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### Attachment styles of staff and people in care-homes : an investigation into effects on challenging behaviour

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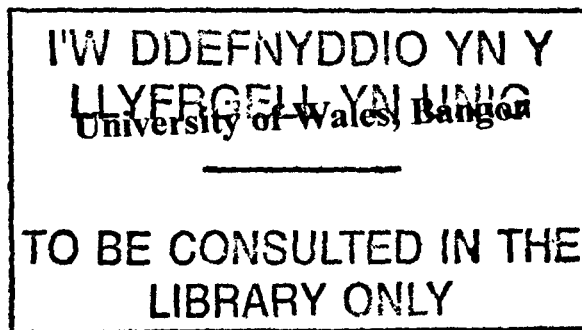
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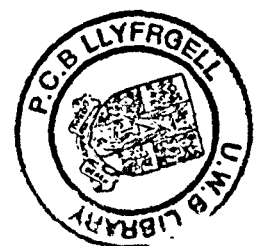
**Attachment Styles of Staff and People in Care-homes: An  
Investigation into Effects on Challenging Behaviour.**

**Patricia Marie Goater**



**Thesis submitted in Partial Fulfilment of the Requirement of the Degree of  
Doctorate in Clinical Psychology (D.Clin.Psy)**

**June 2004**



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*This work is dedicated to Mum, whose natural person-centred approach to dementia care and challenging behaviour, inspired this project!*

## Summary

There is wide acceptance that challenging behaviour (CB) is a common feature of people with dementia. The current literature has demonstrated that a wide variety of factors may contribute to either the amount of CB or the subjective difficulty of management and burden perceived by those who care for people with dementia. This study is preceded by a literature review that examines the contribution of attachment theory to our understanding of why some people with dementia may show greater levels of CB and why both family and professional carers may show such wide variations in their response to CB.

The focus of the main study was to replicate previous findings, ie. that those with 'insecure' attachment styles would demonstrate higher levels of CB, while addressing a methodological weakness in previous research. The attachment styles of paid staff were also investigated and their relationship to perceived levels of CB, positive perceptions of work and burnout examined. Finally the possibility of an interactive effect between staff and resident attachment styles was investigated. Results did not support previous findings and this is discussed with reference to the change in methodology. Limitations to this study and future research directions are discussed. A review of the contributions to theory, research and practice follows. This paper discusses further the strengths and weaknesses of the current research and the contribution made to original knowledge. Future research directions are indicated and the implications for clinical practice are discussed. Finally personal motivations and process issues arising from this research are presented.

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- 4.a: Four-group model of attachment and descriptions.



## Acknowledgements

My first thanks go to those relatives who gave me so much time and information even when it was often difficult for them to talk about their relatives in such a personal manner.

I would also like to thank the staff of the homes that took part: Caledonia Residential Home, Holyhead; Canterbury House EMI nursing home, Rhyl; Plas Crigyll Nursing Home, Bryngwran; Plas Penmon EMI nursing home, Penmon; Sandy Lodge EMI nursing home, Rhyl; and Ty Gwyn Residential Home, Gwalchmai.

A huge thanks goes to my supervisor, Bob Woods for his endless patience, optimism & encouragement throughout the entire project.

Practical help was also received from Claire O'Donoghue who helped in making contact with some of the above residential homes and Richard Hastings who advised on the statistical analysis. Thank you to both.

This project was conducted throughout what were often difficult personal circumstances. For providing the much needed emotional support, baby-sitting, tea and chocolate to get me through this time, and just generally listening to endless whinging, I would like to thank the following: All my fellow '2001 cohort' members (Beth, Jean, Katie, Lesley, Lynn, Sarah & Vanessa), my clinical supervisors, (Frances & Stuart), and friends (Clair, Kerry, Liz, Mairead, & Praveena)

Finally, and most importantly, I would like to thank my daughter, Amy, who was only 2 when I started this course and therefore has little memory of me without deadlines! Thank you Amy, for putting up with your "grumpy Mum", tolerating me when I completely abandoned even the basics of 'Webster-Stratton' parenting and most of all for just making me smile every day and keeping my feet on the ground!

SECTION 1

**ETHICS PROPOSAL**

**Submission to**

**School of Psychology Research Ethics Committee, UWB**

**1 Title of Project.**

ATTACHMENT STYLES OF STAFF AND PEOPLE IN CARE-HOMES:  
AN INVESTIGATION INTO EFFECTS ON CHALLENGING  
BEHAVIOUR.

**2. Name of Investigator(s)**

TRISH GOATER, CLINICAL PSYCHOLOGIST IN TRAINING, NWCPP  
SUPERVISED BY PROFESSOR BOB WOODS, CLINICAL  
PSYCHOLOGIST

**3. The potential value of addressing this issue**

By understanding the effects of resident and staff attachment styles on the amount of challenging behaviour displayed and perceived, we may better understand how to support and train staff in care-homes working with those who have dementia.

**4. Brief background to the study**

There is an increasing awareness that behavioural disturbance is a common feature of dementia (Stokes, 1996). The most common reason for the hospitalisation or institutionalisation of a person with dementia is challenging

behaviour (Steele, Rovner, Chase & Folstein, 1990, Chenoweth & Spencer, 1986) and thus staff working with such people are likely to experience challenging behaviour as part of their daily work. Traditionally behavioural disturbances were seen as a result of the cognitive abnormalities associated with dementia (Fairburn & Hope, 1988). However Kitwood (1989) argues that 80% of the variance of challenging behaviour of those with moderate to severe dementia is unexplainable by organic pathology and that environmental factors clearly play a role in the symptomatology of dementia. Thus other aetiological explanations must be sought.

Stokes (1996) suggests that “ the neuropathology is inextricably interwoven into the pattern of an individual’s life, history and personality” (page 609) and thus characteristics of the resident’s pre-morbid personality may play a role in the amount of challenging behaviour.

One aspect of pre-morbid personality that has received recent attention is attachment style. Miesen (1992, 1993) argues that the attachment style of residents may be particularly pertinent during mid to late dementia and describes a phenomenon called ‘parent fixation’ where most residents with dementia come to eventually believe that their parents are alive and ask after their whereabouts. Miesen proposes that the increasing feeling of unfamiliarity with surroundings, common to the later stages of dementia may be likened to Ainsworth’s ‘strange situation’ and this may influence the behaviour and distress of the resident.

Magai, Cohen, Culver, Gomberg and Malatesta (1997) demonstrated higher levels of positive affect in those people with dementia whose pre-morbid attachment style was rated as secure by family members. Furthermore a relationship was found between high levels of challenging behaviour and people with dementia whose pre-morbid attachment style was rated as 'avoidant' (Magai & Cohen, 1998). However in this latter study both ratings of challenging behaviour and pre-morbid attachment styles were made by adult children caregivers. It must be borne in mind that the attachment styles of carers and dependents are not necessarily independent and indeed carers whose attachment style are rated as avoidant are more likely to experience higher levels of stress and are more likely to institutionalise their dependent relative (Marciewicz, Reis & Gold, 1997) whereas having a secure attachment style protects against stress and raises the likelihood of continuing to care for one's relative within the community (Crispi, Schiaffino & Berman, 1997).

This evidence would suggest that those entering residential or nursing homes are more likely to have insecure attachment styles and display higher levels of challenging behaviour than those who remain in the community and are cared for by relatives. Thus staff who work in such settings have a workload of significant physical and psychological demands (Nasman, Bucht, Eriksson & Sandman, 1993) and it is estimated that such staff experience stress equivalent to that of professional nurses in the NHS (Moniz-Cook, Millington and Silver, 1997). Furthermore those staff who report the most difficulty in managing challenging behaviour are not the care assistants but those who are qualified (Moniz-Cook, Woods & Gardiner, 2000). A possible explanation for this may

be offered by Kitwood (1997), who argues that although many people may be drawn to care work as it is an easy way of finding employment, those who remain and show dedication to this work may have hidden motives for doing so. He proposes that those whose needs were not adequately addressed in childhood may learn a pattern of behaviour where putting the needs of others first is rewarded. Such behaviour may extend into adulthood and may be expressed in the form of care-giving to others. However Kitwood argues that those with these motives may be more likely to burnout as they find it difficult to define the boundaries of their own needs with other's needs. This is supported by evidence suggesting that those who chose caring professions such as social workers, (Vincent, 1996), clinical psychologists, (Leiper & Casares, 2000), and counselling psychologists (DiCaccavo, 2002), are more likely to have childhoods characterised by emotional neglect and/or insecure attachments. Thus although the evidence suggests that a secure attachment style protects against burnout and difficulty of management, it is also more likely that those who actively chose a job in this area of employment have an insecure attachment.

Adshead (1998) argues that staff may be viewed as attachment figures for residents in psychiatric care. However she proposes that those with avoidant attachment styles may perceive the greatest amount of challenging behaviour as they may be poor at recognising their own emotional needs thus leading to a dismissive attitude towards the needs of others. This may lead them to attribute challenging behaviour to confrontational attitudes rather than an

expression of unfulfilled need. She also argues that such staff will experience higher rates of burnout and negative emotion.

The evidence presented so far indicates that both staff and residents in residential homes are likely to experience difficulties when they have an insecure or avoidant attachment style. Furthermore, given that attachment style plays a significant role in the quality of relationships it is proposed that an interaction between staff and resident attachment styles should be examined. Thus this study aims to investigate the effects of both staff and resident's pre-morbid attachment style on challenging behaviour, perceived difficulty, staff burden and positive perceptions.

## **5. The hypotheses**

There are three hypotheses proposed for this study:

- a) Those residents with a premorbid, avoidant attachment style will demonstrate the greatest amount of challenging behaviour.
- b) Those staff with avoidant attachment styles will perceive the greatest amount of challenging behaviour.
- c) The highest estimations of challenging behaviour will be made by staff with avoidant attachment styles when rating residents with pre-morbid avoidant attachment styles.

## **6. Recruitment of participants**

It is hoped that approximately four homes will take part in this study. It is hoped to recruit between 50 – 80 staff and residents.

The manager of each home will be asked for permission to approach their staff for participation and will be asked to provide the following information.

- a) whether any of the residents with dementia are capable of giving informed consent.
- b) names of next-of-kin relatives of those residents who are either unable to give consent themselves or s who have given informed consent for their relatives to be contacted.
- c) all direct-care staff in each home will then be asked individually for consent to take part.

See section 16 for details on gaining consent.

## **7. Research design and procedures employed**

This study will have three distinct parts.

- The first will examine the effect of resident's pre-morbid attachment style on amount and severity of challenging behaviour engaged in.
- The second will examine the effect of attachment style of staff on their perceptions of challenging behaviour, burden and positive perceptions.
- The third part will examine the interaction between staff and resident attachment styles



## Procedure

1. Relatives of the residents with dementia will be initially contacted by post and informed of the current study. They will be asked to complete the Adult Attachment Questionnaire and it will be explained that the main researcher will phone them after one week for their ratings. If, on telephone contact, they indicate that they would prefer to reply in writing, a stamped-addressed envelope will be sent to their home address.
  
2. Home managers will be asked to provide demographic information on all residents in the residential homes i.e. age, gender, length of stay. The home managers will also be asked to fill in a Clinical Dementia Rating Scale for every resident. When all information about the residents is collected, three from each home will be selected (one with 'secure' attachment, one with 'anxious/ambivalent' attachment and the other with 'avoidant' attachment). These selected residents will be the focus of analysis of interaction between staff and attachment styles.
  
3. Staff in the residential homes, who agree to participate, will be asked to fill in the following questionnaires
  - a) Adult Attachment Questionnaire (AAQ)
  - b) Staff Positive Perceptions (SPP)
  - c) Approaches to Dementia Questionnaire (ADQ)
  - d) Maslach Burnout Inventory (MBI)

- e) They will also be asked to fill in the Challenging Behaviour Scale (CBS) for the residents identified for further analysis.

It is anticipated that each staff member will need approximately 30 minutes to fill in all the questionnaires.

- 4. Finally staff will be asked to rate all of the residents in their home, using the CBS, in groups of 3. It has been demonstrated that group ratings have good inter-rater reliability with individual ratings (Moniz-Cook et al., 2001) and will also reduce the amount of time each staff member spends filling in questionnaires. These measures will enable an analysis of the amount of challenging behaviour displayed in relation to pre-morbid attachment style.

## **8. Measures employed**

The following measures will be used in this research.

- a) Adult Attachment Questionnaire (Hazan & Shaver, 1987)
- b) Staff Positive Perceptions (Horne & Hastings)
- c) Approaches to Dementia Questionnaire (Lintern, 2002)
- c) Maslach Burnout Inventory (Maslach & Jackson, 1981)
- d) Challenging Behaviour Scale (Moniz-Cook, Woods, Gardiner, Silver & Agar, 2001)
- e) Clinical Dementia Rating Scale (Hughes, Berg, Danziger, Coben & Martin, 1982)

All measures can be found in the appendices.

**9. Qualifications of the investigators to use the measures**

The main investigator is a 3<sup>rd</sup> year trainee on the North Wales Clinical Psychology Programme.

**10. Venue for investigation**

Data collection will mostly take place in residential nursing homes. However when collecting data from relatives this will mostly occur via telephone contact and thus participants will be in their own homes.

**11. The duration of the study**

It is hoped that data collection will begin in November 2003 and will be completed by April 2004. The submission date for this project is June 18<sup>th</sup>, 2004.

**12. Data analysis**

To overcome the problem of staff from different homes rating residents who may actually be more difficult, the following steps shall be carried out.

Each of the three matched residents in each home shall have approximately 20 scores of challenging behaviour (1 from each member of staff in the home). The mean and standard deviation of these scores shall be calculated and each staff member's individual score will then be converted to a z score. This will give an indication of

how difficult they find a particular resident to manage compared to other staff members in the same home. As this is a standardised score then scores from all staff members from the four homes may be analysed together.

The following relationships shall be analysed in the following way

Staff attachment style and staff Burnout	ANOVA
Staff attachment style and Staff Positive Perceptions	ANOVA
Staff attachment style and Approaches to Dementia	ANOVA
Staff attachment style and degree of difficulty	ANOVA
Resident attachment style and challenging behaviour	ANOVA
Interaction between staff and resident attachment styles as judged by the degree of difficulty experienced	3 X 3 one way ANOVA

**13. Potential hazards to participants / investigators**

There are no identified hazards to participants or investigators.

**14. Potential offence / distress to participants**

It is possible that some participants may experience mild distress due to taking part in this project. Relatives of those with dementia may feel saddened to consider their relative before they became ill eg. for reasons of loss or due to issues around the way that relative was in an intimate relationship with themselves. Details of possible support groups will be provided and the main investigator will take responsibility to be aware of this possibility and aid relatives in finding the appropriate support if necessary.

Staff members may also find the project mildly distressing as they are being asked to consider how they intimately relate to others and about difficulties encountered in their employment. Therefore a list of potential support groups shall also be made available to the staff (see Appendices). The main investigator will also take responsibility to be aware of this possibility and aid staff members in finding the appropriate support if necessary.

**15. Procedures to ensure confidentiality**

All raw data will be kept in a locked filing cabinet in Neuadd Ardudwy. All participants (staff and relatives) will be assigned a number, known only to the investigator and supervisor. In any reporting of this project participants will be referred to by this number only.

