

ARTICLE

Attachment theory in psychiatric rehabilitation: informing clinical practice

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SUMMARY

This article highlights the relevance of attachment theory for psychiatric rehabilitation services and discusses practice implications derived from the theory. Attachment theory can guide the development of interpersonal relationships during recovery and this aspect of rehabilitation is emphasised here. Attachment theory can also be used to help staff predict and understand problematic behaviours such as violence and aggression, and different styles of recovery. The theory can help promote positive staff–service-user relationships by highlighting the qualities of effective caregivers and the way in which people with different attachment styles might benefit from different approaches. We conclude by suggesting ways of teaching rehabilitation staff to become more effective attachment figures.

DECLARATION OF INTEREST

None.

Although attachment theory was initially developed on the basis of observations of infants and their caregivers, attachment relationships and attachment styles have relevance across the lifespan (Ainsworth 1978; Bowlby 1982). Proponents of the theory argue that attachment relationships continue to be important throughout adulthood by providing the individual with a secure base from which to grow and develop (Ainsworth 1978; Bowlby 1982). There is now a substantial body of research to support the concept of adult attachment styles and the influence of ‘secure’ versus ‘insecure’ attachments on interpersonal functioning and relationships in adulthood (Goodwin 2003a; Ma 2006).

A high proportion of people with mental health problems have been found to have an insecure attachment style and this has been seen as a major vulnerability factor for a range of psychiatric conditions (Ma 2006). Accordingly, the role of mental health professionals in facilitating the development of secure attachments has been acknowledged. More specifically, the therapeutic relationship has been conceptualised as an

attachment relationship that can provide a secure base for self-exploration and the modification of insecure attachment styles (Ma 2007). The potential influence of attachment theory on the organisation of healthcare services has also been recognised. The National Advisory Group on Mental Health, Safety and Well-Being set out key principles for the operation of mental health services (Box 1) and argued that attachment theory provides the soundest evidence-base on which to design and measure mental health services (Seager 2007). Our article builds on previous papers highlighting the role of attachment theory in mental healthcare by focusing specifically on the relevance of the theory for psychiatric rehabilitation.

Attachment theory and psychiatric rehabilitation

Attachment theory may have particular relevance for psychiatric rehabilitation services (Box 2). Rehabilitation services provide support

BOX 1 Five universal psychological principles

The following five principles were highlighted by the British Psychological Society's National Advisory Group on Mental Health, Safety and Well-Being.

- 1 Human well-being depends on universal psychological needs as well as physical and social needs.
- 2 A psychologically informed generic policy framework is badly needed to promote psychologically safe mental health services (over and above the growing guidance on specific psychological treatments).
- 3 Attachment theory provides a universal evidence-base that has not yet been harnessed.
- 4 In mental health it is primarily relationships that can kill and cure, so all our staff must be trained and supported psychologically to promote therapeutic responses to service users.
- 5 Choosing between medical and psychological approaches is a false choice.

(Seager 2007)

BOX 2 Relevance of attachment theory for psychiatric rehabilitation

- High levels of insecure attachment in people with severe and enduring mental health problems and personality disorder
- Distressing symptoms and social difficulty may trigger the attachment system
- Attachment system activated by separation from primary attachment figures in the community
- Rehabilitation staff may be the only key attachment figures in some individuals' lives
- Both attachment theory and models of rehabilitation highlight the importance of providing a secure base to promote development towards optimal functioning

to individuals with severe and enduring mental health problems, who typically have multiple care needs, have not responded to standard treatments, have disengaged from mainstream services and/or have comorbid personality disorders (secure rehabilitation services in particular support the last group). Severe mental health problems and personality disorders have consistently been associated with histories of interpersonal traumas such as physical, sexual and emotional abuse, neglect, abandonment and discontinuity of attachments (Fonagy 1996; Bebbington 2004). It is therefore not surprising that people with these diagnoses frequently experience difficulties in interpersonal relationships, including engagement in therapeutic relationships and adult attachment relationships (Berry 2007).

