costly and difficult to roll out on a national basis. However, manuals and DVDs have been produced that psychologists may wish to access to pursue this approach as a clinical intervention⁵⁷. Practitioners in the UK may also consider training in interventions such as Video Interaction Guidance (see below), which has several similarities with the CONTACT intervention.

5.3.5 Interventions evidenced with other groups

A number of evidence-based interventions for children without ID may be appropriate for use in individuals with ID. These include Video Interaction Guidance (VIG)⁵⁸, Circle of Security⁵⁹, and Infant-Parent Psychotherapy⁶⁰. These interventions have several commonalities involving psychoeducation about the child’s attachment needs, development of sensitivity and attunement to the child’s attachment behaviours, review using feedback (often video), and reflection on the parent’s own attachment experiences and how these may exert an influence on their parenting. A meta-analysis found that these approaches tend to be more effective where they have sufficient numbers of sessions and a clear cut behavioural focus⁶¹.

Dyadic Developmental Psychotherapy (DDP)⁶² was developed for foster-parents of neglected or traumatised children and elaborated later with parents and families into attachment-focused family therapy. The approach draws on recent findings in the neuroscience of emotions⁶³. The approach involves establishing an intuitive, non-verbal

55 Schuengel C., Damen S., Worm M. & Kef S. (2012). Attachment representations and response to video-feedback intervention for professional caregivers. *Attachment & Human Development*, 14, 83–99.

56 Van Wouwe H. (2012). Triple C: researching the effects of treatment. *Journal of Intellectual Disability Research*, 56, 683–683.

57 Sterkenburg P. S. (2012). *Developing Attachment: A Workbook for Building up a Secure Relationship with Children or Adults with Severe Intellectual or Multiple Disabilities*. Microweb Edu, Doorn, The Netherlands.

58 Kennedy, H., Landor, M. & Todd, L. (2010). Video Interaction Guidance (VIG) as a method to promote secure attachment. *Educational and Child Psychology*, 27, 3.

59 Cooper, G., Hoffman, K., Powell, B. & Marvin, R. (2005). The circle of Security intervention: Differential diagnosis and differential treatment. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing Early Attachments: Theory, research, intervention and policy* (pp.127–151). New York: The Guilford Press.

60 Lieberman, A.F., van Horn, P. & Ippen, G.C. (2005). Toward evidence-based treatment: Child–parent psychotherapy with pre-schoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1241–1248.

61 Bakermans-Kranenburg, M.J., van IJzendoorn, M.H. & Juffer, F. (2003) Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129, 195–215.

62 Hughes, D.A. (2011). *Attachment-Focused Family Therapy: The workbook*. New York: W.W. Norton.

63 Fosha, D. Siegel, D.J. Solomon, M.F. 2009, *The Healing Power of Emotion*. New York: W.W. Norton.

‘inter-subjectivity’. Practitioners adopt an ‘attitude’ of Playfulness, Acceptance, Curiosity and Empathy (PACE) which is intended to build emotional safety via the attachment caregiving system. A workbook involving video (using actors) is available. The focus on interactional ‘co-regulation’ of difficult or chaotic emotions, by altering the way parents or carers engage with the person, is intended to overcome difficult emotions and past traumatic reactions. Further research is needed to confirm if it is suitable for persons with ID.

Co-regulation of turbulent emotions through attuned relationships between ‘Important Others’ (parents and carers) and people with ID who are challenging is also a core feature of the Heijkoop method⁶⁴. Again, this is a new approach for which detailed research has yet to emerge.

5.3.6 Beginnings, endings and working with other agencies

It is often the case that adults with ID will at some point need a service commissioned by their family and/or statutory services where a move from the family home to a paid care setting is required. This can occur in young adulthood at a chronologically appropriate time, on the death or decline in health of parents later in life, or indeed at any point in between. Occasionally it must be done as a matter of urgency.

Clinical psychologists can helpfully engage with colleagues who are identifying potential placements to ensure services are capable of providing warm, enduring attachments that are resilient to reduce the risk of placement breakdown. Psychologists should offer training to social care professionals and providers, introducing ideas of attachment theory to everyone in the person’s system of support. Awareness that their support is crucial to the person’s wellbeing is not always obvious to staff (or family carers) who may not be securely attached themselves, especially those who may demonstrate an attachment strategy which minimises the importance of attachment relationships and comfort from others⁶⁵.

Particular attention needs to be paid to the quantity and quality of endings in client-carer relationships. People with ID often have repeated endings with paid carers and professionals. They may move out of the family home at the point when their parents’ health is declining or following loss of their parents. The person may need to express their emotional losses in their new relationships, whilst carers may be more focused on thinking positively about the future, creating a mismatch. Care plans should be developed to minimise further unnecessary losses, while carer relationships need to be responsive and supportive. Psychologists and other professionals should also consider the impact of the ending when finishing their interventions.

