Journal of Intellectual Disability Research doi: 10.1111/j.1365-2788.2009.01236.x

VOLUME 54 SUPPLEMENT 1 pp 38–47 APRIL 2010

Original Article

'People who need people': attachment and professional caregiving

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Abstract

From the perspective of attachment theory, this paper discusses individual differences in the quality of caregiving by direct-care staff for persons with intellectual disabilities. Theoretical arguments and findings from related literature are cited to support the probable role of professionals' own attachment experiences and their mental representations thereof. Case examples are drawn from a study on video-based interaction guidance for direct-care staff in group homes for persons with multiple, serious disabilities. These examples illustrate how interventions may avoid attachment-related defences against changing the quality and affective mutuality of personal contact with clients. However, the possibility is discussed that in parallel processes, 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 well-being of persons with disabilities.

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Keywords attachment, direct-care staff, intellectual disability, quality improvement, staff-client relationships, workforce development

Direct-care staff are in the position to bring out the best or the worst in their clients with intellectual disabilities (IDs; Hall & Hall 2002). Quality of care for persons with ID will therefore benefit from better understanding of this particular group of professionals. In his contribution to this volume, Reinders (2009) argued compellingly that knowing the formally trained expertise and skills for executing care protocol does not go into the heart of the matter. Recognising the dyadic nature of caregiving, he stressed that expertise for a particular client is the product of the interpersonal relationship between the direct-care staff member and that particular client. This expertise, consisting of habits and continuous streams of interactions, is conceptualised by Reinders as 'tacit knowledge'. The notion of tacit knowledge calls for a renewed reflection on the nature of professionalism and quality of care. Although clients and direct-care staff may interact on a daily basis, this does not necessarily mean for every staff member that expertise about these client will increase. According to Reinders,

'in the context of that relationship the quality of professional judgment is dependent upon, among other things, the intentionality of being attached and attuned to the particularities of the client' (p. 31). Reinders then goes on to argue that the prevailing approaches to accounting for and managing the quality of care at best disregard but probably discourage this intentionality. This requires analysis on the level of whole care organisations or even on the prevailing philosophy of care in a society at a given point in time. Be that as it may, within any care organisation itself there will be variation as well, and clients may experience higher quality of care from some staff members as compared with others. The intentionality towards attachment and attunement may be a product of the interplay between the individual direct-care staff member and the context. The current paper therefore analyses attachment and attunement from a psychological level. Attachment theory is outlined as a basis for testable hypotheses regarding determinants of quality of care, and as a basis for interventions to promote good-quality care with a high level of attunement. Case examples will be discussed for group home care, showing how care staff may respond differently to a video-based intervention aimed towards increasing quality of interaction with their client. This leads to a discussion of implications for the ways in which the most important human resource in care organisations may be optimised, namely the hearts and minds of direct-care staff.

Contextualising attachment needs: group home care

According to the principles of normalisation, direct-care staff should support their clients in their striving towards culturally normative behaviours and characteristics. Care staff is expected to offer support in a form that should be culturally normative as well (Wolfensberger 1972). Adults with disabilities should be approached and treated by care staff as adults and not as children. Perhaps for that reason, notions such as attachment and attunement on a personal level have been little discussed in the field of ID. Within this field, references to attachment processes have been mostly limited to discussions on the development of children (see Stone & Chesney 1978, for one of the earliest examples). Although Bowlby (1979) argued that 'attachment behavior characterises human beings from the cradle to the grave' (p. 129), attachment has often been misconceived as a developmental issue that is determined in early childhood. To the contrary, seeking attachment support is a culturally normative response to feeling helpless or threatened, among children as well as elderly people (Merz *et al.* 2008). Clegg & Lansdall-Welfare (1995) were the first to recognise the value of the attachment perspective for the care for adults with IDs. They argued that people with IDs in residential care are predisposed towards directing attachment behaviour towards care staff, and may develop emotional insecurity as a result of discontinuities in the care as well as competition for limited amounts of personal attention. From the perspective of mental health promotion as well as normalisation, attachment deserves more systematic attention in the field of ID care from infancy to adulthood.