Attachment theory may also be relevant for individuals in rehabilitation services, as the attachment system is triggered by and determines the individual's approaches to seeking help during periods of psychological stress, and rehabilitation service users often suffer levels of symptoms and social dysfunction that are highly distressing (Berry 2007).

Rehabilitation services typically provide 24-hour support on in-patient wards or in specialist community settings, often for lengthy periods, reflecting the complexity of the population referred (Killaspy 2005). Therefore, individuals in rehabilitation services may be separated from primary attachment figures over extended periods of time, thus creating feelings of loss and insecurity and triggering attachment needs (Schuengel 2001). For others, interpersonal difficulties, distressing symptoms and repeated admissions to hospital may lead to a breakdown in primary attachment relationships. Indeed, mental health staff within rehabilitation services may be the only significant

attachment figures in some individuals' lives (Schuengel 2001).

Although there is no standard definition of the role and remit of rehabilitation services, a survey of the self-defined goals of UK facilities highlighted the importance of a whole-systems approach to care, maximising quality of life and social inclusion, and encouraging skill development and autonomy (Killaspy 2005). Rehabilitation services involve a multidisciplinary team working together to provide a number of evidenced-based medical, social and psychological interventions. Rehabilitation services today also need to incorporate the philosophies and principles of the recovery approach. This approach emphasises empowering service users to manage their own lives in a way that enables them to achieve meaningful lives in the community (Repper 2003). However, according to the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists (2004), evidence for particular rehabilitation service models is weak. Attachment theory provides one potential whole-systems approach to care that would seem highly fitting to the function of rehabilitation services, with its focus on the provision of a secure base to promote personal development and the importance of opportunities to take therapeutic risks (Starkey 1997).

How can attachment theory inform practice?

Attachment theory can inform the practice of psychiatric rehabilitation in a number of ways (Box 3).

Attachment theory, philosophies and organisation of care

First and foremost, attachment theory highlights the fundamental importance of human relationships

BOX 3 Key practice implications of attachment theory

Attachment theory can improve clinical practice by:

- highlighting the importance of developing or maintaining significant relationships in support planning
- informing predictions about the occurrence of problematic behaviours and an understanding of their function
- informing an understanding of the development of different styles of recovery
- highlighting the importance of clear communication, sensitivity and responsiveness to distress, and striking a
- balance between providing reassurance and encouraging the individual to gain independence
- informing assessment of the security of attachments and encouraging individuals with insecure attachment styles to try out new ways of relating to others
- informing assessment of whether services are meeting attachment needs
- informing the development of interventions that improve staff–patient relationships, also taking into account staff attachment styles

across a range of different treatments (Ma 2006, 2007). Individuals have a basic psychological need to form attachments to others and to have at least one significant other whom they can trust and depend on (Ma 2006). In support of this proposition, the development of meaningful relationships has consistently been shown to be a key factor in the recovery process regardless of any particular therapy brand, profession, model or approach (McCabe 2004). The development of meaningful social relationships is also a key component of recovery-oriented approaches to rehabilitation (Repper 2003).

Developing and maintaining relationships

For attachment bonds to develop, it is essential that there are opportunities for service users to develop and maintain relationships with rehabilitation staff. The keyworker system whereby one individual takes responsibility for getting to know the service user and coordinating the different elements of care provided is one method of facilitating the development of such relationships (Goodwin 2003a; Ma 2007). Engaging in one-to-one activities with keyworkers should be prioritised in support plans because the importance of developing this relationship is recognised, not just as a means of organising a series of activities. Service users with negative symptoms or poor social skills may be particularly hard to engage in activities, but given the importance of attachment relationships, their needs in this area should not be overlooked. Staff may find engaging these groups of service users unrewarding as they do not appear to enjoy the activity. Staff should therefore be encouraged to recognise the value of their work.

Relationships outside of rehabilitation services

Given the importance of human relationships, it is equally essential to recognise the value of attachment relationships outside of rehabilitation services. To avoid distress and disruptions associated with separations from these attachment figures, positive contacts with significant others – possibly including community mental health team members – should be maintained or fostered (Adshead 2001). When planning discharge, the significance of separation from rehabilitation staff and the loss that service users may feel in moving on should also be acknowledged. Graded plans for discharge or outreach work may facilitate this process. Similarly, when staff are absent for long periods of leave it is important to recognise the difficult feelings this might evoke for service users and to provide them with opportunities to talk about and prepare for these potential losses (Adshead 1998).