Whatever the reason for the ending, careful thought should be given as to how to say goodbye. Even when it is thought that further contact would be detrimental or impractical, a range of interventions can apply including:

- Planning a goodbye party,
- Taking photos for both to keep,

64 Heijkoop, J. & Clegg, J. (2012) Introduction to the Heijkoop approach to challenging behaviour in ID. In: Ideas Exchange: Emerging Good Practice in ATU Intellectual Disability Specialist Services, 3 February, 2012, Nottingham, UK. (Unpublished).

65 Schuengel, C., Damen, S., Worm, M. & Kef, S. (2012). Attachment representations and response to video-feedback intervention for professional caregivers. *Attachment and Human Development*, 14, 83–99.

- Creating a social story⁶⁶ which explains the ending,
- Writing a goodbye letter or card to keep.

‘A sense of availability, even if only in mind, is fundamental to autonomy in attachment’
John Byng-Hall⁶⁷

5.4 Specific additional considerations

5.4.1 Dementia

There is little research or clinical guidance as to the attachment needs of people with ID who develop dementia. The Faculty’s joint guidance with the Royal College of Psychiatrists⁶⁸ mentions the impact of abuse on apparent cognitive decline, the need for family and carers to be well informed about diagnosis, and potential psychological intervention to ‘enable them to feel emotionally supported and begin to understand the diagnosis’. The confusion and cognitive decline inherent in dementia may affect a person’s internal working model so that they require physical proximity more than before to feel comforted and understood.

Clinical experience and research in the broader field suggests the following implications in terms of the person’s attachment relationships:

- Significant life events such as moving home or changes to daily routine can lead to deterioration in functioning which can mimic dementia,
- Loss of cognitive functioning may be associated with recent attachment related losses such as abuse and bereavement,
- Relationships with family, friends and significant others should be maintained throughout the person’s progression of dementia,
- Moving in the later stages of the condition may increase disorientation and precipitate a decline in functioning,
- The person’s need for physical proximity to others in response to perceived ‘threats’ may increase, leading to new behaviours of calling out, shouting, screaming and pulling people towards them,
- It is important for carers to understand that attachment relationships are life-long and of just as much importance in later stages of life as they are in earlier adulthood. For people with dementia who are disorientated and confused, a higher level of physical proximity and contact is needed in order to maintain the perception of emotional safety.

5.4.2 Autism Spectrum Disorders

Where parents of children diagnosed with ASD recognise their attachment signals and respond in an attuned way, secure attachment relationships will form. However, some children may have primary cognitive difficulties in developing ‘Theory of Mind’ which

66 Test, D.W., Richter, S., Knight, V. & Spooner, F. (2010). A comprehensive review and meta-analysis of the social stories literature. *Focus on Autism and Other Developmental Disabilities*, 26, 1, 49–62.

67 Byng-Hall, J. (2008). The crucial roles of attachment in family therapy. *Journal of Family Therapy*, 30, 129–146.

68 British Psychological Society/Royal College of Psychiatrists (2015). *Dementia and People with Intellectual Disabilities*. Leicester, UK: BPS publications.

make the ‘goal-corrected partnership’ difficult to negotiate, creating a rather one-sided dynamic. It has been proposed within the NICE Guidance in relation to Children’s Attachment that behaviours that seem to denote insecurity could occur directly because of social communication difficulties associated with a diagnosis of ASD, even though parents offer good responsiveness. Interventions therefore need to be informed by research into ASD (e.g. need for concrete concepts, avoiding terms that describe the mental states of others, such as ‘know’, ‘want’, ‘believe’, etc.), as well as research into attachment. Interventions may include Video Interaction Guidance (VIG) or similar, but also elements of ASD-specific interventions such as Social Stories™, social skills training and play based therapies.

5.4.3 People with multiple and/or profound disabilities

People with multiple/profound disabilities may require actual physical proximity at all times, both for survival and to ensure acceptable quality of life. Communication may be difficult to understand and behaviours of concern may be misinterpreted as intended to achieve tangible reinforcement (e.g. food, stimulation via activity) when the person is instead trying to initiate attachment directed behaviours. Interventions such as Intensive Interaction, Integrative Therapy for Attachment and Behaviour (ITAB) and the CONTACT programme have been developed specifically for people with multiple and profound learning disabilities and sensory impairment. They aim to support the development of reciprocal communication and mutually pleasurable interactions through non-verbal communication. Carers are helped to increase their ability to recognise the individual’s cues and respond sensitively to these. Activities are created which are developmentally appropriate and of interest to the individual and choices are supported based on interpreting the individual’s communications about when they want an activity or interaction to change or stop.

5.4.4 Parents with intellectual disabilities

Parents with intellectual disabilities are at increased risk of having their children removed⁶⁹. There is little published research on developing positive attachment relationships and parenting skills in this area, although a video-feedback intervention targeting parental stress has recently been trialled^{70 71}. There is some evidence to indicate that individuals with intellectual disabilities are able to learn about parenting skills⁷², although further research is needed.