For children and adults living in group home care, in particular, access to a network of attachment figures (parents, family, close friends, mentor figures) is often limited. For these clients emotional security and well-being is therefore likely to be largely dependent upon their relationships with direct-care staff. Group homes have the advantage of an adapted environment and specialised trained staff. But for mental health and emotional security, group homes are a risky environment due to frequent changes of staff personnel, high workload of staff, discontinuity in staff presence and limited opportunities for individual support, especially for people who are vulnerable due to their intellectual, physical, and sensory disabilities for developing emotional and behavioural disorders. One reason for this vulnerability is the limitations in signalling and communicating their emotional responses and needs. Extraordinary sensitivity and interest in the client as an individual are required from caregivers to be able to perceive often very subtle cues, connect them to the context and interpret these cues correctly. Clients who do not experience this quality of caregiving, or experience it only sporadically, may develop insecure attachment relationships or may even fail to develop organised attachment relationships at all. Without the necessary coping skills to deal with challenging situations themselves,

these clients are due to experience high levels of stress without the support of an attachment figure (Schuengel & Janssen 2006). Quality of relationships with caregivers, professional or otherwise, is therefore highly relevant for quality of life and quality of care. Empirical findings are emerging that suggest that having possibilities to use direct-care staff as a secure base and a safe haven to regulate their sense of security is positively related to well-being and behavioural adaptation (Clegg & Sheard 2002; De Schipper *et al.* 2006; De Schipper & Schuengel 2008; Schuengel *et al.* 2009).

Professional caregivers' own attachment

Some direct-care staff members may be better able to provide extraordinary sensitive care than others. This may be a matter of training, experience or other factors. But research on helping professionals has shown that the mental representations that professionals have of their own attachment backgrounds are also related to the quality of the therapeutic relationship (Dozier et al. 1994; Tyrrell et al. 1999; Zegers et al. 2006). Clinical workers with autonomous mental representations of attachment, characterised by a balanced, believable and coherent account of their attachment experiences, were generally perceived as psychologically more available to their clients. Also their working alliances were better, and interventions had more 'depth' than for workers with non-autonomous (dismissing or preoccupied) attachment representations. A parallel can be drawn between these findings and the findings on parents of young children, showing that autonomous attachment representations were also associated with higher levels of sensitive, responsive care for their child (Van IJzendoorn 1995). While parenting obviously taps into the mental representation of one's own experiences with seeking emotional security in the relationships with parental figures, research among psychotherapists, case workers and group home caregivers for youth also show that helping clients in need 'pulls' for qualities that are related to attachment representations as well.

To understand the linkages between professionals' own attachment and attachment security experienced by clients, a brief introduction in contemporary attachment theory is necessary. Based on the daily experiences that children have with their attachment figures, children build up expectations about their attachment relationships. These expectations can be positive, as in the case of secure attachment relationships. When parents and children interact in a well-coordinated fashion around the explorative and emotional needs of the child, we assume that one reason why this interaction proceeds so harmonious is that these children correctly expect that their parent will always be attentive and supportive when the child is trying to overcome a challenge on his or her own, and will be accepting and responsive if there is any reason for distress.

Expectations from what the attachment figure has to offer can also be negative in various ways. In insecure-avoidant relationships, we assume that children expect that their signals for emotional support might sometimes be rejected. It therefore makes sense that these children appear to minimise the display of these signals, giving the appearance that they can deal with difficulties on their own. In insecure-resistant relationships, it is assumed that children may be uncertain about the availability of their parents. The strategy of these children appears to be to maximise their display of attachment behaviour (Ainsworth *et al.* 1978). In disorganised attachment relationships, children's tendency to seek contact with their attachment figures appears to be wound up with fear (Main & Solomon 1986). The interpretations of these patterns of attachment are supported by numerous studies showing that quality of caregiving predicts the quality of attachment relationships (see De Wolff & Van IJzendoorn 1997; Van IJzendoorn *et al.* 1999, for meta-analyses) and intervention studies showing that when quality of caregiving improves, children are more likely to become securely attached (see Bakermans-Kranenburg *et al.* 2003, for a meta-analysis).

Importantly, except for the disorganised pattern, the organised insecure patterns of attachment are understood as adaptations that minimise the level of discomfort that partners in the attachment dyad experience (Main 1990). In a sense, children in avoidant or resistant attachment relationships seem to have worked out how the best can be made of a relationship with a parent who may be somewhat rejecting or unpredictable. Although these insecure patterns may be adaptive within this particular situation, the attentional and emotional distortions that

are required for these patterns may limit adaptability to situations that might call for other interactional strategies. Insecure attachment relationships predict, for example, limited social competence and friendship quality (Sroufe *et al.* 2005). In boys with learning disabilities, heightened risk of insecure attachment appeared to explain maladaptive processing of social cues from peers (Bauminger & Kimhi-Kind 2008).

