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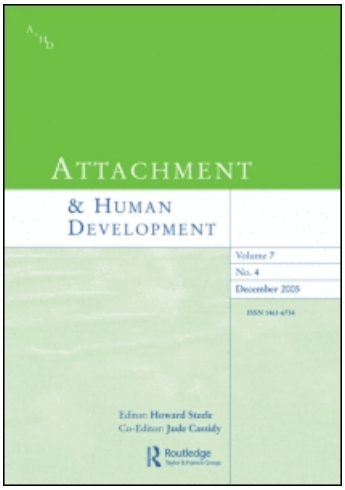
Schuengel, C.; van IJzendoorn, M.H.

published in
Attachment and Human Development
2001

DOI (link to publisher)
10.1080/14616730110096906

document version
Publisher's PDF, also known as Version of record



Attachment & Human Development
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713394054

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Online publication date: 07 October 2010

To cite this Article Schuengel, C. and van Ijzendoorn, M. H.(2001) 'Attachment in mental health institutions: A critical review of assumptions, clinical implications, and research strategies', Attachment & Human Development, 3: 3, 304 — 323
To link to this Article: DOI: 10.1080/14616730110096906
URL: http://dx.doi.org/10.1080/14616730110096906

Attachment & Human Development Vol 3 No 3 December 2001 304–323

Attachment in mental health institutions: A critical review of assumptions, clinical implications, and research strategies

C. SCHUENGEL and M. H. VAN IJZENDOORN

ABSTRACT Attachment is relevant to institutionalized treatment and the therapeutic process in three identifiable ways: (1) patients bring their mental representations of previous and existing attachment relationships to the treatment; (2) attachment is relevant to the extent to which a therapeutic alliance is established and maintained, both in terms of the mental representations of attachment in the patient and in the therapist and how these influence interactive behaviour and expectations in each partner to the therapeutic work; (3) the outcome of the treatment may be related to attachment; for example, when institutional experiences have an enduring impact on attachment representations and the future attachment behaviour of the patient. However, this brief review of attachment concepts reveals that several theoretical, conceptual and empirical questions remain to be answered before evidence-based clinical attachment guidelines can be formulated concerning patient–staff relationships.

KEYWORDS: attachment concepts – institutionalized treatment – therapeutic process – patient–staff relationships

Do meaningful relationships emerge in institutional settings for the treatment of mentally disturbed youth and adults, and if so, what do these relationships have in common with attachment relationships? What consequences for the treatment process and outcome does attachment have? The topic of this special issue of *Attachment & Human Development* is attachment in mental health institutions. In this paper, we discuss a number of fundamental tenets and assumptions of attachment theory. First we ask how attachment theory could be applied in the case of institutional treatment and care. We then

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Attachment & Human Development ISSN 1461–6734 print/1469–2988 online © 2001 Taylor & Francis Ltd
http://www.tandf.co.uk/journals
DOI: 10.1080/1461673011009690 6

examine some of the practical implications that might ensue. Are these implications well supported? Finally, we discuss promising avenues for the empirical study of attachment within mental health institutions. We conclude that current attachment theory and existing attachment measures may not be well equipped to address two basic issues in residential care of profoundly disturbed (adolescent) patients. First, extremely disturbed patients with a history of fragmented and residential care may have been deprived of attachment relationships at some periods in their lives, and their attachment representations may be difficult to capture within the current coding schemes. Second, therapeutic staff working with extremely disturbed and insecure patients may try to offer secure base support to their patients but it is unclear what it takes for patients to accept this offer by using therapeutic staff as a secure base and to turn their interactions into a genuine and healing attachment bond.

ASSUMPTIONS OF ATTACHMENT THEORY RELEVANT TO INSTITUTIONAL CARE

The formation of attachment

Attachment theory claims that throughout the life-span, the attachment behavioral system is continually active (Bowlby, 1988; Bretherton, 1985). This behavioral system regulates the use of attachment figures as a 'secure base' . When frightened or stressed, the attached person retreats to the secure base. Trusting the availability of an attachment figure in times of need, the attached person is able to go out and explore the world. It is generally taken for granted that humans have a natural tendency to form new, alternative and subsidiary attachment relationships given special circumstances (Bowlby, 1984). How and under what conditions do these alternative attachment relationships develop?