Continuity of care

The above underscores the importance of continuity of care and how organisations should give consideration to staff retention. According to attachment theory, this would involve providing staff from different disciplines with opportunities to form meaningful attachments to each other, to their patients and to a model of care, and would therefore avoid frequent staff moves and reorganisation without consultation (Seager 2007). It is also important to be aware that service users may develop attachments to other individuals within the service such as domestic staff and fellow patients. The importance of these attachments needs to be recognised in support care plans and during transitions. The way in which these alternative attachment figures are able to provide a secure base to service users with often highly insecure or dysfunctional ways of relating also needs to be managed to ensure that these people do not risk being overinvolved or involved in conflicting relationships (Schuengel 2001).

Although attachment theory is primarily a theory of human relationships, there is recognition in the literature that individuals may also form meaningful attachments to institutions (Adshead 1998). Ward activities and routines may therefore provide a secure base and their value should not be overlooked in planning support for service users on discharge. For example, it may be important to ensure that an individual can continue to engage in established activities and routines following discharge.

Constraints

The practices above clearly have resource implications. They may also be constrained by institutional policies such as movement between different service levels and the sharing of keyworking roles and responsibilities to reduce staff burden, and by the need of staff members to move on to develop their careers and acquire new skills (Schuengel 2001). One development in particular that affects psychiatric rehabilitation is the establishment of community-based services which emphasise team-based approaches to care over keyworker systems. However, attachment theory's value is to correctly emphasise the development, form and maintenance of human relationships in these contexts (Goodwin 2003a).

Attachment theory and understanding problematic behaviours

In addition to highlighting the importance of human relationships, attachment theory can be used to make predictions about the occurrence of

problematic behaviours in rehabilitation services and can contribute to an understanding of their function (Ma 2007). For example, self-harm, violence and other forms of aggression can be conceptualised as attachment behaviours triggered by threats to attachment relationships such as temporary separation from key staff or the possibility of discharge. These behaviours often evoke in staff counterproductive reactions, including anxiety and overt or covert hostility (Adshead 1998, 2001). Understanding their function and preempting their occurrence may therefore improve staff understanding and their capacity to support service users (Adshead 1998) This is illustrated in the following fictitious case vignette.

Case vignette 1: problem behaviour

John is 45 years old and has a diagnosis of schizophrenia. His mother was frequently admitted to mental health institutions when he was a child and died by suicide when John was 7 years old. He went to live with his father, who was physically abusive. He developed mental health problems at the age of 20 and has spent the past 20 years in mental health services. This has involved frequent moves between different support tenancies triggered by incidents of violence and aggression towards staff. He could not identify any significant interpersonal relationships, apart from keyworkers at his current rehabilitation unit, where he has been a resident for 5 years.

Although he has been verbally aggressive towards others during his stay, staff have worked with him to identify triggers and coping strategies for his anger. Staff have made the decision to understand John's anger and work with him to manage incidents rather than discharging him.

As a result of John's progress, plans were made to discharge him to accommodation with less staff support. Following this decision, there was an increase in John's aggression towards others. The team believed that this was associated with John's anxieties about moving on and the potential loss of relationships he had developed with staff. Staff therefore spent additional time with John normalising anxieties about the move, helping him to think of ways of keeping in touch, and building up new relationships outside of the unit.

Attachment theory and recovery

Attachment theory can help explain the development of different styles of recovery and poorer responses to standard treatments. There is evidence to suggest that individuals recovering from psychosis adopt either an integrative or a 'sealing-over' recovery style (McGlashan 1987; Tait 2003). The former is associated with recognition of the links between previous psychosis and present experiences, whereas the latter is associated with a lack of desire to understand psychotic experiences. Integrative recovery styles are related to lower relapse rates and better social functioning than sealing-over styles (McGlashan 1987; Tait

2003, 2004). Sealing-over recovery styles have been associated with more insecure attachment experiences, possibly because these individuals do not have a sufficient sense of internal security to explore and make links with their psychotic experiences without being overwhelmed (Drayton 1998; Tait 2004). Both sealing-over recovery styles and insecure attachment have also been associated with poor engagement in people with a diagnosis of psychosis (Tait 2004).

