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Attachment behaviours in adults with intellectual disabilities in assisted living facilities: representations from direct-care staff

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Abstract

Background Studies on individuals with intellectual disabilities (IDs) indicate that primary care staff are potential attachment figures. Therefore, the ability to interpret and respond to attachment behaviours with sensitivity is crucial for professionals working with adults with IDs. However, little is known regarding representations and understanding of these attachment behaviours among professionals. This study investigated the representations of attachment behaviours among adults with IDs, as observed and interpreted by direct-care staff in assisted living facilities.

Methods Semi-structured interviews were conducted with 19 support workers in seven assisted living facilities in the French community of Belgium. A thematic content analysis was performed.

Results Professional discourse elicited various forms of attachment behaviours that were sometimes considered challenging. Staff reported difficulties in finding a balance between supporting selective attachment and maintaining 'the right distance' to prevent a negative impact on their work conditions.

Conclusions This study gives insight to how using an attachment-informed framework may provide a new perspective on behaviours of adults with IDs in assisted living facilities, as well as the need to offer professionals the opportunity to reflect upon their practices in relation to this dimension.

Keywords attachment, attachment behaviours, intellectual disability, qualitative study

Introduction

Bowlby (1969/1982) suggested that attachment behaviours are organised within a behavioural system to promote proximity between children and caregivers in response to real or perceived threats. The activation of this behavioural system helps achieve proximity-seeking towards the attachment figure. The desired degree of proximity is considered to vary under differing circumstances. Moreover, Bowlby described this system as being constantly activated (with relative variations in activation).

Proximity-seeking behaviours relate to actions that are available and considered effective by children based on their (emotional) development stage, such as crying or crawling to the parent. The attachment figure provides a secure base to explore the world and develop capacities and a personality. In adults, a

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partner may also become an attachment figure as they are a target of proximity maintenance (proximity provides enjoyment and separation causes distress) and represent a physical and emotional 'safe haven' if their behaviours are available, consistent, and bring support or comfort.

Research on attachment behavioural systems in adults from the general population has extensively focused on romantic relationships, peers and family as a relational context to explore proximity-seeking features (Cassidy 2016). However, when considering the lives of individuals with intellectual disabilities (IDs), research shows that professional primary caregivers should be considered potential attachment figures (Clegg & Lansdall-Welfare 1995; Clegg & Sheard 2002; De Schipper & Schuengel 2010; Schuengel *et al.* 2010; Rinaldi *et al.* 2022).

Intellectual disability is defined as an impairment of both intellectual and adaptive functioning occurring during the developmental period (Schalock *et al.* 2021). Considering cognitive and adaptative impairments, as well as psychosocial and environmental factors (e.g. increased parental distress during childhood, seclusion and lack of social opportunities, and limited autonomy even in adulthood), there are several reasons to believe that the prevalence of attachment difficulties could be higher in people with IDs (Clegg & Lansdall-Welfare 1995; Schuengel *et al.* 2013; Hamadi & Fletcher 2021). However, the variety of methods used within existing studies and the lack of empirically validated measures for adults indicate that these results should be considered with caution (Hamadi & Fletcher 2021). There is also preliminary empirical evidence of a relationship between attachment difficulties, and behavioural and mental health issues in people with IDs; however, again, these studies highlight the need for the continuous development of psychometrically sound measures of attachment in people with IDs (Schuengel *et al.* 2013; Mullen 2018; Rinaldi *et al.* 2022).

Attachment behaviours can be defined as behaviours that occur between an individual and a caregiver that aim to seek and maintain proximity and/or protest separation. They are thought to regulate fear, anxiety or other forms of distress regarding real or perceived threats (Schuengel *et al.* 2013; Cassidy 2016; Gillath *et al.* 2016).

A limited number of studies have focused on attachment behaviours in adults with IDs, such as 'becoming overly fond of support staff (e.g. following them around, crying when they leave …)' (Larson *et al.* 2011, p. 19) and 'overinvesting in one or a few relationships which become a source of jealousy' (Clegg & Sheard 2002, p. 504). However, it is likely that adults with IDs display a wider range of attachment behaviours than overinvestment, jealousy and physical proximity. In order to identify these attachment behaviours in adults with IDs, it may be helpful to take into account the types of behaviours that have been considered as part of a pattern of interaction between children and their attachment figures that lead to emotional security.