Separation from and loss of primary attachment figures may stimulate new attachments. Institutionalization means at least a temporary separation from existing attachment figures, but in some cases it can also create a situation of loss. Separation does not have to be long-term or permanent to stimulate the search for new attachment figures, as is illustrated by attachments to fathers, grandparents, day-care providers, meta-plot *et alia* (Howes, 1999; van IJzendoorn, Sagi, & Lambermon, 1992). However, the tendency to seek out new attachment figures is not invariant. With growing age, there is an increase in children's capacity mentally to represent the whereabouts and accessibility of their attachment figures (Bowlby, 1984). 'Person permanence' may lead to felt security even in the absence of any attachment figure, which eliminates the need for seeking alternative attachment figures. Nevertheless, a secure mental representation of attachment stimulates confident interaction with prospective subordinate attachment figures.

The situation is more complex for children who experience a long-term separation from or loss of their primary attachment figure(s). These disruptions of attachment are accompanied by grief, anger and distress, and lead to disorganization of their attachment behavioral system (Bowlby, 1973, 1980). New caregivers have a heavy burden to rebuild the shaken confidence in the availability of attachment figures, perhaps even more so when the relationship with the lost attachment figure was insecure (Bowlby, 1980).

In summary, even if we could confidently extrapolate from attachment theoretical formulations concerning early childhood, it is difficult to formulate straightforward predictions about whether individuals who enter mental health institutions are likely to form new attachment relationships there. Various individual characteristics and environmental conditions may tip the balance. To name a few possible factors that would favor the formation of new attachments: (1) the person perceives that a separation has occurred, that is, he or she feels that the existing attachment network is insufficiently accessible (while perceiving the separation as brief and temporary, which prevents anger and grief); (2) the mental representation of past and present attachments is secure; and (3) stress is present but mild (stress elicits seeking out a secure base but a new attachment figure may be insufficiently trusted to help or protect in the case of severe stress). Factors that may hamper the formation of new attachments could be: (1) existing attachment figures are perceived to be sufficiently available; (2) the person is still in grief or in anger about the separation from or loss of the existing attachment figure(s); (3) the mental representation of attachment is characterized by distrust; (4) stress is absent, stress is abundant, or the person has at his or her disposal alternative ways of coping with stress. Considering the involuntary and open-ended nature of many placements, and the presence of insecure attachment representations in most individuals placed in mental health institutions, we would be cautious in predicting that taking adolescents or adults from their families and treating them in an institution will always lead to searching for alternative attachment figures within that institution, even if caregivers try to foster attachment by offering secure base support.

Criteria of attachment

It is problematic, in a way even 'embarrassing' (Main, 1999, p. 849), that both attachment researchers and practitioners who want to apply attachment theory outside the parent–child context have to discover that little is known about what is characteristic of attachment relationships as compared with other types of relationships. Studies of attachment relationships have almost always focused on individual differences in the quality of parent–child relationships, *which are assumed to be attachment relationships*. The newer research on attachment representations (or internal working models of attachment), as operationalized in the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), does not study representations of individual

attachment relationships, but focuses on the more general 'conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information' (Main, Kaplan, & Cassidy, 1985, pp. 66–67). As attachment theory is being applied more broadly to non-parental relationships and non-normative parental relationships (e.g. foster care, adoption), we increasingly need methods to tell whether a given child is attached to a specific caregiver. If we do not know the answer to that question, we have to remain cautious when we interpret certain responses and behaviors as indicative of the quality of the relationship. As our analysis of the case of institutionalization shows, it is not self-evident that clients develop attachment relationships to therapeutic staff. Patterns of interaction and perceptions of the relationship with a member of the therapeutic staff can, therefore, not be automatically interpreted as indicative of the quality of attachment relationships or the quality of internal working models of the individuals being observed.

The clinical meaning of attachment theoretical ideas is sometimes also obscured because of confusion about concepts. Ainsworth distinguished between the terms 'attachment/attachment bond', 'attachment behavior' and 'attachment relationship':

> An attachment is an affectional tie that one person forms to another specific person. . . . . Attachment implies affect. Although the affects might be complex and may vary from time to time, positive affects predominate, and we usually think of attachment as implying affection or love. (Ainsworth, 1973, p. 1)

> Attachment behavior is intermittent – sometimes present, sometimes absent. The intensity of attachment behavior varies greatly according to the circumstances of the situation. Yet attachments bridge time and distance and cannot be conceived as present or absent, or varying in intensity, even over long periods of time. We infer the existence of an attachment from a stable propensity to seek proximity to and contact with a specific figure over time. (Ainsworth, 1973, p. 2)