Assessing attachment

Adult Attachment Interview

The Adult Attachment Interview (AAI; Main 1984) assesses attachment states of mind on the basis of a detailed interview of parenting experiences. Insecure attachment is classified on the basis of the coherence of the individual's discourse, with insecure attachment manifesting as breaks and disruptions in narratives, inconsistencies, contradictions, lapses, irrelevances and shifts in person. Fonagy and colleagues (1991) have elaborated this work by focusing on the capacity to 'mentalise' affective experiences – to reflect on and think about the complexity of mental states. They have developed a reflective self-function scale which can be used to analyse the AAI, and scores transcripts for the speaker's recognition of the existence and nature of mental processes taking place in both the self and others.

The AAI is unlikely to have much utility in most clinical settings as it is time-consuming to administer and requires training. However, there are a number of questionnaire measures which assess thoughts, feelings and behaviours in close interpersonal relationships in adulthood. These are easy to administer and interpret, and could be used routinely when patients enter services and as part of periodic reviews (Box 4). The AAI and self-report measures of adult attachment style tap related but distinct manifestations of the attachment system, with the AAI providing a direct measure of attachment-related unconscious processes and self-report measures providing more convenient surface indicators of attachment-related dynamics.

BOX 4 Examples of questionnaire measures

- Relationship Questionnaire (Bartholomew 1991)
- Revised Adult Attachment Scale (Collins 1996)
- Experiences of Close Relationships Scale – Revised (Fraley 2000)
- Psychosis Attachment Measure (Berry 2008a)

Client Attachment to Therapist Scale

Establishing and maintaining an attachment-informed rehabilitation service necessitates a system for evaluating whether service users' attachment needs are being met. Any shortfalls can then be identified and addressed. Mallinckrodt and colleagues (1995) have developed the Client Attachment to Therapist Scale, which is intended to tap the attachment constructs of proximity seeking, safe haven, emotional regulation and secure base in the psychotherapeutic relationship, but may also be applicable across mental health relationships.

Service Attachment Questionnaire

Individuals in rehabilitation services come into contact with a range of different professionals and treatments. Measures of attachment to systems of care might therefore be more useful. Goodwin *et al* (2003b) have developed the Service Attachment Questionnaire (SAQ), which assesses the extent to which services meet individuals' attachment needs. The SAQ is a 25-item measure which has six subscales derived from focus groups with service users about their relationships with services:

- being attended to and listened to
- being there (consistency and continuity)
- being given enough time (ending and leaving)
- safe environment
- relationships which enable helpful talking
- human contact and comfort.

This questionnaire could be administered in addition to questionnaires to assess individual patients' attachment styles and could be used as a regular audit tool.

Modifying attachment

Attachment theory provides specific insights into the type of caregiving that is likely to be most effective. It is not only that effective caregivers are able to communicate clearly and are sensitive and responsive to distress. They are also able to strike a fine balance between providing reassurance and encouraging the individual to gain independence, explore their environment and take risks (Goodwin 2003a). An important part of growth and development for people with insecure attachment styles involves trying out alternative ways of relating to others and of regulating emotions. For example, individuals with insecure dismissing attachment styles who typically avoid emotional displays and close relationships may benefit from interventions which encourage them to verbalise feelings and interact with others. On the other hand, those with preoccupied attachment styles

who are typically overwhelmed by emotions and overly dependent in relationships may benefit from approaches which minimise the focus on emotional distress and encourage them to develop ways of coping independently with stress (Ma 2007).

Case vignette 2: avoidant attachment

Gary is 27 years old and has a diagnosis of schizophrenia. He does not engage with staff on the unit and spends the majority of time in his room. He does not appear to verbalise negative emotional reactions, but following stressful life events, such as the recent death of his father, he absconds from the unit and drinks heavily. He has an avoidant attachment style.