**16. How consent is to be obtained**

Consent from residents

The manager of each home will be asked if there are any residents in the

home that are able to give informed consent for their relatives to be contacted. In the event of any residents being considered able to give consent they will be approached individually by the main investigator who will explain the nature of the project. They will then be asked for permission to approach their next of kin and if they agree they will be asked to sign a consent form (see Appendices).

Consent from next of kin.

The next of kin will be identified for each resident with dementia residing in the targeted nursing homes. These relatives will be contacted by a letter which will explain the nature of the project and what information is required of them. The letter will be accompanied by an information sheet, a copy of the AAQ and details of support groups for relatives of those with dementia. It will be explained that the main investigator will contact them by telephone after a week to ask for their ratings on the AAQ but that they do not have to give this information if they do not wish to do so. Copies of the letters, questionnaire and contacts list can be found in the appendices. As only one piece of information is required from the relative it will be considered that giving this information is equivalent to giving consent.

Consent from staff

Staff will be approached in person by the main investigator and the nature of the project will be explained to them verbally. They will then be given an information sheet, which they will be asked to read and consider carefully. If they then agree to take part in this project they will be asked to sign a consent

form. Copies of the information sheet and consent form can be found in the appendices

**17. Information for participants**

As explained above, information sheets will be provided for all relatives, staff members and those residents that are able to give informed consent. These can be found in the appendices.

**18. Approval of relevant professionals (e.g. GP's, Consultants, Teachers, parents etc.)**

The managers of each home will be approached and approval sought to take part before individual members of staff, residents and relatives are approached.

**19. Payments**

No payments will be made to either participants or organisations at any point during this project.

**20. Equipment required and its availability**

No specialist equipment is needed for this project.

**21. What arrangements you are making to give feedback to participants.**

**The responsibility is yours to provide it, not participants' to request it.**

A summary of the findings will be sent to the four residential homes taking part in the project.



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<sup>1</sup> Unpublished at time of submission to ethics committee. See Section 3 for later publication details.

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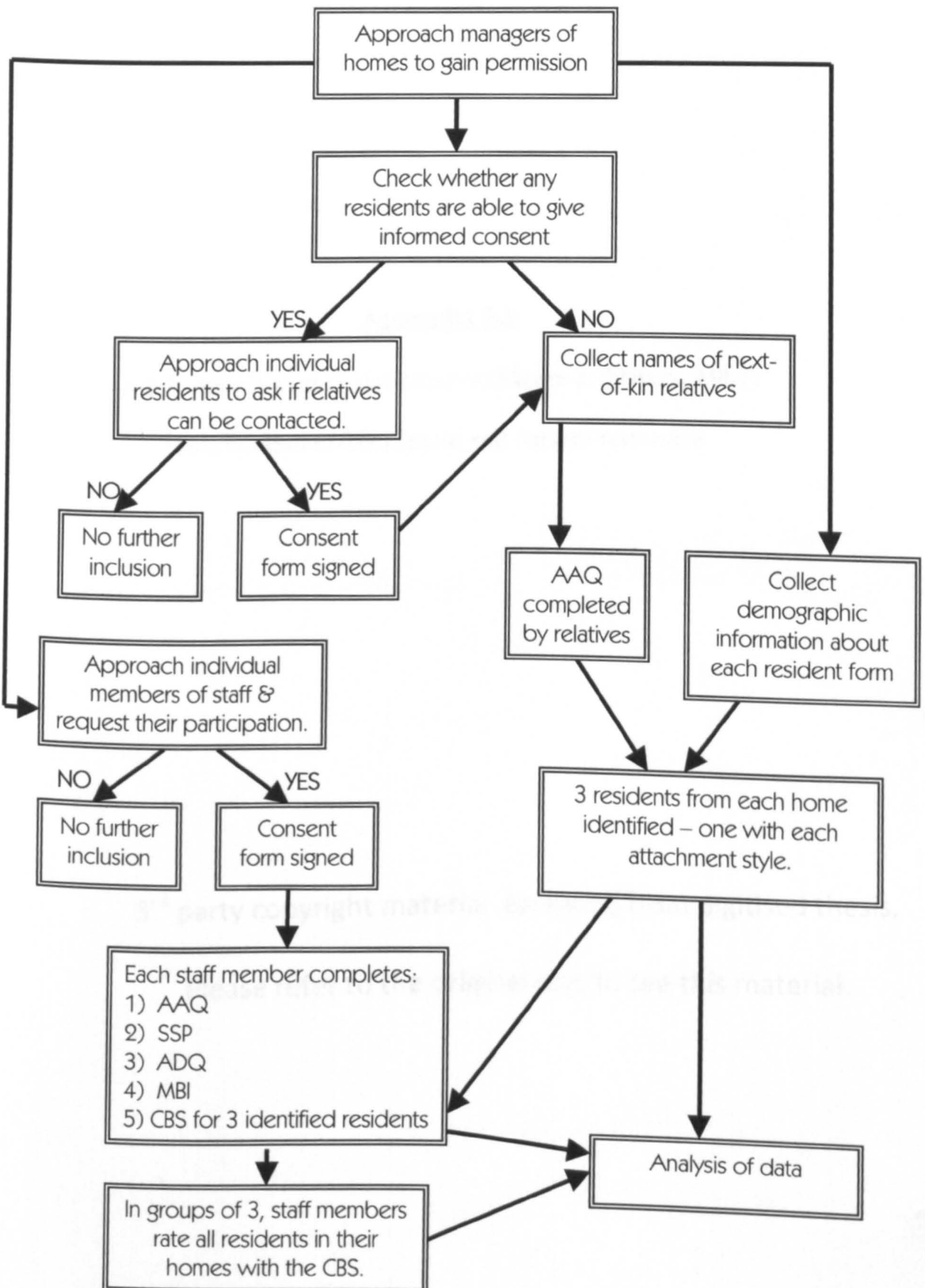
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**Appendix 1.a**

Flow Diagram summarising procedures

## Flow diagram of procedures



**Appendix 1.b**

Adult Attachment Questionnaire (Hazan & Shaver, 1987)

sent to next-of-kins (male and female versions).

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**Appendix 1.c**

Adult Attachment Questionnaire (Hazan & Shaver, 1987)

Staff Version

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**Appendix 1.d**

**Challenging Behaviour Scale**

**(Moniz-Cook, Woods, Gardiner, Silver & Agar, 2001).**

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**Appendix 1.e**

**Staff Positive Perceptions Questionnaire**

**(Hastings & Horne, 2004).**

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**Appendix 1.f**

Approaches to Dementia Questionnaire

(Lintern, 2002).

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**Appendix 1.g**

Maslach Burnout Inventory

(Maslach & Jackson, 1981).

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**Appendix 1.h**

**Clinical Dementia Rating Scale**

**(Hughes, Berg, Danziger, Coben & Martin, 1982).**

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**Appendix 1.i**

Information Sheet for Staff  
(English & Welsh Versions)

(UWB and DSDC logos here)

## **INFORMATION SHEET**

### **Attachment styles of staff and people in care homes: an investigation into effects on challenging behaviour**

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will entail. Please take time to read the following carefully and ask the researchers if you have any other questions.

#### **Background**

Attachment style is a term used to describe our patterns of behaving within relationships. It is generally believed that our early relationships influence our behaviour in all subsequent relationships. We are interested in how the attachment styles of both carers and patients may interact to determine the level of challenging behaviour expressed and perceived.

#### **Why have I been chosen?**

We are hoping to recruit as many staff as possible from the same residential home in order to understand how different staff members may react to the same residents. The residential home in which you work has been chosen to take part in this research.

#### **What will I have to do?**

If you take part you will be asked to fill in a number of questionnaires. Some of these will be about your own feelings and some will be about the residents that you care for. It should take approximately 30 – 45 minutes to complete these questionnaires.

#### **Will my taking part in this study be confidential?**

Yes. All questionnaires will be kept in a locked filing cabinet and will be identifiable by number only. In any public presentation of results, the identity of the individuals involved will always remain anonymous.

#### **Do I have to take part?**

No. It is completely up to you whether you take part or not. If you decide to take part and later decide to withdraw you may do so at any time without giving a reason. Your decision to take part, or not, will not affect you, or the residents in your care, in any way.

#### **What will happen to the results of the study?**

This research is being undertaken as part of the main researcher's requirements for training to become a Clinical Psychologist, at the University of Wales, Bangor. If you have any further questions regarding this study please contact

Trish Goater  
Clinical Psychologist in Training  
NWCPP, School of Psychology  
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or

Professor Bob Woods  
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Any complaints about this project should be addressed to

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Bangor  
LL57 2DG

01248 351151



(UWB and DSDC logos here)

## **TAFLEN WYBODAETH**

### **Arddulliau ymlyniad staff a phobl mewn cartrefi gofal: ymchwiliad i effeithiau ar ymddygiad heriol**

Rydych yn cael eich gwahodd i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu cymryd rhan mae'n bwysig i chi ddeall pam mae'r ymchwil yn cael ei gwneud a beth y bydd yn ei olygu. Cymerwch amser i ddarllen y canlynol yn ofalus os gwelwch dda a holwch yr ymchwilyr os oes gennych unrhyw gwestiynau eraill.

#### **Cefndir**

Term yw arddull ymlyniad a ddefnyddir i ddisgrifio ein patrymau ymddygiad o fewn perthynas. Credir yn gyffredinol bod ein cysylltiadau cynnar â phobl yn dylanwadu ar ein hymddygiad ym mhob perthynas wedi hynny. Mae gennym ddi-ddordeb mewn darganfod sut y gall arddulliau ymlyniad gofaluwr a staff ryngweithio i bennu lefel ymddygiad heriol a fynegir ac a ganfyddir.

#### **Pam rydw i wedi cael fy newis?**

Rydym yn gobeithio recriwtio cymaint o staff â phosibl o'r un cartref preswyl er mwyn deall sut y gall gwahanol aelodau staff ymateb i'r un preswylwyr. Mae'r cartref preswyl yr ydych chi'n gweithio ynddo wedi cael ei ddewis i gymryd rhan yn yr ymchwil hon.

#### **Beth fydd yn rhaid i mi ei wneud?**

Os penderfynwch gymryd rhan gofynnir i chi lenwi nifer o holiaduron. Bydd rhai o'r rhain yn ymwneud â'ch teimladau eich hun a bydd rhai am y preswylwyr rydych yn gofalu amdanynt. Dylai gymryd tua 30 – 45 munud i lenwi'r holiaduron hyn.

#### **Fydd y ffaith fy mod wedi cymryd rhan yn yr astudiaeth hon yn gyfrinachol?**

Bydd. Caiff yr holl holiaduron eu cadw dan glo mewn cwpwrdd ffeilio a rhifau adnabod yn unig fydd amynt. Mewn unrhyw gyflwyniad cyhoeddus o'r canlyniadau, ni ddatgelir pwy oedd yr unigolion a gymerodd ran.

#### **Oes rhaid i mi gymryd rhan?**

Nagoes. Chi'n unig sydd i benderfynu p'run a ydych am gymryd rhan ai peidio. Os penderfynwch gymryd rhan a phenderfynu tynnu'n ôl wedyn, gellwch wneud hynny heb roi rheswm. Ni fydd eich penderfyniad i gymryd rhan, neu i beidio â gwneud hynny, yn effeithio arnoch chi, nac ar y preswylwyr yn eich gofal, mewn unrhyw ffordd.

#### **Beth fydd yn digwydd i ganlyniadau'r astudiaeth?**

Mae'r ymchwil hon yn cael ei gwneud fel rhan o ofynion y prif ymchwilydd i hyfforddi i ddod yn Seicolegydd Clinigol ym Mhrifysgol Cymru, Bangor.

Os oes gennych unrhyw gwestiynau pellach ynglŷn â'r astudiaeth hon, cysylltwch â:

Trish Goater  
Seicolegydd Clinigol dan Hyfforddiant  
NWCPP, Ysgol Seicoleg  
Adeilad Brigantia  
Penrallt  
Bangor  
LL57 2DG

neu

Yr Athro Bob Woods  
Seicolegydd Clinigol  
DSDC, Neuadd Ardudwy  
Safle'r Normal  
Ffordd Caergybi  
Bangor  
LL57 2PY

07780 784869

01248 383719

Dylid cyfeirio unrhyw gwynion am y project hwn at:

Yr Athro C.F. Lowe  
Pennaeth yr Ysgol Seicoleg  
Adeilad Brigantia  
Penrallt  
Bangor  
LL57 2DG

01248 351151

**Appendix 1.j**

Consent Form for Staff

(English & Welsh Versions)

(UWB and DSDC logos here)

## **CONSENT FORM**

### **ATTACHMENT STYLES OF STAFF AND PEOPLE IN CARE HOMES: AN INVESTIGATION INTO EFFECTS ON CHALLENGING BEHAVIOUR.**

- I agree to take part in the named study
  
- I understand that this will involve filling in five questionnaires which will take approximately 30 - 45 minutes.
  
- I understand that my participation in this study is completely voluntary and my decision to take part or not will not affect my job or the residents in my care.
  
- I understand that I am free to withdraw at any time without giving an explanation.
  
- I understand that all information about me will be kept secure and confidential.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_ Date: \_\_\_\_\_

(UWB and DSDC logos here)

## **FFURFLEN GANIATÂD**

### **ARDDULLIAU YMLYNIAD STAFF A PHOBL MEWN CARTREFI GOFAL: YMCHWILIAD I EFFEITHIAU YMDDYGIAD HERIOL.**

- Rwy'n cytuno i gymryd rhan yn yr astudiaeth uchod.
  
- Rwy'n deall y bydd yn golygu llenwi pump holiadur a ddylai gymryd tua 30 - 45 munud.
  
- Rwy'n deall fy mod yn cymryd rhan yn yr astudiaeth hon yn gwbl wirfoddol ac na fydd fy mhenderfyniad i gymryd rhan yn effeithio ar y gofal a gaf mewn unrhyw ffordd.
  
- Rwy'n deall y gallaf dynnu'n ôl unrhyw bryd heb roi eglurhad.
  
- Rwy'n deall y bydd yr holl wybodaeth amdanaf yn cael ei chadw'n ddiogel ac yn gyfrinachol.

Enw'r cyfranogwr: \_\_\_\_\_

Llofnod y cyfranogwr: \_\_\_\_\_ Dyddiad: \_\_\_\_\_

Llofnod yr ymchwilydd: \_\_\_\_\_ Dyddiad: \_\_\_\_\_

**Appendix 1.k**

**Support for Staff Information**

If you have been distressed by this project in any way the following sources of support may be of use.

**RELATE**

An organisation that provides counselling for couples and individuals regarding relationship difficulties.

0845 130 40 10

**Primary Care Counselling Service**  
Access is through your GP.

**Carer's Outreach**  
60 Deiniol Road  
Bangor  
Gwynedd  
LL57 1AA

Tel: 0345 573570

**Alzheimer's Society (North Wales group)**  
Ysbyty Minffordd  
Hendrewen Road  
Bangor  
Gwynedd  
LL57 4DR

[www.alzheimers.org.uk/NWales](http://www.alzheimers.org.uk/NWales)

You may also ask the main investigator to help you access the most appropriate source of support if you wish.