> Affectional bonds are not synonymous with relationships. . . . First, relationships are dyadic, whereas affectional bonds are characteristic of the individual but not the dyad; although they develop in the context of the dyad, they come to entail representation in the internal organization of the individual person. Second, relationships may be either long-lived or fleeting, whereas affectional bonds are by definition long-lasting. Third . . . the nature of a relationship between two individuals grows out of the total history of their interactions. (Ainsworth, 1991, p. 37)

To be sure, according to Ainsworth 'attachment figures cast in the parental mold might be mentors, priests or pastors, or therapists' (1991, p. 36). She expresses doubt, however, whether the attachment to these (often temporary)

attachment figures is as persistent as primary attachments. The same doubt would have to apply to attachments formed to therapeutic staff within institutions. Institutionalized clients might display behaviors towards staff members that are isomorphic to attachment behavior; for example, seeking comfort, seeking support, seeking proximity, or social referencing. 'Secure base use' would be an appropriate term for these behaviors (Waters & Cummings, 2000, p. 166), whereas the term 'attachment behavior' carries the implication that this behavior is evidence for the existence of an attachment relationship. A relationship with a staff member would only be called an attachment relationship, however, if using the staff member as a secure base would be characteristic of their 'history of interactions', that is, would be displayed during an extended period of time. The current state of theory prevents as yet a clear answer to the question what amount of time would be needed for a relationship to qualify as one of persistent attachment.

Perhaps subjective criteria for qualifying a relationship as an attachment relationship are more relevant than objective criteria. At this point, the notion of an 'attachment bond' may play a useful role. 'Attachment bond' refers to the individual's experience of feeling attached to another person. This affective component of the internal working of attachment relationships was emphasized in Bowlby and Ainsworth's work, but has received little empirical attention. Cassidy (1999) has summarized Ainsworth and Bowlby's position on attachment bonds as a special class of affectional bonds as follows:

> First, an affectional bond is persistent, not transitory. Second, an affectional bond involves a specific person, a figure who is not interchangeable with anyone else.... Third, the relationship is emotionally significant. Fourth, the individual wishes to maintain proximity to or contact with the person. Fifth, the individual feels distress at involuntary separation from the person.... An additional criterion exists for an attachment bond: The individual seeks security and comfort in the relationship with the person. (Cassidy, 1999, p. 12)

The latter criterion refers to the special nature of proximity to and contact with the attachment figure: proximity and contact are not just enjoyed, but are of primary importance to the attached person as regulators of stress and arousal.

Table 1 provides a summary overview of the different attachment-related concepts that we have discussed. Keeping the distinctions between the various concepts in mind may help to avoid the pitfalls and misunderstandings that may arise in applying attachment theory to mental health institutions. Particularly pertinent to the present discussion of attachment within mental health institutions is the recognition that using a staff member as a secure base, being involved in an (insecure or secure) attachment relationship with a staff member, and feeling attached to a particular staff member need to be distinguished.

Table 1 Summary of attachment-related concepts

Attachment relationship	*Secure base behavior*	*Internal working model of attachment relationship*	*Attachment bond*	*Mental representation of attachment*
Dyadic History of interaction characterized by secure base use and secure base provision	Individual Using a person as a secure base; that is, seeking security and comfort from a person perceived as wiser and/or stronger	Individual Mental representation of a specific relationship. Cognitive/affective perceptions and expectations of secure base use and availability	Individual The experience that a relationship with a specific person is persistent and emotionally significant, that proximity and contact are desired, that absence leads to distress, and that security and comfort are sought from the person	Individual Conscious and/or unconscious rules regulating access to attachment-related information

The influence of previous and existing attachment relationships

A fundamental thesis in Bowlby's work (1984) is that the mental representation of attachment, formed on the basis of experiences with attachment figures, influences the way new relationships are formed. Given that most patients have (very) insecure attachment representations (a meta-analysis on outpatient and inpatient samples found that only 8% could be classified as autonomous-secure, using the Adult Attachment Interview; van IJzendoorn & Bakermans-Kranenburg, 1996), this prediction may have important implications for institutional treatments that rely on the building of relationships and working alliances with patients. Slade (1999) has described how the different types of attachment representations may be associated with different expectations of patients in a therapy situation (transference) and with reactions of therapists to the conduct of patients resulting from these attachment representations (counter-transference). Implications for treatment may, however, be less clear-cut than they seem. The relative influence of the attachment representation on the therapeutic relationship may vary according to the nature of that relationship. More specifically, the influence of attachment representations is expected to be the strongest within attachment relationships, weaker in non-attachment, affectional relationships, and weakest (and perhaps non-existent) in non-affectional, social relationships (Cassidy, 1999). The influence of attachment representations may also be larger during later stages of relationship development than during earlier stages.