Attachment theory proposes that patterns of attachment in childhood give rise to affective cognitive representations of attachment later in life. These representations are understood as conscious and/or unconscious rules for the access to and interpretation of attachment-related information (Main *et al.* 1985). These rules resemble the behavioural strategies in different types of attachment relationships. In contrast to the quality of attachment relationships, which is judged on the basis of observations of dyadic interaction, mental representations are deduced from the responses adults give on open-ended questions about their relationships with their caregivers [within the Adult Attachment Interview (AAI), as discussed below; Main & Goldwyn 1994].

Minimising strategies similar to avoidant attachment can be observed in adults who may appear dismissing towards their attachment experiences when they fail to remember concrete attachment-related events or idealise their relationships with their parents. Their AAIs will be classified as insecure-dismissing. Maximising strategies similar to resistant attachment can be observed in adults who appear passively or angrily preoccupied with their attachment figures and attachment experiences. Their AAIs will be classified as insecure-preoccupied. A majority of adults (55%; (Van IJzendoorn & Bakermans-Kranenburg 1996) display, however, an autonomous representation of attachment, characterised by open appreciation of their attachment relationships, and a clear, coherent picture of their experiences. Their narratives are dominated neither by the minimising or the maximising strategy. These interviews will be classified as secure-autonomous. Although some correspondence between attachment in childhood and subsequent attachment representations may be expected, and has indeed been found (see Fraley 2002, for a meta-analysis), there is also room for discontinuity, due to intervening experiences that may set attachment relationships in a new light. As an example, some adults look back on a difficult childhood, but appear to have 'worked through' these experiences and to have achieved an autonomous attachment representation.

As noted, adults with autonomous attachment representations not only develop more often secure attachment relationships with their own children (Van IJzendoorn 1995), but also appear to be more effective as therapists or professional caregivers (Dozier *et al.* 1994; Tyrrell *et al.* 1999; Zegers *et al.* 2006). Why this is the case, is still not precisely understood. One possibility is that dismissing or preoccupied attachment representations not only affect the way in which adults process their attachment-related memories, but also the way in which they process current attachment-related information and signals (Zeijlmans van Emmichhoven *et al.* 2003). On more molar measures, persons with secure attachment representations appear to be more sensitive to their partner in marital relationships (Crowell *et al.* 2002), and show more capacity for intimacy (Mayseless & Scharf 2007). Attachment research may therefore help to understand why the 'intentionality of being attached and attuned to the particularities of the client' (Reinders 2009, p. 31) may characterise some caregivers of clients with ID more than others.

Interplay between caregivers' attachment representations and improving quality of care

If attachment representations bias the processing of attachment-related cues, they may also bias the processing of information that is provided in the context of interventions to improve relationships between caregivers and clients. Interventions to support the acquisition of tacit knowledge therefore have to bypass these sources of bias. Given the diversity of attachment representations among care staff (among our sample of 60 group home caregivers we found a distribution of 62% autonomous, 20% dismissing and 18% preoccupied; within this group, 16% also showed unresolved disorganised responses to loss or other attachment-related traumatic experiences; Damen *et al.* 2008), a consequence is that interventions should be at least partly

individualised, to limit the room for using minimising or maximising strategies that would thwart intensive engagement with the social interaction processes at hand. Furthermore, interaction guidance should occur in an emotionally secure climate, also to prevent the activation of the strategies that defend against challenges to the current attachment organisation. Studies with parents with insecure attachment representations have shown that individual interaction guidance is effective in improving maternal sensitivity and consequently mother–infant attachment, on the basis of feedback using video of parents interacting with their own child (Van Zeijl *et al.* 2006; Velderman *et al.* 2006).