**Appendix 1.1**

Letter to next-of-kin  
(English & Welsh Versions)



(UWB and DSDC logos here)

**MR X**  
**ADDRESS LINE 1**  
**ADDRESS LINE 2**  
**ADDRESS LINE 3**

**DATE**

Dear **MR X**,

**NAME OF** Nursing Home, in which your **RELATION** currently resides has been identified to take part in a research project. The manager of the nursing home, **MR A**, has provided me with your details so that I can ask you for some information about your **RELATION**. All information will be kept completely confidential.

The project is investigating how one aspect of personality, called 'attachment style' influences the care of people in residential and nursing homes. I am hoping that this research will enable us to understand how to better train and support care-staff looking after those in care homes. A full explanation of this can be found in the enclosed 'Information Sheet' and I would ask you to read this carefully before deciding if you are happy to provide me with the information I am requesting.

If you are happy to take part in this project I would like you to read the questionnaire enclosed with this letter. In approximately one week I will phone you to ask if you wish to give me this information. If you do not want to then you can say so with no explanation and I will not contact you anymore. If you are happy to provide me with the answers to the questionnaire then I will take your answers over the telephone. There will be no further contact after this. If you would prefer to answer by letter I can send you a stamped addressed envelope on request.

Please read everything provided with this letter carefully before making any decisions.

I will contact you shortly.

Yours sincerely

Trish Goater  
Clinical Psychologist in Training

(UWB and DSDC logos here)

**MR X**

**ADDRESS LINE 1**

**ADDRESS LNIE 2**

**ADDRESS LINE 3**

**DATE**

**Annwyl MR X**

Mae cartref nyrsio, **NAME OF** lle mae eich **RELATIVE** yn byw ar hyn o bryd wedi cael ei bennu i gymryd rhan mewn project ymchwil. Mae rheolwraig y cartref nyrsio, **MRS A**, wedi rhoi eich manylion i mi fel y gallaf ofyn am beth gwybodaeth am eich **RELATIVE..** Cedwir yr holl wybodaeth yn hollol gyfrinachol.

Mae'r project yn ymchwilio i'r modd y mae un agwedd ar bersonoliaeth, a elwir yn 'arddull ymlyniad', yn dylanwadu ar ofalu am bobl mewn cartrefi nyrsio a phreswyl. Rwy'n gobeithio y gall yr ymchwil hon ein galluogi i ddeall sut i hyfforddi a chefnogi'n well y staff gofal sy'n edrych ar ôl pobl yn y cartrefi gofal hyn. Eglurir y project yn llawn yn y 'Daflen Wybodaeth' amgaeedig a hoffwn i chi ei darllen yn ofalus cyn penderfynu a ydych yn fodlon rhoi'r wybodaeth rwyf ei hangen i mi ai peidio.

Os ydych yn fodlon cymryd rhan yn y project hwn hoffwn i chi ddarllen yr holiadur a amgaeir â'r llythyr hwn. Mewn tuag wythnos fe wnafeich ffonio i ofyn a ydych yn fodlon rhoi'r wybodaeth hon i mi. Os na fyddwch eisiau ei rhoi, gellwch ddweud hynny heb egluro pam ac ni wnafeich gysylltu â chi wedyn. Os ydych yn fodlon rhoi'r atebion i mi yna fe wnafeich eu cymryd dros y ffôn. Ni fyddaf yn cysylltu â chi ar ôl hynny. Os yw'n well gennych ateb trwy lythyr gallaf anfon amlen wedi ei stampio atoch.

Darllenwch bopeth a anfonir gyda'r llythyr hwn yn ofalus, os gwelwch yn dda, cyn i chi benderfynu.

Fe wnafeich gysylltu â chi'n fuan.

Yn gywir,

Trish Goater  
Seicoleg Clinigol dan Hyfforddiant

**Appendix 1.m**

Information Sheet for next-of-kin

(English and Welsh versions).

(UWB and DSDC logos here)

## **INFORMATION SHEET**

### **Attachment styles of staff and people in care homes: an investigation into effects on challenging behaviour**

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will entail. Please take time to read the following carefully and ask the researchers if you have any other questions.

#### **Background**

Attachment style is a term used to describe our patterns of behaving within relationships. It is generally believed that our early relationships influence our behaviour in all subsequent relationships. We are interested in how the attachment styles of both carers and patients may interact to determine the level of challenging behaviour expressed and perceived.

#### **Why have I been chosen?**

We are hoping to collect information about as many different residents as possible from the same residential home in order to understand how different staff members may react to the same residents. The residential home in which your relative lives has been chosen to take part in this research.

#### **What will I have to do?**

If you take part you will be asked to fill in one questionnaire, which will simply be about what your relative was like with regards to close relationships. This should take no more than 5 minutes. You will be contacted by telephone by the main researcher who will ask for your ratings over the telephone. This is the only contact that will be made.

#### **Will my relative have to do anything?**

No. Your relative will play no active role in this study. Your relative's care will be unaffected by this research.

#### **Will my taking part in this study be confidential?**

Yes. All questionnaires will be kept in a locked filing cabinet and will be identifiable by number only. In any public presentation of results, the identity of those individuals involved will always remain anonymous.

#### **Do I have to take part?**

No. It is completely up to you whether you take part or not. If you decide to take part and later decide to withdraw you may do so at any time without giving a reason. Your decision to take part, or not, will not affect the care your relative receives, either now or in the future.

**What will happen to the results of the study?**

This research is being undertaken as part of the main researcher's requirements for training to become a Clinical Psychologist, at the University of Wales, Bangor.

---

If you have any further questions regarding this study please contact

Trish Goater  
Clinical Psychologist in Training  
NWCPP, School of Psychology  
Brigantia Building  
Penrallt  
Bangor  
LL57 2DG

or

Professor Bob Woods  
Clinical Psychologist  
DSDC, Neuadd Ardudwy  
Normal Site  
Holyhead Road  
Bangor  
LL57 2PY

01248 382204

01248 383719

Any complaints about this project should be addressed to

Professor C.F. Lowe  
Head of School of Psychology  
Brigantia Building  
Penrallt  
Bangor  
LL57 2DG

01248 351151

(UWB and DSDC logos here)

## **TAFLEN WYBODAETH**

### **Arddulliau ymlyniad staff a phobl mewn cartrefi gofal: ymchwiliad i effeithiau ar ymddygiad heriol**

Rydych yn cael eich gwahodd i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu cymryd rhan mae'n bwysig i chi ddeall pam mae'r ymchwil yn cael ei gwneud a beth y bydd yn ei olygu. Cymerwch amser i ddarllen y canlynol yn ofalus os gwelwch dda a holwch yr ymchwilyr os oes gennych unrhyw gwestiynau eraill.

#### **Cefndir**

Term yw arddull ymlyniad a ddefnyddir i ddisgrifio ein patrymau ymddygiad o fewn perthynas. Credir yn gyffredinol bod ein cysylltiadau cynnar â phobl yn dylanwadu ar ein hymddygiad ym mhob perthynas wedi hynny. Mae gennym ddi-ddordeb mewn darganfod sut y gall arddulliau ymlyniad gofalwyr a staff ryngweithio i bennu lefel ymddygiad heriol a fynegir ac a ganfyddir.

#### **Pam rydw i wedi cael fy newis?**

Rydym yn gobeithio casglu gwybodaeth am gymaint â phosibl o wahanol breswylwyr o'r un cartref preswyl er mwyn deall sut y gall gwahanol aelodau staff ymateb i'r un preswylwyr. Mae'r cartref preswyl y mae eich perthynas yn byw ynddo wedi cael ei ddewis i gymryd rhan yn yr ymchwil hon.

#### **Beth fydd yn rhaid i mi ei wneud?**

Os penderfynwch gymryd rhan gofynnir i chi lenwi un holiadur a fydd yn gofyn cwestiynau ynglŷn â sut roedd eich perthynas o ran cysylltiadau agos â phobl eraill. Ni ddylai hyn gymryd mwy na 5 munud. Bydd y prif ymchwilydd yn cysylltu â chi dros y ffôn i ofyn am eich sgôr i'r cwestiynau. Dyna'r unig gysylltiad a wneir â chi.

#### **Fydd yn rhaid i'm perthynas wneud unrhyw beth?**

Na fydd. Ni fydd eich perthynas yn cymryd unrhyw ran yn yr astudiaeth hon. Ni fydd yr ymchwil yn effeithio o gwbl ar y gofal y mae eich perthynas yn ei chael.

#### **Fydd y ffaith fy mod wedi cymryd rhan yn yr astudiaeth hon yn gyfrinachol?**

Bydd. Caiff yr holl holiaduron eu cadw dan glo mewn cwpwrdd ffeilio a rhifau adnabod yn unig fydd amynt. Mewn unrhyw gyflwyniad cyhoeddus o'r canlyniadau, ni ddatgelir pwy oedd yr unigolion a gymerodd ran.

#### **Oes rhaid i mi gymryd rhan?**

Nagoes. Chi'n unig sydd i benderfynu p'run a ydych am gymryd rhan ai peidio. Os penderfynwch gymryd rhan a phenderfynu tynnu'n ôl wedyn, gellwch wneud hynny heb roi

rheswm. Ni fydd eich penderfyniad i gymryd rhan, neu i beidio â gwneud hynny, yn effeithio arnoch chi, nac ar y preswylwyr yn eich gofal, mewn unrhyw ffordd.

**Beth fydd yn digwydd i ganlyniadau'r astudiaeth?**

Mae'r ymchwil hon yn cael ei gwneud fel rhan o ofynion y prif ymchwilydd i hyfforddi i ddod yn Seicolegydd Clinigol ym Mhrifysgol Cymru, Bangor.

---

Os oes gennych unrhyw gwestiynau pellach ynglŷn â'r astudiaeth hon, cysylltwch â:

Trish Goater	neu	Yr Athro Bob Woods
Seicolegydd Clinigol dan Hyfforddiant		Seicolegydd Clinigol
NWCPP, Ysgol Seicoleg		DSDC, Neuadd Ardudwy
Adeilad Brigantia		Safle'r Normal
Penrallt		Ffordd Caerdybi
Bangor		Bangor
LL57 2DG		LL57 2PY
01248 382204		01248 383719

Dylid cyfeirio unrhyw gwynion am y project hwn at:

Yr Athro C.F. Lowe  
Pennaeth yr Ysgol Seicoleg  
Adeilad Brigantia  
Penrallt  
Bangor  
LL57 2DG  
01248 351151

**Appendix 1.n**

Support for next-of-kin



If you have been distressed by anything to do with this project the following groups may be able to offer you support.

Carer's Outreach  
60 Deniol Road  
Bangor  
Gwynedd  
LL57 1AA

Tel: 0345 573570

Alzheimer's Society (North Wales group)  
Ysbyty Minffordd  
Hendrewen Road  
Bangor  
Gwynedd  
LL57 4DR

Tel: 01248 353608

[www.alzheimers.org.uk/NWales](http://www.alzheimers.org.uk/NWales)

Primary Care Counselling Service  
Access is through your GP.

You may also ask the main investigator to help you access the most appropriate source of support if you wish.

**Appendix 1.0**

Consent Form for residents  
(English & Welsh versions).

(UWB and DSDC logos here)

## **CONSENT FORM**

### **ATTACHMENT STYLES OF STAFF AND PEOPLE IN CARE HOMES: AN INVESTIGATION INTO EFFECTS ON CHALLENGING BEHAVIOUR.**

- I agree to take part in the named study
  
- I understand that this will involve my next of kin being contacted and being asked about their opinion of how I got on with others when I was younger.
  
- I understand that my participation in this study is completely voluntary and my decision to take part or not will not affect my care in any way.
  
- I understand that I am free to withdraw at any time without giving an explanation.
  
- I understand that all information about me will be kept secure and confidential.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_ Date: \_\_\_\_\_

(UWB and DSDC logos here)

## **FFURFLEN GANIATÂD**

### **ARDDULLIAU YMLYNIAD STAFF A PHOBL MEWN CARTREFI GOFAL: YMCHWILIAD I EFFEITHIAU YMDDYGIAD HERIOL.**

- ❑ Rwy'n cytuno i gymryd rhan yn yr astudiaeth uchod.
  
- ❑ Rwy'n deall y bydd angen cysylltu â'm perthnasau agos ynglŷn â hyn a gofyn eu barn ar sut roeddwn yn cyd-dynnu ag eraill pan oeddwn yn iau.
  
- ❑ Rwy'n deall fy mod yn cymryd rhan yn yr astudiaeth hon yn gwbl wirfoddol ac na fydd fy mhenderfyniad i gymryd rhan yn effeithio ar y gofal a gaf mewn unrhyw ffordd.
  
- ❑ Rwy'n deall y gallaf dynnu'n ôl unrhyw bryd heb roi eglurhad.
  
- ❑ Rwy'n deall y bydd yr holl wybodaeth amdanaf yn cael ei chadw'n ddiogel ac yn gyfrinachol.

Enw'r cyfranogwr: \_\_\_\_\_

Llofnod y cyfranogwr: \_\_\_\_\_ Dyddiad: \_\_\_\_\_

Llofnod yr ymchwilydd: \_\_\_\_\_ Dyddiad: \_\_\_\_\_

**Appendix 1.p**

Cover Sheet for Ethics Proposal indicating approval

University of Wales, Bangor

School of Psychology

Research Ethics Committee  
Proposal cover sheet

Chief investigator/Supervisor: Professor R.T. Woods  
Associate investigator/Student: Patricia Baxter

Brief project title: Attachment styles of staff & residents in care homes .  
Date of submission: 7/11/03

Form used to prepare submission:

- School ethics committee outline
- North Wales Health Authority
- Other (please give details) \_\_\_\_\_

NB. All relevant paperwork (including consent forms and any translations) must be completed before submission to the School's Research Ethics Committee.

Declaration of ethical compliance

*NB. Translations not included. When English versions are approved they will be sent for translation before data collection begins.*

This research project will be carried out in accordance with the guidelines laid down by the British Psychological Society and the procedures determined by the School of Psychology at Bangor. I understand that I am responsible for the ethical conduct of the research. I confirm that I am aware of the requirements of the Data Protection Act and the University's Data Protection Handbook, and that this research will comply with them.

(Chief investigator/supervisor)

Signed: *R.T. Woods*

Date: *3rd November 2003*

(Associate investigator/student)

Signed: *P. Baxter*

Date: *3/11/03*

For School Use Only

Reviewer 1 *Kate Hargreaves* Approved \_\_\_\_\_ (Initials) \_\_\_\_\_ (Date)

Reviewer 2 \_\_\_\_\_ Proposal No. *552*

## SECTION 2

# **LITERATURE REVIEW**

**The contribution of attachment theory to our understanding of the difficulties in  
caring for people with dementia.**

Trish M. Goater

North Wales Clinical Psychology Programme  
School of Psychology, University of Wales, Bangor,  
Gwynedd, UK, LL57 2DG  
Tel: 01248 382205  
e-mail: [p.m.goater@bangor.ac.uk](mailto:p.m.goater@bangor.ac.uk)

Professor Bob T. Woods

Director, Dementia Services Development Centre  
Neuadd Ardudwy, University of Wales, Bangor,  
Gwynedd, UK, LL57 2PW  
Tel: 01248 383719  
e-mail: [b.woods@bangor.ac.uk](mailto:b.woods@bangor.ac.uk)



## **Abstract**

Behavioural disturbance is a well recognised feature of dementia but cannot be fully accounted for by changes in organic pathology. This article reviews the literature concerning the contribution of attachment style to both the degree of challenge people with dementia present, and the difficulty encountered by carers. A general review of attachment theory is presented and its application to dementia discussed. Current research suggests that having a pre-morbid 'avoidant' attachment style may predict later higher levels of challenging behaviour. Attachment theory has also been investigated with relation to the subjective burden and difficulty of management experienced by both family and professional carers of people with dementia, with evidence that secure attachment may protect against burnout and predict the likelihood of continuing to care for ones relative in the community. Methodological weaknesses of research so far are discussed and future research directions are suggested.