In addition, considering the cognitive and psychosocial specificities and life trajectories of adults with IDs, these behaviours may vary in form, intensity or frequency compared with typically developing adults, but also to children. For example, behaviours that are quite easily interpreted as seeking support in children, such as asking for a physical touch or a hug, might not be understood as such in adults with IDs. Consequently, care staff may miss the function of such behaviours and leave the adult with ID in emotional distress.

Finally, attachment behaviours of adults with IDs could receive specific attention within the context of assisted living facilities/residential context. Residential care can indeed be considered to predispose people with IDs to display attachment behaviours towards care staff because their access to attachment figures, such as family or friends, is often limited and significant relationships may be scarce. Therefore, emotional security and well-being are likely to depend on the relationships of people with IDs with care staff. Also, residential care may increase emotional insecurities in adults with IDs due to a limited amount of individual attention, as well as the workload, staff turnover and discontinuity of staff presence (Clegg & Lansdall-Welfare 1995; Schuengel *et al.* 2010). For people with a limited ability to express their emotions (Janssen *et al.* 2002; Schuengel *et al.* 2010) because of their intellectual, sensory or physical disabilities or mental health problems, these issues should be given more attention as they would often lack the coping skills to deal with stressful and challenging situations and may experience high levels of distress without the support of a sensitive and

responsive attachment figure (Schuengel & Janssen 2006; Schuengel *et al.* 2010).

Hence, being able to identify, interpret and respond to these behaviours with sensitivity is crucial for professionals working with adults with IDs. However, to date, little is known about how this topic is addressed in professional practice. Therefore, this study investigated the representations of attachment behaviours among direct-care staff in assisted living facilities and aimed to examine the observation and interpretation of behaviours of adults with IDs through an attachment-informed framework.

Methods

Participants

In total, 19 support workers (13 women and 6 men; age: 24–57, M = 34.89, SD = 9.61) were recruited from seven assisted living facilities for adults with IDs in a French community in Belgium (Table 1). The facilities were all group homes of a non-profit organisation, which are accredited and funded by the regional disability agency. They organise accommodation and support adults with mild to severe IDs who have a range of support needs. One facility reported that a significant proportion of their residents also had visual impairments (participants: P19 and P5), while all facilities reported that auditory impairments occurred only for a few residents, or not at all. All facilities included a proportion of people with co-occurring mental health problems and/or challenging behaviours, although no facility specialised in dual diagnosis.

Participants were recruited through chain sampling. We sent an information letter to the management of 25 residences and contacted them by phone. If management agreed, we planned a meeting with the staff to explain the study purpose and answer their questions. Participants were interviewed in person between February and April 2022 by two trained investigators, with each interview lasting approximately 1 h.

The participant inclusion criteria were working at the same assisted living facility (1) at least part time, (2) for at least 6 months and (3) on a daytime or 'mixed' schedule (including day and night shifts). None of the participants worked only night shifts.

All participants signed informed consent forms prior to study participation. Confidentiality concerning all information was ensured during all phases of the research using alphanumeric codes for

Table 1 Characteristics of the sample

Code	Age	Reported gender	Degree	Working years in the facility	Work schedule
P1	33	M	Bachelor's degree	11	Occasional night shifts
P10	57	F	High school degree	18	Occasional night shifts
P11	35	M	Master's degree	12	Exclusively daytime shifts
P12	29	F	High school degree	10	Exclusively daytime shifts
P13	33	M	Bachelor's degree	10	Exclusively daytime shifts
P14	29	F	High school degree	6	Occasional night shifts
P15	40	F	High school degree	13	Exclusively daytime shifts
P16	26	F	Bachelor's degree	4	Exclusively daytime shifts
P17	24	M	High school degree	2	Occasional night shifts
P18	31	F	Bachelor's degree	5	Exclusively daytime shifts
P19	50	F	Bachelor's degree	27	Exclusively daytime shifts
P2	36	M	Bachelor's degree	12	Occasional night shifts
P3	42	F	High school degree	16	Exclusively daytime shifts
P4	21	F	High school degree	2	Exclusively daytime shifts
P5	33	F	Bachelor's degree	10	Exclusively daytime shifts
P6	34	F	Master's degree	11	Exclusively daytime shifts
P7	26	F	High school degree	3	Exclusively daytime shifts
P8	52	M	Bachelor's degree	12	Exclusively daytime shifts
P9	32	F	High school degree	15	Exclusively daytime shifts

P, participant; M, male; F, female.

each participant. This research was conducted in accordance with the guidelines of the Declaration of Helsinki and the European Data Protection Law. The ethics committee of the university approved this study (2022.01.22-BE-002).