In order to improve quality of care by improving quality of interaction in group homes for children and adults with serious visual and IDs, the care organisation Bartiméus in Doorn, the Netherlands, decided to test the effectiveness of the video feedback programme Contact (Janssen *et al.* 2003). This programme was originally developed to improve the quality of interaction between deaf-blind children and their natural and professional caregivers. Based on attachment theoretical principles, it includes group-based as well as individual interaction guidance, using video recordings of interaction settings between the client and the caregivers. As implemented within Bartiméus, the interaction guidance counsellor stimulated the direct-care staff to intensely study the interactive repertoire of their client, analyse their own part in the ongoing interaction, and discover ways in which they might respond more adequately and predictably to the cues and initiatives of the client. Furthermore, the Contact programme is based on the principle of staff empowerment, which means Contact is offered as a response to a need identified by care staff themselves. The team is invited to identify which of their clients is generally receiving an unsatisfactory quality of interaction. The interaction guidance counsellors offer to collaborate with the team to discover ways in which each care staff member might be better able to involve the client in social interaction. This approach therefore avoids the suggestion of blame or inadequacy, and stimulates a sense of equality, development and exploration. The characteristics of the Contact protocol may as a result provide a secure climate for intervention, stimulating caregivers with autonomous and non-autonomous attachment representation to develop their tacit knowledge about their client.

Case examples might illustrate how this can work.

Dave was one of the clients for whom the care staff requested interaction guidance. He was 45 years old at the time, and he lived with 11 other adults with visual impairments and serious IDs (his intelligence quotient was estimated as falling between 20 and 25) in a group home since he was 4 years old. According to the care staff as well as the initial observations of the interaction guidance counsellors, Dave was quite keen on seeking contact with the people around him. Usually, he would try to make contact by reaching out with his arm and moving it around until he would touch a care staff member. However, these bids for contact were usually not accepted by the care staff, because they would interfere with the task at hand, for example, having a hot meal. Dave could sometimes end up with his hand on the staff member's food plate. At other times, his random movements would lead to uncomfortable touching of the staff members' body. So in addition to interfering with the task, the care staff also found it problematic to define what would be appropriate interaction, and to have interaction that would be mutually pleasant, and therefore sustainable.

Diana and Fred were part of the team in Dave's group care home. Before the intervention started, all were interviewed using the AAI (George *et al.* 1996) in order to investigate their attachment representation. Fred talked about the strong contrast between his relationship with his mother and with his father. He provided rich descriptions of the times when he was distressed and went to his mother, and when his mother sat him down and comforted him. They would talk and sometimes she would offer him a possible way to solve his problem; sometimes, she would just let him talk and think out a solution for himself. Fred was quite up front about the more removed relationship he had with his father. Setting his father in context by noting his own difficult upbringing, Fred acknowledged that he could still see some influence of his father in the way that he tried to avoid discussing interpersonal conflicts. Fred nevertheless saw that he was learning more and more to speak out for himself and discuss how others could make him feel. Overall, the narrative of Fred's AAI pointed

predominantly towards a secure autonomous mental representation of attachment.

The Contact programme was implemented as well as tested in a multiple baseline design study. This meant that we were able to compare the quality of Fred and Dave's interaction during the baseline period – before the start of the video-feedback sessions – to the quality of interaction during the period in which Fred received video feedback. During the two baseline sessions, before the start of the individual interaction counselling, the reliability of Fred's responsiveness towards Dave's initiatives during the mealtime sessions was remarkable. Not one initiative of Dave was left ignored. This level of responsiveness, which would be important for Dave in order to be encouraged in his interaction attempts, was maintained across the video-feedback sessions following the start of the intervention. We also observed that the interaction was characterised by mutual affective attunement, indicating that Fred and Dave were getting along well with each other. However, some fluctuations were observed. During the baseline period, observations revealed that Fred was talking with Dave a lot, especially about Dave's emotional expressions. After the start of the video-feedback sessions, a slight deterioration occurred. Fred was more distracted by the noise from the other clients in the group home. However, during the last observation following the third video-feedback session, Fred was talking almost continuously with Dave during the observation. The quality of the conversation was calm and warm, and Fred talked about meaningful experiences for Dave.

Diana clearly had a more difficult time to be able to respond to the questions in the AAI about the events and circumstances that would illustrate her characterisation of her relationship with her parents. She recalled that here relationships were mostly stable, although she noticed that according to her parents, she had been a difficult child. Diana could, however, really not remember when that had been the case. She described her life in her family as fairly uneventful, almost dull, and her youth as normal and fine. However, the most important characteristic of the interview was the failure to recall any concrete memories of interacting with her parents. As a result, the narrative of Diana was indicative of an insecure-dismissing attachment representation.