There is only research on non-patient samples that supports the idea that the influence of attachment representations varies as a function of the status of the relationship. Research on social competence among peers in childhood and adolescence indicates that working models of attachment relationships with parents do matter within non-attachment relationships with peers, but more so in the case of close friendships (see Schneider, Atkinson, & Tardif, 2001, for a meta-analytic review). Research on adults shows that in close relationships, time is an additional factor. Crowell and her colleagues (2001) found among 66 newly-weds that the predictive power of security of the attachment representation of childhood with respect to secure base use increased from 3 months before marriage to 18 months after marriage. Assuming that the commitment of marriage leads to increased secure base use and support (these data were not reported), this means that the progression from presumably affectional to attachment relationships is associated with an increasing role of attachment representations.

To complicate matters even further, attachment representations may determine whether a person is prone to develop affectional and attachment bonds within his or her network of social relationships. Institutionalized youths sometimes express a serious need for close personal relationships with adults (Jaffe, 1967). Nevertheless, especially in mental health institutions for children and adolescents, it is also a common observation that children and adolescents are reluctant to develop close relationships with adults, because they

do not trust adults and are more oriented towards peers. In the absence of research on this issue, it is difficult to determine whether reluctance to 'deepen' relationships among institutionalized patients may be due to their insecure attachment representations, to caregiving that does not reach the minimum responsiveness to elicit secure base behavior, to having sufficient access to an existing network of attachment figures, to not experiencing stress, or to seeking support from peers. Even less is known about the issue of possible 'over-dependence' of patients on staff members.

The attachment representations of therapeutic staff deserve separate attention. Evidence from outpatient samples comes from work by Dozier and her colleagues. Secure case managers appeared to be better able to deal with the 'underlying neediness' of their clients, whether dismissing clients presented themselves as invulnerable (reflecting an underlying need for emotional support) or preoccupied clients presented themselves as needy and dependent (underlying need for autonomy support). The interventions of insecure case managers closely matched the expectations of preoccupied clients, being fragile and needy. The interventions of insecure case managers also matched the expectations of the more dismissing group, in that depth of intervention was low (Dozier & Tyrrell, 1997). Similar patterns were found in a sample of severely disordered outpatients and their therapists. Even though almost all therapists were classified as secure, the dimensional measure of deactivating-hyperactivating attachment strategy interacted with patient attachment classification in predicting working alliance and treatment outcome (Tyrrell, Dozier, Teague, & Fallot, 1999). In the absence of data on the attachment representations of institutional workers, we do not yet know whether this 'goodness-of-fit' plays a role in mental health institutions.

The influence of institutional experience on attachment representations

A crucial element within Bowlby's (1973; 1984) theory is that internal working models and attachment representations remain open to experience. Revision of secure and insecure attachment can be stimulated by new attachment-related experiences. Separation from attachment figures may be traumatic, and institutionalization is a case in point. Adam, Sheldon-Keller and West (1996) found that suicidal ideation in a psychiatrically hospitalized sample of adolescents was associated with unresolved traumatic experiences, which in many cases were traumatic separations from parents. The impact of separation may depend on many factors surrounding the separation and its aftermath. However, even brief separations lead to temporary changes in attachment behavior of children (Robertson & Robertson, 1971). Theoretically, the impact of separation on attachment representations would depend on the pre-existing attachment representation, experiences during the separation, stress experienced within the institution, and the availability of alternative secure base support. In this regard, the comparison between institutionalization and foster care is relevant. Roy, Rutter and Pickles (2000)

showed that children who were put into foster care or institutional care before the age of 12 months showed elevated rates of hyperactivity/inattention symptoms and unsocialized behavior, as compared with controls. However, institutionalized children scored significantly higher on these symptoms than foster children and controls. The difference between the foster care group and the controls was only a trend. The foster care and institutional care groups were comparable with respect to pre-placement conditions. After placement, however, the institutionalized children experienced much less stability of caregiving and less individualized care.