The rehabilitation goals were to help Gary develop more secure and trusting attachment relationships with others and to develop more adaptive coping strategies in relation to stress. This involved very gradually starting to make conversations with Gary when he left his room for meals, followed by efforts to encourage him to use the computer situated in the communal area to play games. It is essential that the process of engaging Gary matches his attachment style: it is slow and gradual to avoid overwhelming him.

In the longer term, staff plan to address the typically avoidant ways in which Gary copes with negative affect by normalising stress reactions, helping him identify his own levels of stress and identify a range of effective ways of coping with these feelings. It is important that staff recognise that even small successes in engaging Gary represent progress given his avoidant interpersonal style.

Case vignette 3: preoccupied attachment

Rachel is 34 years old and has a diagnosis of schizoaffective disorder. She typically becomes very distressed by minor incidents such as busy staff not immediately responding to her needs and she often reports that staff do not like her. She spends a lot of time with staff and is reluctant to do things on her own. She has a preoccupied attachment style.

The rehabilitation goals were to help her regulate high levels of emotional distress and reduce her dependence on staff support. This involved reassuring Rachel that staff would respond to her needs even if they could not meet them immediately. It is essential that staff are consistent in this approach and do not let her down. Staff are also working with Rachel to identify triggers and signs of distress before it escalates. A series of graded coping strategies have been identified, from self-distraction to approaching her keyworker.

Psychological interventions

The potential role of rehabilitation staff in modifying insecure attachment styles raises the question of whether working models of attachment can be modified as a result of significant interpersonal experiences. There is some preliminary evidence from studies of psychological treatments to suggest changes in attachment styles, but the effects are not substantial and changes seem to be greater with more intensive interventions (Daniel 2006). Kilmann *et al* (1999) found that individuals

who participated in an intensive group-based manualised intervention to address a broad range of attachment difficulties achieved more substantial improvements in interpersonal functioning, including more secure attachment patterns at 6-month follow-up, compared with controls who received no intervention. However, Travis and colleagues (2001) report only 24% change to a secure style in time-limited dynamic therapy.

Psychosocial interventions

Psychiatric rehabilitation services provide a wide range of psychosocial interventions over long periods, so in this respect may be more effective than briefer therapies in addressing dysfunctional ways of relating to others. This does not necessarily mean providing emotionally intensive therapies, as these may increase distress in already vulnerable individuals, but involves providing consistent input over a long period of time as and when the person feels able to engage. Many people in rehabilitation services have long histories of abuse and some may never have had positive relationship experiences with significant others. Proximity to identified caregivers may not bring mental relief from anxiety, and in fact may cause more anxiety and arousal. It may therefore take a long time for therapeutic alliances to be established. It may even be the case that some people cannot make alliances at all. Instead, toxic patterns may be repeated in later relationships, as the individuals have no idea how to elicit care productively or how to use it when it is offered by a competent caregiver (Adshead 2001).

Staff attachment styles and relationships

The key role of rehabilitation staff in facilitating the development of secure attachments raises the issue of how far staff have the capacity to take on this role and how they might be best supported in doing so. It is well established that parents differ in their ability to function as a secure base for their children, so it is likely that mental health staff will differ in their ability to function as attachment figures. The caregiver's sensitivity and responsiveness to distress appears to be a significant factor in determining attachment classification in infancy, so may well be a key factor in staff-service-user relationships (Ainsworth 1978). The sensitivity of caregivers has been associated with a number of factors, including maladaptive responses to stress, support and their own mental health (Mallinckrodt 2000). This confirms the importance of staff not being overburdened, having adequate support, regular and skilled clinical supervision, and good enough mental health.