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- 69 Booth T, Booth W, & McConnell D. (2005). The prevalence and outcomes of care proceedings involving parents with learning difficulties in the family courts. *Journal of Applied Research in Intellectual Disabilities*, 18, 7–17.
- 70 Hodes, M.W., Meppelder, H.M., Schuengel C., & Kef, S. (2014). Tailoring a video-feedback intervention for sensitive discipline to parents with intellectual disabilities: A process evaluation. *Attachment & Human Development*, 16, 387–401.
- 71 Hodes, M.W., Meppelder, H.M., de Moor, M.H.M., Kef, S. & Schuengel C. (in press, 2017). Alleviating parenting stress in parents with intellectual disabilities: A randomized controlled trial of a video-feedback intervention to promote positive parenting. *Journal of Applied Research in Intellectual Disabilities*.
- 72 Knowles, C., Machalicek, W. & Van Norman, R. (2015). Parent education for adults with intellectual disability: A review and suggestions for future research. *Developmental Neurorehabilitation*, 18, 336–348.

5.4.5 Diagnosis of personality disorder and/or forensic issues

Research is very limited in this field, though it is known that adults with ID who receive convictions and have a diagnosis of personality disorder show similar rates of early deprivation, abuse and trauma in childhood as do other offenders⁷³. Since a diagnosis of a personality disorder is strongly associated with attachment difficulties in the general population, comprehensive history taking will be important where clients have a forensic history and ongoing interpersonal problems.

Individuals whose early experiences have resulted in a strategy of ‘dampening down’ their emotional and attachment needs may experience empathic responses from others as anxiety provoking. This appears to be related to fear of losing the emotional connection with that person⁷⁴. The process of staff becoming more emotionally available to people with a diagnosis of personality disorder might not lead to the intended clinical improvements, potentially leaving staff frustrated that their attempts to offer comfort and containment are not valued. Therefore it is necessary for staff to have access to a psychological understanding of these complex relationships through supervision, training and opportunities for regular reflection.

Support services may need to offer more intensive and long-term intervention to establish sufficient physical and emotional safety that would keep the individual and their community safe. This may cause challenges for social care and continuing health care professionals in planning and securing a higher level of support than is practically needed for the individual’s level of adaptive functioning (particularly for those people with mild or borderline intellectual disabilities who might not fit neatly into eligibility guidelines).

5.4.6 Supervision and self-care

Clinical supervision, which should be regular, needs to include time to reflect on attachment issues arising in the work of the psychologist. Clinical supervision, as with psychological therapy, is also a process that supports emotional security. It should ideally offer a safe space to share and organise difficult feelings, explore the psychological work creatively and promote a spirit of positive enquiry. As such, it is recommended as essential practice for all grades of clinical psychologist.

Maintaining consistent boundaries for psychotherapy and psychological interventions can be challenging when working with individuals who have complex or fluctuating needs relating to their attachment relationships. This can be further challenged by organisational factors which may reduce the clinician’s confidence and feeling of security. These might include:

- Physical danger that may cause fear in the course of their work, e.g. lone working with clients who have a history of aggression and violence,
- Emotional insecurity that may result from insecure working conditions (e.g. hot desking) and the lack of a secure physical base (e.g. a room to see people in regularly),
- Noisy, disrupted or otherwise unsuitable work environments;

73 Steptoe, L., Lindsay, W.R., Finlay, C. & Millar, S. (2016). Attachment, Personality Disorder and offending: Clinical implications. In Fletcher, H.K., Flood, A. & Hare, D.J. (Eds.) *Attachment in Intellectual and Developmental Disability: A Clinician’s Guide to Practice and Research*. New York: Wiley.

74 Liotti, G. (2011). Attachment disorganisation and the clinical dialogue: Theme and Variations. In Solomon, J. & George, C. (Eds.) *Disorganised Attachment and Caregiving*. New York: Guilford Press.

- High levels of exposure to people in crisis without sufficient means to offer support and resolve such situations,
- Poor or limited supervision arrangements,
- Working cultures that are dismissing of staff distress,
- Organisations which respond to external pressure by increasing demands on staff,
- A lack of training that meets the needs of both the service and the psychologist,
- The availability of psychological support or confidential therapy for psychologists who require emotional support.

It is important for clinicians to identify the needs of the service users and themselves to support the provision of a consistent and stable service. When services attend to the needs of their staff then this is likely to have a positive impact on staff wellbeing and the quality of services offered.