Some studies on institutionalized treatment of disturbed and/or delinquent youth report positive associations between outcome and quality of relationships with staff (Fritsch & Goodrich, 1990; Scholte & Van der Ploeg, 2000). However, it is not clear from these reports whether these associations reflect pre-entry differences in the security of attachment representations or whether the efforts of the staff have contributed to these associations. Indirect evidence that relationships between at-risk youth and supportive non-parental adults can have a positive influence on attachment comes from a large-scale mentoring program (Big Brothers–Big Sisters; Rhodes, Grossman, & Resch, 2000). Compared with controls, at-risk adolescents enrolled in the mentoring program reported improved relationships with their parents. This improvement of attachment relationships mediated the effects of mentoring on self-worth, school values, and grades. As Bowlby (1988) suggested, in order to succeed in therapy, behavioral management, or reconciliation of damaged relationships, one needs a secure base as a foundation.

It has also been argued that learning to use institutional caregivers as a secure base can be harmful, when clients return from the institution with a representation of attachment that is highly discrepant from the way people relate at home. McCord (1992) made this point on the basis of her surprising findings from the Cambridge-Somerville study, a longitudinal experimental study to prevent delinquency. Between 1935 and 1939, 506 high-risk boys were matched in pairs and then randomly assigned to a control and an experimental condition, in which a social worker tried to build a close personal relationship with the pupil. Using state probation records and medical records, McCord discovered 40 years later that the experimental program had produced an adverse effect. Of the 253 pairs, 39 pairs had an undesirable outcome (conviction and/or alcoholism, schizophrenia, manic depression) in the person assigned to the control condition and not in the person in the experimental condition. However, 63 pairs had an undesirable outcome in the person assigned to the experimental condition and not in the person in the control condition. This difference was statistically significant. Dishion, McCord and Poulin (1999) suggested an alternative explanation of these surprising findings: the experimental group had participated in summer camps, which resulted in intensive contacts among deviant youth. These circumstances are conducive to 'deviancy training' by peers. McCord's (1992) earlier explanation stands, however, as a strong warning against overly optimistic

expectations regarding the effect of close mentor relationships with young people compared with the influence of the peer group.

ASPECTS OF INSTITUTIONAL CARE

The preceding analysis showed that attachment is relevant to institutionalized treatment with regard to the input of the therapeutic process (mental representations of previous and existing attachment relationships), the therapeutic process (formation of relationships and bonds to treatment staff), and the output (the influence of institutional experience on attachment representations). Besides showing the relevance of considering attachment, our analysis also opened up several theoretical and empirical questions that should be answered before evidence-based clinical guidelines and predictions can be made. In the current section, we outline some of the clinical questions regarding attachment in institutionalized treatment. We focus on three aspects of care: patient–staff relationships; alternative relationships; and extremely insecure attachment representations.

Patient–staff relationships

One obvious implication of attachment theory for institutional care is that patient–staff relationships should be stable, and therapists should provide a secure base for their clients. Stability is a precondition for security, because both patients and institutional workers will only develop some sort of bond with each other when continuity is to be expected. Stability is also important because of the emotional costs of separation and loss. Establishing secure relationships with clients has been advocated by several writers (Adshead, 1998; Campling, 1996; Fritsch & Goodrich, 1990; Halverson, 1995; Junger-Tas, 1983; Leaf, 1995; Maier, 1994; Moore, Moretti, & Holland, 1998). However, there are also reports of difficulties inherent in the institutional treatment setting that hamper the formation of secure attachment (Moses, 2000; Small, Kennedy, & Bender, 1991). Furthermore, the behavior resulting from the often extremely insecure attachment representations of patients provides an additional challenge (see below). Stimulation of patient–staff attachment places demands on staffing, scheduling of staff and organization, and may constrain other institutional policies; for example, 'graduation' from group to group (Schuengel, Zegers, Jansma, & van IJzendoorn, 2000).

Instead of advocating the establishment of attachment relationships for every patient in every institution, we propose that policy decisions be based on the answers to three preliminary questions. (1) Are patients cut off from their attachment network (if it exists), or do they derive (or are they helped to derive) sufficient security from an existing attachment network? (2) Do the stressors associated with institutionalized treatment exceed the cognitive and behavioral coping abilities of the patients, or can the patients be expected to

cope on their own? (3) Are resources and staffing adequate for providing at least one relationship that is stable enough to develop into an attachment relationship, or are staffing unstable and turnover high? If the staff-to-children ratio in an institutional setting is too large, if the staff turnover is too high, or if the child is to be transferred many times, institutional placement is only likely to be harmful to establishment of new attachments and should be avoided.