Responding to distress

The ability to understand and know how best to respond to another individual's distress is likely to be associated with one's own attachment style. Research has suggested that earlier attachment experiences influence social perceptions and the quality of interpersonal relationships in adulthood (Mallinckrodt 2000) and there is evidence to suggest that individuals with insecure attachment are less able to empathise with others (Joireman 2001), are less psychologically minded (Beitel 2003; Berry 2008b) and form poorer therapeutic alliances in counselling relationships (Dunkle 1996). In a sample of mental health workers and service users with severe and enduring mental health problems, Dozier *et al* (1994) found that case managers who were securely attached were less likely to interact with service users in ways that could potentially reinforce insecure attachment strategies.

Compulsive caregiving

Some healthcare professionals with insecure attachment styles may also be vulnerable to what Bowlby (1977) termed 'compulsive caregiving'. This pattern of insecure attachment may develop as a result of a child caring for a parent and suppressing their own attachment behaviours. In later life, the individual then lacks the ability to express need or ask for care, while retaining an unsatisfied neediness and longing to receive care (Goodwin 2003a). Staff who are 'compulsive caregivers' may be overly involved with service users and therefore are vulnerable to burnout. They are also more likely to blame themselves for failures (Ma 2007).

Improving relationships between staff and service users

Possible associations between staff attachment style and caregiving raise the issue of whether it is possible to provide staff with supervision and support to become more effective caregivers. There is evidence to suggest that it is possible to improve parents' sensitivity to their children's needs through problem-solving and video feedback (Landry 2006). There has also been much work on improving relationships between service users with severe and enduring mental health problems and their relatives, which might inform interventions to improve relationships between staff and service users. This work suggests that family interventions which involve communication skills training, goal planning and problem-solving are effective in helping relatives respond in a less critical or hostile manner towards people with a diagnosis of schizophrenia (Pharoah 2006).

MCQ answers

1 a 2 a 3 a 4 a 5 a

There has been relatively little research into improving the general quality of relationships between staff and service users. However, the available evidence suggests that short-term skills interventions are not effective in leading to long-term changes in staff behaviour (Van Audenhove 2003). Considering staff attachment style may better inform such interventions. Bakermans-Kranenburg and colleagues (1998) investigated the effects of a brief parenting intervention to improve parental sensitivity and found that mothers who were classified as insecurely dismissing were more likely to benefit from video feedback alone, whereas those with preoccupied attachment representations were more likely to benefit from video feedback in conjunction with discussions of childhood experiences.

The application of attachment theory to the provision of psychiatric rehabilitation also raises the issue of under which conditions relationships between staff and service users are in fact 'true' attachment relationships (Ma 2007). Although professional caregiver–patient relationships have been construed as attachment relationships, they are mediated by unique temporal, structural, ethical and sometimes financial boundaries that render them different from childhood attachment relationships or even relationships in adulthood (Goodwin 2003a). It is not clear how far relationships with mental health professionals function as attachment relationships and this should be investigated (Schuengel 2001).

Clinical implications

According to the College's Faculty of Rehabilitation and Social Psychiatry (Royal College of Psychiatrists 2004), investigating the essential elements constituting well-coordinated, high-calibre rehabilitation for service users who currently require costly and long-term support must be a focus for future research. Attachment theory has the potential to inform a system of care in rehabilitation services for individuals with severe and enduring mental health problems who may be difficult to engage. The theory stresses the importance of human relationships in mental health services, facilitates understanding of problematic behaviours, highlights qualities of effective caregiving and makes predictions about therapeutic approaches that might benefit service users with particular attachment styles.

The provision of an attachment-oriented rehabilitation service obviously has resource and management implications. Further work is needed to establish whether insecure attachments can be modified as a result of engagement in rehabilitation

programmes and what the key ingredients of change are. It is important to consider how intensive these interventions can be without worsening symptoms or becoming impractical. There is also a need to establish which factors promote secure attachments in staff–service-user relationships, how to improve caregiving skills and how relationships in healthcare differ from other types of attachment relationships.