**Keywords:** Attachment, Care-giving, Challenging Behaviour, Dementia

## Introduction

It is widely recognised that caring for those with dementia can place great demands on the physical and emotional resources of the carer whether one is a relative (Zarit, Todd & Zarit, 1986) or a member of care-staff (Moniz-Cook, Millington and Silver, 1997). These demands, when experienced by family members, are known as 'care-giver burden' (Zarit et al., 1986). However it is argued that the term 'burden' may place an unwarranted negative connotation on the experience of caring for a relative with dementia. Although demands on relative carers may be experienced as an overwhelming and unwanted experience leading, at worst, to depression and exhaustion (Zarit & Edwards, 1999) it may equally be viewed by others as a rewarding experience (Ingebretsen & Solem, 1998). Staff members in the caring professions may also show wide variations in their response to their role (Moniz-Cook, Woods & Gardiner, 2000).

Family carers are likely to be subjected to difficult and demanding behaviours by those in their care, whilst the responsibility of care may impact on the quality of their own lives (Zarit & Edwards, 1999). For example, a commonly cited reason for the hospitalisation or institutionalisation of a person with dementia is challenging behaviour (Steele, Rovner, Chase & Folstein, 1990, Chenoweth & Spencer, 1986) with commonly identified behavioural problems including physical and verbal aggression, agitation, non-compliance and inappropriate urination (Moniz-Cook, Woods, Gardiner, Silver & Agar, 2001). Thus staff working with such people are also likely to experience challenging behaviour as part of their daily work. However, for a behaviour to be labelled as 'challenging' requires an appraisal by another person.

This may account for the different responses shown by carers to very similar experiences suggest that it is not the objective behaviours and demands that impact on the burden felt, but rather individual appraisals and reactions to this.

Variations in response to the seemingly objective event of developing dementia are also seen in individuals. For example, there is an increasing awareness that behavioural disturbance is a common feature of dementia (Stokes, 1996) and traditionally behavioural disturbances were seen as a result of the cognitive abnormalities associated with dementia (Fairburn & Hope, 1988). However Kitwood (1989) argues that 80% of the variance of challenging behaviour of those with moderate to severe dementia is unexplainable by organic pathology, as demonstrated by post mortem examinations, and thus environmental or psychological factors clearly play a role in the symptomatology of dementia. Other aetiological explanations must therefore be sought.

Stokes (1996) suggests that “ the neuropathology is inextricably interwoven into the pattern of an individual’s life, history and personality” (page 609) and thus characteristics of the patient’s pre-morbid personality may play a role in the amount of behavioural and affective disturbance.

One aspect of pre-morbid personality that has received recent attention is attachment style. Attachment styles have also been implicated in the difficulty, or the rewards, experienced when placed in the caring role. This review examines the literature concerning attachment models, their stability and functions into adult life and the clinical implications with regards to the care of those with dementia.

### Early attachment studies

Drawing from both ethological and psychodynamic theories, and his own observations of children in clinical settings and institutions, Bowlby (1965) proposed that a child needs to experience a loving and nurturing relationship with its mother (or permanent mother substitute) to protect it from later difficulties with relationships and mental health. Bowlby further argued that the provision of this relationship was crucial in the very early years of life and that neglect or deprivation in the first two years could have long-term repercussions, such as affecting an individual's ability to provide adequate parenting themselves. Bowlby proposed that this unique relationship between mother and child, was maintained by an affectional bond and a need to feel secure and safe (1969; 1973) and is demonstrated through behaviour that "results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and / or wiser" (p.292). Bowlby maintained that the goal of such behaviour is to ensure the proximity and availability of the attachment figure which may be used as either a 'secure base' from which to explore the environment or a 'safe haven' to which the infant turns for comfort (Feeney & Noller, 1996).

Bowlby asserted that confidence in the availability of the attachment figure is based on whether the primary attachment figure is responsive to the need for support and protection and whether one judges oneself to be the type of person worthy of being responded to when in need (Feeney & Noller, 1996). Thus attachment style is not seen as an innate characteristic but rather a learned schema based on early experience.

----- Insert Table 1 about here -----

Empirical testing of this theory was carried out by Ainsworth (1979) who first demonstrated the presence of clearly defined attachment styles using the 'Strange Situation' test. Three categories of attachment were identified, based on the behaviour that children demonstrated when the presence of their primary attachment figure was withdrawn. Those whom she classified as 'Secure' showed initial distress at the absence of their mother but were easily soothed by a stranger. However they showed clear preference for their mother on her return. The children delineated as 'Insecurely attached – anxious' showed distress when their mothers left and were not consoled by a stranger. Furthermore the mother's return did not console the infant. The third grouping, 'Insecurely attached – avoidant' showed little anxiety at the absence of their mothers and little preference for her on her return.

Subsequent researchers have proposed a fourth category of attachment behaviour in the 'Strange Situation'. Main and Solomon (1986) identified a group of infants who, at 12 months, demonstrated a disorganized pattern of attachment, although they asserted that infants still showed a 'best fit' onto one of Ainsworth's existing categories. Others (eg. Crittenden, 1992) propose that the disorganized pattern is an alternation between the two existing insecure categories. Mayseless (1996) suggests that a disorganized pattern of attachment may develop when an infant is unable to recognise the conditions under which they can gain proximity to, and approval from, their primary caregiver. However the development of higher cognitive abilities in the disorganized child may allow him / her to understand the conditions needed to gain proximity to the care-giver; eg. by approximately 3 years of age Bowlby (1969) proposes that children are able to understand that their mothers have their own goals

and interests and take these into account (p.368). Thus, at this age, the previously disorganized infant can more confidently predict and control the environment to ensure contact with their mothers. Mayseless asserts that mothers who themselves have unmet attachment needs may direct these towards their child rather than other adults, thus causing a reversal of the attachment relationship. This 'parentified child' may learn to take control of the relationship by either demonstrating extreme compliance or providing care and support to their parents, whilst concurrently deactivating themselves from their own attachment needs. Bowlby (1980) describes the 'compulsive care-giver' as those who learn to derive comfort and security from giving care to others and evidence of compulsive compliance or compulsive care-giving has been demonstrated in children as young as 2½ (Crittenden, 1988).

#### Review of Adult Attachment studies

Hazan and Shaver (1987) first presented empirical data demonstrating that romantic love in adulthood may be viewed as attachment behaviour with attachment styles similar to those identified by Ainsworth being manifested in adult relationships. A subsequent wealth of literature on adult attachment styles has followed with evidence accumulating that the attachment styles developed during years of immaturity remain relatively stable into adulthood, thus supporting Bowlby's earlier predictions that the relationships we have with our very early care-givers would influence all subsequent relationships. Bowlby proposed that the attachment style developed in infancy would serve as an internal working model to both predict the behaviour of important others and influence self-image (1969). However Bowlby also predicted that life events could cause this internal model to be revised although he proposed that changes would be difficult. This may be explained by cognitive models, which maintain

individuals are biased towards noticing information that confirms existing schemas or to interpret this information in a way consistent with these schemas. Thus adult attachment should be viewed as being influenced by the maternal relationship but open to change in the face of particular life-events. There is supporting evidence for this stability: for example, 72% of a middle class sample (Waters, Merrick, Treboux, Crowell & Albersheim, 2000) and 77% of children from 'non-conventional' families (Hamilton, 2000) showed the same attachment categorisation, at the age of 20, as they had in the Ainsworth Strange Situation test at 12 months. However there was little evidence for stability of attachment style in individuals from 'high-risk' families with many transitioning to insecure attachment styles, suggesting that negative life-events may impact negatively on attachment style (Weinfeld, Sroufe and Egeland, 2000).

Further evidence supporting the notion that attachment to parents influences subsequent adult attachments, is presented by Hazan and Zeifman (1994) who demonstrated that a gradual shift from parents to peers, as attachment figures, takes place between the ages of 6 to 17. They suggest that this offers evidence in support of peer attachments arising from an exploration from the parental 'secure base'. They further demonstrated that it takes approximately two years of being in a romantic relationship for that person to take on all aspects of the attachment figure, with those who were in shorter relationships being more likely to show separation protest and secure base functions towards parents, than their partners.

Just as Ainsworth's infants were delineated into particular attachment styles according to clusters of behaviours shown in the 'Strange Situation', so there is evidence that adults with particular attachment styles are identifiable by a tendency to share

common views of the self and others that serve to influence their behaviour in social relationships. Feeney and Noller (1990) reported that those with secure attachment styles rated themselves as generally liked by others, well intentioned, good hearted, dependable, altruistic and interpersonally orientated thus demonstrating that their internal working models of self and others are positive. On the other hand, avoidant individuals are not interpersonally orientated and describe others as untrustworthy. They make minimal social contact, usually attributed to their own lack of confidence. Anxious-ambivalent individuals are also wary about making social contact as they see others as complex and difficult to understand. They also view others and self as having little control over their lives (Feeney & Noller, 1996). Finally those who are identified as 'Disorganized / controlling' may be interpersonally orientated, like 'Anxious / Ambivalent' individuals, but, like 'Avoidant' individuals, may demonstrate a mistrust that others will be available to attend to their needs. This can lead to a deactivation of their own needs and a pattern of 'compulsive care-giving' in order to maintain relationships with others (Mayseless, 1996).

#### Attachment as affect regulation.

Within couples, those who are securely attached only seek their partner's support in times of stress and, in turn, are also able to judge more accurately when to offer support (Simpson, Rholes & Nelligan, 1992). There is evidence that this adaptation to stressful situations may be more generalised: Mikulincer, Florian and Weller (1993) reported that those under severe stress showed different coping styles according to their attachment style. Securely attached individuals turned to others for support whereas avoidant individuals attempted to distance themselves from the situation and anxious-ambivalent individuals focused internally on their emotional responses, often



in a self-critical way. Furthermore, Maysless (1996) reports that at times of stress, 'disorganized / controlling' individuals seek out others to give support to. Thus secure attachment may be viewed as a mediator in responding adaptively to stress whereas insecure styles may elicit maladaptive stress behaviours. Kobak & Sceery (1988) hypothesised that the constant awareness of negative feelings shown by those with anxious-ambivalent individuals may be a behaviour originally learned in order to maintain contact with inconsistent care-givers.

### Attachment and dementia

Miesen (1992, 1993) argues that the attachment style of a person with dementia may be particularly pertinent during mid to late dementia and describes a phenomenon called 'parent fixation' where most people with dementia come to eventually believe that their parents are alive and ask after their whereabouts. Miesen proposes that the increasing feeling of unfamiliarity with surroundings, common to the later stages of dementia may be likened to Ainsworth's 'strange situation' and this may influence the behaviour and distress of the person with dementia. Miesen suggests that requests for parents may be viewed as a reaction to uncertainty and distress rather than a sign of memory impairment. Furthermore attachment behaviours may actually become more exaggerated during dementia; emotional functioning, controlled by deeper brain structures may remain intact whilst inhibitory control associated with higher cognitive functioning is affected by organic damage to the cortex (LeDoux, 1989).

Zarit and Edwards (1999) suggest that confronting a person with dementia, who asks for their mother, with the reality, may increase agitation and the frequency of this

behaviour. This phenomenon is more easily understood when considered in terms of attachment behaviour being invoked by feelings of being in a strange situation.

Anxiety and uncertainty are likely to be increased when confronted with the lack of the attachment figure; however if comfort is offered and the person is encouraged to focus on internal representations of one's mother or memories of attachment events, anxiety should be reduced. Indeed Zarit and Edwards (1999) report that agitation and the frequency of asking for one's mother generally reduces when comfort and opportunities for reminiscence about one's mother are provided.

Magai, Cohen, Culver, Gomberg and Malatesta (1997) demonstrated higher levels of positive affect in those people with dementia whose pre-morbid attachment style was rated as secure by family members. Furthermore a relationship was found between high levels of challenging behaviour and people with dementia whose pre-morbid attachment style was rated as 'avoidant' (Magai & Cohen, 1998). However in this latter study both ratings of challenging behaviour and pre-morbid attachment styles were made by adult children caregivers. Given that those with insecure attachment styles are more likely to have parents with insecure attachment styles, (Maysel, 1996), it is therefore necessary to consider the impact that the attachment style of the carer has on the caring relationship. It is possible that the degree of challenging behaviour expressed and burden perceived by carers could be indicative of the particular attachment history and relationship between the person with dementia and their caregiver. Baldwin and Fehr (1995) suggest that adults may hold multiple attachment schemas, based on varying experiences and thus different attachment orientations may be expressed in different relationships. Moreover Ainsworth (1989) called for more research on the changing attachment relationship as children become

adults and questioned whether the change in the direction of care-giving between parent and child, when the parent becomes impaired through illness or old age, can be healthy.

### Attachment and family carers

Zarit et al., (1986) demonstrated that the subjective burden experienced by carers was not related to the objective burden (eg. the severity of dementia), thus suggesting that the interpretation and personal reaction to the demands placed upon carers is more important than the frequency or intensity with which they actually occur. Given the evidence presented earlier, that adult attachment styles are influential in predicting adaptive affect regulation and ease in relationships with others, it is hardly surprising that the carer's attachment style has been implicated in the difficulty experienced when placed under the demands of the caring role. Cicirelli (1993) compared attachment and feelings of obligation towards mothers in daughter-caregivers. He demonstrated that both factors contributed to the amount of care provided but those who showed high levels of attachment towards their mothers also showed lower levels of subjective burden whereas obligation was associated with higher burden. However this study was limited by measuring only the degree of attachment, or closeness, to one's mother. This was addressed by Carpenter (2001) who investigated the effect of daughter-caregivers' attachment style on practical and emotional care. Those rated as 'secure' were deemed to give greater emotional care to their mothers whereas the amount of practical care was independent of attachment style. This suggests that motives of affection and closeness may impact on the quality of the caring relationship. Furthermore, carers whose attachment style is rated as avoidant are more likely to experience higher levels of stress and are more likely to institutionalise

their dependent relative (Marciewicz, Reis & Gold, 1997) whereas having a secure attachment style protects against stress and raises the likelihood of continuing to care for one's relative within the community (Crispi, Schiaffino & Berman, 1997). It is possible that those with secure attachment styles have wider social networks thus providing the protective factor of support.

Burden is often not relieved when relatives with dementia enter residential care (Crispi et al., 1997) and care-giving behaviours may either contribute to, or alleviate negative emotions and care-giving difficulty (Rankin, Haut and Keefover, 1992). It has been suggested by Ingebretsen and Solem (1998) that attachment theory may offer an explanation for this. They propose that many carers may need to feel elements of 'burden' in order to maintain attachment bonds and thus interventions to remove such burdens must be carefully considered. Indeed providing care for a relative may provide opportunities for emotional closeness and to prepare for the death of the person with dementia (Mullan, 1992). Furthermore, Ingebretsen and Solem suggest that individuals who are losing a spouse or a parent to dementia may be seen as losing their attachment figure. Depending on the attachment style of that person, extreme reactions such as clinging (anxious style) or rejection (avoidant) may be seen. Even those with 'compulsive care-giving' insecure styles, whose personality may seem so well suited to the caring role, may respond with anxiety and depression due to sensing the loss of the person to care for. Alternatively, they devote so much time and energy to the care-giving role that they burnout. However Ingebretsen and Solem (1998) propose that those with secure attachments are more likely to respond in a flexible way, adapting to changes in the relationship, while maintaining the affectional bond between the two.