Procedure

Semi-structured interviews (Fig. 1) were drafted by two researchers and then discussed within the research team regarding the relevance and formulation of main and follow-up questions. The interview began with ice-breaker questions followed by questions on three dimensions: two explicitly related to attachment (attachment in adults with and without IDs, and attachment and behaviour of adults with IDs) and one related to more general aspects of behaviour.

Interviews were fully transcribed by the researchers, and the transcripts were read repeatedly prior to coding, which was conducted following Braun & Clarke's (2006) guidelines. R. R. performed the initial familiarisation through transcription, reading, and re-reading data and recording initial ideas and observations. Complete coding was then performed through a mixed-methods inductive and deductive analysis with the help of NVivo®.

The deductive, theory-driven thematic analysis concerned attachment behaviours that were elicited from participants' discourse using the following *a priori* definition: attachment behaviours are considered to include behaviours that occur between adults with IDs and staff members with the aim of seeking and maintaining proximity or protesting separation with the function of emotion/distress regulation.

As those behavioural manifestations may be highly heterogeneous, further deductive coding was performed using the typology derived from Bowlby's (1969/1982) theories described in Table 2: signalling, aversive and active/motor behaviours (see Fitton 2012 or Cassidy 2016, p. 4, for a summary of this typology). The use of this typology serves mainly to frame the analysis of potentially heterogeneous descriptions of behaviour and to facilitate the reliability of the analyses between research during the coding process. They also help highlight the dynamic of interaction between the adults with IDs and their caregivers.

Subsequently, the data-driven/inductive perspective yielded two more themes that were analysed without trying to fit them within an existing coding frame. Thereafter, these themes were reviewed, labelled and defined.

The first report was generated, including the complete coding structure and content. E. B., C. K. and E. W. repeatedly held discussions about the gathered items from the analysis of the qualitative data. Conflicts were resolved through discussion until full agreement was reached. The main themes and categories derived from this analysis are described in the Results section. They are presented with the number of interviewees whose discourse was coded within a theme or subtheme (*n*) and the number of references (discourse sections) it involved. We propose using the term 'residents' for adults with IDs cared for by the professionals. The professionals' answers are referred to using an assigned number (P1–19).

(1) Ice-breaking questions
- What is your typical day like?

(2) Behaviours and challenging behaviours of adults with ID
- Are there any challenging behaviours among the people with ID that you work with?
- In general, how do professionals react to these challenging behaviours?

(3) Attachment in adults with and without ID
- What does attachment mean to you?
- How is attachment expressed in adults with and without ID?
- How do you know that a person with ID that you work with is attached to you or to another professional?

(4) Attachment and behaviours of adults with ID
- What elements of a person's background can explain their current behaviours?

Figure 1. Examples of main questions within the semi-structured interviews. ID, intellectual disability.

Table 2 Coding structure for attachment behaviours

Theme	Attachment behaviours		
	Signalling behaviours	**Active behaviours**	**Aversive behaviours**
Definition	Behaviours that alert caregivers to the person's need for proximity and interaction.	Proximity-seeking and contact-seeking behaviours.	Behaviours that maintain or restore the interaction or proximity with caregiver with intent to terminate the behaviour.
Subcategories of behaviours	1 Initiating interaction through verbal (e.g. discussing and teasing) or 'social' (e.g. making gifts) channels 2 Manifesting trust (e.g. relying more exclusively on one caregiver and telling him or her things that are not shared with others)	1 Creating or demanding proximity (e.g. following) 2 Initiating or demanding contact (e.g. hugging)	1 Externalised challenging behaviours (e.g. self-injury or outbursts) 2 Internalised challenging behaviours (e.g. withdrawal)
Dynamic of the behaviours	Move the person towards the caregiver	Move the person towards the caregiver	Move the caregiver towards the person

Results

The thematic analysis yielded three main themes:

1 attachment behaviours;
2 dimensions supporting attachment; and
3 dimensions threatening attachment.