References

- Adshead G (1998) Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. *British Journal of Psychiatry* **172**: 64–9.
- Adshead G (2001) Attachment in mental health institutions: commentary. *Attachment and Human Development* **3**: 324–9.
- Ainsworth MDS, Blehar MC, Waters E, et al (1978) *Patterns of Attachment: Psychological Study of the Strange Situation*. Lawrence Erlbaum.
- Bakermans-Kranenburg MJ, Juffer F, Van Ijzendoorn MH (1998) Intervention with video feedback and attachment discussions: does type of maternal insecurity make a difference? *Infant Mental Health Journal* **19**: 202–19.
- Bartholomew K, Horowitz LM (1991) Attachment styles among young adults. A test of a four-category model. *Journal of Personality and Social Psychology* **61**: 226–44.
- Bebbington PE, Bhugra D, Brugha T, et al (2004) Psychosis, victimisation and childhood disadvantage. Evidence from the second British National Survey of Psychiatric Morbidity. *British Journal of Psychiatry* **185**: 220–6.
- Beitel M, Cecero JJ (2003) Predicting psychological mindedness from personality style and attachment security. *Journal of Clinical Psychology* **59**: 163–72.
- Berry K, Barrowclough C, Wearden A (2007) A review of the role of adult attachment style in psychosis: unexplored issues and questions for further research. *Clinical Psychology Review* **27**: 458–75.
- Berry K, Barrowclough C, Wearden A (2008a) Attachment theory: a framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour Research and Therapy* **46**: 1275–82.
- Berry K, Shah R, Cook A, et al (2008b) Staff attachment styles: a pilot study investigating the influence of adult attachment styles on staff psychological mindedness and therapeutic relationships. *Journal of Clinical Psychology* **64**: 355–63.
- Bowlby J (1977) The making and breaking of affectional bonds. I. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry* **130**: 201–10.
- Bowlby J (1982) *Attachment and Loss: Vol. 1. Attachment* (2nd edn). Basic Books.
- Collins NJ (1996) Working models of attachment: implications for explanation, emotion and behaviour. *Journal of Personality and Social Psychology* **71**: 810–32.
- Daniel SIF (2006) Adult attachment patterns and individual psychotherapy: a review. *Clinical Psychology Review* **26**: 968–84.
- Dozier M, Cue KL, Barnett L (1994) Clinicians as caregivers: role of attachment organisation in treatment. *Journal of Consulting and Clinical Psychology* **62**: 793–800.
- Drayton M, Birchwood M, Trower P (1998) Early attachment experience and recovery from psychosis. *British Journal of Clinical Psychology* **37**: 269–84.
- Dunkle JH, Friedlander ML (1996) Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology* **43**: 456–60.
- Fonagy P, Steele M, Moran G, et al (1991) A capacity for understanding mental states: the reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal* **13**: 200–16.