The institutionalization of adolescents is one example. At their age, regular visitations may maintain a sufficient level of security. However, many disturbed adolescents come from deprived and unstable families. Visitation, even if it is established, may fail to provide (enough) secure base support or may even lead to additional stress. In adolescents with clinical problems, coping resources might be poor, or the stresses associated with living with disturbed peers so great, that even regular visitation by parents does not suppress the seeking of subsidiary attachment figures. Because (in contrast to young children) secure base support would not have to be available on a daily basis, it might be possible to accommodate to this need and organize stable mentoring or coaching relationships between institutionalized adolescents and staff (or community volunteers). In this case, the quality of the attachment relationships with members of the staff may even be an important supplemental or corrective experience to the established, insecure relationships with family, partners and friends.

Persons with intellectual disabilities represent a population that is at risk both of forming insecure attachment relationships or failing to form attachments, and of inadequately coping with stress on their own (Janssen & Schuengel, 2001). Although in most western countries the trend is to de-institutionalize within this population, many clients remain dependent upon non-familial caregivers. Often, care arrangements are reasonably stable, and may provide fertile ground for developing attachment to staff. Failure to establish secure relationships, perhaps also because of communicative problems, may be responsible for suboptimal quality of life and the development of severe behavior problems. An example, however, in which the need for attachment relationships with staff is less obvious is formed by adults who are institutionalized for a limited period, who can visit their families or who are visited by their family members, and who have adequate coping resources to deal with daily stressors.

What role should the patient–staff relationship have within the treatment program? Patient–staff attachments may be used to avoid iatrogenic damage resulting from separations from attachment figures and deprivation of secure base support. Attachment may also be used as a secure base from which to explore the various difficult tasks of treatment (confrontation with intrapsychic problems or traumatic memories, exhibiting dependency needs, developing autonomy, dealing with therapeutic staff). Finally, a secure patient–staff attachment relationship may offer a corrective experience and lead to reorganization of the attachment representation (Dozier & Tyrrell, 1997).

The desirable function of attachment would also determine which type of person is most suitable in offering secure base support. For example, the prevention of iatrogenic damage associated with the temporary absence of a stable secure base may be accomplished by group workers or even volunteers from the community. Attachment to the therapist seems appropriate for psychotherapy programs that focus on disorder and trauma. For a corrective experience to have impact on insecure attachment representations, perhaps an intensive one-on-one situation should be created between a patient and a staff member (who may have to fill the role of a parent substitute). In any case, the saliency of attachment issues in a given institutional setting, using the preliminary questions above, must be considered, given the difficulties and risks associated with using attachment as a therapeutic tool.

Alternative relationship

From our analysis it follows that a patient will seek out secure base support, provided that he or she feels cut off from the attachment network and is unable to cope with stressors on his or her own. If secure base support is not provided by staff, patients may seek out alternatives. Anecdotally, attachments to cooks and janitors (often available and with low turnover rate) are observed. Attachment to fellow patients may also be possible. In many cases institutional policy decisions may be made without regard to these attachments. This may inadvertently lead to damage and distress when, for example, a patient is transferred to a new ward. Also, there are few opportunities to train and support these alternative attachment figures in providing secure base support to patients with often highly insecure attachment representations, which may put these people at risk of becoming overinvolved or becoming involved in a conflicted relationship. The implication is that attachment and the provision of secure base support should always be a matter of consideration for institutions caring for people cut off from attachment networks and unable to cope on their own with the stress associated with institutionalization.

Extremely insecure attachment representations

It should be noted that in extremely disturbed individuals, the quality or type of attachment representation may not be adequately described by the current attachment concepts nor adequately established with the current coding system of the AAI (for examples, see Turton, McGauley, Marin-Avellan, & Hughes, this issue). Hesse (1996) was the first to note that some adult attachment interviews did not fit in any of the traditional categories, or fitted in more than one equally well. He described a subject who in the first part of the interview clearly showed idealizing tendencies, but shifted gears in the second part becoming angrily preoccupied with his parents (Hesse, 1996). Hesse proposed to classify these subjects as 'cannot classify' (CC), in order

to emphasize their outlying and undefined status in the context of a system of organized (even if sometimes insecure) representations of past attachment experiences. He suggested that these CC subjects might be among the most disturbed individuals, for whom the current AAI coding system would not offer a sufficient range of indicators. Hesse (1996) described their inability to deal with the AAI issues in a coherent way as a 'global breakdown' of their attachment strategy, in contrast to the 'local breakdown' to be observed in unresolved subjects talking about their loss or abuse experiences.