The first theme referred to the observable behaviour of residents. The second and third themes related to the behaviour of professionals and their beliefs regarding factors impacting attachment and their influence on the behaviour of residents they care for.

Attachment behaviours

Signalling behaviours (n = 17, 45 references) were the most represented category among professionals. They refer to behaviours that alert caregivers to the resident's need for proximity and interaction. These behaviours were mostly perceived as a normative form of bonding and a way for residents to express their need for connection with professionals or to deal with stress and be reassured (n = 16, 29 references). These interactions could be verbal (e.g. trying to bond through chatting or teasing) or social (e.g. making gifts).

> They're a bit like us. When you are attached to someone, you are quicker to go to them if you have a problem, quicker to give them a nice gift, to be attentive. (P18)

Professionals also perceived trust as a form of signalling behaviour, such as residents telling them something they had not told other professionals or relying on them most for answers or support. There was a specific focus on the relationship between the resident and their 'référent' (i.e. a professional who is designated as being more specifically and closely in charge of the person).

> If we give her advice, she will only accept advice from her référent and not from anyone else, especially if she is in a moment where she is not doing very well, where she is a little bit in tension … or when the resident only wants to turn to her référent and not to the other educators who are also there to help her, so I think that it must be a form of attachment. (P1)

Signalling behaviours were sometimes perceived as challenging for professionals (n = 9, 16 references);

particularly, behaviours were considered to exceed the acceptable boundaries between professional and private lives (e.g. the behaviour of residents suggested a friendship, lover's relationship or romantic feelings towards them). In this case, professionals also reported that they would deliberately create some distance from the resident, either physically (e.g. asking a colleague to take care of them) or verbally (e.g. explaining that they must keep a professional distance from them), because they considered it was their responsibility to maintain professionalism and make it clear to residents to avoid misunderstandings about relationships or feelings.

> We try to respond to this need for a link as much as possible, but some of my colleagues have had moments when residents fell completely in love with them, and then it was much more complicated for them. They kept setting boundaries, maintaining these boundaries, but it wasn't easy. (P2)

> And it's important to tell them, to be able to bring them face to face with reality too, so that they don't make too much of a fuss and avoid suffering. (P10)

Behaviours indicating trust were also sometimes considered challenging, as they were viewed as an overinvestment. In these situations, professionals felt invested as parental figures or perceived themselves as the only one who can care for the resident, with jealousy mentioned as a 'by-product' of a broader relational process.

> We don't live here, so we're not always here, and if he creates too much of a bond with one professional, or two or three, the other staff members won't be able to work well with him (…) I had this with a resident. If I was there, he did participate. But if I was not there for two days, he did nothing and refused to speak to anyone. (P12)

Active behaviours (n = 16, 27 references) included active proximity-seeking and contact-seeking, which was sometimes perceived as a normative form of bonding (n = 10, 13 references).

> He likes to be scratched on the hand … it's a way of bonding, of attachment … I think he does it to be reassured. (P1)

However, in other cases (n = 12, 14 references), this physical proximity was considered challenging either in itself or because it involved a type of contact that took on a connotation (e.g. inferring a sexual intent to the touch). In this case, professional distance and boundaries were often referred to.

> It is sometimes difficult to manage, and sometimes people are too intrusive towards us, via hugs; they are physically much too present and do not let us breathe. (P8)

> He hugged her; he needed physical contact, and maybe even more. We can say that it was inappropriate behaviour. (P16)

To a certain extent, professionals sometimes attributed sexual intent to contact-seeking behaviours, even though these behaviours were no different to non-sexual contact-seeking behaviours (i.e. they did not involve touching the person inappropriately).

Finally, aversive behaviours (n = 12, 22 references) maintained or restored the interaction with the professional with intent to stop behaviour. It was generally described as residents (inappropriately) seeking attention or (affective) investment from the professional to restore psychological safety. In this category, professionals reported externalising (e.g. self-injury or outbursts) and internalising challenging behaviours (e.g. withdrawal after the professional's absence).