Key points: Attachment in clinical practice

INTERVENTION

- Attachment theory can be incorporated into psychological interventions across a range of theoretical models.
- Approaches including Positive Behaviour Support, ITAB and CONTACT have reported promising findings in terms of improving people's quality of life and the quality of their relationships with others.
- A number of interventions have good evidence for children without ID which may be of future utility for individuals with ID including Video Interaction Guidance, Circle of Security, Infant-Parent Psychotherapy and Dyadic Developmental Psychotherapy.
- Transitions require careful thought and planning to support new beginnings and endings of relationships.
- Working with people who have additional considerations (such as dementia, ASD, profound and multiple ID, parents with ID and individuals with diagnoses of personality disorder) requires the ability to combine clinical knowledge relevant to the client group with an understanding of attachment theory. This means that formulation and clinical interventions can be individually tailored to best meet the needs of the person and their system of support.
- Psychologists should promote supervision and self-care that allows them to meet the attachment needs of the people with intellectual disabilities whom they work with. Occupational hazards, stress, and a lack of capacity to reflect on one's practice may make this more difficult.

This section has discussed the application of attachment within clinical practice across the broad spectrum of work carried out by clinical psychologists. The next section describes ideas for future research, followed by a list of useful resources and appendices.

6. Recommendations for research

Further research is required to explore a number of areas pertaining to the attachment needs of people with intellectual disabilities.

- A comprehensive survey of the attachment needs of people with intellectual disabilities is required. We do know that people with intellectual disabilities are at higher risk of sexual abuse⁷⁵, being removed from the family of origin, and living in multiple placements⁷⁶, but there is no comprehensive account of the likely attachment sequelae of these risks for the particular client group. NICE Guidance for children at risk of intervention to protect them from attachment difficulties⁷⁷ suggests that measuring parenting quality and sensitivity, multiple socioeconomic factors, and co-existing mental health problems all need to be quantified.
- There is a need for the further development and validation of assessment measures for people with a range of severity of ID. See Appendix 2 for a list of measures that are currently in use.
- Attachment informed interventions for families and paid carers show considerable promise and this work in the Netherlands now forms a substantial body of research for people with intellectual disabilities^{78 79}. Video feedback methodologies are recommended in the NICE guidance for children at risk of care proceedings, and are reported to be useful in persons with ID and those who care for them, in research from the Netherlands. We need UK-based research that replicates and extends these findings.
- We also require systematic studies of Disability Psychotherapy, exploring its effectiveness in helping individuals overcome trauma, and developing the ability to attach and trust in others, leading to success in later relationships. Controlled trials are possible and could use standardised outcome measurement tools as well as waiting list and follow up comparisons.
- The attachment representations of psychologists themselves could be investigated.

75 Turk, V. & Brown, H. (1993). The sexual abuse of adults with learning disabilities; results of a two-year incidence survey. *Mental Handicap Research*, 6, 13–216.

76 Schuengel, C.; Oosterman, M and Sterkenberg, P.S. (2009). Children with disrupted attachment histories: Interventions and psychophysiological indices of effects. *Child and Adolescent Psychiatry and Mental Health*, 3, 26, 1–10.

77 National Institute for Health and Clinical Excellence, (2015). Children’s Attachment: Attachment in children and young people who are adopted from care, in care or at high risk of going into care. nice.org.uk/guidance/ng26.

78 Schuengel C., Damen S., Worm M. & Kef S. (2012). Attachment representations and response to video-feedback intervention for professional caregivers. *Attachment & Human Development*, 14, 83–99.

79 Damen S., Kef S., Worm M., Janssen M. J. & Schuengel C. (2011) Effects of video-feedback interaction training for professional caregivers of children and adults with visual and intellectual disabilities. *Journal of Intellectual Disability Research*, 55, 581–595.

7. Useful online resources

- Circle of Security website and animation:
<https://www.circleofsecurityinternational.com/animations>
- An introduction to attachment and the implications for learning and behaviour:
<http://www.bathspa.ac.uk/education/research/attachment-aware-schools/importance-of-attachment/> – an excellent resource with details of attachment theory and implications for learning and school environments for children in mainstream schools.
- MindEd e-learning – various brief training modules on attachment in non-ID populations (free to access):
<https://www.minded.org.uk/Search>
- Association for Video Interaction Guidance UK website:
<http://www.videointeractionguidance.net/>
- Intensive Interaction website:
www.intensiveinteraction.org
- Information sheet on Attachment & Complex Learning Difficulties and Disabilities Research Project (CLDD):
<http://complexld.ssatrust.org.uk/uploads/attachment-info%20Aug.pdf>
- Materials from the Amsterdam clinical research group can be purchased via this link:
www.webedu.nl/bestellen/bartimeus

Appendix 1. Outcomes of non-secure and disorganised attachment in childhood and adulthood and an indicator of evidence quality