His proposition has been confirmed in some studies in extreme populations. For example, in a sample of personality disordered criminal offenders who were deemed not to be responsible for their serious crime (rape, murder) because of their mental state, and who were placed in a maximum-security forensic hospital, we found a large number of CC subjects. These CC patients appeared to have developed more personality disorders than the other subjects, and they also appeared to establish less satisfactory and more violent relationships with their therapeutic staff (van IJzendoorn *et al*., 1997). In the Adult Attachment Interview, most CC patients also described a large number of caregivers and residential care settings they had experienced in their past, and it might have been this experience of extremely fragmented care that prevented them from becoming attached in any organized way. Their mental state seemed to reflect this fragmented care, and they discussed their attachment experiences in a most incoherent manner, without being aware of their inconsistencies. In some cases, any positive or negative affect seemed to be absent, and this flat profile reminded one of the unclassifiable infants in the Strange Situation who did not seem to be attached at all (see also Frodi, Dernevik, Sepa, Philipson, & Bragesjö, in this issue).

Interviews with patients in residential settings might be more often 'cannot classify' than those from other clinical populations. In these extreme cases, the current attachment concepts and measures may be insufficient to capture the roots and depths of their attachment disturbances, and the proposition of a healing mentor–client attachment relationship might be unrealistic. In the case of a CC attachment representation, the establishment of a new bond with a representative of the residential care setting might not be complementary to a (past or present) network of attachment relationships outside this setting, but it might constitute a completely new experience for the client. Serious transference and counter-transference problems may be expected to develop, and only under the most optimal conditions of stability of care, and sufficient support for the therapist or mentor in working with this extremely difficult group, may some progress be expected. Kobak, Little, Race, and Acosta (this issue) suggest on the basis of their findings in a group of emotionally disturbed children some of whom had experienced many disruptions of attachment, that 'children who lack confidence in the availability of attachment figures, may seek help from teachers in ways that are perceived as inappropriate or dependent' (2001, p. 000).

Wallis and Steele (this issue) found that 10% of their sample of

institutionalized emotionally and behaviorally disturbed adolescents (N = 39) received a CC designation. More than half of the sample (57%) received an unresolved classification. Schuengel, van IJzendoorn, Jansma, Metze, and Venmans (2000) found no CC cases in their pilot sample of institutionalized emotionally and behaviorally disturbed adolescents (N = 20). Only 2 (10%) were identified as unresolved. However, ongoing coding of the main sample reveals that the percentage of CCs may be in the 10% to 20% range. Because of the considerable variance within and between subpopulations, larger studies and meta-analyses are needed to produce more precise estimates of the prevalence of extremely insecure attachment representations, and to provide more insight into their correlates and clinical implications.

RESEARCH STRATEGIES

Most of the studies on attachment in mental health institutions have examined the quality of the attachment representations only when patients enter the institution. As an isolated piece of information, the distribution of attachment categories in institutionalized samples is of limited value, however. The generalizability of this knowledge is limited by the variability in the composition of institutional populations. Knowledge about attachment representations is nonetheless necessary to predict the quality of therapeutic relationships. However, according to Turton, McGauley, Marin-Avellan, and Hughes (this issue), considerable caution has to be exercised in administering the Adult Attachment Interview protocol (George *et al*., 1985) and analyzing interviews with exclusive reliance on existing coding guidelines (Main & Goldwyn, 1994). Another limitation of the extant research is that as yet no differentiation has been made between therapeutic relationships that function as attachment relationships and relationships that do not function as attachment relationships. No information has furthermore been obtained about the development of accompanying attachment bonds or affective bonds. We need to be able to make these distinctions to answer a number of crucial questions. Do attachment relationships develop in institutions at all? If so, what institutional circumstances are conducive or hampering? Do people with certain attachment representations develop attachments at a faster rate than others? There are few examples of how to go about studying these questions, probably because it is difficult to study the existence of an attachment relationship apart from its quality. Using the organizational components of the internal working model of attachment relationships as evidence of the presence of attachment relationships may be problematic because avoidant/dismissing organization may give the mistaken impression of not being attached. Using the affective expression of the internal working model, that is, the attachment bond, may circumvent this problem, especially when affect is measured using physiological responses (e.g. Spangler and Grossmann, 1993,

demonstrated that avoidant babies experienced distress in the Strange Situation, despite their inhibition of attachment behavior).