- Fonagy P, Leigh T, Steele M, et al (1996) The relationship of attachment status, psychiatric classification and response to psychotherapy. *Journal of Consulting and Clinical Psychology* **64**: 22–31.
- Fraleigh RC, Waller NG, Brennan KA (2000) An item-response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology* **78**: 350–65.
- Goodwin I (2003a) The relevance of attachment theory to the philosophy, organization and practice of adult mental health services. *Clinical Psychology Review* **23**: 35–56.
- Goodwin I, Holmes G, Cochrane R, et al (2003b) The ability of adult mental health services to meet clients' attachment needs: the development and implementation of the Service Attachment Questionnaire. *Psychology and Psychotherapy: Theory, Research and Practice* **76**: 145–61.
- Joireman J A, Needham TL, Cummings AL (2001) Relationships between dimensions of attachment and empathy. *North American Journal of Psychology* **3**: 63–80.
- Killaspay H, Harden C, Holloway F, et al (2005) What do mental health rehabilitation services do and what are they for? A national survey in England. *Journal of Mental Health* **14**: 157–65.
- Kilmann PR, Laughlin JE, Carranza LV, et al (1999) Effects of an attachment-focused group preventative intervention on insecure women. *Group Dynamics: Theory, Research, and Practice* **3**: 138–47.
- Landry SH, Smith KE, Swank PR (2006) Responsive parenting: establishing early foundations for social communication, and independent problem solving skills. *Developmental Psychology* **42**: 627–42.
- Ma K (2006) Attachment theory in adult psychiatry. Part 1: Conceptualisations, measurement and clinical research findings. *Advances in Psychiatric Treatment* **12**: 440–9.
- Ma K (2007) Attachment theory in adult psychiatry. Part 2: Importance to the therapeutic relationship. *Advances in Psychiatric Treatment* **13**: 10–6.
- Main M, Goldwyn R (1984) Adult Attachment Scoring and Classification System. Department of Psychology, University of California.
- Mallinckrodt B, Gantt DL, Coble HM (1995) Attachment patterns in the psychotherapy relationship: development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology* **42**: 307–17.
- Mallinckrodt B (2000) Attachment, social competencies, social support, and interpersonal processes in psychotherapy. *Psychotherapy Research* **10**: 239–66.
- McCabe R, Priebe S (2004) The therapeutic relationship in the treatment of severe mental illness: a review of methods and findings. *International Journal of Social Psychiatry* **50**: 1–14.
- McGlashan TH (1987) Recovery style from mental illness and long-term outcome. *Journal of Nervous and Mental Disease* **175**: 681–5.
- Pharoah F, Mari J, Rathbone J, et al (2006) Family interventions for schizophrenia. *Cochrane Database of Systematic Reviews*, issue 4: CD000088.
- Repper J, Perkins R (2003) *Social Inclusion and Recovery: A Model for Mental Health Practice*. Baillière Tindall.
- Royal College of Psychiatrists (2004) *Rehabilitation and Recovery Now (Council Report CR121)*. Royal College of Psychiatrists.
- Schuengel C, Van Ijzendoorn MH (2001) Attachment in mental health institutions: a critical review of assumptions, clinical implications, and research strategies. *Attachment and Human Development* **3**: 304–23.
- Seager M (2007) *Towards Proactive Policy: Five Universal Psychological Principles*. National Advisory Group on Mental Health, Safety and Well-Being Position Paper. British Psychological Society.
- Starkey D, Flannery R B (1997) Schizophrenia, psychiatric rehabilitation and healthy development: a theoretical framework. *Psychiatric Quarterly* **68**: 155–66.
- Tait L, Birchwood M, Trower P (2003) Predicting engagement with services for psychosis: insight, symptoms and recovery style. *British Journal of Psychiatry* **182**: 123–8.
- Tait L, Birchwood M, Trower P (2004) Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *British Journal of Psychiatry* **185**: 410–5.
- Travis L A, Binder J L, Bliwise NG, et al (2001) Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy. *Psychotherapy* **38**: 149–59.
- Van Audenhove C, Van Humbeeck G (2003) Expressed emotion in professional relationships. *Current Opinions in Psychiatry* **16**: 431–5.

MCQs

Select the single best option for each question stem

1 Attachment theory is relevant to psychiatric rehabilitation because:

- a the attachment system is triggered by separations from primary attachment figures in the community
- b there are high levels of secure attachment in people with severe and enduring mental health problems
- c service users typically have few interpersonal difficulties
- d service users often find it easy to form good therapeutic relationships with staff
- e psychiatric rehabilitation aims to protect patients and discourages risk-taking.

2 The importance of human relationships in psychiatric rehabilitation services might be emphasised by:

- a keyworker systems
- b ensuring that service users form lots of different relationships over short periods

c prioritising medical treatments

d frequently moving patients between different wards as they progress

e ensuring that service users do not have contact with community staff while in rehabilitation services.

3 According to attachment theory, effective caregivers should:

- a be responsive and sensitive to distress
- b push towards independence even if service users seem distressed
- c ensure service users do not take risks
- d relate to services in ways that are familiar to them even if they are maladaptive
- e start with a 'blank slate' and not assess patient attachment styles.

4 Which of the following is a method of assessing attachment:

- a Adult Attachment Interview
- b Inventory of Interpersonal Problems
- c Social Functioning Scale

d Interpersonal Sensitivity Index

e Positive and Negative Syndrome Scale.

5 In deriving interventions to improve staff–service-user relationships, it is important to consider the role of:

- a staff attachment style
- b patient symptoms
- c staff age
- d staff knowledge of attachment theory
- e staff intelligence.