Outcomes of attachment insecurity or disorganisation		Key references	Level of evidence ⁸⁰
Childhood & adolescence	Less persistence in problem solving at age two	Meins, E. (1997). <i>Security of Attachment and the Social Development of Cognition</i> . Hove: Psychology Press.	P
	Poorer theory of mind at age 4-6 years	Fonagy, P.; Redfern, S. & Charman, A. (1997). The relationship between belief-desire reasoning and a projective measure of attachment security (SAT). <i>British Journal of Developmental Psychology</i> , 15, 51–63. Meins, E., Fernyhough, C., Russell, J.A. & Clark-Carter, D. (1998). Security of attachment as a predictor of symbolic and mentalising abilities: a longitudinal study. <i>Social Development</i> , 7, 1–24.	M
	Poorer recall of past life events at age 11 years	Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, singular (coherent) vs. multiple model of attachment: findings and future directions for research. In Parks, C.; Stevenson-Hynde, J. & Marris, P. (Eds.) <i>Attachment Across the Life Cycle</i> . London: Routledge.	P
	Incompetence with peers & associated low self-esteem	Groh, A., Roisman, G., Booth-LaForce, C., Fraley, R., Owen, M. & Cox, M. (2014a). Stability of attachment security infancy to late adolescence. <i>Monographs of the Society for Research in Child Development</i> , 79, 51–66. Groh, A., Fearon, R.P., Bakermans-Kranenburg, M.J., van Ijzendoorn, M.H., Steele, R.D. & Roisman, G.I. (2014). The significance of attachment security for children’s social competence with peers: a meta-analytic study. <i>Attachment & Human Development</i> , 16, 103–36.	P

80 (0-opinion only, P-preliminary or single study, M – multiple study, replications, or literature review, E – established by clinical practice or national guidance policies)

Outcomes of attachment insecurity or disorganisation		Key references	Level of evidence
Childhood & adolescence	Diagnosis of Reactive Attachment Disorder (RAD)/Disorganised Attachment Disorder (DAD)	National Institute for Health and Clinical Excellence, (2015). Children's Attachment: Attachment in children and young people who are adopted from care, in care or at high risk of going into care. nice.org.uk/guidance/ng26.	E
	Diagnosis of Oppositional Defiant Disorder		E
	Diagnosis of Conduct Disorder		E
Adulthood	Proneness to paranoia/ diagnosis of schizophrenia	Sitko, K., Bentall, R., Shevlin, M., O'Sullivan, M. & Sellwood, W. (2014). Associations between specific psychotic symptoms and specific childhood adversities are mediated by attachment styles: an analysis of the National Comorbidity Study. <i>Psychiatry Research</i> , 217, 3, 202–209. Dozier, M., Stevenson, A.L., Lee, S.W. & Velligan, D.I. (1991). Attachment organisation and familial over-involvement for adults with serious psychopathological disorders. <i>Development and Psychopathology</i> , 3, 475–489.	P
	Depressive symptoms (non-clinical) & diagnosis of mood disorder	Ma, K. (2006). Attachment theory in adult psychiatry. [1] Conceptualisations, measurement, and clinical practice. <i>Advances in Psychiatric Treatment</i> , 12, 440–449.	M
	Diagnosis of obsessive compulsive disorder	Myhr, G., Sookman, D. & Pinard, G. (2004). Attachment security and parental bonding in adults with obsessive-compulsive disorder: a comparison with depressed out-patients and healthy controls. <i>Acta Psychiatrica Scandinavica</i> , 109, 447–456.	P
	Eating disorder	Ward, A., Ramsay, R. & Turnbull, S. (2001). Attachment in anorexia nervosa: a transgenerational perspective. <i>British Journal of Medical Psychology</i> , 74, 497–505.	P
	Diagnosis of avoidant, depressive, paranoid or schizotypal personality disorder (associated with dismissing attachment)	Brennan, K. & Shaver, P. (1998). Attachment styles and personality disorders: their connections to each other and to parental divorce, parental death, and perceptions of parental care-giving. <i>Journal of Personality</i> , 66, 835–878.	M
	Diagnosis of dependent, histrionic or borderline personality disorder (associated with preoccupied attachment)	Fossati, A., Feeney, J.A., Donati, D., Donini, M., Novella, L., Bagnato, M., Carretta, I., Leonardi, B., Mirabelli, S. & Maffei, C. (2003). Personality disorders and adult attachment dimensions in a mixed psychiatric sample: a multivariate study. <i>Journal of Nervous and Mental Disease</i> , 191, 1, 30–37. Nakash-Eisikovits, O., Dutra, L. & Westen, D. (2002). Relationship between attachment patterns and personality pathology in adolescents. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 41, 1111–1123.	M