A promising line of research was started by Dozier and her colleagues (Dozier & Tyrrell, 1997; Tyrrell *et al*., 1999) on the fit between the attachment representations of outpatients with the attachment representations of therapists. The question of goodness-of-fit between patients and therapists is relevant for mental health institutions. Because patients and staff are often forced to interact on a daily basis in an institution, the interaction between staff members and the patients with sometimes extremely insecure attachment representations may result in corrective experiences as well as explosive situations (Adshead, 1998). This research has the potential to elucidate basic scientific questions about the role of latent cognitive structures (attachment representations) in social behavior and relationships. At the same time, it may help institutions to manage processes of staff–patient interaction.

If the generated knowledge on attachment in mental health institutions is to be practically applied, instruments have to be developed to guide treatment and care decisions and to monitor attachment processes and developments. With respect to attachment representations, the Adult Attachment Interview and its associated coding system place considerable demands on staff time and expertise, which precludes standard use as a screening or intake instrument (Steele & Steele, 2000). For some purposes, it may be sufficient to have screening instruments that can at least tease apart whether the predominant attachment strategy is preoccupied or dismissing. For the measurement of changes in internal working models of therapeutic or mentoring relationships, many questionnaires of working alliance *et alia* exist, but few contain operationalizations of reported secure base use and perceived secure base availability, the two core dimensions of internal working models of attachment relationships (Zegers & Schuengel, 2001).

CONCLUSION

In our review of the application of attachment theory to mental health institutions, we formulated some conditions under which entry into a mental health institution would give rise to the formation of new attachment relationships and some conditions under which this is not likely. When speaking about attachment, we should attempt to separate attachment from other phenomena. Attachment *relationships* are fairly straightforwardly defined by secure base use (attachment behavior) and secure base support (caregiving behavior) (Waters & Cummings, 2000). Perceptions of secure base and support form the core dimensions of working models of specific attachment relationships. The individual's experience of being in an attachment relationship may be best captured by the concept of attachment *bond* (Ainsworth, 1973, 1991; Cassidy, 1999).

In theory, all types of social experiences and relationships may in some way

or another be influenced by attachment representations of past attachment experiences. However, the influence may be stronger if a relationship gives rise to an affectional bond, and strongest in the case when this affectional bond is an attachment bond. Conversely, social experiences and relationships within mental health institutions, whether planned or not, may challenge or confirm existing attachment representations, again more strongly when affectional or attachment bonds have been established. Based on these ideas about attachment relationships in mental health institutions, we have outlined three preliminary questions that may be used to evaluate the saliency of concerns about attachment in institutional treatment settings. The three questions are as follows. Is the patient cut off from his or her original attachment network? Do the new stressors exceed his or her coping? Is stable secure base support in the institutional setting feasible? The answers to these questions may determine whether attachment should be a target of therapeutic intervention, or be used for the purpose of avoiding iatrogenic damage. Finally, our analysis showed some intriguing avenues for research, some of which concern fundamentals of attachment theory. In an era when attachment theory was primarily applied to parent–child relationships, the questions 'What is attachment?' and 'How can we identify attachment?' did not require great attention. Institutional and foster care demand that these questions receive clear answers. If it is shown that attachment relationships may develop within institutional settings, the consequences are far-reaching. Treatment policies may have to be adapted (e.g. to foster stability of relationships), and diagnosis and treatment planning will have to be supplemented with information about attachment. Without claiming the need for 'attachment therapy' (Slade, 1999, p. 577), this paper recognizes that attachment may stimulate promising new treatment opportunities and modalities in institutional mental health settings.

ACKNOWLEDGEMENTS

Work on this paper was facilitated by a grant from the Dutch Department of Justice to Carlo Schuengel and Marinus van IJzendoorn. The authors wish to thank the anonymous reviewers for their helpful suggestions regarding an earlier version of this article.

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