Given that relatives are often caring for the person that was their primary care-giver it does not seem unreasonable to assume that they may respond with the same emotional reaction to the anticipated loss of the parent as they would have done as children, especially if the attachment style has remained stable.

Murray-Parkes (1991) demonstrated that those with secure attachment styles showed less distress in response to bereavement at 12 and 36 month follow ups. He suggests that “since grief results from the severance of bonds it would be surprising if atypical or pathological grief were not sometimes the consequence of atypical bonds”. This may be equally true of the ‘anticipatory grief’ reported by relatives of those with progressive conditions such as dementia; thus the threat of losing an attachment figure may invoke feelings and behaviours congruent with their attachment style.

Main (1991) demonstrated that those with insecure attachment styles had difficulty in remembering prior attachment experiences, whereas secure individuals experienced more ease with accessing such memories. This may be explained by the view that those with secure attachment styles are able to internally represent the parent when the parent is absent; if such internalisation has not fully occurred in those with insecure attachment styles, the threat of physical loss of the parent is likely to initiate greater negative affect. In the study by Crispi et al. (1997) many carers indicated that it was difficult to visit relatives in residential homes, as they preferred to “try and remember them as they were”. Perhaps this experience is exacerbated if accessing memories of previous attachment experiences with this relative is already difficult.

### Attachment and professional caring

Attachment theory was applied to the work setting by Hazan and Shaver (1990) who demonstrated that avoidant subjects were more likely to use work to avoid social relationships, anxious subjects were more likely to report that difficulties in relationships affected their work whereas secure subjects showed high job satisfaction and were able to maintain a healthy balance between work and relationships with neither impacting on the other.

Evidence presented earlier would suggest that those entering residential or nursing homes are more likely to have insecure attachment styles and display higher levels of challenging behaviour than those who remain in the community and are cared for by relatives. Thus staff who work in such settings have a workload of significant physical and psychological demands (Nasman, Bucht, Eriksson & Sandman, 1993) and it is estimated that such staff experience stress equivalent to that of professional nurses in the NHS (Moniz-Cook et al., 1997). Furthermore, those staff who report the most difficulty in managing challenging behaviour are not the care assistants but those who are qualified (Moniz-Cook et al., 2000). A possible explanation for this may be offered by Kitwood (1997), who argues that although many people may be drawn to care work as it is an easy way of finding employment, those who remain and show dedication to this work may have unconscious motives for doing so. He proposes that those whose needs were not adequately addressed in childhood may learn a pattern of behaviour where putting the needs of others first is rewarded. Such behaviour may extend into adulthood and may be expressed in the form of care-giving to others. However Kitwood argues that those with these motives may be more likely to burnout as they find it difficult to define the boundaries of their own needs with other's needs.

This is supported by evidence suggesting that those who chose to enter the caring professions such as social workers, (Vincent, 1996), clinical psychologists, (Leiper & Casares, 2000), and counselling psychologists (DiCaccavo, 2002), are more likely to have childhoods characterised by emotional neglect and/or insecure attachments. Furthermore the study by Leiper and Casares (2000) offered evidence that those with insecure-anxious attachment styles were more likely to report greater job satisfaction when working with more severely disturbed clients. Thus although the evidence suggests that a secure attachment style protects against burnout and difficulty of management, it is also more likely that those who actively choose a job in this area of employment, or who derive greater job satisfaction working with challenging clients, have an insecure attachment style.

Adshead (1998) argues that staff may be viewed as attachment figures for residents in psychiatric care. However she proposes that those with avoidant attachment styles may perceive the greatest amount of challenging behaviour: she argues that such staff may be poor at recognising their own emotional needs thus leading to a dismissive attitude towards the needs of others. This may lead them to attribute challenging behaviour to confrontational attitudes, and thus as personally directed, rather than an expression of unfulfilled need. She also argues that such staff will experience higher rates of burnout and negative emotion as they are unlikely to seek emotional support from others.

#### Interaction between carer and person with dementia.

The evidence reviewed so far indicates that the personal attributes of the individual with dementia may impact on the well-being of their carers. However the well-being

and understanding of the carers is also likely to impact on the individual with dementia in their care. For example when residents are exposed to a high ratio of carers who allow opportunities for free emotional expression and physical care, they can often regain some of the faculties that were thought to be lost (Kitwood, 1989). Kitwood further argues that the presence of dementia should merely be regarded as setting limits on the functional possibilities of the brain but that a set course of deterioration is far from inevitable. Thus the personal reaction of the individual with dementia and their carers is crucial if a person is to function to their true potential. Kitwood argues that feelings of betrayal and abandonment (pertinent emotions to attachment) may promote neurological changes in the brain; however pleasurable activities, such as a visit by a person to whom they feel close and secure with, may stimulate changes in both the degree and balance of neurotransmitters. This may account for anecdotal reports of people with dementia seeming 'like their old self' at such times. Lyman (1989) argues that many of the behavioural disturbances witnessed in those with dementia are iatrogenic, with prescriptive and controlling environments fostering a sense of dependence and helplessness; in environments that encourage self-determination functioning of those with dementia may improve.

### Conclusion

There is gathering evidence that attachment theory has much to offer in helping us to understand both variations in the presentation of those with dementia and the difficulties faced by family and professional carers. Effective care-giving is a demanding job that requires much more than providing physical and practical support and assistance. Those providing care for people with dementia need to also develop a personal relationship with the dementing person that provides emotional support,



security and sensitivity to the individual needs of those in their care. In the words of Kitwood (1989)

*“Caregiving involves something far more skilled than attempting to adjust the dementing person to our (cognitive) reality; it involves the immensely subtle task of attuning ourselves to his or her (emotional) reality”*

Secure attachment has been demonstrated to promote adaptive strategies for affect regulation and increase the ease with which people are able to register distress and offer support to others. Such attributes are certainly applicable to the role of carer to those with dementia.

The evidence presented so far indicates that people with dementia, family carers, and residential staff are all more likely to experience difficulties or negative affect when they have an anxious or avoidant attachment style. Furthermore, when carers respond negatively to their role this may impact on the person in their care, which may promote iatrogenic symptoms, thus increasing the objective burden that carers experience and further adding to the subjective burden. Given that attachment style plays a significant role in the quality of relationships it is proposed that studies investigating the interaction between care-giver and resident attachment styles should be carried out. Although there is a growing body of research examining separately the contribution of carer attachment styles and the person with dementia, the possibility of an interactive effect has not been examined. For example, Magai and Cohen (1998) demonstrated that care-giver burden was highest when relatives (mostly spouses and children) were caring for those with premorbid insecure attachment

styles. However it seems unlikely that in such close relationships the attachment style of the carer themselves is independent of the person cared for. Furthermore the carer's attachment style may have been a contributory factor towards fostering an environment that reduced or promoted difficult behaviours. The degree of challenging behaviour and burden may also be more indicative of the particular relationship history between carer and person cared for, than due to an enduring attachment 'trait' of the person themselves.

In research examining the interactive effects of relationships between couples, there is evidence that there may exist a 'goodness of fit' between attachment styles, which may serve the needs of individuals involved eg. a woman with an anxious attachment style and an avoidant male may find that each other serves to confirm their beliefs about self and others and, as such, a stable relationship may exist (Feeney & Noller, 1996). Similar investigations of interactive effects between carers and residents may help us to understand which staff are best suited to working with difficult clients, when to consider a residential placement for individuals with dementia being cared for by relatives and how carers (both staff and relatives) may need to be personally supported in order to carry on with this emotionally demanding work.

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**Table 1: Bowlby's three key propositions of Attachment Theory (1973, page 235)**

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1. When an individual is confident that an attachment figure is available whenever he or she desires it, that person is much less prone to either intense or chronic fear than an individual who, for any reason, has no such confidence.

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2. Confidence in the availability of attachment figures, or lack of such confidence, is built up slowly during the years of immaturity (infancy, childhood and adolescence); whatever expectations are developed during those years tend to persist relatively unchanged throughout the rest of life.

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3. The varied expectations of the accessibility and responsiveness of attachment figures that individuals develop during the years of immaturity are tolerably accurate reflections of the experiences those individuals have actually had

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**Appendix 2.a**

Notes for Contributors to '*Dementia*'.



# dementia

The international journal of social research and practice

## NOTES FOR CONTRIBUTORS

1. The aim of the journal is to publish original research or original contributions to the existing literature on social research and dementia. When submitting papers for consideration, please attach a letter confirming that all authors have agreed to the submission, and that the article is not currently being considered for publication by any other paper or electronic journal.
2. Each paper submitted, if considered suitable by the Editors, will be refereed by at least two anonymous referees, and the Editors may recommend revision and re-submission.
3. Length of papers. Brief articles should be up to 3000 words and more substantial articles between 5000 and 8000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length. Please also supply an abstract of 100–150 words, and up to five keywords arranged in alphabetical order.
4. When submitting papers for consideration, please supply a total of three paper copies (containing text and all illustrations). Rejected papers will not be returned to authors. In addition, an electronic version should be sent by email as a Word document.
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SECTION 3

**EMPIRICAL PAPER**

**Attachment Styles of Staff and People in Care-homes: An  
Investigation into the Effect on Challenging Behaviour.**

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**Abstract**

Attachment theory has been implicated in the degree of challenging behaviour that people present during the course of dementia. Evidence so far, suggests that those with pre-morbid 'avoidant' attachment styles show higher levels of challenging behaviour. However, ratings of attachment style and challenging behaviour have invariably been made by one family carer and it is argued that this presents a possible confounding variable, given that the attachment style of the carer, or the attachment relationship between the two could affect both subjective and objective difficulty of management. This study aimed to remove this problem by asking next of kins to rate the attachment style of relatives in residential homes while asking staff to rate challenging behaviour. Staff attachment styles were also assessed and their impact on burnout and positive perceptions of work investigated. Results indicated that there was no relationship between attachment style of residents and the degree of challenge presented. Attachment style of staff was not implicated in perceptions of challenging behaviour but did impact on positive perceptions and burnout. The implications of these findings are discussed, limitations of this study considered and future research directions indicated.

**KEYWORDS:** Attachment, Caregiving, Challenging Behaviour, Dementia



## **Introduction**

There is an increasing awareness that behavioural disturbance is a common feature of dementia (Stokes, 1996) and those who take on the caring role for people with dementia can experience great demands on both their physical and emotional resources (Zarit & Edwards, 1999; Moniz-Cook, Millington & Silver, 1997). A common reason for the hospitalisation or institutionalisation of a person with dementia is challenging behaviour (Steele, Rovner, Chase & Folstein, 1990, Chenoweth & Spencer, 1986) and thus staff working with such people are likely to experience challenging behaviour as part of their daily work. Traditionally behavioural disturbances were seen as a result of the cognitive abnormalities associated with dementia (Fairburn & Hope, 1988). However Kitwood (1989) argues that 80% of the variance of challenging behaviour of those with moderate to severe dementia is unexplainable by organic pathology and that environmental factors clearly play a role in the symptomatology of dementia. Thus other aetiological explanations must be sought.

Stokes (1996) suggests that “the neuropathology is inextricably interwoven into the pattern of an individual’s life, history and personality” (page 609) suggesting that characteristics of the individual’s pre-morbid personality may play a role in the amount of challenging behaviour.

## **Attachment Theory**

One aspect of pre-morbid personality that has received recent attention is attachment style. Beginning with observations of children in clinical settings, and drawing on psychodynamic and ethological theories, Bowlby (1965) proposed that a child needs

to experience a loving and nurturing relationship with its mother (or primary caregiver) to protect it from later difficulties with relationships and mental health.

Bowlby further proposed that this relationship served the dual functions of a 'safe haven' to which the infant turns for comfort and a 'secure base' from which the infant can explore its environment (1969;1973). Empirical data on attachment relationships between mother and child were first presented by Ainsworth (1979) who developed the 'Strange Situation' test and demonstrated the existence of three identifiable clusters of attachment behaviours by infants of 12 – 18 months old in response to the absence, and return, of their mothers. These behavioural patterns of response were felt to represent differentiable 'attachment' styles and were labelled as 'secure', 'insecure-anxious' and 'insecure-avoidant' attachment styles.

Hazan and Shaver (1987) first presented empirical data demonstrating that romantic love in adulthood may be viewed as attachment behaviour with attachment styles similar to those identified by Ainsworth being manifested in adult relationships.

Subsequent research has demonstrated that one's attachment style can have remarkable consistency throughout the life span with between 72 % - 77% of young adults (Waters, Merrick, Treboux, Crowell & Albersheim, 2000; Hamilton, 2000) reporting the same attachment style as they had in the 'Strange Situation' test at 12 months. Thus there is gathering support for Bowlby's (1969) assertion that the attachment relationship between mother and infant would serve to influence all subsequent relationships and act as a working model to predict the behaviour of others and influence self image.

### Attachment Theory and Dementia

Miesen (1992, 1993) argues that the attachment style of an individual may be particularly pertinent during mid to late dementia and describes a phenomenon called Parent Fixation where most people with dementia come to eventually believe that their parents are alive and ask after their whereabouts. Miesen proposes that the increasing feeling of unfamiliarity with surroundings, common to the later stages of dementia may be likened to Ainsworth's 'strange situation' and this may influence the behaviour and distress of the person with dementia. Furthermore attachment behaviours may actually become more exaggerated during dementia; emotional functioning, controlled by deeper brain structures may remain intact whilst inhibitory control, associated with higher cognitive functioning, is affected by organic damage to the cortex (LeDoux, 1989).

Magai, Cohen, Culver, Gomberg and Malatesta (1997) demonstrated higher levels of positive affect in those people with dementia whose pre-morbid attachment style was rated as secure by family members. Furthermore a relationship was found between high levels of challenging behaviour and people with dementia whose pre-morbid attachment style was rated as 'avoidant' (Magai & Cohen, 1998). However a weakness of this latter study is that both ratings of challenging behaviour and pre-morbid attachment styles were made by adult children caregivers. It must be borne in mind that the attachment styles of carers and dependents are not necessarily independent and those with insecure attachment styles are more likely to report mothers with similar attachment behaviours (Mayseless, 1996). Furthermore, the carer's attachment style may contribute to the amount of challenging behaviour and

burden experienced. For example, daughters caring for their mothers with dementia have been shown to report less subjective burden and offer greater levels of emotional support, irrespective of practical support offered, when they report greater levels of attachment to their mothers (Cicirelli, 1993) or have secure attachment styles (Carpenter, 2001). Moreover carers whose attachment style is rated as avoidant are more likely to experience higher levels of stress and are more likely to institutionalise their dependent relative (Marciewicz, Reis & Gold, 1997) whereas having a secure attachment style protects against stress and raises the likelihood of continuing to care for one's relative within the community (Crispi, Schiaffino & Berman, 1997). Baldwin and Fehr (1995) argue that adults may hold multiple attachment models which are derived from varying attachment experiences; thus the amount of challenging behaviour expressed and perceived may be indicative of the particular long-term attachment relationship and history between mother and daughter, rather than a trait of the individual with dementia.