Appendix 2. Table of assessments relating to attachment

Assessment Name	Age group	Used for ID?	Standardised Training required?	Clinical/ Research use	Mode of assessment	Focus of assessment (see 3.7)
Strange Situation	Child	Yes	Yes	Research & clinical	Observation	Representation (A,B,C,D)
Adult Attachment Interview	Adult	No	Yes	Research & clinical	Interview	Representation (F, D, E, U)
Attachment Q-Sort	Child	Yes	No	Research & clinical	3rd party observer rating	Representation (secure – insecure)
Adult Attachment Projective Picture System (AAP)	Adults	Yes	Yes	Research & clinical	'Judge' coded	Representation (F, D, E, U)
Secure Base Safe Haven Observation List (SBSHO)	Child & young people	Yes	No	Research & clinical	3rd party observer rating	Behaviours (secure)
Manchester Attachment Scale – Third party measure ³¹ (MAST)	Adults	Yes	No	Clinical & research	3rd party observer rating	Behaviours (secure)
Quality of Early Relationship Rating Scale (QuERRS)	Adults	Yes	No	Clinical & research	Clinician rated	Relationship (A,B,C,D)
Choice-description method	Adolescents & adults	Yes	No	Clinical & research	Self-report	Style
The Disturbances of Attachment Interview (DAI)	Children	Yes	No	Clinical	3rd party interview	Disorder
Clinical Observation of Attachment (COA)	Children	Yes	No	Clinical & research	Observation	Disorder

Appendix 3. Further features of available attachment assessments

- i) Secure Base Safe Haven Observation List (SBSHO). This list contains 20 items on a 7-point Likert scale and is intended for children with moderate to severe intellectual disabilities. The SBSHO is based on the Attachment Q-Sort which is a well-validated instrument for assessing attachment quality⁸¹. Although based on direct observation methodology, the SBSHO is based on third party judgements of attachment behaviours. Internal consistency has been reported as high, inter-rater agreement to be moderate ($r=0.60$) and concurrent validity was established against the Attachment Q-Sort.
- ii) Manchester Attachment Scale – Third party measure (MAST). The MAST contains 16 items each consisting of a 4-point Likert scale, that a staff member or family carer will make ratings against judgements of attachment behaviour that they have observed in their caring role as with the SBSHO. The MAST was developed in work with adults, is internally consistent, and seems to be able to demonstrate a relationship between psychological and behavioural difficulties. Inter-rater reliability has not yet been reported.
- iii) Quality of Early Relationship Rating Scale (QuERRS). Also for adults, the QuERRS is a 20-item rating scale to aid clinicians undertaking psychological therapies with persons who have mild to moderate ID, and who can refer to their family of origin and current relationships. The QuERRS asks the clinician to consider factor scores and then, if preferred, to consider the dominant category of attachment apparent in the therapeutic conversation. It appears to have acceptable inter-rater reliability and internal consistency⁸², and may be able to predict if short or long-term psychotherapy is required if a psychodynamic approach is taken⁸³. A Factor Analytic study⁸⁴ supports a four-factor solution with 16 items loading on (1) poor recollection versus realistic coherence, (2) unacceptability versus acceptability of the predictive value of attachments, (3) continued resentment of parents versus serenity towards difficulties, and (4) ongoing hypersensitivity to threat.
- iv) Adult Attachment Projective Picture System (AAP). A trained and certified practitioner identifies the interpersonal expectations of the person from their response to a series of line drawings, achieving a detailed picture of their attachment

81 Van IJzendoorn, M.H., Vereijken, C.M.J.L., Bakermans-Kranenburg, M.J. & Riksen-Walraven, J.M. (2004). Assessing attachment security with the attachment Q sort: meta-analytic evidence for the validity of the observer AQS. *Child Development* 75, 1188–1213.

82 Skelly, A. & Reay, R. (2013). Quality of Early Relationships Rating Scale (QUERRS): A screening tool to aid psychotherapy assessment in people with mild to moderate learning disabilities. *Clinical Psychology and People with Learning Disabilities*, 11,1-2, 33–44.

83 Skelly, A. & Burman, H. (2015). Forty-four worthwhile interventions: Clinician-rated attachment style and outcome of psychodynamic psychotherapy for people with intellectual disabilities. *Bulletin of the Faculty for People with Intellectual Disabilities*, 13(1), 20–29.

84 Skelly, A. & Harvey, H. (2017). Attachment representations in psychological therapy of people with Intellectual Disabilities: A preliminary factor analytic study of the Quality of Early Relationships Rating Scale (QuERRS). *The Bulletin of the Faculty for People with Intellectual Disabilities*, April.

representations with the confidence of a ‘developmental’ and diagnostic model rather than a hypothesis based on indirect ratings. A series of case studies demonstrating clinical utility in adults with mild to moderate ID has been reported⁸⁵. The AAP requires considerable training in order to code transcripts reliably, and it is perhaps the most rigorous method available to be evidenced with adults with ID. Inter-rater reliability, test-retest reliability, and freedom from the effects of verbal intelligence or social desirability are described for mainstream use⁸⁶, along with excellent concurrent validity with the AAI. Recent work suggests that the AAP is especially useful in identifying a process of pathological mourning in adults presenting with psychological distress to clinical services⁸⁷.