> When he's not with us, he tears his clothes. So, I think it must have something to do with either his mom, with his dad whom he doesn't see often, even if he takes him back every month, or with us because he always needs to be with an educator. (P4)

Dimensions supporting attachment

This theme included professionals' representations and practices identified as relevant to promote attachment behaviours and face challenging behaviours of residents. Two main categories were identified within this theme: safe haven and privileged relationship. The most frequently cited category was

related to safe haven (n = 14, 43 references), including situations and practices that make it possible to restore psychological security by making the environment more readable or responding sensitively to a perceived emotional need through different channels (e.g. being present, comforting, chatting, making space outside the group and establishing a nurturing physical contact).

> You can't act coldly; the person would feel it. Instead, we're going to tell him: 'Your référent isn't working today, if you have anything set up with your référent, it'll be when he comes back. Your project is not gone, it's coming back.' (P7)

> Another technique that I know well, which works well with residents, is 'the turtle'. So, we get down on the ground and we take the person by the back. It's kind of like a hug where you're going to talk to the person and stuff like that, and it also calms a lot of seizures in the residents. (P18)

The second most-cited category was the privileged relationship (n = 13, 39 references) between a specific member of staff and the resident they care of. Overall, professionals felt comfortable mentioning that it was an integral part of their work. Sharing daily life with residents with IDs made it possible to work with the person, leading to trust, mutual knowledge and respect.

> Because it depends on the resident's family, whether they're present or not, but it's true that residents who have less contact with their family may need more attention from us as well. So, they're trying to fill the gap, I guess. We're kind of family for them, I guess. (P4)

This category also yielded many thoughts on the 'right distance' to adopt with the residents they care for. Some professionals considered that being sensitive to the residents' needs could create an attachment bond, which could be complicated to manage.

> Some [residents] could say 'you could be my mom!' Well, that's a no! I tell them clearly, 'I'm not your mom, I am your educator' and I use a tone in my voice to make it very clear. On the other hand, I think that the one who doesn't have an attachment bond wouldn't know how to do his job well. I try not to show them too much of this attachment even if they feel it. (P19)

Thus, this theme included ethical and practical considerations and almost a constant navigation between the realisation that this relationship is the basis of the work and the difficulty to keep an appropriate professional distance.

> So, I … if I speak for myself, it's … it's a bit complicated … I questioned myself, saying, 'Yes, it's good, maybe you're filling a need and finally when you're not there anymore, it's going to hurt him even more,' so I've taken a certain distance now. (P15)

Dimensions threatening attachment

This theme included professionals' representations and/or practices that were identified as threatening for attachment and potentially increasing challenging behaviours of residents. Four categories were identified within this theme: (1) lack of significant relationships, (2) discontinuation in life course, (3) trauma and abuse and (4) insensitive practices. The most-cited category was lack of significant relationships (n = 14, 21 references), either in the past or currently, with the common observation from professionals that many residents they care for do not see their families and may consequently express greater emotional needs. The scarcity of contact with peers, specifically from a social inclusion perspective, was highlighted.

The second most-cited category was discontinuation in life course (n = 13, 19 references) due to many of the residents they care for having been abandoned at some point (often during early childhood) or due to major disruptions, such as moving to a different residence or home one or more times.

Trauma and (physical or emotional) abuse, as well as neglect, were also mentioned (n = 10, 10 references). Finally, contrary to the second theme (dimensions supporting attachment), few references have been made for professional practices that could interfere with attachment except for the final and least-cited category: insensitive practices (n = 2, 2

references), including elements of discourse related to relatives or professionals' bearing limiting fundamental freedoms and dialogue, taking a position of authority without considering the (emotional) needs of residents.

Discussion

This study focused on the representations of attachment behaviours of adults with IDs to gain insights on how behaviours were observed and interpreted through the context of attachment relationships with direct-care staff of living facilities.

Although our analysis of attachment behaviours was supported by a predefined typology (signalling, active and aversive), our results highlighted the variety of behavioural manifestations that might fall into these categories when it comes to professional representations. This provides more insight on previously studied categories of attachment behaviours such as being overly fond of support staff and overinvesting in one or a few relationships, which become a source of jealousy (Clegg & Sheard 2002; Larson *et al.* 2011). It also supports Schuengel *et al.* (2013), who stated that 'no single, isolated behaviours can be defined as attachment behaviours. Rather, behaviours are identified as attachment behaviours by the function that these behaviours serve within the social context' (p. 3).