During the two mealtime observations during the baseline period, before the start of the individual interaction counselling, Diana more often than not missed Dave's initiatives for interaction. Diana's responsivity during the second observation was clearly worse than during the first observation. However, a dramatic improvement occurred after Diana had participated in her first video-feedback session with the interaction counsellor. During the following sessions, unfortunately, Diana increasingly ignored or missed Dave's initiatives. In terms of affective attunement, very few moments of contact and interaction were observed during the baseline. Again, after the first video-feedback session, Diana had started to take much more initiatives and engage in much more mutual interaction. Diana talked to Dave and asked him questions. For the first time, she sat next to Dave while interacting. However, during the observations that followed, Diana and Dave seemed to return to their former pattern, in which there was little affective engagement. While there was some interaction, it was less on a personal level and Diana did not talk as much with Dave as during the first observation and the start of interaction counselling.

These findings are in line with other research showing that relatively short-term, behaviourally focused intervention programmes are successful in improving sensitive caregiving among parents, even parents with non-autonomous attachment representations (Bakermans-Kranenburg *et al.* 2003; Velderman *et al.* 2006; Juffer *et al.* 2007). However, these improvements may be easier to achieve and maintain for caregivers with autonomous attachment representations compared with caregivers with non-autonomous attachment. Systematic, controlled study in the total sample of 85 caregivers will have to show whether these hypotheses hold up against empirical testing.

Stimulating caregivers to interact with clients in ways which may be contrary to their natural inclination may cause psychological discomfort and strain. We therefore also looked at the job experience and satisfaction of these caregivers, in relation to their attachment representation (Van Brussel 2008). As it turned out, caregivers with autonomous as well as dismissing attachment had higher overall satisfaction with their job than caregivers with preoccupied attachment. Interestingly, the aspect that caregivers

with dismissing attachment were most satisfied about, was the autonomy that their job provided. Caregivers with autonomous attachment were most satisfied about the work itself and the relationships with colleagues. Caregivers with preoccupied attachment were most dissatisfied about the support they received from their colleagues and supervisors. Especially the responses of caregivers with preoccupied attachment provide reason for concern about the misbalance they may experience between the support they provide their clients and the support they receive from others.

Together, these findings raise a number of issues that should be addressed, before these findings can be put to work. The remainder of this paper will briefly introduce these issues.

Selection or training?

Although the literature reviewed suggests that people with autonomous attachment may be more fit to be professional caregivers, their competence and motivation for doing this work are determined by multiple factors. It would therefore not be good practice to single out one particular characteristic as a selection criterion, even if the practical obstacles for doing so will ever be solved. This is all the more reasonable because the right kind of training may improve caregivers' attunement to their clients for any (of for all) caregiver. Therefore, training is to be preferred over deliberate selection of caregivers with particular attachment types. Not all training might achieve this effect, however. The type of individualised training and support to empower direct-care staff may require expertise in developmental, psychosocial processes. Furthermore, for some care staff training and counselling may be required on a regular basis to prevent that the progress is washed out with time. Care staff themselves may, however, contribute to their own selection. They may self-select, for example, when the demands of interpersonal contact create discomfort due to their dismissing or preoccupied attachment representation. Care staff may decide that the intentionality of attachment and attunement to the client is 'not for them'. This may already occur in the course of their job training, or later on. A related form of selection occurs when care staff members drop out because of fatigue or burnout. This may result from the emotional demands of their jobs, in combination with the tendency to be dissatisfied with the level of support received from others. This latter form of selection will often be accompanied with suffering on the part of the staff member and with waste of human resources. The question is, what the direction should be of counselling and support and whether training should be offered in these cases, in order to overcome the difficulties these caregivers experience in their work. The dilemma is between on the one hand, supporting staff members when they look for other work, while they may have been able to continue working as a caregiver with the proper kind of training and support, and on the other hand, stimulating caregivers to remain within the profession, despite the fact that they may continue to feel ill-fitted and require continuous support and attention.

Parallel processes

Reinders' contribution points towards pressures from the organisational context or even organisational culture that impact the point at which good-quality care is delivered, namely within the interpersonal contact between client and direct-care staff member. While the 'pull' from the client may be for inherently subjective qualities such as attachment and attunement, the pull from management and systems for monitoring quality of care may be for qualities that can be more objectively measured, such as activities or standardised procedures. This may create a tension for care staff because these demands may be competing. Furthermore, professionals may experience little positive feedback from their organisational context if they invest a lot in attachment and attunement. Their client may show appreciation. But clients usually do not have a say in personnel evaluation and promotion. Reinders' call for attention to the effects of quality systems and policies is therefore important and topical.