- v) The Clinical Observation of Attachment⁸⁸ (COA) is a structured observational assessment tool similar to the strange situation which places the child in anxiety provoking situations aimed to activate their attachment system. The child’s attachment behaviours are rated, looking for the following: showing affection to the caregiver, seeking comfort, reliance on the caregiver for help, cooperation, exploratory behaviour, controlling behaviour, reunion responses, and response to strangers. Although developed as a measure for typically developing children, the assessment has been used successfully with children with ID. This approach can be used to guide observations and may be adapted for adults with ID by clinicians who have experience in working within an attachment informed framework.
- vi) Choice-description method. This method involved participants choosing between self-descriptions of attachment style in romantic and friendship relations and adults⁸⁹ and also adolescents⁹⁰. Issues have been raised in relation to the evidence produced by this method in terms of the ability to determine between-group effects with small sample sizes. We do not have reason to be confident that the attachment behaviour of the person would correspond to their choice of description. In addition, persons with dismissing (avoidant) categorisation may deny attachment problems because they psychologically avoid the salience of attachment difficulties to any behavioural or emotional symptoms they may have.
- vii) Screening of Attachment Disorders. The Society explicitly encourages the use of psychological formulation as the end point of assessment for clinical psychologists, which may include diagnosis that has acceptable reliability and validity⁹¹ but should

85 Gallichan, D. & George, C. (2014). Assessing attachment status in adults with intellectual disabilities: the potential of the Adult Attachment Projective Picture System. *Advances in Mental Health and Intellectual Disabilities*, 8, 103–119.

86 George, C. & West, M. (2011). The Adult Attachment Projective Picture System: Integrating Attachment into Clinical Assessment. *Journal of Personality Assessment*, 93, 5, 407–416.

87 Gallichan, C.J. & George, C. (2016). Attachment trauma and pathological mourning in adults with intellectual disabilities. In Fletcher, H.K., Flood, A. & Hare, D.J. (eds) *Attachment in Intellectual and Developmental Disability: A Clinician’s Guide to Practice and Research*. New York: Wiley.

88 Boris, N.W., Fueyo, M. & Zeanah, C.H. (2007). The clinical assessment of attachment in children under five. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 2, 291–293.

89 Larson, F., Alim N. & Tsakanikos E. (2011). Attachment style and mental health in adults with intellectual disability: self reports and reports by carers. *Advances in Mental Health and Intellectual Disabilities* 5, 15–23.

90 Weiss J., MacMullin J., Waechter R. & Wekerle C. (2011) Child maltreatment, adolescent attachment style, and dating violence: considerations in youths with borderline-to-mild intellectual disability. *International Journal of Mental Health and Addiction* 9, 555–576.

91 Division of Clinical Psychology, British Psychological Society. (2011). *Good Practice Guidelines on the Use of Psychological Formulation*. Leicester, UK: BPS publications.

not be confused with psychiatric formulation which is centrally based on the diagnosis made in each case. Diagnosis is, therefore, something that psychologists may consider as neither necessary nor sufficient to determine that attachment is a central or important factor in their clinical formulation.

- viii) The Disturbances of Attachment Interview (DAI)⁹² is a 12-item semi-structured interview for caregivers, which was originally designed to screen for potential ‘inhibition’ (potential inhibited/emotionally withdrawn attachment disorder) and ‘disinhibition’ (potential disinhibited social engagement disorder). A study of 20 children with ID has demonstrated high inter-rater reliability, with inhibition associated to a history of multiple placements, and disinhibition associated with a history of poor parenting using negative emotional communication⁹³. These findings suggest that the measure captures disturbance in attachment that is a result of negative experiences and finding those children whose circumstances may be significantly improved by intervention.
- ix) Assessment (and treatment) of Reactive Attachment Disorder (RAD) in children was the subject of a detailed set of practice guidelines in the USA in 2005⁹⁴. This is a specific method of assessment based on rigorous examination of the research evidence and is interesting because the structured or semi-structured observations with attachment figures and unfamiliar persons (analogous to the SSP), with variations in stress are recommended. In addition, an attachment history should be taken from the parents. Psychologists in adult ID services may be involved in cases where RAD was diagnosed in childhood. However, there is no adult assessment procedure available, and there is no evidence base for its use in children with ID, where behavioural phenotypes for some conditions and the person’s cognitive functioning could potentially confound the findings.

92 Gleason M.M., Fox N.A., Drury S., Smyke A., Egger H.L., Nelson C.A., Gregas M.C. & Zeanah C.H. (2011). Validity of evidence-derived criteria for reactive attachment disorder: Indiscriminately social/disinhibited and emotionally withdrawn/inhibited types. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50, 216–231.

93 Giltaij H.P., Schuengel C. & Sterkenburg P.S. (2012) Disordered social behaviour in children with (mild) intellectual disability: Diagnostic distinctions between autism and disordered attachment. *Journal of Intellectual Disability Research*, 56, 680–680.