Analyses also emphasised the importance of considering specific features of attachment behaviours in adults with IDs, as the psychosocial status of adults seems to have an impact on how attachment behaviours are perceived and interpreted by professionals. For example, some of the behavioural dimensions often considered for children and adolescents with IDs (De Schipper & Schuengel 2006, 2010), such as the dimension of safety for exploring the environment, were not present in the professionals' discourse. Conversely, the professionals' discourse elicited other noteworthy points within the attachment framework, such as those related to intimacy and sexuality, and how responding to some attachment behaviours may mislead the adult with ID on the nature of their relationship.

Overall, the professionals were very conscious of being potential attachment figures for residents with IDs, which extends from previous data (Clegg & Sheard 2002; De Schipper & Schuengel 2010; Schuengel *et al.* 2010). However, it was observed that this specific position and the interpersonal dynamic it involved raised potential tension and questions from the professionals' perspective. Namely, professionals often reported thoughts on the 'right distance' to adopt with the people they care for. This result is congruent with Schuengel *et al.* (2010) who noted the complexity of attachment in caregiving, specifically in group home care, as it may be difficult to strive for culturally normative behaviours of adults and acknowledge attachment and attunement at the same time, especially because the caregiver's own attachment is likely to influence their representations and practices for improving quality of care.

Our results further emphasise that the 'frontier' between sensitive responsiveness and professional posture is a moving topic in practices. In this study, this topic seems particularly related to the role of *référent*. Typically, in the geographical context of the study (French community of Belgium), each member of the direct-care staff must perform this role for one or more adults. It is an organisational practice that is widespread in residential settings and systematic in the institutions included in this study. Each resident has a single *référent*. The role is often informal, without written record of it, no specific training and no clearly defined tasks. Rather, the professional is seen as the privileged contact of one or more residents. There are also no guidelines on the allocation or change of *référents*. Although residents can choose in some institutions, this is not systematic.

It seems likely that this role promotes selective attachment, insofar as it requires the professional to develop greater knowledge of the resident, create a relationship of trust and follow their projects more closely. It is therefore useful for getting to know the resident, identifying their needs and individualising the responses provided. However, it also creates an ambivalence about reinforcing selective attachment, given that professionals may not always be there and because the ratio of staff to residents does not allow a focus on certain adults' needs (e.g. the professionals must occupy this role on top of their other regular tasks). Schuengel *et al.* (2010) emphasised this potential tension, theorising it as competing demands regarding what matters for quality of care between the adult with ID and management perspectives. Most often, this includes subjective qualities such as attachment and attunement for the resident, while

management may prioritise objective and measurable features such as activities and procedures and provide insufficient or no encouragement for professionals to invest in attachment and attunement.

Consistently, professionals either described attachment behaviours as normative forms of bonding or described it as challenging. It is interesting to note that there were no clear boundaries between these categories, and the difference seems to be mostly influenced by professionals' beliefs, particularly those associated with potential consequences on their work conditions. Yet again, the same behaviour may be thought to serve or to impact the professionals' ability to work with the resident in a sensitive yet professional manner.

Overall, the results of this study suggest that focusing on attachment between adults with IDs and professionals in residential contexts could allow professionals to reflect upon the topics of emotional needs and relationship management in adults with IDs, as well as on their practices and behaviours to ensure quality of support. Using attachment as an alternative framework for understanding the behaviours of people with IDs indeed emphasises the intrinsic dyadic nature of caregiving – extending beyond children's needs and how interpersonal relationships can influence the quality of care.

Several studies have highlighted the potential of this attachment dimension for improving the support practices of professionals along with the well-being and behavioural adaptation of people with IDs (Clegg & Sheard 2002; Janssen *et al.* 2003; Damen *et al.* 2008; De Schipper & Schuengel 2010; Damen *et al.* 2011). Furthermore, these studies emphasise the importance of using staff expertise and knowledge to foster sensitivity and responsiveness.