The approach advocated in the current paper does not deny the importance of ongoing reflection on the influence of societal and economic pressures on care staff, which currently appear to disfavour the kind of human to human contact that truly promotes quality of life on both sides. This paper suggests, however, that these societal pressures might resonate more with some care staff than with

others, and that professionals within care organisations may take counteractive measures. In this case, manualised interventions and well-circumscribed protocols were used to support individual care staff with their individual difficulties in establishing high-quality contact with a particular client. The success of intervention methods aimed at professionals, such as described in this paper, demonstrates that 'tacit knowledge' can be explicitly discussed and stimulated. However, the reason for the success of such interventions may be that the mode of intervention closely parallels the virtues it aims to stimulate in the caregivers. The method Contact was designed to support and empower care staff, based on the assumption that staff members themselves are usually well aware of poor-quality relationships with clients. This is a latent support need that can be brought to light by simply asking staff if they known of such situations. The method involves bringing all the care staff for a particular client together, and to stimulate the articulation of their tacit knowledge about ways to connect to the client. This part of the intervention stimulates reciprocal support within the group. A crucial (and expensive) element, however, appears to be the focused attention by an interaction coach for individual staff members. The protocol involves coach and staff member to sit and watch videotaped interaction sessions between staff member and client. Both watch the interaction for the first time, and the interaction coach supports and reinforces the staff member in discovering ways to attune better to the client. The interaction coach therefore does not assume the position of an expert pointing out the faults in staff behaviour and instructing staff how to change their behaviour. An empowering approach requires that interaction coaches are not only insightful with respect to dyadic interaction, in order to provide the correct selective reinforcement of behavioural changes shown by staff as well as to provide expert insight when asked for by the staff member, but are also sensitive and attuned towards care staff, because for some of the staff, engagement and attunement to the clients' signals and desire for contact may feel unnatural or even averse. It is perhaps no coincidence that the interaction coaches, who were part of the psychologist staff, were able to implement this approach in an organisation that has also in the past shown interest in the quality of interpersonal relationships in care, and has facilitated research to provide scientific evidence that improvements in these qualities can be achieved (Sterkenburg *et al.* 2008a,b; Schuengel *et al.* 2009). For these reasons, the requirement to deliver evidence-based care justifying the spending of the public means does in itself not limit the promotion of the personal knowledge and expertise that Reinders so rightly connects to good-quality care.

Clients with disabilities are more vulnerable because of their limitations in signalling and communicating their emotional responses and needs. Extraordinary sensitivity and interest in the client as an individual are required from caregivers to be able to perceive often very subtle cues, connect them to the context, and interpret these cues correctly. In order for people with disabilities to flourish, care staff therefore need to realise their full potential of social functioning. Direct-care staff members spend hours with their clients, in washing, feeding, walking them. Moreover, they have to get into contact with them, to know them, and to develop a bond. The care staff members are significant central figures in the life of the clients, and the way in which they feed, walk with, and talk to their clients can really make a difference.

Conclusion

This paper set out to discuss a psychological perspective on the concept of 'tacit knowledge', an important attribute that enables direct-care staff to build high-quality social relationships with clients with IDs. Contrary to the philosophical concept of tacit knowledge, the perspective of attachment theory enables researchers to operationalise attributes that may be related to 'the intentionality of being attached and attuned to the particularities of the client' (Reinders 2009, p. 31). We agreed with Reinders that such intentionality and the resulting aspects of attachment are largely disregarded in the discourse within the field, although the causes might be misunderstandings surrounding the implications of attachment theory as well as policies that favour quality aspects of care that appear more readily measurable. In order to correct this state of affairs, more efforts are needed to translate theories

like attachment theory in ways that are appropriate to the field. Furthermore, more efforts need to be done to develop quality indices with strong links to the qualities of human contact that are highlighted by theories like attachment theory. Scientists perhaps need to work harder to produce the kind of evidence that can be publicly discussed and scrutinised, and which may justify the positive selection pressures (and training efforts) that stimulate professionals to expand their personal knowledge and their expertise embodied in the personal relationships they maintain with their clients. Produce 'hard evidence' to promote the 'soft forces'.

Conflicts of interest

The authors have declared no conflicts of interest.

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