#### Attachment Styles and Care Staff

This evidence would suggest that those entering residential or nursing homes are more likely to have insecure attachment styles and display higher levels of challenging behaviour than those who remain in the community and are cared for by relatives. Thus staff who work in such settings have a workload of significant physical and psychological demands (Nasman, Bucht, Eriksson & Sandman, 1993) and it is estimated that such staff experience stress equivalent to that of professional nurses in the NHS (Moniz-Cook et al., 1997). Furthermore, those staff who report the most difficulty in managing challenging behaviour are not the care assistants but those who are qualified (Moniz-Cook, Woods & Gardiner, 2000). A possible explanation for

this may be offered by Kitwood (1997), who argues that although many people may be drawn to care work as it is an easy way of finding employment, those who remain and show dedication to this work may have hidden motives for doing so. He proposes that those whose needs were not adequately addressed in childhood may learn a pattern of behaviour where putting the needs of others first is rewarded. Such behaviour may extend into adulthood and may be expressed in the form of caregiving to others. However Kitwood argues that those with these motives may be more likely to burnout as they find it difficult to define the boundaries of their own needs with other's needs. This is supported by evidence suggesting that those who chose caring profession such as social workers, (Vincent, 1996), clinical psychologists, (Leiper & Casares, 2000), and counselling psychologists (DiCaccavo, 2002), are more likely to have childhoods characterised by emotional neglect and insecure attachments. Thus although the evidence suggests that a secure attachment style protects against burnout and difficulty of management, it is also more likely that those who actively chose a job in this area of employment have an insecure attachment.

Adshead (1998) argues that psychiatric staff with avoidant attachment styles may perceive the greatest amount of challenging behaviour: she asserts that such staff may be poor at recognising their own emotional needs thus leading to a dismissing attitude towards the needs of others. This may lead them to attribute challenging behaviours to confrontational attitudes, and thus personally directed, rather than an expression of unfulfilled need. She further argues that such staff will experience higher rates of burnout and negative emotion as they are unlikely to seek emotional support from others.

The evidence presented so far indicates that both staff and people with dementia in residential homes are likely to experience difficulties when they have an insecure attachment style. Furthermore, given that attachment style plays a significant role in the quality of relationships it is proposed that the interaction between the carer and resident attachment styles should be examined. Thus this study aimed to investigate the effects of both staff and residents' pre-morbid attachment style on challenging behaviour, perceived difficulty, staff burden and positive perceptions. However in order to address the methodological weakness of earlier studies, where ratings of attachment style and challenging behaviour were made by the same person, here relatives were asked to rate attachment style and staff were asked to rate challenging behaviour. Based on findings of previous studies, it was firstly hypothesised that residents with secure attachment styles would show the least challenging behaviour whereas the highest levels would be demonstrated by residents with avoidant attachment styles. Secondly it was hypothesised that those staff with secure attachment styles would report the least challenging behaviour from those in their care and additionally would gain higher scores on positive attitudes towards their work and lower levels of burnout, whereas staff with avoidant styles would report the highest levels of challenging behaviour and burnout and the lowest scores on positive attitudes. Finally it was hypothesised that a cumulative effect would exist with avoidant staff reporting the highest level of challenging behaviour from those residents rated as avoidant.

## **Method**

### **Sample**

The next-of-kin (NOK) relatives of 84 residents with dementia from 6 nursing homes across North Wales were contacted initially by post. Of these, 67 were able to be contacted by telephone and 3 refused to take part. Thus the final sample of participants offering information regarding the attachment style of their relative was 64. 14 were spouses, 35 were children, 6 were siblings and 9 were other relatives (eg. niece, nephew, cousin). The residents about whom the information was collected ranged in age from 63 to 98 (mean = 84.6, SD = 7.4). Their length of stay in residential care ranged from 2 months to 129 months (mean = 22.8, SD = 23.2).

46 members of staff working in the residential homes voluntarily took part in this study. Demographic information was not provided for two participants. For those whom information was given, 7 were male and 37 female. The average age of the staff members was 35.6 (SD = 14.3) and amount of experience as direct care staff within residential care averaged 75 months (SD = 90). 22 had no relevant qualifications, 16 had taken NVQs related to care-work and 6 were registered nurses. English was the first language for 35 staff participants and 9 were bilingual with Welsh as their first language.

### **Measures**

**Adult Attachment Questionnaire (AAQ).** (Hazan & Shaver, 1987)

This questionnaire was originally a forced choice questionnaire where the respondent is required to indicate which of the described attachment styles (secure, avoidant and anxious) best describes them. Distributions of attachment styles, reported by Hazan

and Shaver (1987) were 56% for 'Secure', 20% for 'Anxious' and 24% for Avoidant. In this study, participants were asked to rate either themselves (staff), or their relative in residential care, on a scale of 1 – 5 for each description, in addition to indicating the attachment style best describing themselves or their relative.

Clinical Dementia Rating Scale (CDR). (Hughes, Berg, Danziger, Coben & Martin, 1982)

This is a 6 item questionnaire which yields a 5 scale rating for dementia ('Healthy', 'Questionable Dementia', 'Mild Dementia', 'Moderate Dementia' and 'Severe Dementia'). Of the residents in this study, 5 were considered to have 'Mild Dementia', 29 to have 'Moderate Dementia' and 30 to have 'Severe Dementia'.

Challenging Behaviour Scale (CBS). (Moniz-Cook, Woods, Gardiner, Silver & Agar, 2001).

The CBS measures the frequency and difficulty of management for 25 identified challenging behaviours and yields final scores of 'Incidence' (Range 0 – 25), 'Frequency', and 'Difficulty' (both ranging from 0 – 100) and a 'Challenge' score (ranging from 0 – 400). Good internal consistency was reported in the development of this scale with Cronbach's Alpha scores ranging from .82 - .87 for the four subscales. In this study, Cronbach's Alpha scores of 0.79, 0.76, 0.71 and 0.82 were gained for the subscales of 'Incidence, Frequency, Difficulty and Challenge' respectively. These results are comparable to those reported by Moniz-Cook et al. (1998) and suggest good internal consistency.



Staff Positive Perceptions Questionnaire (SPP). (Hastings & Horne, 2004)

The SPP is a recently developed 43 item questionnaire aimed at those who work with people who have learning disabilities. In this instance all questions were adapted to refer to working with people who have dementia. It has a total score ranging from 43 to 172, and response options are 'Strongly Disagree', 'Disagree', 'Agree' and 'Strongly Agree'; responses are scored 1 – 4 respectively. Internal consistency, re-test reliability and construct validity of this measure have been reported to be high (Hastings & Horne, 2004). In this study, Cronbach's Alpha was .86 suggesting good internal consistency and thus justifying the adaptation of this questionnaire to those who work with people who have dementia.

Approaches to Dementia Questionnaire (ADQ). (Lintern, 2002)

The ADQ is a 19 item questionnaire that measures positive attitudes towards people with dementia. Each item is scored 1 – 5 with response options being 'Strongly Disagree', 'Disagree', 'Neither Agree nor Disagree', 'Agree' and 'Strongly Agree'. It has a 'Total' score range of 19 – 95. It also yields two sub-scores of 'Hope' and 'Person-centeredness', derived from factor analyses, with ranges of 8 – 40 and 11 – 55 respectively. Internal consistency of the total score and subscales is good, as is its re-test reliability. Its validity has been demonstrated by its prediction of quality of observed care-worker behaviour (Lintern, 2002). Internal consistency in this study was good with 'Hope' and 'Person-Centredness' scales yielding Cronbach's Alpha scores of .61 and .76 respectively.

### Maslach Burnout Inventory. (Maslach & Jackson, 1981)

The MBI is a 22 item questionnaire that assesses three aspects of burnout: emotional exhaustion (EE: range 0 – 36), depersonalisation (DP: range 0 – 30) and reduced personal accomplishment (PA: range 0 – 48). Scores are yielded for each of these subscales; a total score is not calculated. The MBI has been demonstrated to have high internal consistency and re-test reliability (Maslach & Jackson, 1981). Although other measures of burnout have subsequently been developed, which may conceptualise burnout differently, this measure is still the most widely used and was thus selected to enable easy comparison to other research.

### Procedure

#### *Stage One*

Managers of 6 homes across North Wales were approached and asked to identify all residents in their care with a diagnosis of dementia. The NOKs for all residents were then sent information regarding the nature of the research project and an adapted copy of the AAQ (Hazan and Shaver, 1987). NOKs were given a week to decide if they wished to take part before being contacted by telephone by the main researcher when answers to the AAQ were taken. A cut-off point of 1 month after letters were sent was set for collecting the above information, before proceeding to the next stage.

The manager of the home completed the CDR (Hughes et al, 1982) and, with two other members of staff, also completed a CBS (Moniz-Cook, et al., 2001) for each resident.

The relationship between attachment style and the degree of challenge presented was examined using ANOVAs for the forced choice attachment type and Spearman's correlation coefficient for attachment ratings.

### *Stage Two*

Of the 6 participating homes, 4 had residents with each of the adult attachment styles as judged by NOKs. Three residents from each home (those who were considered by relatives to have an attachment profile most strongly representative of each particular attachment style) were identified. When two or more residents had equally representative profiles, one of these was chosen by a means of random selection.

Staff from these four homes were asked to complete the following questionnaires: AAQ, an adapted version of the SPP: (Hastings & Horne, 2004), Approaches to Dementia Questionnaire (ADQ: Lintern, 2002) and the Maslach Burnout Inventory (MBI: Maslach & Jackson, 1981).

On the AAQ, staff members were asked to rate themselves on a scale of 1 – 5 for each description and to also indicate which attachment style best described them.

### *Stage Three*

The relationship between staff member's attachment styles and their individual perceptions of the degree of challenge for the three identified residents was investigated. Staff were asked to individually fill in a CBS for each of the three identified residents in their home. In order to be able to compare staff across homes, the mean score for each resident was calculated, and the raw score for each subscale

of the CBS for every staff member was transformed into a z score. Due to the low numbers of staff with an anxious attachment style ( $n = 2$ ) staff were delineated into 'secure' and 'insecure' groups. These data were then analysed using a 2 X 3 mixed factorial ANOVA.

## Results

### Descriptives

The attachment style of 37 residents (57.8%) was rated as 'Secure' by relatives. 6 (9.4%) were rated as 'Anxious' and 21 (32.8%) were rated as 'Avoidant'. The percentage of those reporting a 'Secure' attachment style is consistent with the figures reported by Hazan and Shaver (1987). However a greater proportion were judged by relatives to be 'Avoidant' and a smaller percentage judged to be 'Anxious'.

Of the staff, 31 (67.4%) rated themselves as 'Secure', 2 (4.3%) rated themselves as 'Anxious' and 13 (28.3%) as 'Avoidant'. Thus there were a greater percentage of those with a secure attachment style and much less with an anxious attachment style, than the distribution reported by Hazan and Shaver (1987).

Negative correlations were found between ratings of residents' secure and anxious attachment and between ratings of secure and avoidant attachment. There was a small significant relationship between anxious and avoidant attachment styles. With regards to staff a different pattern emerged; between secure and anxious ratings and between secure and avoidant ratings there were non-significant correlations. However there was a strong correlation between anxious and avoidant attachment ratings. The figures for these can be seen in Table 1 and are compared with the

patterns of correlation in Hazan and Shaver's (1987) two samples, as reported by Levy and Davis (1988).

----- Insert Table 1 about here -----

Before the main statistical analysis, data was examined for normality using the one sample Kolmogorov-Smirnov test. With regards to resident participants, data on the amount of time spent in the home and severity of dementia was not normally distributed; however, given that participants were living in residential homes, it is unsurprising that dementia ratings were skewed towards the moderate and severe scores. Analysis of data collected on staff showed that time spent as direct care staff to those with dementia and 'DP' scores on the MBI were not normally distributed. For both staff and residents, results of the one sample Kolmogorov-Smirnov test, indicated that ratings on the three attachment styles were not normally distributed. Data were therefore analysed using Spearman's correlations.

### Analysis

#### *Relationship between resident attachment style and challenging behaviour.*

Data on residents were analysed using ANOVAs and Spearman's correlation coefficient. No relationship was found between resident attachment style, or attachment ratings, and consensual staff ratings on the CBS. A summary of the data and findings can be seen in Tables 2, 3 and 4.

----- Insert Tables 2, 3 and 4 about here -----

There was an even distribution of mild, moderate and severe dementia classifications within each attachment style and thus severity of dementia was not considered to be a confounding variable.

----- Insert Table 5 about here -----

*Relationship between staff attachment style and ratings of challenging behaviour.*

As only 2 staff members rated themselves as having an 'Anxious' attachment style, staff were regrouped into 'Secure' and 'Insecure' types. Data on the 'DP' subscale of the MBI was also recoded into those scoring '0' (n = 21) and those scoring 1 or above.

The data collected from staff were analysed using Spearman's correlation. A positive correlation existed only between staff who rated themselves highly on secure attachment (regardless of overall attachment style) and the frequency of challenging behaviour perceived from the securely rated resident ( $\rho = .338$ ,  $p = .023$ ). Given the high number of correlations conducted on this data, the alpha was adjusted to control for chance findings. The p value of .05 was divided by the number of correlations (36) to give a new level of .0014. Once the alpha had been adjusted the significance disappears. No other significant correlations were gained between any aspect of challenging behaviour and either the attachment style of staff members, or the ratings of each attachment style.

*Relationship between staff attachment ratings and attitudes towards work.*

There were no significant differences in ratings between self-reported, forced choice attachment style and measures of positive attitudes and burnout. However positive correlations did exist with ratings of the attachment types. Those who rated themselves highly on anxious and avoidant styles gained higher scores on the SPP. High ratings of avoidant attachment style was significantly associated with high scores on the 'EE' subscale of the MBI.

----- Insert Table 6 about here -----

There was also a positive relationship between SPP and the 'EE' subscale ( $\rho = .325$ ,  $p = .031$ ).

High scores on the 'Person Centred' subscale of the ADQ were correlated with high scores on many subscales of the CBS. The results of these can be seen in Table 7.

----- Insert Table 7 about here -----

However high scores on the ADQ, PC subscale also showed positive correlations with SPP (Pearson's  $r = .412$ ,  $p = .005$ )

*Interaction between staff and resident attachment styles.*

To assess the third hypothesis, that an interactive effect would exist between staff and resident attachment style, the individual staff scores, of 'Secure and 'Insecure' staff, for 'Frequency', 'Difficulty' and 'Challenge' of the CBS for residents were compared

using a 2 X 3 mixed factorial ANOVA. There were no significant results for all analyses. Results can be seen in Table 8.

----- Insert Table 8 about here -----

### Discussion

The results gained in this study did not support earlier studies showing high levels of challenging behaviour in those residents with dementia whose pre-morbid attachment style was avoidant. There was no relationship between either a forced choice measure of attachment style, nor of Likert scale ratings of attachment types, and the amount of challenging behaviour demonstrated by residents in this study. The attachment style of staff members also showed no relationship to the frequency, difficulty or overall challenge of perceived CB. There are several possible explanations for this. Firstly it should be noted that, due to the time constraints of this study, the numbers of staff recruited to this study were low and thus any conclusions are made only tentatively. With regards to the methodology of this study the following may offer explanations for the results gained.