For example, *Contact* (Janssen *et al.* 2003; Damen *et al.* 2011) is a programme designed to support professionals in connecting with their clients (people with IDs) through reciprocal support and video feedback sessions, both facilitated by an interaction coach. Although interaction coaches receive specific training, they do not act as experts but foster the staff's empowerment through guidance and counselling. This programme has been shown to positively impact the quality of interactions of staff working with individuals with IDs and visual impairments (Damen *et al.* 2011). Van Wingerden *et al.* (2019) highlighted that an educational perspective may also be beneficial for improving some aspects of interaction between children and adults with IDs and their caregivers. They lead a randomised control trial on a learning programme providing information on attachment and encouraging reflection on interacting with an adult or child with ID through a mobile application. Their results showed that knowledge and empathic concern improved significantly in caregivers after the 2.5-h intervention (distributed over 30 days). However, the lack of significance of this intervention on empathy and self-efficacy of caregivers may imply questioning how best to combine theoretical knowledge, tacit knowledge and reflection on experiential aspects to have a tangible impact on the quality of interactions.

While the results presented in this study reinforce the idea that professionals have tacit knowledge about the needs of residents and practices that can improve the quality of support – which can be highlighted through a dialogical approach – several professionals in this study also reflected on the scope of their actions and appropriate ways of positioning themselves, given the constraints of residential contexts in terms of attachment of residents. Therefore, they emphasised the importance of offering professionals' opportunities to reflect upon these subjects while considering the ethical dimension of practices.

Limitations

This study has some limitations. First, conducting the study in assisted living facilities restricts the generalisation of data. This option was deliberately chosen to increase the potential for discussion with professionals based on the nature of previous literature. In addition, attachment and attunement processes are crucial in these settings, as professionals and adults with IDs spend much of their time together. However, this also implies a restricted perspective on adults' behavioural register. For instance, we noted the marginality of the theme related to the behaviours of residents towards strangers. It is likely that in a more inclusive and outward-looking living context, this theme would be deployed in a broader and perhaps more contextualised way. It would be interesting to complement the current data with cross-cultural samples and more inclusive perspectives. Moreover, the use of a qualitative paradigm for the topic of attachment behaviours in adults with IDs should be

considered a significant but preliminary step towards more systematic investigations, including quantitative assessment; complementary outcome measures of behavioural, developmental and emotional features; and broader and more representative samples.

Our study did not provide direct information on how variables such as severity of IDs and complexity of adult needs would influence professional perspectives on attachment behaviours.

We can also hypothesise that more direct assessments of adults with IDs would help specify whether some behaviours that were considered signalling attachment were a form of social behaviours. As a social species, humans seek proximity with peers they are not attached or bonded with, and not all sociable behaviours are attachment behaviours (Cassidy 2016). Although we attempted to circumscribe an operational definition of attachment behaviours that would allow for a systematic exploration of representations and knowledge of professionals, direct observation and assessment would be needed to clearly differentiate these features, which we currently lack evidence for.

Finally, throughout attachment theory research, a broad range of behaviours have been considered as potentially fulfilling attachment functions, and typologies of discrete behaviours have not been subjected to empirical research. Therefore, while using three behaviour types has provided a frame of reference for understanding attachment behaviours in the context of this study, it should not substitute for an in-depth analysis of behaviours of adults with IDs, as well as the interaction pattern in which they occur in future research and clinical practice.

Perspectives

Future studies can aim to develop a series of items to elaborate an observation checklist, based on the model of the Secure Base and Safe Haven Observation (De Schipper & Schuengel 2010), and assess its psychometric and clinical properties. Such assessment tools would be useful to allow for the direct measurement of adults, specify their relationships with developmental history and address the question of selective attachment that was raised as a matter of ambivalence in the professionals' discourse.

Moreover, future studies should examine whether behaviours that were highlighted in this study were displayed in a selective/preferential (adaptative) or indiscriminate (maladaptive) way and what this could imply for a reflective perspective on professionals' practices. From a clinical perspective, our results suggest that specific attention should be given to support professionals' reflections about selective attachment with the residents they work with. The line between sensitive responsiveness and professional posture could also be the subject of specific attention in the training of professionals and at institutional and service policy levels, especially because, from an attachment-driven perspective, these environments might be considered 'risky' due to staff turnover, workload or discontinuity of staff presence.

Conclusion

Direct-care staff in assisted living facilities may become attachment figures for people with IDs and may experience associated challenges. An attachment-informed framework can help provide a new perspective of their behaviour of adults with IDs in assisted living facilities, widen the range of responses to these behaviours and emphasise challenges faced by professionals regarding how relations with these adults shape their practices. These results are the first steps towards a more systematic assessment and deeper understanding of attachment behaviours of adults with IDs towards direct-care staff, as well as the impact these behaviours might have on professional practices and on the attachment, behaviours and emotional regulation of people with IDs.