94 American Academy of Child and Adolescent Psychiatry. (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1206–1219.

Appendix 4. Self-assessment tool

Whilst there is still a limited evidence base to guide good practice in attachment and ID, this self-assessment tool has been developed based on the recommendations made in the NICE Guidelines *Children’s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care*⁹⁵ as the contents were felt to have good face validity for adults with ID. Whilst the tool is intended to help services **identify good practice** in working in an attachment-informed way it is not meant to be either prescriptive or limiting to services.

There are 7 proposed ‘standards’ included and blank templates to enable services to add to and develop their own ‘standards’ in addition to these. Services are encouraged to share additional standards with the working group who developed these guidelines so that these can be incorporated into future guidelines and standards as a continual work in progress.

As mentioned previously, it is important for clinicians to have a good understanding of attachment theory and the evidence base when using the self-assessment tool. Further research is needed to establish the validity of the 7 proposed standards within the tool for people with ID.

Standard 1 – Care co-ordination and stability	Action to be taken	By whom?	Date to be completed/ reviewed
<p>Ensure that the health, education and social care processes and structures surrounding people with attachment difficulties are stable and consistent. This should include checking that for each individual service user the following are in place:</p> <ul style="list-style-type: none"> • a care management system to coordinate care and treatment; • collaborative decision-making among all health, education and social care professionals, the individual if possible and their parents and carers; • the same key worker, social worker or personal adviser or care coordinator throughout periods of instability e.g. change of placement, loss or bereavement. 			

95 NICE, (2015). *Children’s Attachment: Attachment in children and young people who are adopted from care, in care or at high risk of going into care*. London: National Collaborating Centre for Mental Health.

Standard 2 – Identification of attachment difficulties	Action to be taken	By whom?	Date to be completed/ reviewed
<p>Health and social care provider organisations should train key workers, social care workers and workers involved with adults with attachment difficulties in:</p> <ul style="list-style-type: none"> • recognising attachment difficulties and parental/carer sensitivity; • recognising and assessing multiple socioeconomic factors that together are associated with an increased risk of attachment difficulties in the general population; • recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment, including trauma; • knowing when and how to refer for appropriate interventions for attachment difficulties. <p>Health and social care professionals should routinely ask questions relevant to attachment history and the individual’s relationships with significant others during their initial assessments.</p>			

Standard 3 – Training and support for carers supporting people with attachment difficulties	Action to be taken	By whom?	Date to be completed/ reviewed
<p>Health and social care providers should:</p> <ul style="list-style-type: none"> • Assess the need for comprehensive education and training for potential carers to prepare them for the challenges involved in supporting adults with attachment difficulties and the likely impact on them and their wider systems of support. • Provide on-going support and advice, either by telephone or in person, and proactively monitor difficulties in placements to identify opportunities to provide additional support, if there are significant attachment difficulties or if disruption to the placement is likely. 			

Standard 4 – Care plans	Action to be taken	By whom?	Date to be completed/ reviewed
<p>Health and social care providers should maintain an up-to-date care plan detailing:</p> <ul style="list-style-type: none"> • How the adult will be supported with their attachment needs. • Who the key person will be who can advocate for the adult and to whom the adult can go for support. • If there is need for a safe space in which the person with attachment difficulties can go in times of emotional distress (with a plan as to how they will be supported at such times). 			

Standard 5 – Interventions for adults in supported living/residential care	Action to be taken	By whom?	Date to be completed/reviewed
<p>Professionals with expertise in attachment difficulties should:</p> <ul style="list-style-type: none"> • Work with the supported living/residential staff group and identify any key attachment figures to work specifically with the person with attachment difficulties. • Offer parental sensitivity and behaviour training adapted for professional carers in supported living/residential care. • Ensure parental sensitivity and behaviour training for professional carers: <ul style="list-style-type: none"> – first consists of a single session with the carers followed by at least 5 (and up to 15) weekly or fortnightly carer–adult sessions (lasting 60 minutes) over 6 months – is delivered by a trained health or social care professional – includes: coaching the residential carers in behavioural management , reinforcing sensitive responsiveness, ways to improve caring quality – Includes homework to practise applying new skills. 			

Standard 6 – Intensive support for placements at risk of breakdown	Action to be taken	By whom?	Date to be completed/ reviewed
<p>Health and social care professionals arrange for additional support and resources (such as mentoring or day visits with a social worker or health professional) to adults and/or their carers:</p> <ul style="list-style-type: none"> • at the first sign of serious difficulties in the placement, or; • if there have been frequent changes of placement, or; • if there is more than one adult with attachment difficulties in the placement. 			

Standard 7 – Placement breakdown – supporting relationships to continue	Action to be taken	By whom?	Date to be completed/ reviewed
<p>If a placement breaks down, aim to maintain the relationship between the adult and carers whenever possible and if it is in the best interests of the adult with attachment difficulties.</p>			

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