The measure of attachment may not have adequately assessed the attachment style of residents and staff. Correlations between the ratings of the different attachment types showed a different pattern for staff than for Hazan and Shaver's samples (1987) thus suggesting that the sample of staff in this study differed from the normal population. Levy and Davis (1988) reported a near zero correlation between anxious and avoidant ratings. However, in this sample of staff, a high correlation existed between anxious and avoidant ratings, and it is possible that this represents a fourth attachment style.



One original aim of this study was to examine the effect of pre-morbid attachment style on the amount of challenging behaviour expressed by people with dementia whilst removing the confounding variable, in Magai and Cohen's (1998) study, of both attachment and challenging behaviour ratings being made by the same person. Thus this study utilised the same measure of attachment in order to make meaningful comparisons between results. However it is becoming increasingly accepted that an additional 'Disorganized' pattern of attachment exists (Feeney & Noller, 1996), which is identifiable in infants in the 'Strange Situation' test (Main & Solomon, 1986) and has been compared to a 'Fearful-Avoidant' type by Brennan, Shaver and Tobey (1991) in adults. Some researchers maintain that this 'Disorganized' pattern is an alternation between the two existing insecure patterns (eg. Crittenden, 1992) and this may explain the high correlation between the two insecure patterns in our staff group. Furthermore, Bowlby (1980) asserted that this 'Disorganized' group of infants develop into older children and adults who learn to deactivate their own needs whilst deriving comfort and security from giving care to others; he dubbed this group 'Compulsive care-givers'. This assertion is reminiscent of Kitwood's (1997) argument that many people who show commitment to care work do so to fulfil their own emotional needs. It may have therefore been prudent to use a measure of attachment that assessed for this fourth grouping, and, in particular, for evidence of 'compulsive care-giving' traits.

Caution must also be shown with regards to the validity of the resident attachment style. These ratings were made by relatives who are not necessarily aware of the private thoughts and feelings experienced by the resident they are rating.

Furthermore, Baldwin and Fehr (1995) suggest that adults may hold multiple

attachment schemas, which are expressed in the context of different relationships and circumstances. Thus the ratings from NOKs may possibly be indicative of the particular attachment relationship between the two and do not necessarily represent a stable trait of the resident. Indeed one NOK remarked to the main investigator that her mother was now loving and pleasurable to be with for the first time in her life, lending anecdotal evidence to the possibility that attachment style is not necessarily stable or indeed, may not be preserved during the course of dementia.

It is also possible that the CBS did not adequately measure those aspects of challenging behaviour that are more personal to staff members. Whilst the CBS has been demonstrated to have high validity in measuring the objective degree of challenge that an individual presents to services, this questionnaire may not adequately assess individual staff members' reactions to the CB they face. An additional questionnaire assessing more personal reactions, such as attributions about CB may have yielded results more pertinent to attachment style.

To gain sufficient numbers of participants, staff and residents from several homes had to be compared. The conversion of raw scores to z scores was able to partly address the problem of different residents being compared as a representation of a 'secure', 'anxious' or 'avoidant' type. However it cannot be ignored that within this relatively small data set, 4 different residents of each type of attachment style were analysed together and thus a great many characteristics of these residents are likely to be very different. The constraints of this particular study meant it was not possible to 'match' residents on any characteristics other than attachment style. It is also possible that ratings by individual members of staff were influenced by characteristics of the home

in which they worked. In a larger sample it is likely that a degree of matching could take place and additionally the comparison of a larger sample of those with the same attachment style, and a greater number of participating homes, would reduce the effect of extraneous variables.

Finally, the lack of any relationship between the attachment style of resident or staff, and CB may simply be due to the removal of the confounding variable present in previous studies, eg. ratings of attachment and CB being made by the same person. This would support Baldwin and Fehr's (1995) assertion, that multiple attachment schemas may exist within an adult, based on varying attachment experiences; thus earlier studies may reflect a long term attachment history between family and carers which is not necessarily reflected as an enduring trait, across all contexts, in the individual with dementia.

Although there was no significant correlation between high ratings of secure attachment and low scores on the MBI, a significant positive correlation between high MBI, EE scores and high ratings on 'Avoidant' attachment types, (and a non-significant trend for high ratings of 'Anxious' attachment to correlate with high MBI, EE) does support the hypothesis that secure attachment protects against aspects of burnout. However the hypothesis that those with 'Secure' attachments would show greater positive attitudes towards their work was not supported. Those staff with high 'Anxious' and 'Avoidant' ratings also showed higher ratings on the SPP. High scores on the MBI, EE and SPP were also related. Thus, staff who are more insecurely attached also show more signs of burnout whilst concurrently deriving greater pleasure from their work. Again this pattern is reminiscent of the 'compulsive care-giving' style described by Bowlby (1980) and this is supported by Mayseless (1996)

who reports that at the very times when those with this 'compulsive care-giving' attachment style feel under stress they seek out others to care for in order to gain feelings of security and comfort.

The finding that those who scored highly on the ADQ, PC subscale also perceived the greatest levels of CB from 'Secure' and 'Anxious' residents would at first seem counter-intuitive. However, as discussed previously, the CBS does not directly measure personal reactions to CB and it may thus be that those who are high in 'Person-centeredness' may be those who are more sensitive at noticing behaviours in others that require attention. It is possible that those high in 'Person-Centeredness' do not experience negative emotions due to the CB they perceive and the absence of a measure to assess this is a limitation of the present study. However this does not explain why those scoring high on the ADQ, PC should not notice CB in 'Avoidant' residents. Further investigation of the relationship between 'Person-Centeredness' and perceptions of CB is warranted.

In order to address some of the issues raised by this study the following research directions are suggested.

It is suggested that the data obtained in this study offers tentative evidence for a significant presence of those with the fourth 'Disorganized' attachment style, which may include those with compulsive care-giving styles. Further research should therefore investigate the attachment styles of staff in residential homes, utilising a measure based on the four-group model of attachment. This would allow the distribution of the four attachment types to be examined and, in particular, whether

the 'Disorganized' attachment style is more prevalent among care staff than in a normal population. It is possible that measuring this fourth category of attachment style would yield different results in terms of whether attachment style has any impact on the amount of challenging behaviour perceived by care-staff.

Further research should also use an additional measure of challenging behaviour, which would estimate the personal impact on the staff member. The CBS does not measure constructs such as whether the challenging behaviour is believed to be personally directed, for example; such an attribution could greatly affect a staff member's ability to cope emotionally with their job over time and could lead to higher scores on burnout measures whilst having no effect on more objective measures of challenging behaviour.

Finally it is suggested that there is a need for longitudinal research in this area. With the increasing trend for memory clinics to be available, thus diagnosing those with dementia at earlier stages, it may be possible for participants to be recruited while still in early stages of dementia. Such participants would be able to report on their own attachment styles thus removing the potential problem of attachment style being inaccurately reported by someone else. Participants could also be followed up whilst being initially cared for by both relatives and later by paid carers in residential settings. This would allow an examination of whether the degree of challenging behaviour was the same across settings or changed in different situations and whether challenging behaviour was associated with attachment style of the person with dementia or carer in either setting. Such data could also possibly provide evidence towards understanding whether attachment style is a stable and enduring trait within

the individual with dementia or whether attachment style is contextually based on current relationships.

### Conclusion

This present study did not support the finding of earlier studies, namely that pre-morbid attachment style in residents can predict the amount of challenging behaviour expressed during the course of their condition. Limitations of the present study include a measure of attachment based on the three-group model and a measure of challenging behaviour that does not directly measure the personal impact of the behaviour on the person rating. However the limitation of previous studies, where ratings of attachment style and challenging behaviour were made by the same person, was addressed and thus it is possible that different results were gained as a result of this. Further research, as discussed above, is needed to address the limitations of this study.

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Table 1: Correlation of ratings between three attachment types

Correlation between ratings		Residents	Staff	Hazan & Shaver's (1987) samples
Secure & Anxious	Correlation =	-.41	.150	-.14 / -.12
	p =	.001**	.326	
Secure & Avoidant	Correlation =	-.767	-.272	-.66 / -.53
	p =	.000**	.070	
Anxious & Avoidant	Correlation =	.268	.459	.10 / .04
	p =	.032*	.002**	

\* = Significant at .05 level

\*\* = Significant at .01 level

*Note: Spearman's correlation used for this study but it is not clear what method of analysis was used for Hazan & Shaver's sample.*

Table 2: Resident attachment style and scores on the subscales of the CBS.

		<i>Challenging Behaviour Scale</i>			
		Incidence	Frequency	Difficulty	Challenge
Secure N = 37	Mean	10.94	30.00	19.19	58.78
	SD	4.67	14.54	12.07	41.20
Anxious N = 6	Mean	7.20	17.20	10.40	28.40
	SD	3.70	10.31	6.73	25.75
Avoidant N = 21	Mean	11.40	30.50	20.25	59.45
	SD	5.39	13.87	10.70	32.36

Table 3: Results of ANOVA investigating relationship between forced choice attachment style and scores on CBS.

CBS subscale	F	p
Incidence	1.540	.223
Frequency	2.024	.141
Difficulty	1.557	.219
Challenge	1.495	.233

Table 4: Results of correlations between ratings of attachment types and CBS subscales.

Resident Attachment Style		Incidence	<i>Challenging Behaviour Scale</i>		
			Frequency	Difficulty	Challenge
Secure	rho	.007	.038	.006	-.014
	p	.960	.773	.963	.915
Anxious	rho	-.171	-.200	-.204	-.224
	p	.187	.125	.115	.082
Avoidant	rho	.048	.052	.085	.099
	p	.711	.691	.516	.449



Table 5: Numbers of each classification of dementia severity within each resident attachment style.

Resident Attachment	<i>Clinical Dementia Rating Scale</i>		
	Mild	Moderate	Severe
Secure	4	17	16
Anxious	0	2	4
Avoidant	1	10	10

Table 6: Correlations of staff attachment ratings with SPP and MBI, EE.

Ratings of Staff Attachment Type		SPP	MBI, EE
Secure	Spearman's rho =	.083	.139
	p =	.590	.370
Anxious	Spearman's rho =	.305	.267
	p =	.044*	.080
Avoidant	Spearman's rho =	.322	.307
	p =	.031*	.040*

\* = Significant at .05 level

Table 7: Correlations between individual staff ratings of the CBS and scores on the ADQ, PC.

Attachment style of Resident	Subscale of CBS	Correlations with staff scores on ADQ, PC	
		<i>Correlation</i>	<i>p</i>
Secure	Frequency	.449	.002**
	Difficulty	.213	.156
	Challenge	.257	.084
Anxious	Frequency	.363	.013*
	Difficulty	.455	.001**
	Challenge	.385	.008**
Avoidant	Frequency	.219	.143
	Difficulty	.234	.118
	Challenge	.185	.220

\* = significant at .05 level

\*\* = significant at .01 level

Table 8: Scores of 2 X 3 mixed factorial ANOVA.

		<i>Subscale of CBS</i>		
		Frequency	Difficulty	Challenge
Staff Attachment style	F	.126	.129	.010
(Secure vs. Insecure)	p	.724	.721	.921
Resident Attachment style	F	.003	.205	.282
(Secure vs Anxious vs Avoidant)	p	.956	.653	.598
Staff Attachment X	F	.339	.013	.344
Resident Attachment	p	.564	.909	.560

**Appendix 3.a**

Notes for Contributors to '*Attachment & Human Development*'



Product Search

All Products



## Journals Listing

Alphabetical Listing

Journals by Subject

## Resources

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## Call For Papers:

**Attachment & Human Development** welcomes papers outlined in the aims and scope. The main areas of focus are:

**Research papers** - incorporating an attachment perspective, based on clinical or non-clinical populations in humans, or in other animals where results have clear implications for human development.

**Reports of clinical work** - involving assessment, treatment or outcome based on an attachment framework. Contributions based on group data or single-cases are welcome.

**Theoretical papers** - advancing the understanding of human development and attachment processes in terms of one or more diverse perspectives including psychology, psychiatry, should psychotherapy, ethology, anthropology, sociology, history, physical health and social policy.

All papers are rigorously reviewed double-blind by an international panel of research scholars to ensure that their quality matches the high standards of the journal. If authors are submitting a paper that has previously been rejected by another journal, the submission should include these earlier reviews and an account of how they have been dealt with.

Authors should submit three complete copies of their text, tables and figures, with any original illustrations to:

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SECTION 4

**CONTRIBUTIONS TO**  
**THEORY, CLINICAL**  
**PRACTICE & LEARNING.**

**CONTRIBUTIONS TO THEORY, CLINICAL PRACTICE**  
**AND LEARNING.**

**Implications for future research and theory development**

The findings generated by this study were not those expected, given the existing literature within this area. Previous researchers, such as Magai and Cohen (1998) had demonstrated a clear relationship between those with 'avoidant' attachment styles and high levels of challenging behaviour. However in their study, both ratings of attachment and challenging behaviour were made by the same person (a family carer). It was felt by the present author that this was a major methodological weakness, given that there exists a debate about the stability of attachment and whether attachment styles represent an enduring and stable trait within an individual, are indicative of the quality of a particular relationship or whether adults can actually hold multiple attachment schemas due to a variety of relationship experiences (Baldwin & Fehr, 1995; Feeney & Noller, 1996). Thus this study utilised the same measure of attachment as Magai and Cohen, which was rated by a family member, whilst the measure of challenging behaviour was rated separately by paid, residential carers. This difference in methodology may therefore, be one explanation for the absence of any significant relationship between challenging behaviour and attachment style in the present study. Thus the main contribution of this study has been to demonstrate that currently accepted associations between pre-morbid attachment style and subsequent challenging behaviour during the course of dementia, may not actually exist when the means of measurement are changed. These findings suggest that previous research may have measured attachment style and challenging behaviour in the context of one particular, long-standing relationship, but has not necessarily demonstrated the



existence of attachment style predicting challenging behaviour across the context of additional relationships. Of course, this is only one study which has small numbers of participants and, as discussed in the previous section, has its own methodological weaknesses such as an unsatisfactory measure of attachment and a measure of challenging behaviour that does not investigate the personal meaning to the person rating. It is therefore suggested that further research, using a similar design, but utilising different measures of challenging behaviour and attachment, is warranted. Further investigation of the relationship between attachment style and challenging behaviour, may address the issue of whether attachment style is a 'trait' or 'context-based' schema.

A further contribution to knowledge, offered by this study, is to demonstrate that those staff who rated themselves highly on both 'insecure' types of attachment also scored highly on both the 'emotional exhaustion' subscale of the Maslach Burnout Inventory and positive perceptions of care-work. This finding, which at first would seem counter-intuitive, is explicable within an attachment framework. Those with 'compulsive care-giving' traits, often found in those with a 'Disorganized' attachment style (Bowlby, 1980) are reported to seek out others to care for when they are under stress (Mayseless, 1996). It is suggested that this finding has important implications for clinical practice and is discussed further in the next section. What is unclear from this study is exactly how much the positive perceptions staff have of their work might act as a buffer against the more negative demands of care-work. There is a need for future research to investigate this relationship more. Qualitative means of analysis may identify how staff deal with these conflicting feelings. A longitudinal design, tracking individual staff members over the period of a year or two, repeating

measurements of burnout and positive perceptions at regular intervals may also help us to understand whether changes in one construct have any impact on the other.