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Ethics approval statement

The ethics committee of the university approved this study.

Consent statement

All participants included in this study gave their informed consent.

Permission to reproduce material

Contact the corresponding author.

Data availability statement

Data are available upon request.

References

Bowlby (1969/1982) *Attachment and Loss: Volume 1. Attachment*. Basic Books, New York.

Braun V. & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77–101.

Cassidy J. (2016) The nature of the child's ties. In: *Handbook of Attachment Third Edition Theory, Research, and Clinical Applications* (eds J. Cassidy & P. R. Shaver), pp. 3–24. Guilford Press, New York.

Clegg J. & Sheard C. (2002) Challenging behaviour and insecure attachment. *Journal of Intellectual Disability Research* **6**, 503–6.

Clegg J. A. & Lansdall-Welfare R. (1995) Attachment and learning disability: a theoretical review informing three clinical interventions. *Journal of Intellectual Disability Research* **39**, 295–305.

Damen S., Kef S., Worm M., Janssen M. J. & Schuengel C. (2011) Effects of video-feedback interaction training for professional caregivers of children and adults with visual and intellectual disabilities. *Journal of Intellectual Disability Research* **55**, 581–95.

Damen S., Kef S., Worm M., Schuengel C. & Janssen M. J. (2008) The effect of contact on the quality of interaction between persons with visual and intellectual disabilities and their caregivers. *Journal of Intellectual Disability Research* **52**, 772.

De Schipper J. C. & Schuengel C. (2010) Attachment behaviour towards support staff in young people with intellectual disabilities: associations with challenging behaviour. *Journal of Intellectual Disability Research* **54**, 584–96.

De Schipper J. C., Stolk, J. & Schuengel, C. (2006). Professional caretakers as attachment figures in day care centers for children with intellectual disability and behavior problems. *Research in Developmental Disabilities*, **27**, 203–16.

Fitton V. A. (2012) Attachment theory: history, research, and practice. *Psychoanalytic Social Work* **19**, 121–43.

Gillath O., Karantzas G. C. & Fraley R. C. (2016) What are the implications of attachment processes for psychopathology and therapy? *Adult Attachment*, 241–66.

Hamadi L. & Fletcher H. K. (2021) Are people with an intellectual disability at increased risk of attachment difficulties? A critical review. *Journal of Intellectual Disabilities* **25**, 114–30.

Janssen C. G. C., Schuengel C. & Stolk J. (2002) Understanding challenging behaviour in people with severe and profound intellectual disability: a stress-attachment model. *Journal of Intellectual Disability Research* **46**, 445–53.

Janssen M. J., Riksen-Walraven J. M. & Van Dijk J. P. M. (2003) Contact: effects of an intervention programme to foster harmonious interactions between deaf-blind children and their educators. *Journal of Visual Impairment and Blindness* **97**, 215–29.

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

Mullen G. (2018) Intellectual disability and attachment theory among adults: an early systematic review. *Journal of Intellectual and Developmental Disability* **43**, 252–63.

Rinaldi R., Bastelé E. & Haelewyck M. C. (2022) Attachment and challenging behaviours in adults with intellectual disability: a scoping review. *Journal of Mental Health Research in Intellectual Disabilities* **15**, 197–216.

Schalock R. L., Luckasson R. & Tasse M. J. (2021) *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports*, 12th edn. American Association on Intellectual and Developmental Disabilities (AAIDD), Washington, DC.

Schuengel C. & Janssen C. G. C. (2006) People with mental retardation and psychopathology: stress, affect regulation and attachment. A review. *International Review of Research in Mental retardation* **32**, 229–60.

Schuengel C., de Schipper J., Sterkenburg P. & Kef S. (2013) Attachment, intellectual disabilities and mental health: research, assessment and intervention. *Journal of Applied Research in Intellectual Disabilities* **26**, 34–46.

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

Van Wingerden E., Wouda M. & Sterkenburg P. S. (2019) Effectiveness of m-learning HiSense APP-ID in enhancing knowledge, empathy, and self-efficacy in caregivers of persons with intellectual disabilities: a randomized controlled trial. *Health and Technology* **9**, 893–901.

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