The measure of attachment used in this particular study was chosen for two reasons. Firstly, as a major focus of this study was to attempt to replicate the results of Magai and Cohen (1998) with ratings of attachment and challenging behaviour being made by separate informants for the first time, it was felt that changing the measure of attachment as well would make any comparison of the results difficult. Additionally the Adult Attachment Questionnaire (Hazan & Shaver, 1987) is a very quick measure to use and it was considered unrealistic to utilise a more detailed measure of attachment when it was already estimated that each staff member would need approximately half an hour to fill in all the questionnaires. However, in hindsight, a measure of attachment based on the 'four group' model of attachment would have been prudent. Bartholomew (1990) proposed that four attachment styles could be identified by using Bowlby's (1969;1973) assertion that attachment style represented internal working models about self and other. Bartholomew (1990) proposed that these models of self and other could each be divided into negative and positive, thus yielding four attachment groups. Bartholomew proposes that the 'Preoccupied' style is analogous to Hazan and Shaver's (1987) category of 'Anxious', 'Dismissing' is analogous to 'Avoidant' and 'Fearful' is analogous to Main & Solomon's (1986) 'Disorganized / Controlling' type. Bartholomew and Horowitz (1991) subsequently developed four attachment descriptions which can be used in questionnaire format in exactly the same way as Hazan and Shaver's descriptions (for further details of the four-group model and descriptions, see Appendix 4.a). The use of this questionnaire

would allow measurement of this fourth category of attachment whilst being almost as quick to use as Hazan and Shaver's measure.

The validity of asking NOKs to rate their relative's pre-morbid attachment style should also be questioned. Firstly, it was apparent that a great many of the NOKs spoken to experienced great difficulty with this task and often reported that they were simply making their 'best guess'. Secondly there exists evidence from longitudinal research that even when rating self attachment style, people are more likely to 'recall' current attachment status (Kirkpatrick and Hazan, 1994). This evidence casts doubt on the ability of NOKs to accurately recall pre-morbid attachment styles of their relatives.

The small sample size of this study does generate some difficulties in making conclusions from the results gained. For example the conversion of raw scores to z scores was able to partly address the problem of different residents being compared as a representation of a 'secure', 'anxious' or 'avoidant' type. Were there a larger number of participating homes, with perhaps 20 or more residents of each type being compared across as many participating homes, the effect of possible extraneous variables be reduced enough to be more confident that the results gained indicated particular trends with relation to attachment style. However, in this study, only 4 residents of each type were rated and the impact of extraneous variables such as the characteristics of the home in which they reside, other aspects of personality and experience etc. cannot be ignored.

Although non-significant, there was a trend for those residents with 'anxious' attachment styles to show less challenging behaviour. However given the small sample size (only 5 residents with this style) this trend is noteworthy and warrants further investigation.

With regards to the weaknesses in methodology encountered in this study the future research design is suggested.

The utilisation of a longitudinal study may address some of the questions raised by this research. The difficulty of asking a relative to rate attachment style could be addressed by recruiting participants who present at memory clinics with early signs of dementia. These participants would be able to rate their own attachment style and it is suggested that a questionnaire based on the four group model of attachment be used. It would also be interesting to ask relatives to rate attachment for the person with dementia, thus allowing an investigation into the accuracy of relative ratings. Asking NOKs to re-rate their relative at different stages of dementia would also demonstrate how stable such ratings are or whether they are affected by changes in the current relationship. It is further proposed that challenging behaviour be measured at regular intervals. Although an objective measure of challenging behaviour, such as the CBS, used in this study, should be used, an additional measure of attitudes towards the challenging behaviour should be considered, such as an adapted version of the Attributions Style Questionnaire used in learning disabilities research (eg, Noone, Jones & Hastings, 2003). It is possible that the attachment style of the carer was not related to objective measures of challenging behaviour but subjective constructs such as attributions could show relationships to attachment style, burden and burnout.

Finally a longitudinal design could track changes in challenging behaviour and attachment behaviours during any transitions from being cared for in the community to residential care, thus further addressing the question of stability of attachment as a trait within an individual, or whether attachment may be more contextually based on a particular relationship.

It is also suggested that qualitative research may make a valuable contribution to our understanding of the difficulties encountered by relative carers and the stability of personality during the course of dementia. It was striking while talking to relatives on the telephone that many were able to give coherent and articulate accounts of their relative's history and show great understanding of why they may express particular behaviours as a consequence. This caused the researcher to consider whether this kind of understanding contributed to ease of care or different attributions towards difficult to manage behaviours. There were also several relatives who reported extreme changes of personality during the course of dementia. One daughter, whose mother was one of the 'avoidant' residents rated by staff in stage two of this project commented that "she has been cold and hard all her life but now she's really loving. She's a pleasure to be with for the first time in her life". Such comments cast doubt on whether attachment behaviours show stability across the life-span and during dementia.

### **Implications for clinical practice**

The absence of any significant relationship between resident attachment style and challenging behaviour, in this study, would at first suggest that there would be little

scope for integrating this into clinical practice. However, within the literature on challenging behaviour in learning disabilities, there exists evidence that staff rarely make their own, unbiased opinions about those in their care but are easily influenced by the informal opinions passed on by others. Noone, Jones and Hastings (2003) demonstrated that staff members' attributions of an incident could be influenced by manipulating information given to them before witnessing the incident. Participants watched an identical video clip of an episode of challenging behaviour but made different attributions depending on previous information. This demonstrates the potential influence of receiving informal information about a person on staff's individual appraisals of challenging behaviour. Given that the present study offers preliminary evidence for the relationship between challenging behaviour and attachment style, to not necessarily show stability across all contexts, it would be important to alert staff to this finding. Should staff be influenced by the informal reports of family carers, prior to the person with dementia residing in a particular home, one can imagine a scenario where staff hold negative views about a resident's behaviour which may not necessarily apply to the residential setting. However these negative views could influence the new relationship between staff carers and resident. Thus making staff aware that previous reports of challenging behaviour may not necessarily show stability into a new setting, could encourage staff to respond to the resident in a more appropriate and individualised way.

This study also identifies the support of care-staff as a potential area for intervention. The finding of positive correlations between ratings of the 'insecure' attachment styles, emotional exhaustion and positive perceptions, could indicate that there are a number of staff who could be demonstrating 'compulsive care-giving' tendencies.

That is, they deal with stress by actively seeking out others to care for and such care-giving behaviours are likely to result in feelings of security and comfort. However there is a danger that this strategy of dealing with stress may not be adaptive.

Ingebretsen and Solem (1998) report that family caregivers with compulsive care-giving styles often cope maladaptively by devoting so much time and energy into the caring role that they push themselves to physical exhaustion, withdraw from social networks (in order to devote more time to caring) and may react with feelings of anger and rejection if their efforts are not appreciated. It does not seem unreasonable to expect that staff carers may experience similar reactions.

It is possible that these findings may also be applicable to other 'professional carers'. For example, Leiper and Casares (2000) investigated the attachment style of clinical psychologists and similarly found that there were high rates of 'secure' participants when utilising Hazan and Shaver's (1987) three group forced choice measure of attachment, but also suggested that their data offered evidence of a high rate of 'compulsive caregivers'. Insecurely attached psychologists were also reported to derive greater rewards when working with more challenging clients, supported by the finding in this study that those perceiving the most stress, also derive the greatest positive perceptions of their work. Leiper and Casares (2000) suggest that these findings are applicable to all caring professionals and call for further research into the attachment organisation of those who seek such employment. Furthermore, they suggest that as those with insecure attachment styles appear to be suited to working with difficult clients, finding ways to enable them to maintain this role could be important. This may be equally true of those staff investigated in this study. As those with 'avoidant' or 'compulsive care-giving' styles are unlikely to recognise their own emotional needs, a possible implication of these findings would be to ensure that

management practices are structured to offer more proactive means of support, such as regular meetings akin to the supervision that currently benefit professions such as psychology and nursing. Awareness of these personal motivations to pursue employment as care-staff could also be built into current training practices, with advice given on how to manage stress and anxiety more adaptively.

### Personal issues arising from this study

#### Motivations for this study

My mother has worked as a care-assistant in a residential nursing home for 13 years and has often recounted stories of the residents in her care whom she describes as 'showing spirit'. She has always demonstrated an ability to understand the motivations for the behaviours of those that she cares for and above all, her attitude has always been one of admiration for those residents that she believes to be making positive attempts to communicate their needs and desires. Years later, when I began working with 'learning disabilities' and 'older adults' psychological services I realised that those 'spirited, communicative' behaviours described to me by my Mum were actually labelled as 'challenging behaviours' by most professionals. Thus an interest began in how individual staff members react to the difficult behaviours by those that they care for and how these emotions and attributions may impact on the care they are able to give.

This interest was subsequently fostered by clinical work with many clients who presented with 'challenging behaviour' but where intervention with the carers was often the most appropriate course of action. Thus I approached Bob Woods, with a vague idea of investigating staff attitudes towards the challenging behaviour of those



with dementia, who referred me to the paper by Magai and Cohen (1998). An initial reading of this paper raised for me the confounding variable of the same person rating both challenging behaviour and attachment. Previous clinical work had demonstrated to me that the way family members approached their caring responsibilities were often influenced by their individual personalities and the long-standing relationship history between themselves and the person cared for. Thus it struck me that ratings of challenging behaviour were not necessarily valid, objective ratings but may reflect the subjective burden perceived by the carer. Furthermore, ratings of attachment were likely to be influenced by the current relationship difficulties. In considering how to address this issue while combining my interest in the attitudes of staff towards challenging behaviour, the current study was conceived.

### **Process Issues arising from this study**

#### **Practical difficulties encountered.**

Recruitment was the biggest obstacle to this project. The design of this project meant that I needed to recruit homes to the project with a large enough sample of people with dementia to make it likely that each of the three attachment styles would be represented among the residents. Thus I aimed for homes where there were at least 10 residents with dementia. Seven homes agreed to take part in this study; however the first two homes recruited had relatively small samples and when all potential information was received from next-of-kin relatives only 8 were identified from one and 6 from another, none of which were rated as having an anxious attachment style. As stage 2 of this project required that staff rated the challenging behaviour of three residents, one with each attachment style, these homes were unable to take part in further data collection, although this data was used in stage one of this study. As one

of the homes that later agreed to take part, could only identify 6 residents with dementia it was decided to not recruit this home to the study due to the low likelihood of all attachment styles being represented in the sample. Eventually 4 homes were recruited with large enough numbers of residents with dementia, that it was possible to identify residents with each of the attachment styles in each home.

The reduction from 7 to 4 homes for participation in Stage 2 meant that the numbers of staff available for recruitment were now lower than anticipated. The managers of three homes were sympathetic to this predicament and allowed staff to complete all the questionnaires in work time, thus adding to their motivation to take part. However in a fourth home, this stage of analysis coincided with the manager going on long-term leave and the assistant manager needing to prepare for an up and coming inspection. The numbers of staff recruited from, what was potentially, the largest of all the participating homes were therefore small.

### Contact with relatives

The first, and possibly the most personally challenging, aspect to this research was to contact next-of-kin relatives to gain information about the attachment style of the residents. A letter, information sheet and Adult Attachment Questionnaire (AAQ; Hazan & Shaver, 1987) were sent to each relative explaining the nature of the study and that the main researcher would contact them after 1 week to ask for their answers to the AAQ. It was anticipated that each telephone contact would take between 5 – 10 minutes; in reality the majority of phone calls lasted at least 20 minutes and many longer. Although some calls lasted longer due to relatives wanting further information about the study before agreeing to take part, most calls were long due to

the relative seeming to enjoy discussing their experiences and memories of their relative. The most difficult phone calls were those where the relative became upset when talking about their loved ones; although it was always made clear to the NOK participants that they had no obligation to take part in the research, and I tried to deal with any distress that arose, as sensitively as I could, I experienced a great deal of discomfort at times when relatives were upset. However, of those relatives that did become upset, all reported that they felt they were doing something positive to help their relative, and others like them, by participating this research.

### Time Scale.

Personal circumstances meant that the commencement of data collection was delayed for approximately 4 months. Furthermore, due to the unanticipated length of time it took to ensure as many NOK's were contacted as possible, data collection with staff members commenced even later than hoped. It was the main researcher's intention to remain with staff participants while they filled in their questionnaires, thus being available to answer questions and to ensure that they did not confer with fellow staff members. However it became apparent that the time available for this stage of data collection would not allow this approach. Time was therefore spent with managers of each home, explaining how to fill in each questionnaire, to ensure that somebody was available to answer questions. Managers then took responsibility for disseminating the research packs to their staff. However this may have led to confidentiality being compromised; although staff members were given questionnaires in folders in order for completed questionnaires to be unseen by others, knowing that they may have to approach managers for advice, or worrying about whether managers might look at

their answers before returning them to the main researcher, may have led to them feeling obliged to answer in a more socially acceptable way.

To conclude this section, it should be recognised that the tight time scale added to the limitations of this study. In an ideal world, a larger number of both resident and staff participants would have been recruited, the researcher would have made more face to face contact with all participants and data collection would have begun much earlier. However this is the largest research project that the current researcher has ever embarked upon and the experience has been invaluable. Whilst we can be taught in the classroom how to design methodologically valid research, statistically analyse and present our findings appropriately, there are some of the 'behind the scenes' skills such as the charm, diplomacy, patience (and when all else fails, bribery and tears!) needed to recruit sufficient numbers of participants, that can only be gained by experience!

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**Appendix 4.a**

Four-group Model of Attachment (Bartholomew, 1990)

Attachment Descriptions based on Four-Group Model  
(Bartholomew & Horowitz, 1991)



**Four Group Model of Attachment (Bartholomew, 1990)**

		<b>MODEL OF SELF</b> <i>(Dependence)</i>	
		<b>Positive</b> <i>(low)</i>	<b>Negative</b> <i>(high)</i>
<b>MODEL OF OTHER</b> <i>(Avoidance)</i>	<b>Positive</b> <i>(low)</i>	<b>SECURE</b> Comfortable with intimacy and autonomy	<b>PREOCCUPIED</b> Ambivalent (Hazan) Overly dependent
	<b>Negative</b> <i>(high)</i>	<b>DISMISSING</b> Denial of attachment Counter-dependent Avoidant (Hazan)	<b>FEARFUL</b> Fear of attachment Avoidant (Hazan) Socially avoidant

*Descriptions of Four Attachment Types (Bartholomew & Horowitz, 1991)*

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**Secure:** It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me.

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**Dismissing:** I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient and I prefer not to depend on other or have others depend on me.

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**Preoccupied:** I want to be completely emotionally intimate with others but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

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**Fearful:** I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others.

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**Word counts for each section excluding references, appendices and tables.**

<b>Title</b>	<b>15</b>
<b>Summary:</b>	<b>253</b>
<b>Section 1: Ethics Proposal</b>	<b>2615</b>
<b>Section 2: Literature Review</b>	<b>4625</b>
<b>Section 3: Empirical Paper</b>	<b>5459</b>
<b>Section 4: Discussion Paper</b>	<b>3564</b>
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<b>Appendices</b>	<b>1143</b>
<b>Section 3: References</b>	<b>957</b>
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